Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2019-20 Budget Cycle

Request Title

R-01 Medical Services Premiums

Dept. Approval By: 11/1/18

OSPB Approval By:

	Supplemental FY 2018-19
	Budget Amendment FY 2019-20
X	**Change Request FY 2019-20**

Summary Information	Fund	FY 2018-19 Initial Appropriation	FY 2018-19 Supplemental Request	FY 2019-20 Base Request	FY 2019-20 Change Request	FY 2020-21 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$7,631,479,929**	**$0**	**$7,490,298,522**	**$354,643,647**	**$577,056,406**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,114,180,322	$0	$2,069,399,458	$166,725,932	$268,827,369
	CF	$939,712,695	$0	$936,485,470	$79,381,786	$132,869,385
	RF	$77,385,674	$0	$77,310,675	$74,999	$73,435
	FF	$4,500,201,238	$0	$4,407,102,919	$108,460,930	$175,286,217

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Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Department of Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
Medical Services Premiums

FY 2018-19, FY 2019-20, and FY 2020-21 Budget Request

November 2018

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MAJOR FORECAST CHANGES

- Acute Care – The current request is approximately $86.3 million under the February request in total funds. This includes a reduction of $90.7 million federal funds and an increase of $10.3 million General Fund compared to the February request. The decreases in federal funds are driven primarily by dampening caseload and per capita projections of expansion populations. The increases in General Fund are driven by increases in per capita and caseload estimates for traditional Medicaid populations such as Disabled Adults 60 to 64 (OAP-B), Disabled Individuals to 59 (AND/AB), and MAGI Pregnant Adults. The most significant changes in the caseload projection were for the MAGI Parents/Caretakers 69% to 133% FPL population (a decrease of 7,556, or 9.59%), MAGI Adults (a decrease of 23,242, or 6.34%), SB 11-008 Eligible Children (a decrease of 6,566, or 9.72%), MAGI Pregnant Adults (an increase of 3,451, or 37.77%), and SB 11-250 Eligible Pregnant Adults (an increase of 402, or 18.66%). Other substantial adjustments to this forecast include: carrying forward the FY 2017-18 impact of the requirement to reset rates for Durable Medical Equipment (DME) to 100% of Medicare rates per the 21st Century Cures Act; the targeted and across-the-board rate increases made as part of HB 18-1322 the Long Appropriations Bill; and savings from the new cost-containment team created under SB 18-266 "Controlling Medicaid Costs."
- Community-Based Long-Term Care – The current request is approximately $ 52.7 million above the February request. The increase contains two effects: a $30 million increase due to new policy which consists mostly of rate increases and $23 million increase due to a higher forecast driven by higher than anticipated FY 2017-18 cost per utilizer and caseload actuals for Long-Term Services and Supports (LTSS) waivers and Private Duty Nursing (PDN).

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. The Department's request identifies, and in some cases amends, the fiscal impact of various State and federal policy 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 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.

2. 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 93.5% FMAP in FY 2018-19, 91.5% FMAP in FY 2019-20, and a 90.0% FMAP in FY 2020-21 as the federal match for these populations falls from 95% to 94% in January 2018, 93% in January 2019, and 90% in January 2020. 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 through September 30, 2019; the enhanced FMAP is expected to be 88.0% in FY 2018-19, 79.38% in FY 2019-20, and 67.88% in FY 2020-21.

3. 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 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.

4. The State's FMAP for Medicaid services will be 50% in FY 2018-19. Data from the Colorado Population Forecast, the U.S. Census, and the Legislative Council is used to estimate the FMAP for FY 2019-20 and FY 2020-21, at 50.00%. These changes are outlined in Exhibit R. Medicaid administrative costs will also continue to receive 50.00% Federal Financial Participation (FFP). 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.

5. 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 December of the current fiscal year. This introduces a small degree of uncertainty regarding actuals that was not present previously. The FY 2017-18 actuals contained within this request reflect data for FY 2017-18 as of August 15, 2018.

6. The Department launched its new Medicaid Management Information System (MMIS), interChange, on March 1, 2017. Some provider payments were delayed while the Department and providers navigated the new system. The Department estimates that approximately $176 million in payments were delayed from FY 2016-17 to FY 2017-18.

7. In FY 2016-17, the Department overcollected approximately $132 million in drug rebates. The Department anticipates that FY 2017-18 and FY 2018-19 drug rebate payments from manufacturers will be less to account for the overcollection in the previous fiscal year.

8. 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 13, 2017. 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.

    - 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. To stay within federal timely filing requirements, the Department has made payments using the new random moment time sample (RMTS) methodology to Denver Health for outstationing services provided in calendar year 2016 equaling approximately $2 million total funds to date. The Department continues to work with CMS to answer questions and expects to have approval of the RMTS methodology soon, although the Department has not yet received final approval. No deferral or disallowance of federal funds has been received to date.

- In November 2016 OIG conducted an audit of Medicaid's Targeted Case Management (TCM) program. The objective of the audit was to determine whether the Department's Medicaid payments for TCM services were in accordance with Federal and State requirements. The audit period reviewed was from October 2013 to September 2015. The Department received the draft audit report in October 2017 and provided its corrective action plans in December 2017. There was one recommendation requesting the Department to return $2,292,964 to the federal government. After receiving OIG's decision to uphold the finding after reviewing additional documentation provided by the Department, the Department agreed to review the claims, make a determination on the amount, and refund the federal government the appropriate federal share. The Department anticipates completion of its review by December 30, 2018.

- In April 2018 CMS conducted a provider screening and enrollment review to assess the state's compliance with the regulations outlined in 42 CFR Subpart E. This review was designed to identify providers that have been or currently are actively enrolled in a state Medicaid or CHP program but have either been revoked "for cause" by Medicare or terminated "for cause" by a Medicaid program in a state other than the state with which they are currently enrolled or are actively billing. After review CMS issued a draft finding identifying $4,502.66 in Medicaid payments made to one provider for services performed after they had been revoked by the Medicare program. The Department reviewed the claims during CMS' review period and determined that $4,729.57 was actually paid to the one provider that had been revoked. The Department is currently drafting a response to CMS regarding this finding.

- On July 11, 2018, the Centers for Medicare and Medicaid Services (CMS) deferred $495,388 federal financial participation funds related to the Department's contingency fees resulting from recovering funds from third parties. CMS State Medicaid Manual addresses contingency fee reimbursement for third-party liability collections. The Manual instructs each state to report any proper administrative expenses (attorney/contractor collection fees) incurred in making the recovery, which are eligible for reimbursement. Colorado State law provides the state Department will pay its reasonable share of attorney fees. The Department continues to work to resolve with CMS's questions

- On July 25, 2018, CMS deferred $1,018,632 federal financial participation funds related to general administrative costs. CMS asks the states additional questions regarding CMS-64 submissions each year. CMS deferred the funds while

awaiting the Department's responses and support documentation to their questions. The Department continues to work with CMS to answer the questions.

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 the caseload forecast is complete, 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 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 expenditure data 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 that 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: Children's Home-and Community-Based Services Waiver
- 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:

- Healthcare Affordability and Sustainability 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 expenditure 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% and then ramped down each year until it returned to 50.00% beginning October 1, 2017. For more information about historic FMAP and FMAP changes, see Exhibit R.

Certain populations and services receive different FMAPs than the new standard 50.00% that begins October 2017, summarized in the table below. Clients who transitioned from CHP+ to Medicaid under SB 11-008 and SB 11-250 receive the CHP+ FMAP, which is approximately 65%. Section 2105(b) of the Social Security Act further modifies the enhanced FMAP for CHP+ clients, including clients who transitioned from CHP+ to Medicaid and are funded under Title XXI, by an additional 23 percentage points, effective October 1, 2015 through September 30, 2019. The enhanced FMAP steps down to 11.5 percentage points effective October 1, 2019 before returning to 65% effective October 1, 2020, per the HEALTHY KIDS Act. Therefore, FMAP for clients who transitioned from CHP+ to Medicaid receive 88.00% FMAP in FY 2018-19, 79.38% FMAP in FY 2019-20, and 67.88% in FY 2020-21. Clients in the BCCP program also receive a 65% match. The expansion populations, MAGI Parents/Caretakers 69% to 133% and MAGI Adults, receive a match of 94% beginning January 1, 2018, though this falls to 93% beginning January 1, 2019, resulting in a final FMAP of 93.50% for these populations for FY 2018-19. The match for this population falls again to 90% beginning January 1, 2020, resulting in a final FMAP of 91.50% for these populations for FY 2019-20 and 90% for FY 2020-21. 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 82.63%, 81.13%, and 80% for FY 2018-19, FY 2019-20, and FY 2020-21 respectively. The Disabled Buy-In population receives the standard match for expenditure net of patient premiums.

Calculation of expenditure by financing type can be found in Exhibit A and calculation of FMAP can be found in Exhibit R.

Population-Based FMAPs			
Fiscal Year	**FMAP**	**Population(s)**	**Comments**
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	HAS Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%
FY 2019-20	79.38%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.00%	Clients in the BCCP Program	Please see Exhibit F
	91.50%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	81.13%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.00%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	HAS Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%
FY 2020-21	67.88%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.00%	Clients in the BCCP Program	Please see Exhibit F
	90.00%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	80.00%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	50.00%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	HAS Fee portion matched at 50.00%, Medicaid Buy-In Fund 0%

Service-Based FMAPs			
Fiscal Year	**FMAP**	**Service**	**Comments**
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
FY 2019-20	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 2020-21	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.

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. Most programs in Medical Services Premiums are paid with 50% General Fund and 50% federal funds. However, the following programs are paid for using different funding mechanisms:

- Breast and Cervical Cancer Program: This program typically receives a 65.00% FMAP. 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 expenditure. 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 number 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. 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 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). FMAP for these clients remains at the same level as if the clients had enrolled in Children's Basic Health Plan (CHP+) instead of Medicaid, or 65%. Section 1205(b) of the Social Security Act increases the enhanced FMAP by an additional 23 percentage points, effective October 2015 through September 2019 and stepping down to 76.5% until October 2020. Therefore, FMAP for this population for FY 2018-19, FY 2019-20, and FY 2020-21 is expected to be 88.00%, 79.38%, and 67.88%, 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) 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. 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 2018-19, FY 2019-20, and FY 2020-21 is expected to be 88.00%, 79.38%, and 67.88%, respectively.

- MAGI Parents/Caretakers 69% to 133% FPL: This population began participation in Medicaid in FY 2009-10 and is funded with a combination of federal funds and HAS Fee. 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, with ramp down every year until it reaches 90% effective January 1, 2020. 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 HAS 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 with ramp down every year until it reaches 90% effective January 1, 2020. 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 HAS 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: HAS Fee, premiums paid by clients, and federal funds. While the program receives federal match on the HAS 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 HAS 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 HAS Fee, as required by statute. The Department can claim 75% of the expenditure 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 HAS 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 HAS 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 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 accounts 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 Colorado Autism Treatment 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 16.9% of the total will receive receives no FFP, while 5.7% receives 100% FFP. These assumptions are held constant in FY 2018-19, 2019-20, and in FY 2020-21.

- 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.

- Upper Payment Limit Financing: Offsets General Fund as a bottom-line adjustment to total expenditure. 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 expenditure in excess of the current reimbursement methodology. Prior to FY 2017-18, these payments were made with certified public expenditure. Going forward, these payments are to be made with General Fund, wherein the Department is currently pursuing approval of the new payment model from CMS that uses random moment time study (RMTS) methods. The Department anticipates the State share of these payments to be fully General Funded with federal financial participation starting in FY 2017-18, dependent upon CMS approval. Recently, CMS raised questions about the Department's outstationing payments made to hospitals over the last five years. The Department continues to work with CMS to answer questions and has yet to issue a new payment using the new methodology. No deferral or disallowance of federal funds has been received to date. The FY 2018-19, FY 2019-20, and FY 2020-21 estimates each account for one calendar year of payments under the new RMTS methodology.

- Hospital Supplemental Payments: Hospital payments are increased for Medicaid hospital services through a total of five supplemental payments, three 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 payments is to increase hospital reimbursement payments for Medicaid inpatient and outpatient care, up to a maximum of the federal Upper Payment Limit (UPL), and to create hospital quality incentive payments that reward hospitals for enhanced quality, health outcomes and cost effectiveness.

- 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 2018-19, FY 2019-20, and FY 2020-21 totals are based on the total amounts Denver Health and Memorial Health Systems were able to certify in prior fiscal years.

- 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.

- 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 2018-19, FY 2019-20, and FY 2020-21 estimates are based on the Legislative Council's Amendment 35 revenue forecasts.

- 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. 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 State Plan Amendment (SPA) associated with this program has been approved by CMS and the Department began making payments in FY 2017-18.

- 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 2018-19, FY 2019-20, and FY 2020-21 totals are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.

- Emergency Transportation Provider Payments: Public emergency medical transportation (EMT) providers incur significant uncompensated costs for services provided to Medicaid clients. Because these providers receive public funds, the Department has an opportunity to obtain a federal match on expenditures made by public entities. Implementation of a certified public expenditure (CPE) program for public ground EMT providers would allow the Department to make supplemental payments to public (EMT) providers for EMT services to Medicaid clients Pursuant to 42 CFR § 433.51, public funds may be considered as the State's share in claiming federal financial participation when the public funds are certified by the contributing public agency as representing expenditures eligible for federal financial participation. EMT service providers eligible to participate in this program would receive supplemental reimbursement payments by completing a federally approved cost report form. The supplemental reimbursement payment is based on claiming federal financial participation on CPEs that have already been incurred by the public provider. To be eligible for the reimbursement, the CPE cannot be claimed at any other time to receive federal funds under Medicaid or any other program. The supplemental reimbursement amount is determined by a methodology approved by Centers for Medicare and Medicaid Services (CMS).

- University of Colorado School of Medicine Payment: As one of the initiatives under SB 17-254, the Colorado Legislature approved a transfer of $61.9 million funds from the University of Colorado School of Medicine (UCSOM) to the Department beginning in FY 2017-18, to gain access to federal matching funds. The Department then would reimburse UCSOM approximately $123 million through a UPL payment for physician services.

- 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 comes 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 2018-19, FY 2019-20, and FY 2020-21.

Cash and Reappropriated Funds	FY 2018-19	FY 2019-20	FY 2020-21
Tobacco Tax Cash Fund (SB 11-210)	$2,044,200	$2,024,280	$2,006,385
Healthcare Affordability and Sustainability 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)	$9,103,717	$9,102,153	$9,100,557
Service Fee Fund (SB 13-167)	$200,460	$200,460	$200,460
Total	**$27,262,269**	**$27,153,722**	**$27,146,368**

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1997-98 through FY 2020-21. 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 2008-09 through FY 2017-18.

A description of the forecasting methodology for Medicaid caseload, including all adjustments, is 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, expenditure 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. This expenditure is 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. This expenditure is 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 2018 Request to FY 2018-19 Appropriation and FY 2019-20 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 2018 forecast to the Department's Long Bill plus Special Bills appropriation for FY 2018-19, as well as the November 2018 forecast and the Department's base spending authority for FY 2019-20. 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 expenditure 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 and out-year per capita costs, although the Department adjusts the selected trend where necessary.

Percentages selected to modify per capita costs are calculated to assess the percentages considering 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.

Due to payment delays because of transitioning to the interChange payment system, the per capita costs reported in FY 2016-17 are overall artificially low and those in FY 2017-18 are artificially high. Any trends applied to the FY 2017-18 per capita costs would need to be artificially low to return the FY 2018-19 base per capita costs to expected levels. To account for the FY 2016-17 service payments that were made in FY 2017-18, the Department incorporated a separate adjustment of the FY 2017-18 per capita in the section labeled "Removing Impact of Delayed Payments for FY 2016-17 Service Dates" in Exhibit F1. In this section $155,981,696 of estimated FY 2016-17 delayed payments are removed from FY 2017-18 actual expenditures and a counterfactual per capita is calculated using actual FY 2017-18 caseload. A percentage is then applied to this counterfactual FY 2017-18 per capita to calculate the FY 2018-19 base per capita.

The table below describes the trend selections for FY 2018-19, FY 2019-20, and FY 2020-21. The selected trend factors for each year, with the rationale for selection, are as follows:

Aid Category	FY 2018-19 Per Capita Selection	FY 2019-20 Trend Selection	FY 2020-21 Trend Selection	Justification
Adults 65 and Older (OAP-A)	1.93%	6.30%	6.30%	The Department expects per capita to continue growing and therefore selected a positive trend. Adjusting for the payment delay from FY 2016-17, there was an increase in per capita between FY 2016-17 and FY 2017-18. For FY 2019-20 and FY 2020-21, the Department selected the same 6.30% trend reflected in the S-1.
Disabled Adults 60 to 64 (OAP-B)	0.00%	3.30%	3.30%	The Department assumes OAP-B per capita experienced a level shift in FY 2017-18 and that expenditures will stay relatively flat in FY 2018-19. In FY 2019-20 and FY 2020-21, the Department anticipates the per capita of this population will follow historic growth patterns and selected the average per capita trend between FY 2010-11 (DA) and FY 2015-16.
Disabled Individuals to 59 (AND/AB)	0.00%	2.94%	2.94%	The Department assumes the AND/AB per capita experienced a level shift in FY 2017-18 and that expenditures will stay relatively flat in FY 2018-19, particularly with a greater caseload forecast relative to the S-1. In FY 2019-20 and FY 2020-21, the Department anticipates the per capita of this population will continue to grow and kept the same positive trend from the S-1 forecast. This trend is based on half of the per capita growth in FY 2013-14. Use of prescription drugs and inpatient hospital services is high in this population. CMS projects per capita drug spending will increase between 4% and 6% annually from 2016 through 2024.

Aid Category	FY 2018-19 Per Capita Selection	FY 2019-20 Trend Selection	FY 2020-21 Trend Selection	Justification
Disabled Buy-in	3.73%	3.73%	3.73%	The Department kept the same positive trend chosen in the S-1 forecast based on payment-delay-adjusted per capita growth in FY 2017-18. Utilization of prescription drugs and physician services is growing in this population.
MAGI Parents/ Caretakers to 68% FPL	-4.08%	0.00%	0.00%	The Department selected a negative trend in FY 2018-19 based on average per capita changes between FY 2014-15 and FY 2016-17. On average, per capita has been decreasing since FY 2010-11 for this population. For FY 2019-20 and FY 2020-21, the Department selected the same flat trend from the S-1 forecast with the expectation that the base per capita will stay relatively constant.
MAGI Parents/ Caretakers 69% to 133% FPL	2.00%	2.00%	2.00%	The Department selected a positive trend with the expectation that per capita will continue to increase as it has up to FY 2015-16. Additionally, caseload for this population is lower than forecasted in the S-1, putting upward pressure on the per capita. Utilization of prescription drugs and physician services has also increased.
MAGI Adults	0.00%	0.00%	0.00%	The Department selected the same flat trend used in the S-1 request. On average, per capita for this population has decreased over the last five fiscal years and caseload for this population is lower than anticipated, putting upward pressure on the per capita. Utilization of prescription drugs has also increased. As such, the flat trend was also chosen to remain conservative.

Aid Category	FY 2018-19 Per Capita Selection	FY 2019-20 Trend Selection	FY 2020-21 Trend Selection	Justification
Breast and Cervical Cancer Program	9.00%	0.00%	0.00%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program Per Capita Detail and Fund Splits" for a description of this trend factor.
Eligible Children (AFDC-C/ BCKC-C)	0.00%	1.50%	1.50%	The Department selected a flat trend for FY 2018-19, assuming there was a level shift in per capita in FY 2017-18. The Department expects per capita to remain relatively constant in FY 2018-19. For FY 2019-20 and FY 2020-21, the Department expects per capita to continue growing and therefore selected a positive trend. Average per capita growth between FY 2013-14 through FY 2017-18 is approximately 4.07%. The Department expects this growth to dampen slightly and selected a 1.50% trend.
SB 11-008 Eligible Children	0.00%	0.00%	0.00%	The Department selected a flat trend and assumes there was a level shift in per capita in FY 2017-18. The Department expects per capita to remain relatively constant in the future.
Foster Care	0.00%	0.00%	0.00%	The Department selected a flat trend and assumes there was a level shift in per capita in FY 2017-18. The Department expects per capita to remain relatively constant.
MAGI Pregnant Adults	-11.00%	0.00%	0.00%	The Department selected a negative per capita and assumes per capita will decrease to FY 2015-16 levels, particularly with a higher caseload relative to the S-1. The Department expects per capita to stay at similar levels in FY 2019-20 and FY 2020-21.

Aid Category	FY 2018-19 Per Capita Selection	FY 2019-20 Trend Selection	FY 2020-21 Trend Selection	Justification
SB 11-250 Eligible Pregnant Adults	0.00	0.00%	0.00%	The Department selected a flat trend for this population. The per capita changes in FY 2016-17 and FY 2017-18 average to a net trend of 0.00%.
Non-Citizens	3.00%	1.50%	1.50%	The Department expects per capita to continue increasing and kept the same positive trends chosen in the S-1 forecast based on the growth in per capita in FY 2017-18. The Department assumes the growth in FY 2017-18 represents a level shift. There has been greater use of inpatient hospital services in this population.
Partial Dual Eligibles	0.00%	0.00%	0.00%	The Department expects per capita to stay relatively constant and therefore chose a flat trend.

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:

- Annualization of 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 legacy MMIS was unable to take the 5% cap into consideration, causing some clients to pay over the cap. The new interChange system, implemented March 1, 2017, will prevent clients from paying copays that exceed 5% of their household income, and as a result, the Department needs to reimburse providers for the full cost of the service without subtracting copay for these clients.
- Annualization of SB 17-267 Sustainability of Rural Colorado – Increased Copays, accounts for the decrease in the Department's payment for services due to collection of greater copays. SB 17-267 stipulates copays for pharmacy must be at least double the average amount paid by recipients in state fiscal year FY 2015-16 and copays for hospital outpatient services must be at least double

the amount required to be paid as specified in Department rules as of January 1, 2017, subject to federal law. As of January 1, 2018, copays for pharmacy are $3.00 and are $4.00 for hospital outpatient services.

- Annualization of SB 17-091, Allow Medicaid Home Health Services in the Community, 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 demonstrated compliance with this rule starting July 1, 2017 through SB 17-091 which removed language from statute stipulating a home health services must be received "in the home."
- Annualization of 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).
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Adjustment for Children's Extensive Support (CES) Waiver, accounts for the transition of costs previously delivered under the CES waiver to EPSDT per CMS instruction.
- HB 18-1328, Redesign of the Children's Habilitation Residential Program (CHRP), this bill moves the administration of the CHRP waiver from the Department of Human Services (DHS) to the Department and is expanding the eligibility criteria to include children with very severe Intellectual and Developmental Disabilities (IDD) needs that are also living at home as well as in foster care. Services that are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) under CHRP will now be paid from Acute Care.
- HB 18-1407, Access to Disability Services and a Stable Workforce, requires the Department to seek federal approval for 6.5% increase in the reimbursement rate for certain services specified in the bill that are delivered through the home-and community-based services (HCBS), intellectual and developmental disabilities (IDD), supported living services (SLS), and Children's Extensive Supports (CES) and will increase the state plan services from new DD waiver enrollees. The Department projects an increase in acute care expenditure due to new DD waiver enrollments being added over the course of FY 2018-19.
- Annualization of 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. Effective January 1, 2018, the Department revised its policy to no longer use a fibrosis score to determine if a patient will be approved for treatment and removed the policy that patients could receive approval for one completed course of hepatitis C medications per lifetime. The Department also updated the preferred agents and the prior authorization criteria related to all the hepatitis C products. Based on these policy changes, the Department projects it will spend less than forecasted in prior requests on hepatitis C medications.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. The Department anticipates necessary MMIS systems edits will be in place by November 1, 2018 to reimburse pharmacists for their prescribing services.

- Annualization of 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 expenditure due to the avoided dispensing fees that are more frequent when a client receives drugs in smaller quantities.
- Repay Overcollection of Drug Rebates in FY 2016-17, accounts for adjustments to FY 2017-18 drug rebate collections due to voided pharmacy claims from the legacy system being billed to drug manufacturers in FY 2016-17. Manufacturers did not claim the entirety of their credit in FY 2017-18 and the Department expects to receive $81.3 million less in rebates in FY 2018-19.
- HB 18-1322 Long Bill, Provision for 12 Month Supply of Contraceptives, will allow pharmacists to fill a 12-month supply of birth control after an initial 3-month trial dispensing, which will increase the number of total contraceptives dispensed by allowing women to pick up a year-long supply of contraceptives.
- FY 2018-19 R-10 Drug Cost Containment Initiatives, The Department was appropriated administrative funds to implement a prior authorization system on physician administered drugs and hire a contractor to help with designing an alternative payment methodology for drugs, particularly those that fall under the categories of high-cost and specialty. The Department anticipates prior authorization of physician administered drugs will begin in January 2019 and result in decreased utilization.
- Outpatient Specialty Drug Carveout, accounts for an emergency rule made by the Department in August 2018. The Department is updating the pricing methodology for certain specialty drugs delivered in the outpatient hospital setting. Under the emergency rule, the Department will reimburse hospitals for 50% of actual invoiced drug costs; this percentage increases to 72% if the drugs have a value-based agreement.
- FY 2017-18 R-7 Oversight of State Resources – Physician Administered Drugs, incorporates the impact of changing the reimbursement rates of physician administered drugs to an average of 2.5% over the average sales price (ASP) and the cost avoidance associated with members no longer needing to receive this service at higher cost outpatient facilities. Due to more competitive reimbursement in the physician setting, the Department anticipates patients will be matched to more appropriate drugs and less physicians will advise members to receive drugs in a hospital setting. The Department implemented this methodology earlier than anticipated, on July 1, 2017.
- FY 2017-18 R-7 Oversight of State Resources – Client and Provider Investigations, accounts for the expected increase in recoveries due to hiring dedicated staff in the Department's Program Integrity section to investigate client and provider fraud.
- Client Over-Utilization Program, accounts for a lock-in program starting July 1, 2018. This initiative originally sought to increase enrollment to 200 clients in the Client Overutilization Program (COUP) by 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 targets the abuse of prescription medication, inappropriate use of emergency room and/or physician services. The Department implemented COUP on July 1, 2018, but anticipates lower enrollment than originally requested.

- Annualization of SB 17-254 Long Bill – Community Provider Rate Increases (1.402% Across-the-Board), incorporates the acute care impact of the 1.402% across-the-board rate increases approved during the 2017 legislative session. Though the Department was not officially appropriated an amount for physician services that are not associated with codes that received a rate increase through HB 16-1408, the adjustment includes an estimated impact for these services. The rate increases are effective July 1, 2017, except for rate increases to services provided under HCBS waivers. Rate increases associated with HCBS waivers are effective October 1, 2017 and are accounted for in Exhibit G.
- Annualization of SB 17-254 Long Bill – Targeted Rate Increase – Transportation, accounts for a 7.01% targeted rate increase to transportation services, including emergency transportation, non-emergency transportation, and non-medical transportation offered under HCBS waivers. The rate increases are effective July 1, 2017, except for rate increases to services provided under HCBS waivers. Rate increases associated with HCBS waivers are effective October 1, 2017 and are accounted for in Exhibit G.
- Annualization of SB 17-254 Long Bill – Targeted Rate Increase – Home Health, factors in targeted rate increases to acute home health services, including skilled nursing, physical therapy, occupational therapy, and speech therapy.
- FY 2018-19 R-9 Community Provider Rate Increase (1.0% Across-the-Board), incorporates the acute care impact of the 1.0% across-the-board increases approved during the 2018 legislative session. The rate increases are effective as of July 1, 2018.
- FY 2018-19 R-9 Community Provider Rate Increase (Targeted Neonatology), incorporates neonatology rate increases to 92% of 2015 Medicare rates. The rate increases are effective as of July 1, 2018.
- FY 2018-19 R-9 Community Provider Rate Increase (6.61% Transportation), incorporates targeted increases of 6.61% to NEMT and EMT services. This percentage is the net effect of funds appropriated in HB 18-1322 Long Appropriation Act and HB 18-1321 Efficient Administration Medicaid Transportation. The rate increases are effective as of July 1, 2018.
- Compliance with 21st Century Cures Act – DME Rates Adjustment, incorporates the projected decrease in DME rates. Per section 1903(i)(27) of the Social Security Act, there is a limit on the available FFP for state Medicaid fee-for-service expenditure on DME. The 21st Century Cures Act changed the effective date of this requirement to January 1, 2018. This adjustment is based on the total amount that a contractor determined the Department currently reimburses for DME over Medicare rates. The adjustments will be made in FY 2018-19
- Set DME Rates According to Medicare, will tie DME rates for certain services to Medicare rates, which are updated annually on January 1st. The policy intends to mitigate the effects of the DME rate decreases resulting from the 21st Century Cures Act.
- Prospective Payment System (PPS) – Rural Health Center Rate Adjustment, incorporates an expenditure increase due to setting prospective payment system (PPS) rates for several rural health centers that did not previously have PPS rates.
- 2017 JBC Action: PT/OT Supplemental Footnote, allows members to receive more than 48-units of physical therapy or occupational therapy services with prior authorization. The adjustment accounts for reimbursement of services beyond the 48-units. R-6 (FY 2012-13), Dental Efficiency, reduces expenditure through refinement of Department policy regarding provision of orthodontics. Payment structure and clinical qualifying criteria for authorization are being evaluated and revised.

- 2017 JBC Action: Post-Partum Depression Screening, expands maternal depression screening to be billable three times in the first year postpartum under the child's Medicaid ID.
- HB 18-1006, Infant Newborn Screening, will expand newborn screening for genetic and metabolic diseases, increases access to follow-up services, and creates a funding source for newborn hearing loss screening. This bill increases state revenue and expenditures on an ongoing basis.
- FY 2017-18 Legislative Action – Elective Circumcisions, incorporates funding for elective circumcisions that was not previously appropriated through SB 17-254, Long Appropriations Bill.
- Circumcision Rate Increase, accounts for an increase in circumcision rates effective March 2018. Circumcision rates had not been updated since 2011.
- Deluxe Vision Frames, accounts for the net effect of allowing deluxe vision frames to be reimbursed for reasons of medical necessity. The estimate accounts for an increase in reimbursement relative to standard frames and the expected decrease in frame breakage due to more durable materials.
- Annualization of 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.
- FY 2017-18 R-6 Delivery System and Payment Reform – Primary Care Increase Continuation, continues the primary provider rate increases approved in HB 16-1408.
- HB 17-1353, Implement Medicaid Delivery & Payment Initiatives – Primary Care Incentives, incorporates the payment reform primary care incentives, which transitions the FY 2017-18 continuation of HB 16-1408's primary care rate increase into a primary care incentive payment tied to quality and performance metrics.
- FY 2017-18 R-6 Delivery System and Payment Reform – Vaccine, accounts for a reduction to expenditure due to annually setting reimbursement rates for vaccine stock equal to the private sector cost based on the immunization list published by the Center for Disease Control and Prevention (CDC).
- FY 2018-19 R-8 Medicaid Savings Initiatives – Prior Authorization Requirements (PAR) Savings, will account for savings in Acute Care expenditure from improved utilization management (UM) by implementing new prior authorization requirements (PAR) for several services that are at risk for over utilization.
- FY 2018-19 R-8 Medicaid Savings Initiatives – Public Assistance Reporting Information System (PARIS) Savings, accounts for savings from automating a system in Colorado Benefits Management System (CBMS) to identify individuals on the PARIS interstate match file which identifies Colorado Medicaid enrollees who are also enrolled in another state's Medicaid program. The reductions will come from preventing the MMIS from generating certain capitation payments for clients who do not live in Colorado.
- FY 2018-19 R-8 Medicaid Savings Initiatives – Non-Emergent Medical Transportation (NEMT) Savings, allows the Department to reduce the amount it spends on public transportation by taking advantage of a Regional Transportation District (RTD) program that will allow the Department to pay half price for bus passes for members through Medicaid's NEMT service.

- FY 2018-19 R-8 Medicaid Savings Initiatives – Discounted Bus Tickets, shows the estimated cost to the Department for taking advantage of half-price RTD bus tickets for Medicaid members.
- HB 18-1321, Efficient Administration Medicaid Transportation, requires the Department to create and implement a method for meeting urgent transportation needs within the existing NEMT benefit. The adjustment accounts for the increase in utilization of urgent NEMT trips that are scheduled within 48 hours and the increase in the NEMT broker's administrative costs.
- HB 17-1353 Implement Medicaid Delivery & Payment Initiative – Substance Use Disorder (SUD) & Serious Persistent Mental Illness (SPMI) Savings through Integration of Care, accounts for estimated savings associated with integrating behavioral and physical health care, especially better care coordination for populations with substance use disorders and serious and persistent mental illnesses.
- SB 18-266, Controlling Medicaid Costs, requires the Department to implement new initiatives to control Medicaid expenditures.
- Annualization of 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.
- Annualization of SB 10-167, Colorado False Claims Act increases enrollment in the Health Insurance Buy-In (HIBI) program. As of December 2017, there were 763 enrollees in the program. The Department expects to increase enrollment by approximately 2% per month through FY 2017-18.
- Annualization of 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.
- Additional Week 53 Pay Period in FY 2019-20, factors in an additional payment period in FY 2019-20. Payments are typically made on the Monday of each week and there are 53 Mondays in FY 2019-20.

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. All Breast and Cervical Cancer Program expenditure receives an enhanced federal match rate of approximately 65.00%. 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 was expanded to include ages 21 through 39, based on CDPHE's FY 2016-17 R-4 "Cervical Cancer Eligibility Expansion." This change did not have an impact of the anticipated magnitude, and the previous caseload adjustment for this policy change has now been removed as the policy change is incorporated into the trend.

Per Capita Cost

The Department assumes base per capita growth for this population will be higher than recent years based on per capita expenditure for the population in FY 2017-18. With the implementation of the ACA expansion in January 2014 many clients who were eligible through the Breast and Cervical Cancer Program were re-determined as eligible for the MAGI Adult population instead. Per CMS direction, the Department was unable to claim the enhanced ACA FMAP for those clients while they were still actively receiving cancer treatment, and the Department manually moved them from MAGI Adults to the Breast and Cervical Cancer Program category. Based on analysis of affected clients, the Department determined that the clients included in the manual adjustment were no longer receiving cancer treatment and the Department stopped completing the adjustment as of July 2017. The number of clients in the Breast and Cervical Cancer Program is now much lower, but the per capita costs of clients remaining in the program are higher as they are more likely to use high-cost cancer treatment services as evidenced by the growth in per capita in FY 2017-18. Therefore, the Department adjusted the per capita up for FY 2018-19 and assumes it will decrease slightly in FY 2019-20 and FY 2020-21.

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 Adult 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 the expenditure that will be funded by the Adult Dental Cash Fund.

The Department forecast expected expenditure based on the most recent actuals. Because of lower per capita trend estimates, the Department has lowered the forecast for FY 2018-19 through FY 2020-21.

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. This expenditure is 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. The Department experienced a slight decrease in FY 2016-17 in gross expenditure. In FY 2017-18, there was another significant decrease in gross aggregate and per-capita expenditure due to the brand name preference of Abilify being removed in April 2017, as well as a large decrease in the unit price of aripiprazole (the generic version of Abilify).

Federal Funds Only Pharmacy Rebates

The Patient Protection and Affordable Care Act (ACA) increased the number 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. 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 number of rebates that are federal funds only. Estimates are based on FY 2017-18 data. The trend chosen to forecast rebates in FY 2018-19 is based on the percent growth in prescription drugs between FY 2016-17 and FY 2017-18. For FY 2019-20 and FY 2020-21, this trend is based on the price increase of the top 20 prescribed Medicare drugs in FY 2016-17; this trend was selected because of the overlap in drugs between Colorado's Medicaid program and Medicare.

Family Planning - Calculation of Enhanced Federal Match

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, 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 (CMS) for enhanced federal funds.

In FY 2016-17, the Department received more rebates attributed to Family Planning than it should have, as the result of a rebate payment error. As such, the Department's total reported expenditures are artificially high in FY 2016-17 and artificially low in FY 2017-18 are artificially high than historic years and are not an accurate reflection of actual expenditure. The Department has trended forward the FY 2015-16 expenditure by current projected caseload growth for FY 2018-19, FY 2019-20, and FY 2020-21.

Indian Health Service

In 1976, the Indian Health Care Improvement Act (PL 94-437) 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 American 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 is working to implement better coordination of services for IHS clients, which will allow the Department to claim the enhanced federal financial participation on more services than is currently allowable. Implementation has been slower than anticipated and therefore the Department has shifted out the impact of better care coordination to FY 2018-19. The Department has also experienced high growth in FY 2017-18, which it is believed to be the result of more accurate billing associated with IHS clients coinciding with the implementation of interChange. The forecast for FY 2018-19, FY 2019-20, and FY 2020-21 was adjusted slightly down relative to the February forecast based on FY 2017-18 actuals being lower than forecasted.

Expenditure by Half-Year

As an additional reasonability check, this section presents previous fiscal years' 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 per capita by six-month period can be quickly compared, and historic 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, the 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-LTSS waiver claims for an average of 24,994 clients per month. From July 2016 through the end of February 2017, the Department paid HCBS-LTSS waiver claims for an average of 26,089 clients per month.

Clients receiving CBLTC services currently have access to 11 HCBS waivers, each targeted to specific populations. Of the 11 waivers administered by the Department, 7 are included in the Medical Services Premiums line item and the remaining 4 fall under the Office of Community Living. The HCBS waivers that are included in the Medical Services Premiums line item are referred to throughout this narrative as HCBS-LTSS waivers. 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 Children with Autism (CWA) waiver ended operation on June 30, 2018. The waiver's information was included in this request but will be removed in future requests. The waivers included in the Medical Services Premiums line item are:

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

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

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-LTSS 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 the HCBS-LTSS 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 current methodology includes a forecast for each waiver's enrollment, utilizers, and cost per utilizer. Percentages selected to modify enrollment, utilizer, or per-utilizer costs are calculated to assess the percentages considering 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-LTSS 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 that identified clients as being attributed to waivers. During FY 2014-15, the Department noticed that enrollment was not trending with utilization and that clients reported as enrolled in some waivers were actually enrolled in other waivers based on 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. When the Department launched interChange, procedures for inputting PARs changed which caused delays in entering and approving PARs. These changes led to concerns about the consistency of the PAR data so the Department returned to using number of clients with paid claims per month measure for waiver enrollment in the FY 2018-19 R-1 forecast. The Department believes, however, that the changes have been adopted by case managers and there are no longer concerns about the reliability of PARs. Therefore, the Department has returned to using average monthly PARs as the enrollment measure for LTSS waivers. The Department believes that this measure is the most accurate depiction of waiver enrollment as services under waivers cannot be rendered without an active PAR.

Since the Department is using an enrollment based methodology to define caseload, a utilization adjustment must be used prior to developing final projected expenditure. The Department has chosen to use the historic ratio of average monthly utilizers to average monthly enrollments to adjust projected expenditure for each waiver. For most waivers, the maximum ratio of utilizers to enrolled participants in each waiver was utilized to adjust final expenditure in FY 2018-19, FY 2019-20, and FY 2020-21. For some waivers, however, the Department adjusted this historic maximum as it looks to be insufficient for recent behavior.

The selected enrollment, utilization adjustments, and cost per utilizer trend factors for FY 2018-19, FY 2019-20, and FY 2020-21, with the rationale for selection, are below. In most cases, the Department kept the trends for both enrollment and cost per utilizer steady for each of the three years. In situations where trends differ each year, the variation is noted.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Elderly, Blind and Disabled Waiver	FY 2018-19 through FY 2020-21: 4.97% respectively	FY 2018-19 through FY 2020-21: 1.87%, 1.80%, 1.74% respectively	Enrollment history is steady, growing at an average of just under 5% each year. Recent growth has been slightly above historical averages, so the trend is an average of the most recent two years. Per utilizer cost history has grown at approximately 5% on average since FY 2008-09. This average includes a major outlier in FY 2016-17, however, so this trend has been adjusted down slightly.
Community Mental Health Supports Waiver (CMHS)	FY 2018-19through FY 2020-21: 3.50%, 3.30%, 3.16% respectively	FY 2018-19 through FY 2020-21: 0.00%, 1.56%, 1.61% respectively	Enrollment growth is on a steady incline, growing at almost 6% per year. After strong growth in FY 2016-17, enrollment has returned to slightly lower than average levels. Cost per utilizer decreased in FY 2017-18 amid some interChange-related billing issue. The Department chose a 0.00% trend as it waits for the billing issues to be resolved.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Disabled Children's Waiver	FY 2018-19 through FY 2020-21: 9.99%, 7.31%, 6.81% respectively	FY 2018-19 through FY 2020-21: 7.13%, 3.13%, 2.95% respectively	Since the Department has made significant efforts to better manage clients waiting for enrollment, waiver enrollment has increased strongly since FY 2011-12. Recent enrollment has been higher than expected and growth has only slowed slightly. Growth in FY 2016-17 was over 15%, but slowed in FY 2017-18 which the Department believes will continue. 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. Growth of per enrollee costs has begun to slow slightly and the Department believes this trend will continue although there will still be growth since a higher percentage of the waiver's population is utilizing the service.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Consumer Directed Attendant Support-State Plan	FY 2018-19 through FY 2020-21: 0.00%	FY 2018-19 through FY 2020-21: 0.00%	Additional enrollment in this program is currently prohibited. When CDASS becomes available on other 1915(c) waivers, members 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. All clients are expected to leave the waiver in FY 2018-19 for CDASS expansion under the Supported Living Services waiver. The Department moved to a needs-based allocation plan in FY 2011-12 to align with the CDASS waiver benefit; interestingly, average cost per utilizer 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 was lower than previous estimates. Since all waiver clients are moving to the SLS waiver during FY 2018-19, the Department does not make any assumptions for cost per utilizer.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Brain Injury Waiver	FY 2018-19 through FY 2020-21: 9.13%, 9.87%, 4.69% respectively	FY 2018-19 through FY 2020-21: 5.15%, 0.86%, 0.86% respectively	Historically there has been slow and steady growth in BI enrollment. However, since FY 2014-15 enrollment growth rates have been increasing each year. Driven by an increase in providers and the number of beds available for the supported living program (SLP), the Department expects waiver enrollment to grow through the out-year. Historic cost per utilizer growth has been just over 1% annually. FY 2017-18 cost per utilizer was much lower than predicted values, in part due to billing issues providers are experiencing. Similar to the CMHS waiver, the Department has applied a 0% in the first year while billing issues are sorted out and modest growth in other years.
Children with Autism Waiver	FY 2018-19 through FY 2020-21: N/A	FY 2018-19 through FY 2020-21: N/A	The waiver expired June 30, 2018 therefore this request only includes run-out claims for the waiver and no additional enrollments.
Children with Life Limiting Illness Waiver	FY 2018-19 through FY 2020-21: 7.01%, 6.55%, 6.70% respectively	FY 2018-19 through FY 2020-21: 5.88%, 2.94%, 2.94% respectively	Waiver programmatic changes have improved the program, resulting in large growth. After a slight downturn, enrollment growth returned to a high level and grew at just over 16% in FY 2016-17. Strong growth is expected for future years but has been adjusted downward from FY 2016-17 levels. Cost per utilizer growth has been volatile but positive for most of the duration of the waiver. There has been strong growth in the number of providers for this waiver over the past year so the Department is expecting strong growth in the first year and halved the selected trend in future years.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Spinal Cord Injury Adult Waiver	FY 2018-19 through FY 2020-21: 16.50%, 9.17%, 9.16% respectively	FY 2017-18 through FY 2019-20: 3.02%	Senate Bill 15-011 "Pilot Program Spinal Cord Injury Alternative Medicine" reauthorized 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. The Department believes growth from this reauthorization bill has been fully realized this year and has applied a strong growth trend in enrollment for future years. Cost per utilizer has been growing steadily with the increased number of waiver utilizers with stronger growth in the past two years. Cost is primarily composed of consumer directed services like CDASS and IHSS. The Department believes the recent strong growth will slow and has applied a modest trend of just over 3% each year.

Legislative Impacts and Bottom-Line Adjustments

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

Expenditure

- 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 began to increase. The program is coming to an end and can no longer transition clients beginning on January 1, 2019. To address this, the Department decreased the expected enrollment until it is close to zero in

the last year of this request. The Department has decreased the cost per client for some CCT services based on actual utilization of recent clients which also decreased the impact to other areas of the forecast.

- FY 2018-19 R-7 HCBS Transition Services Continuation and Expansion/HB 18-1326 Support For Transition From Institutional Settings – The Department's R-7 request, and the accompanying bill, moved services previously available under the CCT program to the HCBS waivers and to the Medicaid State Plan. The CCT grant program had been in operation since April 2013 but will expire on December 31,2020. HB 18-1326 appropriated 5.0 FTE to administer the new program once the CCT grant ends which will provide community transition services and supports to persons who are in an institutional setting, who are eligible for Medicaid, and who desire to transition to an HCBS setting.
- 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 2020-21 costs to CLTBC result from reassessing a sample of Long-Term Services and Supports (LTSS) members after the pilot study is complete. The Department assumes pilot program implementation will begin January 1, 2019, with full program implementation estimated on July 1, 2020.
- FY 2017-18 Non-Medical Transportation 7.01% Targeted Rate Increase: The Joint Budget Committee approved a 7.01% rate increase to Non-Medical Transportation providers, which is a service in the Elderly, Blind, and Disabled, Community Mental Health Supports, Brain Injury, and Spinal Cord Injury waivers. The rate increase was effective October 1, 2017
- FY 2017-18 Homemaker and Personal Care $0.50 Hourly Rate Increase: The Joint Budget Committee approved these targeted rate increases effective October 1, 2017, to raise the hourly rate by $0.50 for all Homemaker and Personal Care services.
- FY 2017-18 Across the Board 1.402% Rate Increase: The Joint Budget Committee approved a 1.402% across the board rate increase, to be effective October 1, 2017 for the CBLTC waivers. The rate increase applies to all waiver services provided through CBLTC waivers.
- interChange Payment Lag Adjustment: The Department has included an expenditure bottom line impact to adjust for interim payments made after the launch of interChange. Due to billing issues, the Department issued interim payments to providers to assist providers when they were not able to get paid due to system issues. In addition, after the interChange launch pay lag times temporarily increased. Pay lag refers to the period between when the member first received the service and when the claim was paid. The Department estimated that these interim payments, and increased payment lag, accounted for $12.7 million in FY 2017-18. This expenditure has been incorporated into the cost per enrollee trend for FY 2017-18 and therefore is removed in FY 2018-19 to avoid double counting the effect.
- Children with Autism Waiver Run out: The Children with Autism waiver expired June 30, 2018. The bottom line impact in FY 2018-19 accounts for three months of claims run out after the end of the waiver.
- FY 2018-19 R-8 Assorted Medicaid Savings Initiatives: Non-Medical Transportation Bus Pass Savings – This approved request implemented a discounted public transportation option. Through Regional Transit District (RTD), into the Non-Medical Transportation (NMT) benefit for the adult HCBS non-IDD waivers. The request included savings because the Department assumes some NMT utilizers will switch to the public transportation option from more costly options like taxi.

- FY 2018-19 Across the Board 1.00% Rate Increase – The Joint Budget Committee approved a 1.00% across the board rate increase, effective July 1, 2018. The rate increase applies to waiver services that did not also receive a targeted rate increase in FY 2018-19.
- FY 2018-19 Alternative Care Facility 25% Targeted Rate Increase – The Joint Budget Committee approved a targeted rate increase for Alternative Care Facility (ACF) providers effective October 1, 2018.
- FY 2018-19 Personal Care & Homemaker 5.25% Rate Increase – The Joint Budget Committee approved a targeted rate increase for personal care and homemaker services within the adult HCBS non-IDD waivers of 5.25% effective January 1, 2019. These services therefore did not receive the 1.00% across the board rate increase effective July 1, 2018.
- FY 2018-19 Non-Medical Transportation 6.61% Rate Increase - The Joint Budget Committee approved a targeted rate increase for Non-Medical Transportation (NMT) effective January 1, 2019.

Hospice

Hospice expenditure for FY 2018-19, FY 2019-20, and FY 2020-21 is forecasted as the sum of two primary categories of services. The first – Nursing Facility Room and Board expenditure – is expenses incurred on a per-diem basis for clients receiving hospice services in a full-time capacity at a nursing facility. This expenditure represents approximately 73% of total hospice expenditure in FY 2017-18. 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 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 expenditure for hospice clients mirrors the Class I Nursing Facility forecast.

Hospice nursing facility room and board total expenditure estimates for a 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 a time trend model with monthly control variables to estimate FY 2018-19 patient days; this increased patient days for the fiscal year relative to the February 2018 forecast. This trend estimate assumes patient days will continue to grow at a slow pace due to an increasingly aging Medicaid population. 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[4]. 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 or three times per week, generally by nurses. In FY 2017-18, Hospice Routine Home Care expenditure was approximately $13.5 million and thus represented 83% 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 2017-18 by 2.66% for FY 2018-19, FY 2019-20, and FY 2020-21; the trends were selected with the assumption that patient days would continue to grow over time. The Hospice Routine Home Care per diem is forecasted by applying approximately a 1.99% trend to daily rates in FY 2018-19. This 1.99% trend was the average rate increase over the last three fiscal years. Starting on January 1, 2016, the Department was instructed by CMS to implement a tiered rate system for Routine Home Care Services. [5] Patient days incurred in the first sixty days of service are billed a higher rate than days incurred beyond the sixty-day threshold.

The next-largest component of hospice services expenditure is Hospice General Inpatient Care. This expenditure is incurred for services provided to hospice patients at inpatient facilities under severe circumstances. In FY 2016-17, the Department paid approximately $2.3 million for Hospice General Inpatient Care. The Department estimated FY 2018-19, FY 2019-20, and FY 2020-21 service costs by forecasting its rates and patient days. Patient days are estimated to grow at a moderate rate of 2.87% based on actual patient days in FY 2016-17, and rates were estimated by applying a 5.35% trend (growth in rates between FY 2014-15 and FY 2017-18 YTD) to FY 2016-17 observed rates.

The remaining components of hospice services expenditure in total represent approximately $180,000 of expenditure based on FY 2017-18 YTD actual expenditure. There is significant variation in these remaining services by fiscal year. The Department estimated that

[4] 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.
[5] For more information, refer to: https://www.colorado.gov/pacific/sites/default/files/2016%20Hospice%20Rates%20and%20Rules.pdf

expenditure would be $196,350 in FY 2018-19 and will increase by about 10% in FY 2019-20 and FY 2020-21. Expenditure for this category has fluctuated significantly over the past few years.

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 impact of a rate increase that affects Hospice services other than Nursing Facility Room and Board: the across the board rate increase, which increases the Hospice rate by 1.00%. 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. During the FY 2017-18 Legislative Session, PDN services received an across the board rate increase to bring the rate up 1.00%. The rate increases were implemented on July 1, 2018.

As PDN expenditure is the product of the units utilized per client, the number of utilizers, and the rate, and the Department expects rates to remain constant, expenditure forecasts for FY 2018-19, FY 2019-20, and FY 2020-21 are primarily based on unit per utilizer and utilizer forecasts for those fiscal years. The unit per utilizer and utilizer forecasts are separated into three pieces: RN; LPN; and grouped RN Group, LPN Group, and Blended Group.

The Department forecasts growth in FY 2018-19 at 11.43%, which is due to lower than expected growth in average units per utilizer. The Department anticipates that the average units per utilizer will increase in FY 2018-19 based on historical patterns. The trend is decreased in the request and out-years to 8.03% and 8.17% respectively, which is consistent with historical growth trends. Additionally, in the previous forecast, the total client counts for PDN were lowered in the historical actuals in addition to in the forecasted actuals to help better reflect the actual total client counts due to a more accurate methodology being employed in this forecast. This change in methodology involved moving from the sum of all unique client counts across all PDN services and instead using the unique client count for PDN as a whole. The sum of unique client count totals across the PDN services was not accurate because clients can utilize multiple services at once and as a result this sum was higher than the actual unique client total.

Private Duty Nursing Utilization Trends and Justification			
Service	**Average Month Utilizer Trend Selection**	**Units Per Client Trend Selection**	**Justification**
Registered Nursing (RN)	FY 2018-19 through FY 2020-21: 5.24%, 5.35%, and 2.25% respectively.	FY 2018-19 through FY 2020-21: 5.08%, 1.48%, and 1.49%, respectively.	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 FY 2016-17 with growth for the year of 13.99%. The growth dropped in FY 2017-18 to 8.60%. The Department anticipates that the growth in FY 2016-17 and FY 2017-18 was driven mostly by implementation of InterChange, and that the growth will return to a similar pattern that the Department observed in FY 2015-16. RN units per client have historically decreased; however, in FY 2016-17, there was growth of 13.63% and in FY 2017-18 the Department saw a growth of -9.03% The Department anticipates that this decrease is caused by implementation of InterChange, and the units per client will revert to historical levels of utilization. The Department expects growth in units per client to go back to positive and eventually flatten in FY 2019-20.

Private Duty Nursing Utilization Trends and Justification			
Service	**Average Month Utilizer Trend Selection**	**Units Per Client Trend Selection**	**Justification**
Licensed Practical Nursing (LPN)	FY 2018-19: 4.11% FY 2019-20 through FY 2020-21: 4.11%.	FY 2018-19: 6.93% FY 2019-20 through FY 2020-21: 3.32%.	LPN services drove about 18.92% of total expenditure in FY 2017-18. LPN average utilizers per month have grown mostly in the double digits over time, with an average of 16.86% per year, reaching maximum growth in FY 2013-14 of 43.65%. In FY 2017-18 average utilizers per month was 13.00%. Average utilizers per month did not grow as fast as the Department's February expectations. The Department anticipates that LPN utilizers growth in FY 2017-18 is due to implementation of Interchange and the Department anticipates that trend in utilizer growth will increase at a slower rate in FY 2018-19 ongoing. LPN units per client have historically decreased, with average yearly growth of -2.45%; and, in FY 2017-18 growth was negative at -9.80%. The Department assumes that this larger decrease in utilization is due to implementation issues with InterChange, and expects the utilization to revert to historical trends in utilization. The Department increased its growth trends to 6.93% in FY 2018-19, and then reduced growth trend to 3.32% in FY 2019-20 ongoing.

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 2018-19 through FY 2020-21: 11.11%, 11.11%, and 12.00%, respectively.	FY 2018-19: 11.27% FY 2019-20 through FY 2020-21: 3.68%.	LPN-group, RN-group, and Blended RN/LPN drove about 12.72% of total expenditure in FY 2017-18 and represent the smallest number of average utilizers per month as well. Due to recent large growth years in FY 2017-18 and slow growth in FY 2015-16 and FY 2016-17, the Department has chosen to forecast FY 2018-19 at a higher trend of 11.11%, and FY 2019-20, and FY 2020-21 at 11.11% %, and 12.00% respectively. For the grouped and blended PDN services, units per client growth has been very positive over the last few years, but decreased significantly in FY 2017-18. The Department assumes that this decrease in units per client is due to implementation issues with InterChange. For this reason, the Department used an increased trend of 11.27 %, and average yearly growth patterns based on several years of historical growth for FY 2019-20, and FY 2020-21, which resulted in a constant growth rate of 3.68%.

Long-Term Home Health

Long-Term Home Health (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), and 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. LTHH rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change. During the FY 2016-17 Legislative Session, LTHH services received a 1.4% across the board rate increase as well as a 6% targeted rate increase for the RN/LPN service and the three therapy services. The rate increases were implemented on October 1, 2017.

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 low utilization, telehealth is forecasted by total expenditure.

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 2018-19 through FY 2020-21: 2.10% Home Health Aid Extended: FY 2018-19: 0.00%, FY 2019-20 through FY 2020-21: 3.68%	Home Health Aid Basic: FY 2018-19: -1.73% FY 2019-20 through FY 2020-21: 1.05%. Home Health Aid Extended: FY 2018-19: 4.23% FY 2019-20 through FY 2020-21: 0.00%.	HHA Basic and HHA Extended account for the bulk of the total FY 2017-18 expenditure. Average utilizers per month for HHA Basic and Extended have steadily increased along a linear path since FY 2008-09 with a large increase in growth in FY 2017-18 that the Department believes is primarily driven by systems implementation and payment issues. As such, the trend was reduced to lower than average historical growth assuming a leveling of client growth. HHA Basic units per utilizer growth has been historically positive which the Department continued in the current forecast. HHA Extended units per utilizers decreased significantly in FY 2017-18 because of billing and systems issues. As a result, the Department increased the FY 2018-19 trend to reach a more normal level and assumed 0.00% growth from there.

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 2018-19 and FY 2019-20 through FY 2020-21: 0.00%, 0.43%, and 3.00%, respectively.	FY 2018-19 and FY 2019-20 through FY 2020-21: -35.93%, 0.00%, and 0.00%, respectively.	Average monthly utilizers have grown linearly since FY 2012-13, with a surge of enrollment in FY 2017-18 driven by prior period claim true-up because of the new claim system implementation. As such the Department reduced the trend to 0.00% in FY 2018-19 and slowly ramped up growth to account for a normalization of utilizers. Units per utilizer have grown slightly over time with large growth in FY 2017-18 because of claims repayment from systems issues. To account for this the Department reduced the trend to get to a more normal unit amount and assumed 0.00% growth from there.

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 2018-19 through FY 2020-21: 1.92%. RN Brief Second or more: FY 2018-19 through FY 2020-21: 9.60%.	RN Brief First of Day: FY 2018-19 through FY 2020-21: 0.68% RN Brief Second or more: FY 2018-19 and FY 2019-20 and FY 2020-21: 11.47% and 0.00% respectively.	For RN Brief First of Day, the Department chose a small trend aligned with historical growth for average monthly utilizers. There was a large increase in the number of utilizers because of the claims system implementation in FY 2017-18 but the Department assumes this will move back to a more normal growth rate. The large increase in utilizers drove the units per utilizer down in FY 2017-18. The Department assumes this will recover to a more normal level of growth in the request and out year. Growth in utilizers for Second or More Visit of the day has seen strong growth for the past few fiscal years. The Department assumed this trend would continue in the request and out years. Because of billing issues associated with the implementation of the new claims system the Department saw a significant decrease in the number of units per utilizer for RN Brief Second or more. The Department assumes the units per utilizer will recover to a more normal level and assumed a large increase in FY 2018-19 and FY 2019-20 to reach that level. After the recovery, it is assumed growth would be 0.00% as the need per client should be steady.

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 2018-19 through FY 2020-21: 8.91%. Occupational Therapy: FY 2018-19 through FY 2020-21: 7.51%. Speech/Language Therapy: FY 2018-19 through FY 2020-21: 5.49%.	Physical Therapy: FY 2018-19 through FY 2020-21: 0.00%. Occupational Therapy: FY 2018-19: -46.32% FY 2019-20 through FY 2020-21: 0.00%. Speech/Language Therapy: FY 2018-19 through FY 2020-21: 0.00%.	Growth in all the therapy services has been high over the past few fiscal years. The Department assumes that this growth will start to slow as a new normal is reached. As such, the Department selected positive trends but about half of what historical growth has been recently. Units per utilizers for the therapy services has been steady for the past few years. As such, all but Occupational Therapy (OT) growth was assumed at 0.00%. OT experienced a spike in units per utilizer in FY 2017-18 because of billing issues from the new claims system implementation. The Department believes this was a onetime spike and assumes a negative trend in FY 2018-19 to bring units per utilizer back to a more normal level and assumes 0.00% growth after that.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior average monthly enrollment and utilization/cost per client trend factors, the Department adds total-dollar bottom-line impacts to 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

- 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 was implemented on March 1, 2017.
- 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 and saw steady increases in the number of clients utilizing the program throughout the years as additional program changes were made to improve the success of clients transitioning to the community. The federal grant for this program is ending. As such, the Department will not be allowed to enroll any new clients on the program past December 2018. The Department has adjusted the estimate in this exhibit to reflect those final enrollments and close out the grant.
- 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 Department's 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 2018-19.
- 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. Because of SB 17-091 "Allow Medicaid Home Health Services in the Community" and 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.

- FY 2018-19 R-08 Assorted Medicaid Savings Initiatives – PAR savings: This initiative creates a requirement that adult Long-Term Home Health Services require review and authorization by the Department's utilization management vendor before a client receives services. This will ensure the Department is not paying for duplicative or unnecessary services and will drive savings.

Enrollment

- N/A

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 (CBLTC). The grant allows the Department to provide transitional services to ease the movement from nursing facilities 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 facility to help them adapt to a 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 Centers for Medicare and Medicaid Services (CMS). The Colorado Choice Transitions (CCT) exhibit illustrates the total cost of the program by delineating the two types of services the Department offers through the program: demonstration services (new services offered through the program) and qualified services (existing waiver services and home health). These costs are reflected in Exhibits F and G as a bottom line impact. The exhibit then reports the estimated costs avoided due to transitioning clients from nursing facilities. Following the net impact of the program, the exhibit reports 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. After December 31, 2018, the CCT program will no longer be able to transition new clients due to the time-limit in the grant for transitions being reached, which can be seen in the CCT exhibit by the noticeable drop in expected average monthly enrolled clients in the request and out year. This leads to a decrease in overall CCT expenditure as well. After December 31, 2020, the CCT program will no longer continue in its current form as this is when the grant expires.

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 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.

Historically, 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 45.2% between FY 1999-00 and FY 2016-17. This is due to Department efforts 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 have continued to increase into FY 2017-18; 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 expenditure 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.

HB 13-1152 extended the 1.5% rate reduction of HB 10-1324, SB 11-125, and 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[6]:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2018-19.
- 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 2018-19. 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 2018-19 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2018-19.
- 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 2018-19.
- Of the estimated total reimbursement for claims incurred in FY 2018-19, only a portion of those claims will be paid in FY 2018-19. The remainder is assumed to be paid in FY 2019-20. The Department estimates that 92.06% of claims incurred in FY 2018-19 will also be paid during FY 2018-19. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2018-19.
- During FY 2018-19, the Department will also pay for some claims incurred during FY 2017-18 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2017-18 to calculate an estimate of outstanding claims to be paid in FY 2018-19.
- The sum of the current year claims and the prior year claims is the estimated expenditure in FY 2018-19 prior to adjustments.

[6] For clarity, FY 2018-19 is used as an example. The estimates for FY 2019-20 and FY 2020-21 are based on the estimate for FY 2018-19, and follow the same methodology.

- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in Footnotes 6 and 7.
- Legislative impacts are added as bottom-line adjustments. For FY 2018-19, 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 2018-19 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 2018-19, FY 2019-20, and FY 2020-21 calculations for Class I Nursing Facilities:

- Expenditure for the Hospital Backup Program are included as bottom-line adjustments for FY 2018-19 through FY 2020-21. Please refer to Footnote 6 on page EH-7 for more detail. The Department carried forward estimates from the February forecast for FY 2018-19 and FY 2019-20 which was based on FY 2017-18 utilization and rates. For FY 2020-21, the Department applied the forecasted growth trend from FY 2019-20.
- 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 2018-19, FY 2019-20, and FY 2020-21. Footnote 7 on page EH-7 contains additional detail about these recoveries.
- HB 13-1152 extended the 1.5% nursing facility per diem rate cut of HB 12-1340 permanently, effective July 1, 2013.

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 2017-18 that will be paid in FY 2018-19 and the percentage of claims incurred in FY 2018-19 that will be paid in FY 2019-20 and subsequent years. The Department applies the same factor to the FY 2019-20 and FY 2020-21 estimates.

The Department uses the IBNR adjustment calculation for the November 2018 Request using paid claims data through April 2018. For reference, the following table lists IBNR factors calculated for previous Change Requests and compares them with the current IBNR factor.

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%
November 2017	93.16%
February 2018	92.71%
November 2018	92.06%

Patient Days Forecast[7]

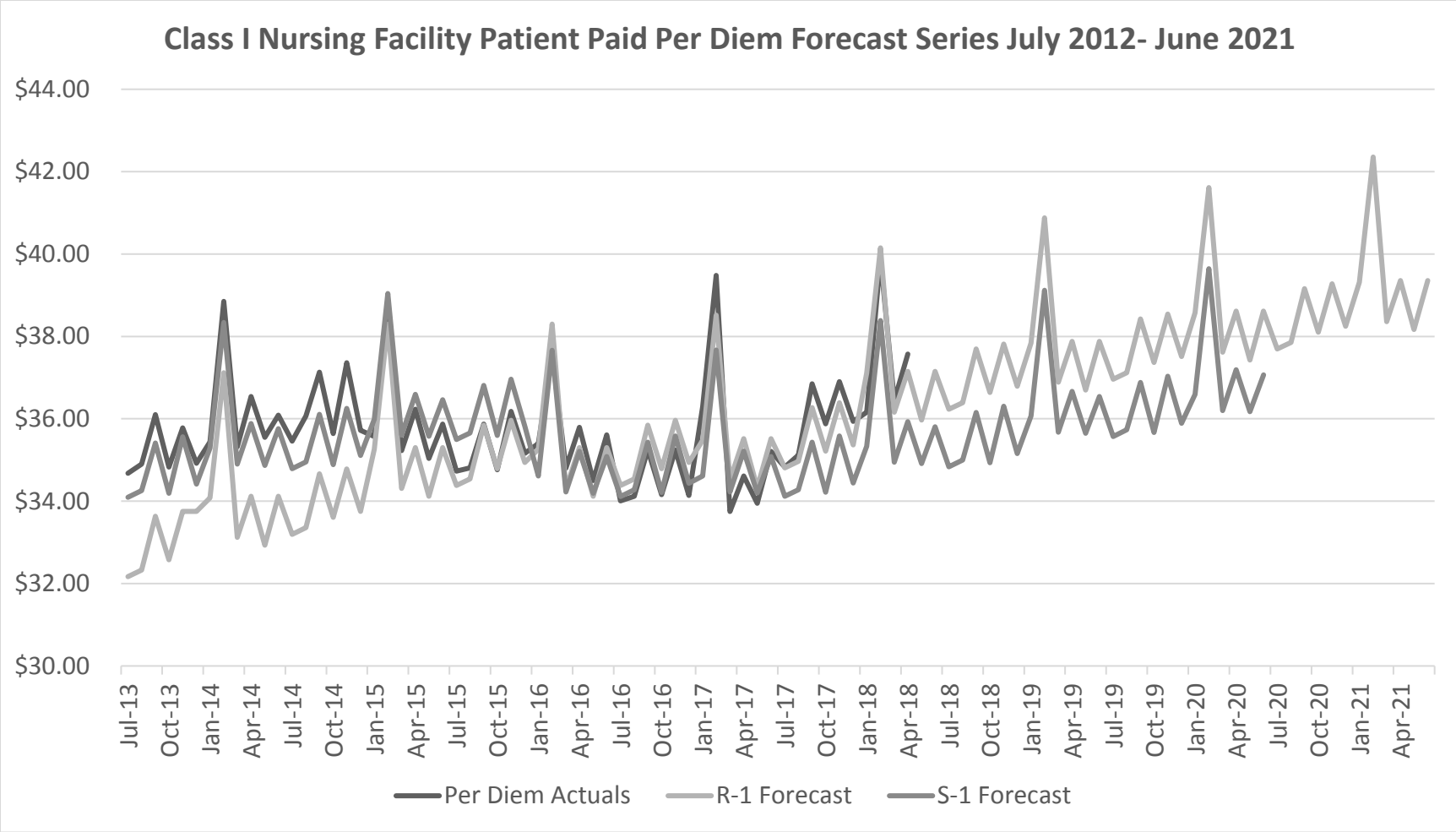
The Department observed almost no change in patient days in FY 2017-18. There was a variance of 0.65% between FY 2017-18 actuals and the February forecast. As such, the Department carried forward the February forecast for FY 2018-19 and FY 2019-20, expecting modest growth in patient days based on a growing elderly population. For FY 2020-21 patient days, the Department applied the FY 2019-20 trend of 1.45%. .

Patient Payment Forecast Model

The Department utilizes a seasonally adjusted model that accounts for cost of living adjustment (COLA) increases to forecast patient payment. Neither the current period nor the previous 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.

The Department increased the patient payment forecast based on recent increases in COLA and updated patient payment information from FY 2017-18. Previously, due to data mapping issues in the interChange, the Department was unable to reforecast patient payment used the February 2017 forecast.

[7] 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 2016-17.


Class I Nursing Facility Patient Paid Per Diem Forecast Series July 2012- June 2021
$44.00
$42.00
$40.00
$38.00
$36.00
$34.00
$32.00
$30.00
Jul-13
Oct-13
Jan-14
Apr-14
Jul-14
Oct-14
Jan-15
Apr-15
Jul-15
Oct-15
Jan-16
Apr-16
Jul-16
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Oct-18
Jan-19
Apr-19
Jul-19
Oct-19
Jan-20
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Per Diem Actuals
R-1 Forecast
S-1 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 0.9998, suggesting 99.98% of the variation in this series can be explained by the monthly seasonality and COLA increases.

Nursing Facility Rate Methodology Changes

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

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

	general services under certain circumstances; and made changes to the method of implementing pay-for-performance payments. HB 10-1324 implemented a 1.5% rate reduction to the core rate components effective March 1, 2010 through June 30, 2010.
FY 2010-11	HB 10-1379 implemented a 2.5% rate reduction to the core rate components effective July 1, 2010, through June 30, 2011. This bill also reduced the maximum general funds portion of the core per-diem rate to 1.9% growth for FY 2010-11.
FY 2011-12	SB 11-125 increased the level of the provider fee to $12.00 per non-Medicare day plus annual inflation. Additionally, the bill reprioritized the hierarchy for the components of nursing facility supplemental payments. Growth beyond the General Fund cap is prioritized last under the new hierarchy.
FY 2011-12	SB 11-215 extended the 1.5% rate reduction from the prior year. The rate reduction expired July 1, 2012.
FY 2012-13	HB 12-1340 extended the 1.5% rate reduction from the prior year. The rate reduction expired July 1, 2013.
FY 2013-14	HB 13-1152 extended the 1.5% rate reduction from the prior year. The rate reduction is permanent.
FY 2014-15	SB 14-130 raises the basic minimum payable for personal needs to any recipient admitted to a nursing facility or intermediate care facility for individuals with intellectual disabilities from $50.00 to $75.00 monthly; 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). 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, like class I nursing facilities. Due to the opening of a new facility in July 2016, there was an increase in caseload over FY 2016-17. This increase continued in FY 2017-18, but the Department expects caseload to level off as facility capacity is reached. Therefore, the Department has held caseload constant throughout the forecast period. Should additional facilities open, the Department would revise the caseload forecast accordingly.

Cost per capita increased significantly from FY 2016-17 to FY 2017-18. The Department anticipates per capita to increase a small amount, estimated at 2.20%, in each of the forecast years. The Department anticipates that expenditure per aid category would only change if enrollment varies by aid category. However, total expenditure would 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-A), Disabled Adults 60-64 (OAP-B), and Disabled individuals to 59 (AND/AB). PACE rates are amended once per year, generally on July 1 of each year.

Exhibit H6 contains two distinct summary measures by fiscal year: 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.

The Department has added several PACE providers over the last ten years. Senior Community Care of Colorado (Volunteers of America) 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 Loveland in November 2015. Most recently, TRU Community Care opened in February 2017 and serves Boulder and Weld counties. One new facility, HopeWest, is expected to open in fall of 2019.

Expenditure estimates for PACE for FY 2018-19, FY 2019-20, and FY 2020-21 are the product of two pieces: projected enrollment and cost per enrollee. As is consistent with historical enrollment data suggesting linear trends for PACE enrollment, growth trends 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 because of the way 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 one bottom line impact to FY 2018-19 that is for retroactive payments made for services rendered in FY 2017-18. 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 November 2018 request has increased from the February 2018 request for the request and out years.

Per-enrollee costs for FY 2018-19 are determined by cross-walking the actual FY 2018-19 rates net of patient payment for PACE services with an eligibility-type distribution estimate derived from FY 2018-19 enrollment projections. As such, they only represent an estimate to the extent that eligibility type and provider distributions for FY 2018-19 are unknown. The rates were determined at the beginning of the fiscal year and are known for this forecast.

SB 16-199 requires the Department to develop a new actuarially sound Upper Payment Limit (UPL) methodology that uses "grade of membership (GoM) 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 will continue to use the current rate setting methodology, without GoM, is required to hold the percentage of the upper payment limit used to calculate capitations payment for FY 2016-17 as the minimum percentage for FY 2019-20. The Department anticipates the new UPL methodology, with GoM, will be applied in FY 2019-20.

Based on recent CMS guidance to calculate the PACE upper payment limit net of patient payment, forecasted rates for FY 2018-19, FY 2019-20, and FY 2020-21 are lower than rates of the most recent years, which were calculated using an upper payment limit that included patient payment.

The grade of membership (GoM) model places a downward pressure on the overall PACE upper payment limit. This decrease is the result of evaluating what services members would receive if not for the PACE program. Prior to the GoM model, the PACE capitation rates assumed that, if not for PACE, 56% of the PACE population would receive community services via Home- and Community-Based services (HCBS) programs, with the remaining 44% requiring long term care services in nursing facilities. The GoM model, which incorporates more current data about the members being served in PACE, identifies that approximately 66% of the fee-for-service PACE-comparable population would receive HCBS, while 34% would receive care in nursing facilities. Because HCBS is generally less expensive than nursing facilities, this has the overall effect of dampening the upper payment limits and effectively reducing the payment rate for PACE organizations in the coming fiscal year, when compared to the current rate methodology without the GoM

model. To account for this anticipated decrease in the rates, the Department has applied a 6% negative adjustment to the FY 2019-20 cost per utilizer.

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.[8] 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.

[8] 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.

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:[9]

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%
2018	$422.00	2.18%	$134.00	0.00%

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

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

To forecast FY 2018-19, the Department inflates the actual expenditure in the second half of FY 2017-18 by half the estimated increase in caseload along with the anticipated growth in Medicare Part B Premiums. For the second half of FY 2018-19, the Department inflates the first half expenditure by half of the caseload growth along with the anticipated growth in Medicare Part B Premiums. The total estimated expenditure for FY 2018-19 is the sum of the first half actual expenditure and the second half estimated expenditure.

To forecast FY 2019-20, the Department first inflates the estimated expenditure from FY 2018-19 by half the estimated caseload trend for FY 2019-20, as reported in Exhibit B. This figure represents the approximate expenditure for the first half of FY 2019-20. Then, the Department inflates the estimated first half expenditure by half the estimated caseload trend for FY 2019-20 and the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2019-20 is the sum of the first half and second half estimates. The forecast of FY 2020-21 expenditure utilizes the same methodology as the forecast of FY 2019-20. In this request, the Department assumes that the Medicare Part B premium will be $135.50 in CY 2019, $141.10 in CY 2020, and $148.50 in CY 2021.

Starting in March 2017, the Department was unable to accurately report client eligibility information to CMS for SMIB due to issues with the new MMIS. This information is used to determine the proper FMAP to pay for each member's Part A and Part B premiums. The Department applied an allocation methodology from March 2017 until accurate data was available in July 2018. The previous allocation methodology understated the General Fund contribution. The Department is now using an allocation methodology based on revised data, leading to the Department contributing more General Fund dollars for Part A and Part B premiums than in previous forecasts.

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. 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.

Beginning with the November 2014 Request, the Department estimates expenditure based directly on the contractor's program enrollment estimates 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.

- SB 10-167 "Medicaid Efficiency and Colorado False Claims Act" impacts the HIBI program in FY 2017-18 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 2017-18. The new contract re-procured in July 2017 increased the administration costs for per member per month rate starting in FY 2017-18. The new cost of administration is a tiered cost structure based off the total enrollment of the program. Savings because of SB 10-167 are captured in the Acute Care exhibit. 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 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, HCBS-LTSS waivers, 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.

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.

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-LTSS waiver enrollment, as determined by average monthly enrollment. This figure is therefore consistent with the caseload growth of the HCBS-LTSS 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 2018-19, the Department's projection uses the total base contracts amount, which is the current amount allocated to SEPs in the FY 2018-19 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.

- FY 2018-19 Across the Board 1.00% Rate Increase: The Joint Budget Committee approved a 1.00% rate increase implemented July 1, 2018. The rate increase affects all waiver services and therefore is relevant to Single Entry Point agencies who are providers of waiver services.
- 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 2020-21 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 July 1, 2020. Costs in the effected years include reassessing every Long-Term Services and Supports members with the selected needs assessment tool.

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 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.

Because 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. 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 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 November 2018 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 Accountable Entities (RAEs) that receive service FMAP and that are incorporated in the ACC exhibit.

The 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 982,000 by June 2017. 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 2016-17 include payments for the Statewide Data Analytic Contractor (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.

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 year, 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 through FY 2017-18. The first, which began September 2014, is a $0.50 reduction in the base PMPM for RCCOs. A portion of these funds are 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 are only paid 65% of their PMPM for clients who have been unattributed to a PCMP for at least six consecutive months. These funds are spent in full 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.

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 was lower than previously anticipated, primarily driven by reductions in caseload. However, while enrollment was lower for income-based adults, children, and pregnant women, enrollment was higher for populations of elderly and individuals with disabilities. The Department reduced the expenditure forecast based on overall lower caseload expectations in each year. However, the savings assumptions for Acute Care increased because the populations that were previously under-forecast are associated with the highest levels of savings. The SDAC contract was absorbed

by the MMIS contractor in the middle of FY 2016-17, and has therefore been removed from this exhibit as the new contract is no longer under Medical Services Premiums.

The Department implemented Phase II of the ACC, which was requested in the FY 2017-18 R-6 "Delivery System and Payment Reforms" request approved in HB 17-1353 "Implement Medicaid Delivery & Payment Initiatives". Phase II of the ACC includes mandatory enrollment of the Medicaid population into the ACC, which would only exclude clients enrolled in a managed care program such as a health maintenance organization or the Program of All-Inclusive Care for the Elderly (PACE) and the Non-Citizens-Emergency Services and Partial Dual Eligibles eligibility categories. The ACC Phase II also combines the RCCOs and Behavioral Health Organizations (BHOs) into a single entity called a Regional Accountable Entity (RAE). RAEs will be responsible for further integrating behavioral and physical health care to achieve improved outcomes and cost reduction. PMPM for the RAEs will be $15.50, with a portion of the PMPM pushed through from the RAEs to PCMPs. RAEs will receive capitated payments for managed Behavioral Health just as BHOs do currently.

The increased caseload expectations due to mandatory enrollment and the changes to PMPM under ACC Phase II have been built into the ACC forecast trends, based on anticipated enrollment in other managed care programs and caseload, for FY 2018-19 and beyond.

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 ACC 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.

The additional PMPM for the ACC:MMP ended on December 31, 2017, and the ACC:MMP was effectively absorbed into the base ACC. Starting in FY 2018-19 and beyond, the ACC:MMP will be fully absorbed into ACC Phase II and is no longer included as a separate bottom-line adjustment.

Legislative Impacts and Bottom-Line Adjustments

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 (HMO), 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. On June 30, 2017, the Kaiser-Access HMO ended. The impact of this change is accounted for directly in the forecast of expected ACC enrollment in FY 2017-18, and not as a bottom-line impact.

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 - HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

These exhibits summarize the source of funding for the Health Care Affordability Act of 2009 cash-funded expansion populations. These estimates are incorporated into the Calculation of Fund Splits in Exhibit A.

Healthcare Affordability and Sustainability Fee Fund

HB 09-1293 originally established the Hospital Provider Fee Fund to provide for the costs of certain expansion populations on Medicaid, outlined below. SB 17-267 replaced the Hospital Provider Fee Fund with the Healthcare Affordability and Sustainability (HAS) Fee 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

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. This expansion population receives 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 fell to 95%. On January 1, 2018, it fell to 94%, then on January 1, 2019, it falls to 93%, and on January 1, 2020 it falls to 90%, where it will remain. Effective July 1, 2017, this population is financed with the HAS Fee for the State share of expenditure.

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

MAGI Adults

With the advent of SB 13-200, effective July 1, 2013, MAGI Adults are 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 fell to 95%. On January 1, 2018, it fell to 94%, and then to 93% on January 1, 2019 and 90% on January 1, 2020, where it will remain. Effective July 1, 2017, the State share of expenditure for this population is financed with the HAS Fee. Clients in this category are not eligible to receive HCBS Waiver services; in cases where it appears that these clients have received waiver services, this expenditure receives 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 enhanced expansion federal medical assistance percentage (FMAP) that began 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 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 the full enhanced expansion FMAP. Instead, with the approval of a resource proxy for the non-newly eligibles, 75% of expenditure receives expansion FMAP while the remaining 25% receives the standard FMAP, funded from the HAS 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 HAS Fee Fund, effective July 1, 2017, 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 HAS Fee Cash Fund to fund the state share of continuous eligibility for Medicaid children. Because this population is not an expansion population, it receives standard FMAP. 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 breaks 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 expenditure 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 individuals with disabilities with income up to 450% of the federal poverty level to pay premiums 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 premiums from the Medicaid Buy-in fund are applied first, and then the remaining expenditure is split at standard medical FMAP as federal funds and HAS Fee Cash Fund. For more information on the funding detail for this population, see Calculation of Fund Splits under Exhibit A.

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

Hospital Supplemental Payments

The Department increases hospital payments for Medicaid hospital services through a total of five supplemental payments, three 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 HAS 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. The HAS Fee replaced the Hospital Provider Fee effective July 1, 2017, under SB 17-267.

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 using certification of public expenditure.
- Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditure.

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 expenditure. These offsets started in FY 2001-02. Nursing facilities account for the larger portion of Upper Payment Limit funding. Home health has expenditure that is less by comparison and will experience little impact related to changes in reimbursement rates.

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 if 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 could utilize UPL financing for outpatient hospital services as well. However, FY 2010-11 was the last year the Department could 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 used 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. A new line of recoveries, Credit Balance and Audits, was added in the re-procured contract effective July 1, 2017. Based on the Department's FY 2018-19 R-08 "Assorted Medicaid Savings Initiatives", the Department was appropriated two FTE to increase staffing to review trust compliance issues and identify additional recoveries for the Department.

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 re-procured in FY 2017-18. 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 9 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 expenditure by aid category from the estimated final expenditure by service categories. This is a necessary step because expenditure in the Colorado Operations Resource Engine (CORE) is 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. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditure 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.

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 December of the current fiscal year. This introduces a small degree of uncertainty regarding FY 2017-18 actuals that was not present previously. In addition, the Department is continuing to validate data as it is reported in the new Medicaid Management Information System (MMIS) reporting layer for FY 2016-17 and FY 2017-18. This includes known issues with expenditure reported for certain service categories. The data presented in this request is based on information available as of August 15, 2018.

EXHIBIT N - EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2008-09 through FY 2016-17 final actual expenditure is 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 2017-18 final actual total expenditure for Medical Services Premiums, including fund splits, the remaining balance of the FY 2017-18 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 2017-18, FY 2018-19, and FY 2019-20 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 expenditure. The Cash Flow Pattern is one forecasting tool used to estimate final expenditure 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 expenditure.

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

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

This exhibit details 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)

This exhibit calculates 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, the FY 2019-20 FMAP estimate is calculated using historic data from the BEA. This FMAP calculation 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 October 1, 2018. Therefore, FMAP for FY 2018-19 and past time periods 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 2020-

21 FMAP estimate is based on data after calendar year 2018, which the BEA does not forecast. The forecasts for personal income come from the legislative council's most recent forecast for the U.S. and Colorado, and the population forecasts come from the U.S. census for U.S. data and the Department of Local Affair's most recent forecasts for Colorado.

The current forecast for FY 2020-21 calculates to 50.05% FMAP. However, because this value is based on forecasts that are subject to change, and the period is so far forward, the Department has chosen to maintain estimated FMAP at the standard 50.00% level in FY 2020-21. The Department will monitor this estimate and restate in a future request, as needed.

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 that 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 2018-19 Budget Cycle Requests

This section describes the impact from legislation passed during the 2018 Legislative Session, including impacts from the Department's FY 2018-19 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

Legislative Actions Approved as Part of HB 18-1322, Long Appropriations Bill

The General Assembly approved several actions that were incorporated in HB 18-1322, the Long Appropriations Bill. Among them were an adjustment to increase supplemental payments to the University of Colorado School of Medicine, as well as allowing Medicaid members to fill a 12-month supply of prescription contraceptives after an initial 3-month trial fill.

FY 2018-19 R-7: "HCBS Transition Services Continuation and Expansion"

The Department's request moved services from the Colorado Choice Transitions (CCT) program to the Home and Community Based Services (HCBS) waivers and to the Medicaid State Plan. The approved funding will be used to redesign and relocate some of the current

CCT services into the HCBS waivers and the State Plan to make them available before the CCT grant program ends. The request also included 5.0 FTE required to implement the transition services appropriately.

FY 2018-19 R-8: "Medicaid Savings Initiatives"

The legislature allows the Department to implement five separate initiatives that would lead to savings in the Medicaid program, including: increased utilization management; automation of public assistance reporting information system matching; increased trust unit recoveries; increased access to public transportation benefits; and, implementation of a parental fee for eligibility in the Children's Home and Community-Based Services (HCBS) waiver for higher income families.

FY 2018-19 R-9: "FY 2018-19 Provider Rate Adjustments"

The legislature approved a series of rate increases through HB 18-1322, the Long Appropriations Bill. Among them are targeted increases for EMT and NEMT providers, increases in neonatology rates to 92% of Medicare, increases in per diem rates for alternative care facilities, and 1.0% across-the-board increases any providers that did not receive a targeted increase and are eligible for rate increases. The increases for transportation providers and alternative care facilities followed recommendations made by the Medicaid Provider Rate Review Advisory Committee (MPRRAC). The bill also allowed the Department to rebalance physician service rates in a budget-neutral manner

FY 2018-19 R-10: "Drug Cost Containment Initiatives"

This provision allows the Department to implement a Prior Authorization Requirement (PAR) on physician administered drugs and to develop alternative payment models (APMs), which typically are voluntary collaborations between a drug manufacturer and a Medicaid program, intended to hold manufacturers accountable for the outcomes they claim for their drugs and help Medicaid programs control exorbitant drug costs. Utilization management of Physician Administered drugs and alternative payment models are tools the Department can use to manage benefits and lesson pressure on the state's financial resources.

FY 2018-19 R-16: "Certified Public Expenditures for Emergency Medical Transportation Providers"

Public emergency medical transportation (EMT) providers incur significant uncompensated costs for services provided to Medicaid clients. The uncompensated expenditures cannot be claimed or reimbursed through Medicaid or any other program. This request gives the Department the opportunity to partially offset the uncompensated costs through certification of public expenditures (CPE). EMT service providers eligible to participate in the program would receive supplemental reimbursement payments by completing federally

approved cost form. The supplemental reimbursement payment is based on claiming federal financial participation on CPEs that have already been incurred by the public provider.

2018-19 R-17: "Single Assessment Tool Financing"

The Department requested the shifting of funds between fiscal years for the implementation of SB 16-192. The net General Fund effect of this request was $0 but granted roll forward authority on all contractor funding related to the single assessment tool.

HB 18-1321: "Efficient Administration Medicaid Transportation"

This bill directs the Department to create and implement an efficient and cost-effective method to meet urgent transportation needs within the existing Medicaid non-medical transportation benefit. To do this, the Department will implement a voucher program that will increase the current broker's service area to cover the entire State. The Department will be responsible for the program and will provide ongoing oversight and administration to ensure compliance from the vendor and transportation providers.

HB 18-1326: "Support for Transition from Institutional Settings"

This bill requires the Department to provide support and services to Medicaid clients transitioning from an institutional setting to a home- or community-based setting. The bill specifies that clients may receive services including: intensive case management; household set-up; home-delivered meals; peer mentorship; and, independent living skills training. The Department will also be responsible for submitting a report November 1, 2019, and continuing each November 1 thereafter, on the supports and services provided under this new program.

HB 18-1328: "Redesign Residential Child Health Care Waiver"

This bill requires the Department to redesign the Child Habilitation Residential Program (CHRP) and submit a waiver application to the federal government for approval. The bill transfers administration of CHRP from the Department of Human Services to the Department. It removes the statutory requirement that children be placed in foster care to receive waiver services. It directs the Department to redesign the program so that it provides access to home- and community-based services that allow a child or youth to remain in or return to his/her family home, while also providing out-of-home services and crisis stabilization services.

HB 18-1407: "Access to Disability Services and Stable Workforce"

This bill requires the Department to seek federal approval for a 6.5 percent increase to the reimbursement rate for specific services that are delivered through the home- and community-based services (HCBS-DD) waivers. It specifies that the increased funding must be

used to increase compensation for direct support professionals. The bill requires the Department to include the data in its annual report concerning the waiting list for services and supports. Additionally, the bill directs the Department to offer enrollment in the HCBS-DD waiver any person with an intellectual and developmental disability on the waiting list for services who is at risk of experiencing an emergency, as outlined within 25.5-10-207.5(VIII)(6)(b)(I) through (V).

SB 18-266: "Controlling Medicaid Costs"

This bill requires the Department to implement new cost control strategies, value-based payments, and other approaches to reduce the rate of expenditure growth in the Medicaid program. It also requires that the Department design and implement an evidence-based hospital review program to ensure that the utilization of hospital services is based on a recipient's need for care. Under the bill, the Department will make data tools available for the Regional Accountable Entities and providers to help guide Medicaid clients to the most cost-effective providers and practices.

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.

The Department anticipates pharmacists will be able to enroll as a provider for OTC prescribing purposes on November 1, 2018.

ACC Savings

The Accountable Care Collaborative (ACC) 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 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 Department estimates the savings that will accrue because 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. 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. The first six months of actual data for FY 2016-17 showed that enrollment in the ACC was slower than anticipated, though enrollment in the second half of FY 2016-17 ramped up, primarily driven by the implementation of the new Medicaid Management Information System (MMIS) and a system issue that disregarded previous opt-outs while passively enrolling clients into the ACC. Enrollment in the first half of FY 2017-18 was lower than expected, driven by reductions in caseload. While the Department estimates savings for the ACC, these estimates have been increased in FY 2017-18 from the previous request due to enrollment increases for high-savings populations, even though overall enrollment was lower than expected.

The Department plans to launch Phase II of the ACC on July 1, 2018, which will entail mandatory enrollment of clients into the ACC. Because mandatory enrollment will only exclude clients enrolled in another managed care program, such as a health maintenance organization (HMO) or the Program of All-Inclusive Care for the Elderly (PACE), or clients in the Non-Citizens-Emergency Services or Partial Dual Eligibles populations, Phase II of the ACC is expected to increase savings due to care coordination due to the additional clients enrolled in the program. However, in line with its original request, the FY 2017-18 R-6 "Delivery System and Payment Reform," the Department anticipates a 6-month delay from the start of Phase II before realizing savings due to enhanced care coordination. The increased savings to Acute Care for the ACC Phase II are included here only for savings because of increased enrollment due to

mandatory enrollment. Expected savings due to the integration of physical and behavioral health care are accounted for under the impact of HB 17-1353 "Implement Medicaid Delivery & Payment Initiatives."

The chart below shows program expenditure and estimated savings for FY 2014-15 through FY 2019-20. RCCO/RAE administrative payments include the reductions attributable to the policy changes mentioned in Exhibit I. For more detailed information on the ACC program, refer to Exhibit I.

Accountable Care Collaborative Expenditure and Assumed Savings

Service Category		FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Program Administration (Exhibit I, PIHP)	**SDAC**	$2,975,000	$2,250,000	$0	$0	$0	$0
	RCCO/RAE	$107,268,716	$111,937,658	$108,803,094	$195,756,865	$212,892,302	$219,589,692
	PCMP	$30,705,487	$34,336,020	$36,138,377	$0	$0	$0
	Total Administration	**$140,949,203**	**$148,523,678**	**$144,941,471**	**$195,756,865**	**$212,892,302**	**$219,589,692**
Program Savings (Exhibit F, Acute)	**Incremental**	**($28,277,387)**	**($7,955,394)**	**($19,918,981)**	**($39,638,265)**	**($53,840,498)**	**($14,797,331)**

(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 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 target the abuse of prescription medication, inappropriate use of emergency room and/or physician services. The Department implemented COUP on July 1, 2018, but anticipates lower enrollment than originally requested. The Department has calculated savings associated with the COUP program and intends to adjust savings as the program increases enrollment and achieves additional savings.

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 a new Program of All-Inclusive Care for the Elderly (PACE) provider 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 expenditure due to increased PACE enrollment to Acute Care is $5,614,017 in FY 2018-19, $4,179,911 in FY 2019-20, and $4,459,130 in FY 2020-21.

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. The Department has been able to partially implement the components of SB 10-167, though full implementation is ongoing. 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 initially delayed to allow for contract execution. The Department

has begun the enrollment process, but it has gone more slowly than anticipated. As of June 2018, there were 749 clients enrolled in HIBI. The Department assumes approximately 1% enrollment growth per month through FY 2020-21.

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. 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 2018-19 through FY 2020-21.

FY 2017-18 through FY 2019-20 Total HIBI Impact from SB 10-167

Item	FY 2018-19	FY 2019-20	FY 2020-21
Provider Payment	$483,600	$548,154	$617,352
Premiums Payment	$2,100,960	$2,367,519	$2,668,876
Total Savings (Realized in Acute Care)	($3,662,991)	($4,127,733)	($4,653,143)
Incremental Savings for Bottom-Line Impact in Exhibit F	($579,742)	($464,742)	($525,410)
Total Impact	**($1,078,431)**	**($1,212,059)**	**($1,366,915)**

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 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 $$27,289,043total funds costs avoided in FY 2018-19, $$29,485,566costs avoided in FY 2019-20, and $0 costs avoided in FY 2020-21 as the program will have ended by that date. The services and clients will transition to Home and Community Based Services program by FY 2020-21. These figures do not include any expenditure from the rebalancing fund. Please see the narrative on CCT in Exhibit G for more detail.

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 implemented the program August 15, 2018.

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 expenditure 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.

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 Brain 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 implemented the program into the Brain Injury Waiver and the Spinal Cord Injury Waiver on March 1, 2017. 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 2018-19 R-5, Office of Community Living Cost and Caseload Adjustments.

SB 16-192 "Assessment Tool Intellectual and Developmental Disabilities"

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. The tool must be used for adults and children including services for persons with intellectual and developmental disabilities. The bill requires the department to begin utilizing the tool as soon as practicable after selection and complete any client reassessments within 30 days of being requested by a member. Funds included in this request represent funding for the pilot program and all client reassessments.

FY 2017-18 R-6: "Delivery System and Payment Reform"

The JBC approved a number of components in the Department's FY 2017-18 R-6 request, including: the Department's adoption of the Enhanced Ambulatory Patient Grouping (EAPG) system as of October 31, 2016; continuation of the primary care rate increases approved in HB 16-1408, but with General Fund state share; and changing the reimbursement methodology for vaccine stock so that vaccine stock rates are set annually based on the immunization list published by the Center for Disease Control and Prevention (CDC).

FY 2017-18 R-7: "Oversight of State Resources"

Through the Department's FY 2017-18 R-7 request, reimbursement rates of physician administered drugs were increased to an average of 2.5% over the average sales price (ASP). The Department also calculated a cost-avoidance estimate due to members no longer receiving these drugs at higher cost outpatient facilities. Due to more competitive reimbursement in the physician setting, the Department

anticipates patients will be matched to more appropriate drugs and less physicians will advise members to receive drugs in a hospital setting. The Department implemented this methodology on July 1, 2017.

FY 2017-18 R-11: "Vendor Transitions"

With the implementation of Phase II of the Accountable Care Collaborative (ACC) on July 1, 2018, the Department requested and the General Assembly appropriated transition funding for the transition from the current Regional Collaborative Care Organizations (RCCOs) to the Regional Accountable Entities (RAEs) in FY 2017-18, to prepare for any changes in vendors that might occur in July 2018 and to ensure a continuum of care for Medicaid clients enrolled in the ACC.

FY 2017-18 R-16: "University of Colorado School of Medicine Supplemental Payment"

In the 2017 legislative session, the General Assembly approved a transfer of $61.9 million from the University of Colorado School of Medicine (UCSOM) to the Department beginning in FY 2017-18 to gain access to federal matching funds. The Department would then reimburse UCSOM approximately $123.8 million through a UPL payment for physician services.

SB 17-091 "Allow Medicaid Home Health Services in the Community"

SB 17-091 expands the locations where clients can receive home health services. 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 adjustments in Exhibit F and Exhibit G account for an increase in utilization due to clients receiving additional home health services in the community. The Department demonstrated compliance with this rule as of July 1, 2017 through SB 17-091, which removes language from statute stipulating home health services must be received "in the home."

SB 17-256 "Hospital Reimbursement Rates"

SB 17-256 reduces the cash funds appropriation from the Hospital Provider Fee by $264,100,000 in FY 2017-18. This restriction was removed by SB 17-267 "Sustainability of Rural Colorado."

SB 17-267 "Sustainability of Rural Colorado"

SB 17-267 replaces the existing Hospital Provider Fee program with the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) as of July 1, 2017. Under CHASE, the Department can charge and collect the Healthcare Affordability and Sustainability

(HAS) fee that functions similarly to the Hospital Provider Fee. The Department must also increase copays in pharmacy and outpatient services.

HB 17-1353 "Implement Medicaid Delivery & Payment Initiatives"

HB 17-1353 approved the payment reform and Accountable Care Collaborative (ACC) Phase II portions of the Department's FY 2017-18 R-6 "Delivery System and Payment Reform" request, for FY 2018-19 and beyond. This includes increased estimates for ACC savings due to the integration of physical and behavioral health care, especially for clients with diagnoses of substance use disorder and/or serious and persistent mental illness, as well as movement from the continuation of the previous primary care rate increases to primary care incentive payments and other payment reform initiatives. Note that savings to the ACC due to increased enrollment under mandatory enrollment under Phase II are accounted for in the section labeled "ACC Savings," as this change was incorporated directly into the forecast model for the ACC.