Schedule 13

Department of Health Care Policy and Financing

Funding Request for The FY 2021-22 Budget Cycle

Request Title

R-03 Child Health Plan Plus

Dept. Approval By:

OSPB Approval By:

	Supplemental FY 2020-21
	Budget Amendment FY 2021-22
X	**Change Request FY 2021-22**

Summary Information	**Fund**	**FY 2020-21** Initial Appropriation	**FY 2020-21** Supplemental Request	**FY 2021-22** Base Request	**FY 2021-22** Change Request	**FY 2022-23** Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$244,867,093**	**$0**	**$244,826,174**	**($31,086,304)**	**($20,320,541)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$23,311,123	$0	$23,307,075	$10,398,339	$13,581,058
	CF	$51,011,989	$0	$51,009,606	($8,994,295)	($8,388,180)
	RF	$0	$0	$0	$0	$0
	FF	$170,543,981	$0	$170,509,493	($32,490,348)	($25,513,419)

Line Item Information	**Fund**	**FY 2020-21** Initial Appropriation	**FY 2020-21** Supplemental Request	**FY 2021-22** Base Request	**FY 2021-22** Change Request	**FY 2022-23** Continuation
05. Indigent Care Program, (A) Indigent Care Program, (1) Indigent Care Program - Children's Basic Health Plan Administration	**Total**	**$5,083,274**	**$0**	**$5,033,274**	**$0**	**$0**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	CF	$1,632,747	$0	$1,622,437	$139,209	$139,209
	RF	$0	$0	$0	$0	$0
	FF	$3,450,527	$0	$3,410,837	($139,209)	($139,209)
05. Indigent Care Program, (A) Indigent Care Program, (1) Indigent Care Program - Children's Basic Health Plan Medical and Dental Costs	**Total**	**$239,783,819**	**$0**	**$239,792,900**	**($31,086,304)**	**($20,320,541)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$23,311,123	$0	$23,307,075	$10,398,339	$13,581,058
	CF	$49,379,242	$0	$49,387,169	($9,133,504)	($8,527,389)
	RF	$0	$0	$0	$0	$0
	FF	$167,093,454	$0	$167,098,656	($32,351,139)	($25,374,210)

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
Children's Basic Health Plan

FY 2020-21, FY 2021-22, and FY 2022-23 Budget Request

November 2020

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CHILDREN'S BASIC HEALTH PLAN

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

Points of Interest

- Federal funding for the CHIP program was reauthorized, retroactive to October 1, 2017. The program has been reauthorized for six years initially then an additional four years, expiring September 30, 2027.
- Federal financial participation was also reauthorized at the additional 23% increase for FFY 2017-18 and FFY 2018-19. Beginning in FFY 2019-20, the federal match rate was reduced by 11.50% and by FFY 2020-21 the federal match rate reduces to 65.00%.
- With the passage of the ACA and the enhanced federal financial participation, the Department has been able to pay for the state's share of costs entirely with cash funds. With the expiration of the enhanced match in FY 2020-21, the Department anticipates that it will need to start funding a portion of the expenses with General Fund. This is due to the exhaustion of the CHP+ Trust fund, which will take place sometime in FY 2020-21.
- In the 2017 legislative session, SB 17-267 "Sustainability of Rural Colorado" was passed and creates the Colorado Healthcare Affordability and Sustainability Enterprise within the Department to manage the Healthcare Affordability and Sustainability (HAS) Fee, which replaces the Hospital Provider Fee assess under current law. Beginning in FY 2017-18, the state share of the populations with FPL greater than 205% will be paid with the HAS Fee.
- Beginning January 2014, an income rating code used to identify clients from 201%-205% changed to 201%-213% as part of the MAGI conversion. Clients under 205% FPL receive funding from the CHP Trust Fund while clients over 205% FPL receive funding from the Healthcare Affordability and Sustainability (HAS) fee fund. With the implementation of the interChange, the Department is now able to identify discrete FPLs for CHP+ members. Between January 2014 and March 2017, the Department used a distribution of clients over 200% FPL prior to January 2014 to assign clients with that particular income rating code to the appropriate cohorts.
- Following the declaration of a public health emergency by the Secretary of Health and Human Services during the COVID-19 pandemic, CMS notified states that an increased FMAP would be available for each calendar quarter occurring during the public health emergency, including retroactively to January 1, 2020. To be eligible to receive the 6.2 percentage point FMAP increase, states must adhere to a set of requirements which include, but are not limited to, maintaining eligibility standards, methodologies, and procedures; covering medical costs related to the testing, services, and treatment of COVID-19; and not terminating individuals from Medicaid if such individuals were enrolled in the Medicaid program as of the date of the beginning of the emergency period or during the emergency period.

History and Background Information

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

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

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

The eligible CHP+ populations are:

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

CBHP CAPITATION PAYMENTS

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

in the prenatal program are served by the self-funded program (SMCN) administered by Colorado Access and the costs of their services are billed in full directly to the State.

In FY 2013-14, there was a budget amendment passed (BA-11) to align the CHP+ oral health care benefits with the CHIPRA legislation of 2009. CHP+ dental coverage had been lacking periodontics care, orthodontic care, prosthodontic care, and the required coverage of all medically necessary oral health care. Such services were added to the scope of coverage and the dental program's annual maximum was increased from $600 to $1000. These changes in the oral health care benefits led to significant increases in the dental rates beginning in FY 2014-15.

Effective July 1, 2010, the Department implemented a new reimbursement schedule for inpatient hospital payments and effective October 31, 2016 implemented a new reimbursement schedule for outpatient hospital payments. The Department is now using the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and the Colorado Medicaid Enhanced Ambulatory Patient Groups (EAPGs) for outpatient services.

Analysis of Historical Expenditure Allocations across Eligibility Categories

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

Description of Transition to New Methodology

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per-capita rates, the Department has moved to a capitation trend forecast model beginning with the FY 2014-15 Request. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends for each eligibility category, rather than a weighted rate for all categories, future expenditures are forecasted per the characteristics of a specific eligibility category: the actuarially agreed-upon capitation rate and caseload for the nine categories rather than the previous three (children's medical, children's dental, and prenatal). In addition to viewing the nine eligibility categories separately, the Department has divided up the categories further to analyze each group that has a specific rate. This grouping separates by age as well as FPL. The different age groups apply only to children: 0-1, 2-5, and 6-18. The same FPL brackets apply to both children and prenatal: under 100%, 101%-156%, 157%-200%, 201%-205%, and 206%-260%. These individual analyses are then aggregated in the FPL brackets 0%-205% and 206%-260%. The age groups are each considered separately. By tying forecasted capitation rates directly to each category, the methodology may provide more accurate

estimates of expenditures by eligibility category as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to health maintenance organizations and the state managed care network.

In estimating the future per capita costs, the Department has also started incorporating claims distribution and retroactivity adjustments to the projected rates beginning with the November 2013 request. The adjustments are described in further detail in Exhibit C8.

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

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

EXHIBIT C1 - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

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

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

EXHIBIT C2 - CALCULATION OF FUND SPLITS

Exhibit C2 details fund splits for all Children's Basic Health Plan budget lines for the current fiscal year Supplemental and the out-year Budget Request. Capitation expenditures are split between traditional clients and expansion clients. The State share for the traditional clients (0%-205% FPL) is funded from the CBHP Trust fund and the State share for expansion clients (206%-260% FPL) is funded from the Healthcare Affordability and Sustainability Fee Fund (SB 17-267).

The Patient Protection and Affordable Care Act (Sec. 2101 (a)) enhanced the CHP+ FMAP 23 percentage points beginning October 1, 2015 through September 30, 2019 (SSA 2105 (b)). The average for the State Fiscal Year (SFY) 2018-19 was 88.00% and would have been 79.38% in SFY 2019-20 and 67.88% in SFY 2020-21 with the expiration of the enhanced 23 percentage point bump. However, the Families First Coronavirus Response Act passed in response to the COVID-19 pandemic allows states to claim an enhanced FMAP through the end of the calendar quarter in which the Secretary of Health and Human Services has declared a public health emergency or extended that emergency. This has increased the actual FMAP in SFY 2019-20 to 81.55% and the projected FMAP for FY 2020-21 to 71.13%. In addition, beginning in FY 2020-21, the Department expects that it will need to begin funding the program with a combination of General Fund and CHP+ Trust Fund for members to 205% FPL. The Department is also expecting to recover payments in FY 2019-20 for prior year dates of service but is unsure of the magnitude at this time. Due to state fiscal rules, the Department is unable to offset current year expenditure for prior year recoveries, and therefore, the recoveries are counted as revenue to cash funds.

EXHIBIT C3 - CHILDREN'S BASIC HEALTH PLAN SUMMARY

Exhibit C3 presents a summary of Children's Basic Health Plan caseload and capitation expenditures itemized by eligibility category and a summary of the bottom line adjustments to expenditure, as well as expenditures for CBHP Administration. The net capitation payments include the impacts of the reconciliations for manual enrollments. Exhibit C6 illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT C4 - CBHP CASELOAD

Exhibit C4 contains the caseload history for each of the eligibility categories broken down by poverty level (0%-205% and 206%-260%) and also broken down by age group for children's categories (ages 0-1, 2-5, and 6-18). Each of the tables that comprise Exhibit C4 is described below. Forecast details for CHP+ caseload can be found starting on page 20 of this narrative.

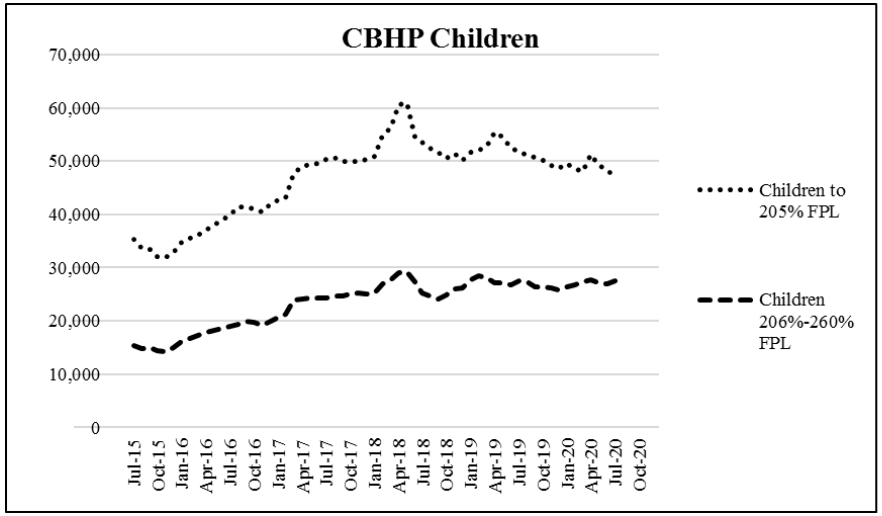
Children's Basic Health Plan Caseload by Fiscal Year

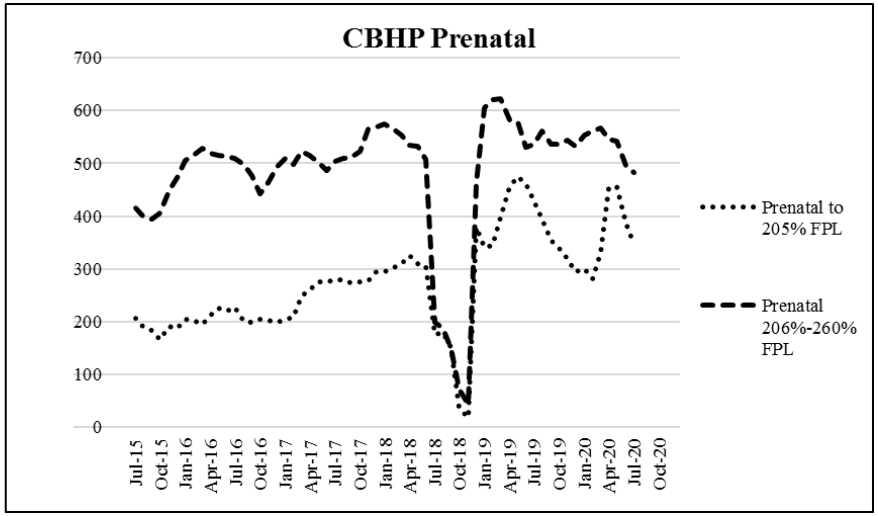
Caseload for the Children's Basic Health Plan is displayed in one table showing caseload by all CHP+ eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The caseload numbers are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

Children's Basic Health Plan Caseload by Month

These tables show the actual caseload by month as reported in the JBC monthly report for the three most recent fiscal years. The Department uses data for members attributed to HMOs as the basis for thee forecast because it is a more accurate reflection of actual caps that will be paid in the fiscal year. All capitations paid for clients not initially tied to an HMO is captured in bottom line impacts.

As can be seen in the graphs shown below and on page C4-5, From January 2013 to January 2014 caseload decreased steadily for populations under 205% FPL, due to the implementation of SB 11-008 and SB 11-250 and the MAGI conversion, and increasing for populations above 205% FPL. The most recent months (January 2020 – June 2020) have seen caseload declining due to the continuous coverage policy associated with the Families First Coronavirus Response Act. As a condition of claiming a higher FMAP under the Act, the Department must maintain continuous coverage for clients, meaning it cannot disenroll members if they were enrolled in the program as of the beginning of the emergency period or becomes enrolled during the emergency period. This continuous coverage policy has effectively ceased all churn of children from Medicaid onto CHP+. However, because CHP+ clients can still churn onto Medicaid this has caused caseload to fall as families lose income and qualify for Medicaid.





Children's Basic Health Plan Per Capita Historical Summary

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

Children's Basic Health Plan Historical Expenditures Summary

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

EXHIBIT C5 - CHILDREN'S BASIC HEALTH PLAN FUNDING SOURCES

Traditional Population Expenditures and Funding

This exhibit shows expenditures for the traditional population in isolation and provides additional detail to the calculation of fund splits. Traditional populations include those from 0%-205% FPL. These populations receive the enhanced CHP+ Federal Match and receive cash funds from the CHP Trust Fund, CO Immunization Fund, and Health Care Expansion Fund. Once the available cash funds have been used, the General Fund covers the remaining State share of expenditures for clients under 205% FPL. The available funding from the CHP Trust Fund and the CO Immunization Fund is forecasted using the published projections in the 2019 Tobacco MSA Payment Forecast, allocation changes from HB 16-1408 "Cash Fund Allocations for Health-related Programs", and the actual expenditures from prior years. Calculations can be seen in exhibit C5.

As described above for exhibit C2, the CHP+ Federal Match increased by 23 percentage points in October 2015 and remained in effect until September 30, 2019. Beginning October 1, 2020, when the enhanced federal match rate steps down to 67.88% (not accounting for any potential enhanced FMAP from the Families First Coronavirus Response Act) the Department expects General Fund will be needed for this population as there will no longer be enough revenue in the CHP+ Trust Fund to support expenditures.

Expansion Population Expenditures and Funding

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

Children's Health Plan Plus Enrollment Fees

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

EXHIBIT C6 - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

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

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

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

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

After calculating total expenditure for capitations, the anticipated reconciliation payments for manual enrollments for each fiscal year are estimated and added to total expenditure. The sum of expenditure for capitation payments and reconciliation payments for manual enrollments is the total CBHP Capitation Payments summarized in exhibit C3. Following the addition of projected reconciliation payments for manual enrollments are any applicable bottom-line impacts to expenditure. Details are discussed below in exhibit C7.

Actuarially Certified Capitation Rates

Capitated rates for the health maintenance organizations are required to be actuarially certified and approved by CMS, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the

historically certified capitation rates to derive the capitation rate presented in Exhibit C6. The methodology for determining the forecasted capitation rate is the subject of exhibits C8 through C10.

Incurred-but-not-Reported Estimates

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

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

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

Reconciliation payments for manual enrollments

As mentioned above, the Department makes reconciliation payments for clients that were manually enrolled. These are projected by applying growth rates from projected caseload (exhibit C4) and rate inflation (exhibit C9) to the expenditure for reconciliation payments for manual enrollments in the previous fiscal year. In FY 2018-19, the Department did not make any manual enrollment reconciliation payments for FY 2018-19; the payments made were only for prior fiscal years. Going forward the Department estimates that these reconciliations will no longer be necessary.

Delta Dental MLR Reconciliation

The Department requires its dental contractor to maintain a medical loss ratio of 80% or greater. In the past, the department has recouped funds from the contractor due to having a ratio of less than 80%. The Department expects to recoup funding again from the contractor in FY 2019-20 and beyond, but is unsure of the magnitude at this time. Therefore, the Department is estimating about $100,000 in recoupments.

Health Insurance Providers Fee (HIPF)

The Affordable Care Act imposed a requirement that for-profit health insurers are required to pay a fee. The amount of the fee is determined through a series of calculations that accounts for the total required collection and number of insurers. The fee was assessed in CY 2016 and will be assessed in CY 2018. There was a moratorium on the fees in CY 2019, but the fees will resume in CY 2020, which the CHP+ HMOs will need to pay through the Department. The Tax Cuts and Jobs Act of 2017 repealed this tax on for-profit health insurers and FY 2020-21 will be the last year this tax is collected.

HB 19-1038 Dental Services for Pregnant Women

In 2019, the state legislature passed HB 19-1038 which provides dental services to all prenatal CHP+ clients. Starting October 1, 2019 all pregnant women will benefit from the same dental services as CHP+ children except for orthodontics (braces). The benefits include diagnostic services (exams and x-rays), preventive (fluoride, sealants, and cleanings), basic restorative services (fillings), endodontics (roots canals), and emergency dental services. The annual maximum allowable benefit is $1,000 per calendar year (July 1st through June 30th) while the member is eligible and enrolled.

SMCN Medical Advance Reconciliation

New members on the CHP+ plan are enrolled in to one of five HMOs. Prior to enrollment in an HMO, the member is enrolled in the State Managed Care Network (SMCN) where the members receive services in a fee-for-service delivery model. The Department pays the SMCN a prospective capitation payment for services. At the end of the year, the Department reconciles with the SMCN based on actual costs. If the prospective capitation payment is more than actual services, the Department recoups money; if it was insufficient the Department owes money to the SMCN. In FY 2020-21 the Department has identified nearly five million dollars that it owes the SMCN for the period April 2019 – April 2020.

EXHIBIT C8 - CBHP RETROACTIVITY ADJUSTMENT AND CLAIMS DISTRIBUTION ADJUSTMENT MULTIPLIER

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

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

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last seven years of claims and caseload data. Exhibit C8 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The Department did experience a significant amount of duplicate claims through calendar year 2013, but these duplicate claims have been removed from this analysis. Historically, the Department's methodology for calculating the retroactivity factor was to use claims and caseload data for each cohort (i.e. Children to 205% FPL Medical, Children to 205% FPL Dental, Children 206%-260% FPL Medical, etc.), but due to trouble identifying a subset of the population, 201%-205% FPL, retroactivity is skewed. As a result, the new methodology used is to calculated an aggregate retroactivity factor based on all children for medical and dental, and all prenatal adults across all FPL groups and use that single factor for both FPL groups for children and prenatal women. Details on the selected retroactivity adjustment can be found on page C8-1.

Claims Distribution Adjustment Multiplier

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

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

EXHIBIT C9 - CBHP CAPITATION RATE TRENDS AND FORECASTS

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

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

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

It is important to note the overall weighted point estimate presented in the exhibit is weighted across several factors. First, the rate is weighted within an eligibility category. Within an eligibility category, the rate is weighted by the health maintenance organizations' and state managed care network's proportion of claims processed within that eligibility category, the proportion attributable to each FPL category (0%-100%, 101%-156%, 157%-200%, and above 200%), and for children the proportion for each age range (ages 0-1, 2-5, and 6-18). Next, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the weighted CBHP total rate may not be a clear indicator of the rate trends across all eligibility categories.

Exhibit C9 presents the weighted point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit C6 in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years. Below is a table showing the actual weighted rate for FY 2019-20, and the projected weighted rates through FY 2022-23.

Fiscal Year	Children Medical to 205% FPL	Children Medical 206%-259% FPL	Children Dental to 205% FPL	Children Dental 206%-259% FPL	Prenatal to 205% FPL	Prenatal 206%-259% FPL	Weighted CBHP Total
FY 2019-20 Actuals	**$170.82**	**$171.97**	**$19.82**	**$19.37**	**$980.81**	**$970.08**	**$199.81**
FY 2020-21 Estimated Rate	$170.66	$171.60	$19.93	$19.53	$980.81	$970.08	$199.00
% Change from FY 2019-20	*-0.06%*	*-0.22%*	*0.55%*	*0.83%*	*0.01%*	*0.00%*	*-0.46%*
FY 2021-22 Estimated Rate	$179.43	$180.15	$20.63	$20.22	$980.81	$970.08	$209.16
% Change from FY 2020-21	*3.49%*	*3.65%*	*1.06%*	*0.35%*	*0.00%*	*0.00%*	*5.11%*
FY 2022-23 Estimated Rate	$187.96	$183.09	$21.19	$20.77	$980.61	$970.08	$224.63
% Change from FY 2021-22	*4.75%*	*1.63%*	*2.71%*	*2.72%*	*0.00%*	*0.00%*	*7.40%*

EXHIBIT C10 - FORECAST MODEL COMPARISONS

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

Exhibit C10 also presents, a series of forecast models each eligibility category. From the models or from historical changes, a point estimate is selected as an input. Based on the point estimates, the adjustments presented in Exhibit C8 are then applied and the final, adjusted point estimate is then used in the expenditure calculations of Exhibit C6.

Final Forecasts

Exhibit C10 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected in Exhibit C10 (see below).

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

Then the claims-based rate is adjusted a second time, this time by the retroactivity adjustment. From Exhibit C8, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit C8, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the

caseload must be adjusted to capture retroactivity. To keep CBHP caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to derive the expenditure calculation presented in exhibit C6. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

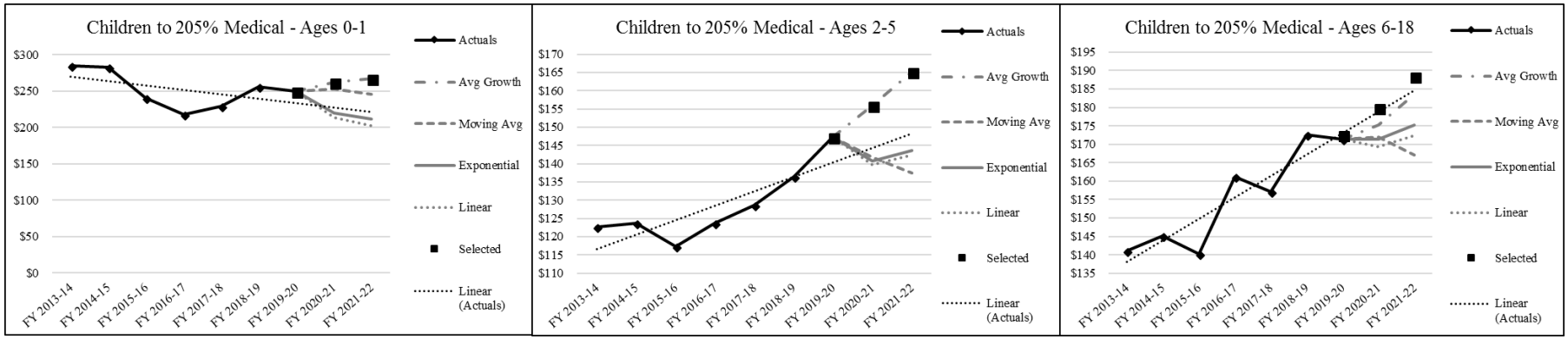
The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented in Exhibit C10.

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

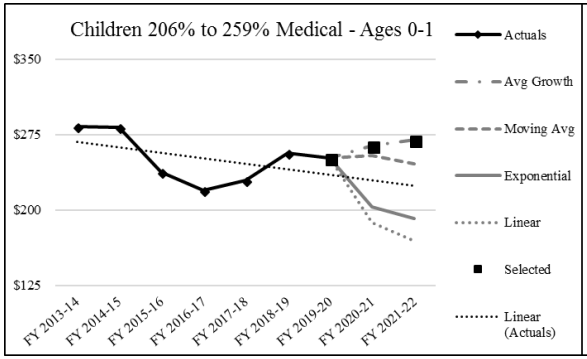
The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

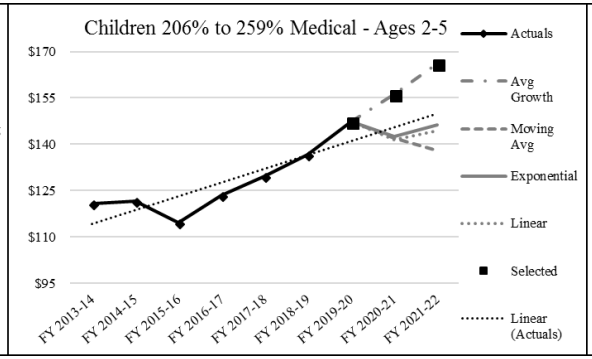
Capitation rates are required to be actuarially sound and are built from a blend of historical rates. The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. The tables beginning on the next page show the trends selected for the current and request years by eligibility category.

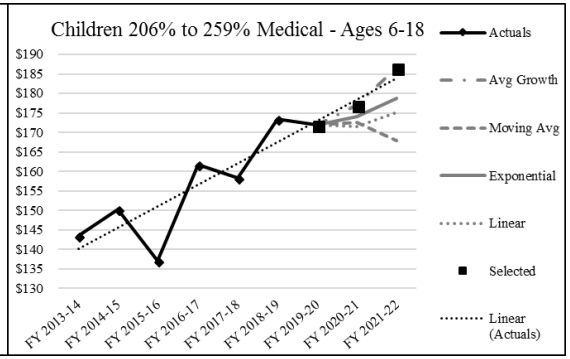
Rate Trends for Children Medical to 205% FPL			
Aid Category	**FY 2020-21 Trend Selection**	**FY 2021-22 Trend Selection**	**Justification**
Children to 205% FPL Medical Ages 0-1	**-2.51%** Average Growth Model	**4.94%** Average Growth Model	Due to the emergency caused by the COVID-19 pandemic rates have been re-negotiated and have been lowered for FY 2020-21. FY 2021-22 rates are expected to increase due to enrollment increases and the dissolution of the SMCN.
Children to 205% FPL Medical Ages 2-5	**7.85%** Average Growth Model	**5.99%** Average Growth Model	Despite some lowering due to the public health emergency, FY 2020-21 rates overall grew substantially due to higher utilization and enrollment. The Department forecasts rates to increase due to enrollment increases and the dissolution of the SMCN.
Children to 205% FPL Medical Ages 6-18	**-0.63%** Average Growth Model	**4.94%** Average Growth Model	Due to the emergency caused by the COVID-19 pandemic rates have been re-negotiated and have been lowered for FY 2020-21. FY 2021-22 rates are expected to increase due to enrollment increases and the dissolution of the SMCN.



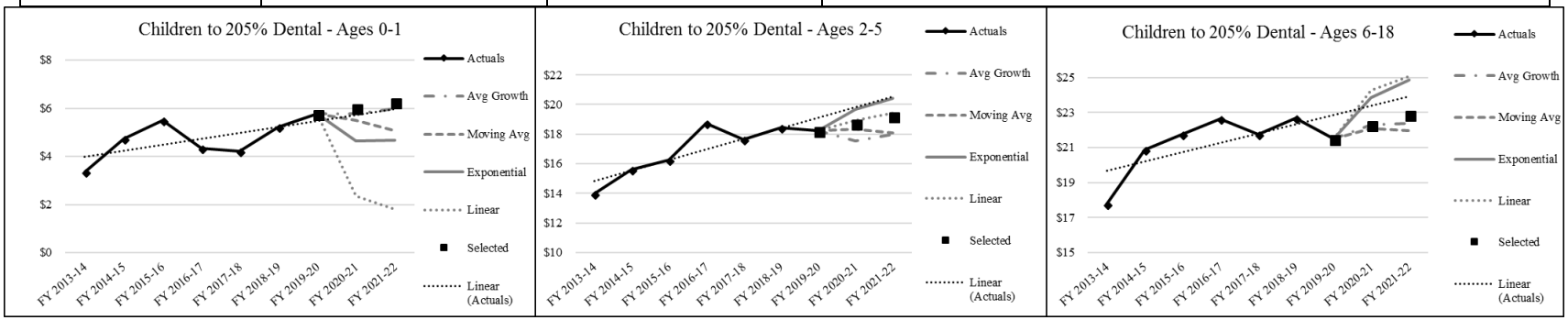
Rate Trends for Children Medical 206% to 260% FPL			
Aid Category	**FY 2020-21 Trend Selection**	**FY 2021-22 Trend Selection**	**Justification**
Children 206% to 260% FPL Medical Ages 0-1	**-2.06%**	**4.75%**	Due to the emergency caused by the COVID-19 pandemic rates have been re-negotiated and have been lowered for FY 2020-21. FY 2021-22 rates are expected to increase due to enrollment increases and the dissolution of the SMCN.
	Growth from FY 2016-17 to FY 2017-18	Two Period Moving Average	
Children 206% to 260% FPL Medical Ages 2-5	**7.70%**	**6.06%**	Despite some lowering due to the public health emergency, FY 2020-21 rates overall grew substantially due to higher utilization and enrollment. The Department forecasts rates to increase due to enrollment increases and the dissolution of the SMCN.
	Average Growth Model	Average Growth Model	
Children 206% to 260% FPL Medical Ages 6-18	**-0.83%**	**4.75%**	Due to the emergency caused by the COVID-19 pandemic rates have been re-negotiated and have been lowered for FY 2020-21. FY 2021-22 rates are expected to increase due to enrollment increases and the dissolution of the SMCN.
	Average Growth Model	Average Growth Model	



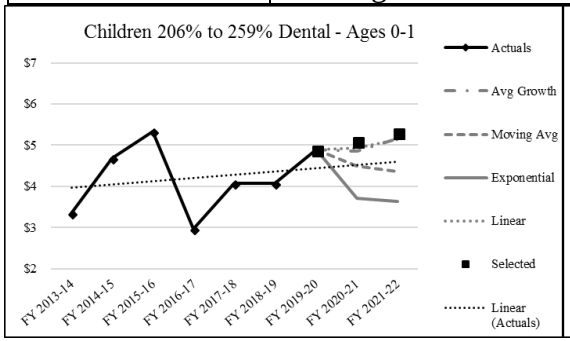


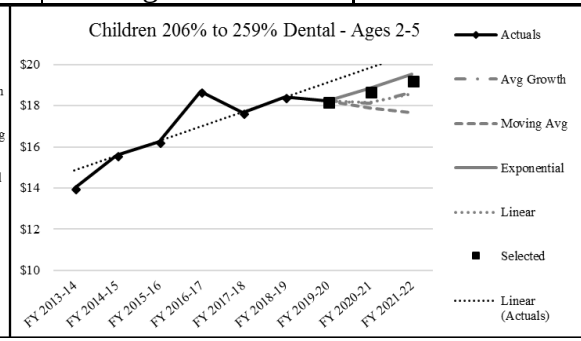


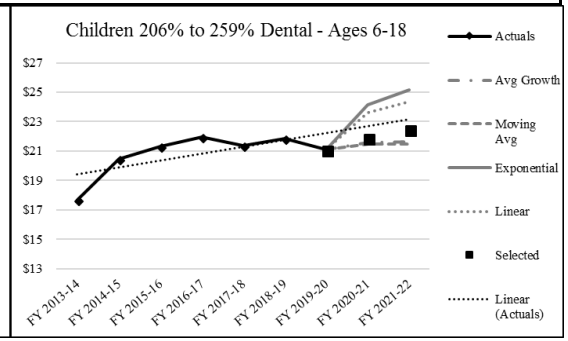
Rate Trends for Children Dental to 205% FPL			
Aid Category	**FY 2020-21 Trend Selection**	**FY 2021-22 Trend Selection**	**Justification**
Children to 205% FPL Dental Ages 0-1	**10.54%** Growth from FY 2017-18 to FY 2018-19 Rate	**4.16%** Growth from FY 2017-18 to FY 2018-19 Rate	Rates for this cohort increased again in FY 2019-20. This is due growing utilization. As caseload is expected to grow the Department forecasts a small positive trend in FY 2021-22.
Children to 205% FPL Dental Ages 2-5	**-1.08%** Average Growth Model	**2.74%** Average Growth Model	Rates for this cohort decreased in FY 2019-20. This is due to a decrease in utilization. As caseload is expected to grow the Department forecasts a small positive trend in FY 2021-22.
Children to 205% FPL Dental Ages 6-18	**-5.12%** Two Period Moving Average Model	**3.67%** Two Period Moving Average Model	Rates for this cohort increased again in FY 2019-20. This is due growing utilization. As caseload is expected to grow the Department forecasts a small positive trend in FY 2021-22.



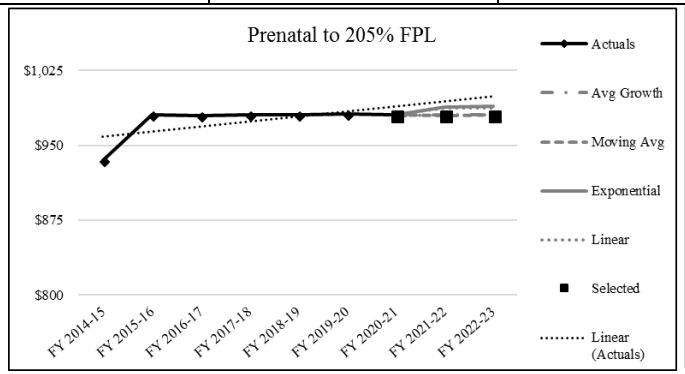
Rate Trends for Children Dental 206% to 260% FPL			
Aid Category	**FY 2020-21 Trend Selection**	**FY 2021-22 Trend Selection**	**Justification**
Children 206% to 260% FPL Dental Ages 0-1	**10.54%** Growth from FY 2017-18 to FY 2018-19 Rate	**4.16%** Growth from FY 2017-18 to FY 2018-19 Rate	Rates trend similarly for dental regardless of FPL and the Department has chosen to stick with the trends for the Children 0-205% FPL.
Children 206% to 260% FPL Dental Ages 2-5	**-1.08%** Trend from 0-205% FPL Ages 2-5	**2.74%** Trend from 0-205% FPL Ages 2-5	Rates trend similarly for dental regardless of FPL and the Department has chosen to stick with the trends for the Children 0-205% FPL.
Children 206% to 260% FPL Dental Ages 6-18	**-5.12%** Trend from 0-205% FPL Ages 6-18	**3.67%** Trend from 0-205% FPL Ages 6-18	Rates trend similarly for dental regardless of FPL and the Department has chosen to stick with the trends for the Children 0-205% FPL.

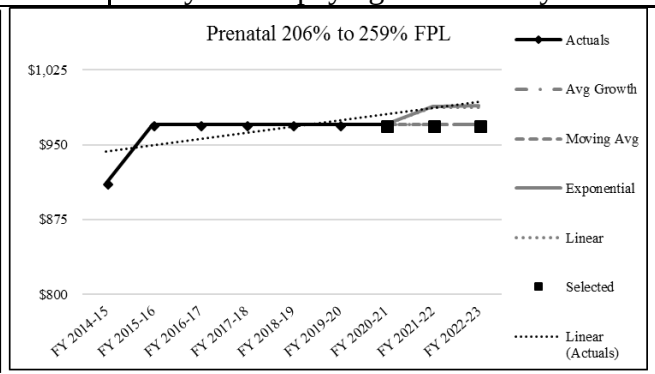






Rate Trends for Prenatal			
Aid Category	**FY 2020-21 Trend Selection**	**FY 2021-22 Trend Selection**	**Justification**
Prenatal to 205% FPL	**0.00%** Average Growth Model	**0.00%** Average Growth Model	In the past the Department has recouped money from the SMCN due to systems issues. The Department has trued up its payments with the SMCN and is not expecting to recoup payments as the system is paying out correctly.
Prenatal 206%-260% FPL	**0.00%** Average Growth Model	**0.00%** Exponential Growth Model	In the past the Department has recouped money from the SMCN due to systems issues. The Department has trued up its payments with the SMCN and is not expecting to recoup payments as the system is paying out correctly.





CBHP CASELOAD

Length of Stay

CBHP caseload is not only affected by the number of individuals served but also the length of time they remain in the program. The Department has started tracking the average length of stay for each eligibility category to further understand the behavior of the CHP+ clients. Results for FY 2015-16 (shaded) is subject to change as there may not be sufficient run out to capture the true length of stay for all clients. The Department anticipates an increase in the average length of stay as continuous eligibility for Medicaid Eligible Children and CHP+ Children was implemented March 1st, 2014.

		CHP Children 0%-205%	CHP Children 206%-260%	CHP Prenatal 0%-205%	CHP Prenatal 206%-260%
FY 2015-16	Avg. LOS Mo's	16.30	15.89	8.75	8.08
	% > 12 Mo's	81.51%	78.49%	12.72%	9.30%
FY 2016-17	Avg. LOS Mo's	15.55	16.07	7.23	7.06
	% > 12 Mo's	54.26%	59.42%	2.22%	1.54%
FY 2017-18	Avg. LOS Mo's	17.23	17.19	7.95	8.28
	% > 12 Mo's	67.92%	69.85%	9.31%	8.72%
FY 2018-19	Avg. LOS Mo's	15.52	16.11	8.77	8.70
	% > 12 Mo's	65.18%	67.78%	13.89%	10.09%
FY 2019-20	Avg. LOS Mo's	9.69	10.96	5.23	6.27
	% > 12 Mo's	13.85%	16.53%	2.00%	2.44%

CBHP Caseload Models

The Department's caseload projections utilize statistical forecasting methodologies to predict CBHP caseload by eligibility category. Historical monthly caseload data is used from July 2007 to December 2018. CBHP caseload increased significantly in FY 2016-17 and coincides with the implementation of the interChange. A large percentage of the growth experienced are for members that are not tied to an HMO. For the purpose of forecasting caseload, the Department has chosen to forecast based on those clients that are actively tied to an HMO because that appears to be the best representation of actual enrollment and expenditure. As a result, caseload figures in the

exhibits may not tie directly to those mentioned below for forecasting. The following forecasting models are used to forecast CBHP caseload: trend and monthly seasonal dummy variables, ARIMA models, trend stationary, and difference stationary. The Department is now using the software EViews 6 to estimate these models.

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

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

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

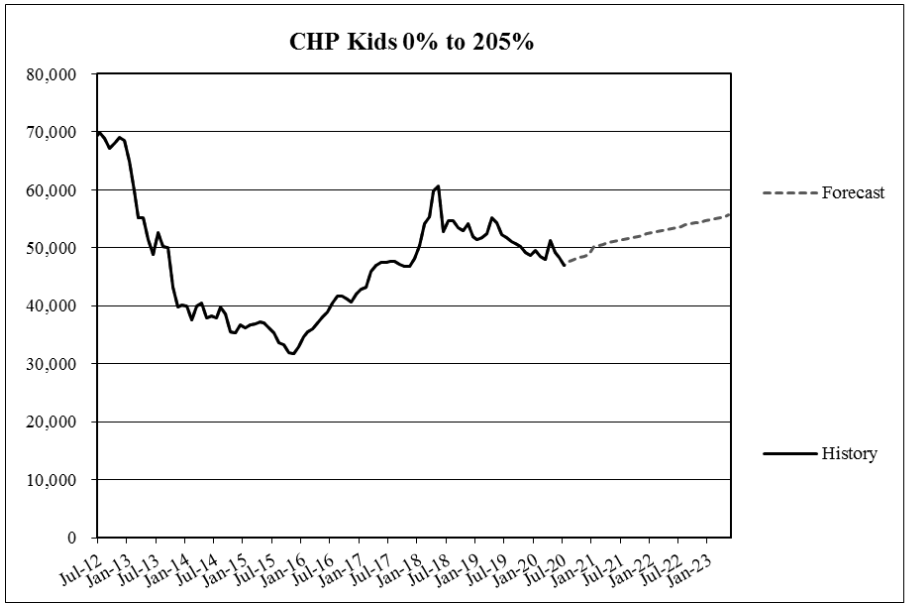
- Trend Stationary: $\log(y) = c + \text{trend} + \varepsilon$
- Difference Stationary: $\text{differenced}(\log(y)) = c + \varepsilon$

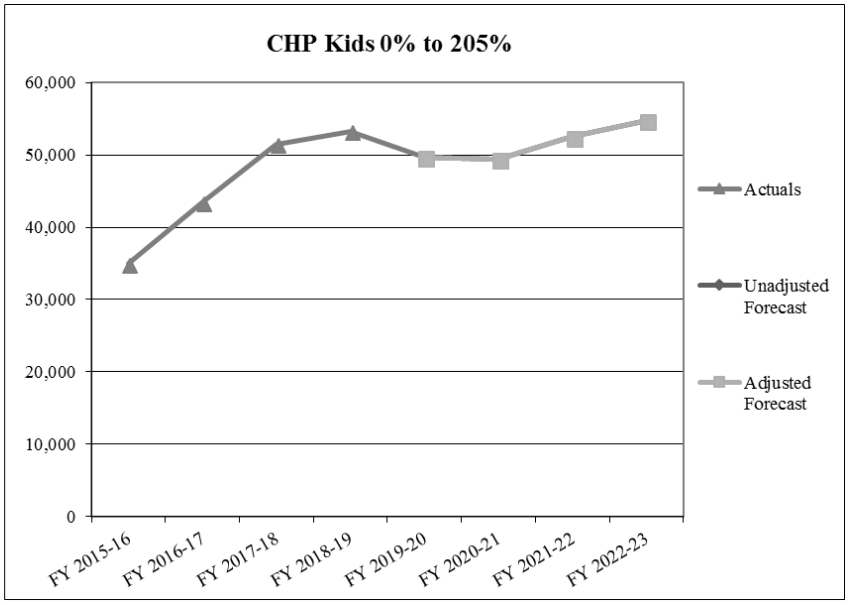
Model Selection

Models are created for each individual group that receives a separate rate. These groups are separated by FPL for both children and prenatal: under 100%, 101%-156%, 157%-200%, 201%-205%, and 206%-260%. Children's groups are also separated by age: age groups 0-1, 2-5, and 6-18. A model is selected to forecast each group After several different forecasts are produced, the Department normally chooses one for each category and then aggregated to the FPL categories for children and prenatal; under 205% and 206%-260%. When selecting a model, the Department closely analyzes the historical data as well as the goodness of fit of the model.

CHILDREN'S BASIC HEALTH PLAN CASELOAD FORECAST

Children's Caseload Projections (Exhibit C4)





- This population before the COVID-19 pandemic was mostly flat with either little growth or declines, but since the start of the pandemic has been declining as this population is churning into Medicaid as incomes fall. Regular churn from Medicaid to CHP+ has stopped as a result of the continuous coverage policy. The Department expects that once the continuous coverage policy expires, there will be an influx of clients from Medicaid to CHP+ but that this will be netted out by the disenrollements of clients who have been locked into CHP+.

- This population includes the subpopulation created through SB 07-097 and was implemented beginning March 1, 2008. Children in this population have family incomes between 201% and 205% FPL.

Total Children 0 to 205%			
	Actuals	Monthly Change	% Change
Jun-18	52,727	-	-
Jul-18	54,597	1,870	3.55%
Aug-18	54,705	108	0.20%
Sep-18	53,563	(1,142)	-2.09%
Oct-18	52,994	(569)	-1.06%
Nov-18	54,213	1,219	2.30%
Dec-18	51,990	(2,223)	-4.10%
Jan-19	51,443	(547)	-1.05%
Feb-19	51,783	340	0.66%
Mar-19	52,429	646	1.25%
Apr-19	55,174	2,745	5.24%
May-19	54,418	(756)	-1.37%
Jun-19	52,215	(2,203)	-4.05%
Jul-19	51,765	(450)	-0.86%
Aug-19	51,007	(758)	-1.46%
Sep-19	50,774	(233)	-0.46%
Oct-19	50,192	(582)	-1.15%
Nov-19	49,242	(950)	-1.89%
Dec-19	48,657	(585)	-1.19%
Jan-20	49,553	896	1.84%
Feb-20	48,577	(976)	-1.97%
Mar-20	48,077	(500)	-1.03%
Apr-20	51,230	3,153	6.56%
May-20	49,125	(2,105)	-4.11%
Jun-20	48,337	(788)	-1.60%

May 2020 Forecast	
Forecasted June 2020 Level	59,130

Base trend from June 2020 level			
FY 2020-21	48,337	-2.76%	(1,374)

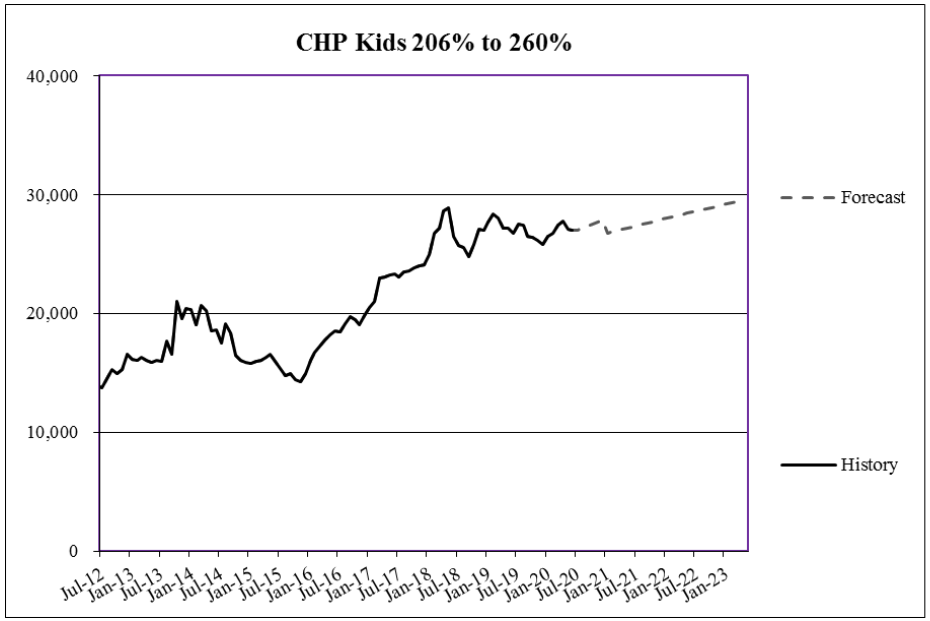
	Caseload	% Change	Level Change
FY 2011-12	63,216	-0.04%	(28)
FY 2012-13	62,261	-1.51%	(955)
FY 2013-14	42,510	-31.72%	(19,751)
FY 2014-15	37,036	-12.88%	(5,474)
FY 2015-16	34,940	-5.66%	(2,096)
FY 2016-17	43,453	24.36%	8,513
FY 2017-18	51,478	18.47%	8,025
FY 2018-19	53,294	3.53%	1,816
FY 2019-20	49,711	-6.72%	(3,583)
FY 2020-21	49,426	-0.57%	(285)
FY 2021-22	52,500	6.22%	3,074
FY 2022-23	54,789	4.36%	2,289

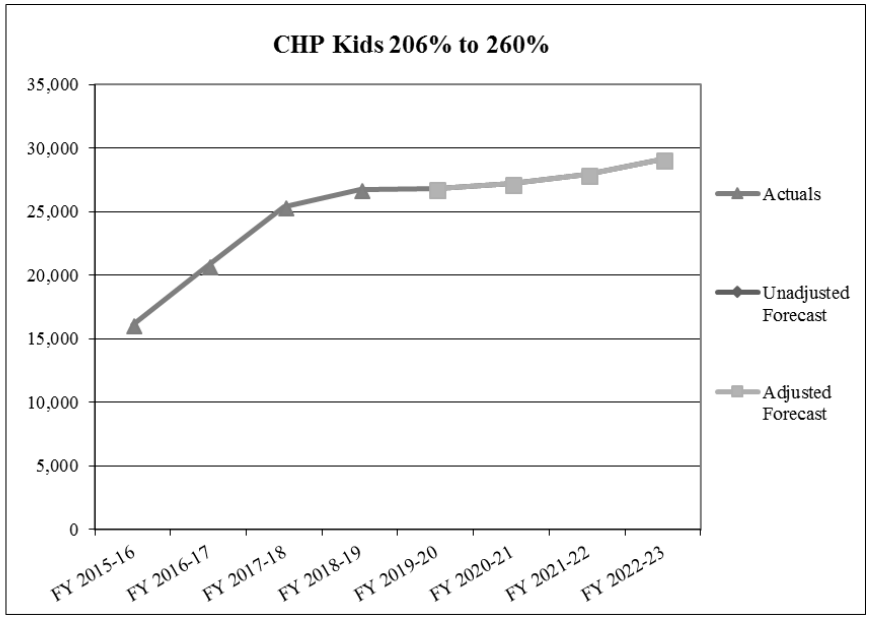
Actuals		
	Monthly Change	% Change
6-month average	(53)	-0.05%
12-month average	(323)	-0.61%
18-month average	(203)	-0.37%
24-month average	(183)	-0.33%

May 2020 Projection			
FY 2018-19	53,294	-0.41%	1,816
FY 2019-20	49,829	-6.50%	(3,465)
FY 2020-21	54,173	8.72%	4,344
FY 2021-22	56,575	4.43%	2,402

Monthly Average Growth Actuals		
FY 2014-15 1st Half	(224)	-0.48%
FY 2014-15 2nd Half	101	0.28%
FY 2014-15	(80)	-0.14%
FY 2015-16 1st Half	(709)	-1.96%
FY 2015-16 2nd Half	1,003	2.84%
FY 2015-16	147	0.44%
FY 2016-17 1st Half	514	1.30%
FY 2016-17 2nd Half	916	2.09%
FY 2016-17	715	1.69%
FY 2017-18 1st Half	116	0.25%
FY 2017-18 2nd Half	753	1.77%
FY 2017-18	435	1.01%
FY 2018-19 1st Half	(123)	-0.20%
FY 2018-19 2nd Half	38	0.11%
FY 2018-19	(43)	-0.04%
FY 2019-20 1st Half	(593)	-1.17%
FY 2019-20 2nd Half	(53)	-0.05%
FY 2019-20	(323)	-0.61%

Monthly Average Growth Comparisons		
Request	Monthly Change	
	S-3	R-3
FY 2020-21 1st Half	2,293	96
FY 2020-21 2nd Half	(1,508)	386
FY 2020-21	392	241
FY 2021-22 1st Half	(1,591)	192
FY 2021-22 2nd Half	80	192
FY 2021-22	(755)	192
FY 2022-23 1st Half		192
FY 2022-23 2nd Half		192
FY 2022-23		192





- This population before the COVID-19 pandemic was mostly flat with either little growth or declines, and since the start of the pandemic this population has maintained this trend. There has been less churn into Medicaid from this eligibility group. The Department expects that once the continuous coverage policy expires, there will be an influx of clients from Medicaid to CHP+ but that this will be netted out by the disenrollements of clients who have been locked into CHP+.

- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Children in this population have family incomes between 206% and 260% of the federal poverty level.

Children 206% to 260%

	Actuals	Monthly Change	% Change
Jun-18	26,473	-	-
Jul-18	25,694	(779)	-2.94%
Aug-18	25,515	(179)	-0.70%
Sep-18	24,805	(710)	-2.78%
Oct-18	25,835	1,030	4.15%
Nov-18	27,062	1,227	4.75%
Dec-18	26,976	(86)	-0.32%
Jan-19	27,664	688	2.55%
Feb-19	28,377	713	2.58%
Mar-19	27,988	(389)	-1.37%
Apr-19	27,128	(860)	-3.07%
May-19	27,150	22	0.08%
Jun-19	26,710	(440)	-1.62%
Jul-19	27,516	806	3.02%
Aug-19	27,411	(105)	-0.38%
Sep-19	26,478	(933)	-3.40%
Oct-19	26,373	(105)	-0.40%
Nov-19	26,170	(203)	-0.77%
Dec-19	25,793	(377)	-1.44%
Jan-20	26,447	654	2.54%
Feb-20	26,731	284	1.07%
Mar-20	27,431	700	2.62%
Apr-20	27,800	369	1.35%
May-20	27,110	(690)	-2.48%
Jun-20	26,958	(152)	-0.56%

May 2020 Forecast	
Forecasted June 2019 Level	27,345

Base trend from June 2019 level			
FY 2020-21	26,958	0.40%	106

	Caseload	% Change	Level Change
FY 2009-10	136	#N/A	#N/A
FY 2010-11	4,023	2858.09%	3,887
FY 2011-12	11,049	174.65%	7,026
FY 2012-13	15,575	40.96%	4,526
FY 2013-14	19,043	22.27%	3,468
FY 2014-15	16,668	-12.47%	(2,375)
FY 2015-16	16,100	-3.41%	(568)
FY 2016-17	20,808	29.24%	4,708
FY 2017-18	25,411	22.12%	4,603
FY 2018-19	26,742	5.24%	1,331
FY 2019-20	26,852	0.41%	110
FY 2020-21	27,231	1.41%	379
FY 2021-22	27,950	2.64%	719
FY 2022-23	29,169	4.36%	1,219

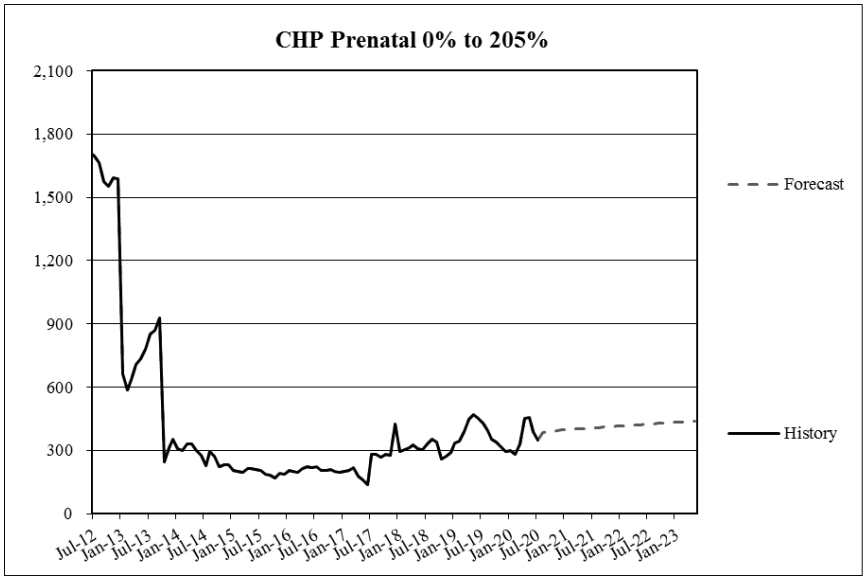
Actuals		
	Monthly Change	% Change
6-month average	194	0.76%
12-month average	21	0.10%
18-month average	(1)	0.02%
24-month average	20	0.10%

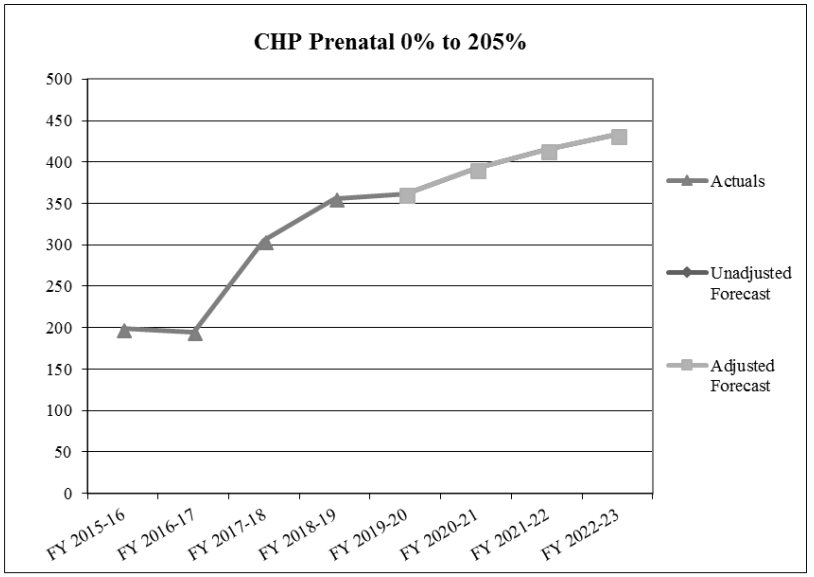
May 2020 Projection			
FY 2018-19	26,742	5.24%	1,331
FY 2019-20	26,875	-29.54%	133
FY 2020-21	29,628	10.24%	2,753
FY 2021-22	30,915	4.34%	1,287

Monthly Average Growth Actuals		
FY 2014-15 1st Half	(541)	-3.00%
FY 2014-15 2nd Half	119	0.75%
FY 2014-15	(247)	-1.34%
FY 2015-16 1st Half	(237)	-1.44%
FY 2015-16 2nd Half	610	3.74%
FY 2015-16	187	1.15%
FY 2016-17 1st Half	203	1.09%
FY 2016-17 2nd Half	587	2.81%
FY 2016-17	395	1.95%
FY 2017-18 1st Half	132	0.56%
FY 2017-18 2nd Half	397	1.71%
FY 2017-18	264	1.14%
FY 2018-19 1st Half	84	0.36%
FY 2018-19 2nd Half	(44)	-0.14%
FY 2018-19	20	0.11%
FY 2019-20 1st Half	(153)	-0.56%
FY 2019-20 2nd Half	194	0.76%
FY 2019-20	21	0.10%

Monthly Average Growth Comparisons		
Request	Monthly Change	
	S-3	R-3
FY 2019-20 1st Half	1,151	153
FY 2019-20 2nd Half	(757)	(98)
FY 2019-20	197	27
FY 2020-21 1st Half	(528)	102
FY 2020-21 2nd Half	49	102
FY 2020-21	(240)	102
FY 2021-22 1st Half		102
FY 2021-22 2nd Half		102
FY 2021-22		102

Prenatal Caseload Projections (Exhibit C4)





- The caseload of prenatal clients with FPL 0% to 205% was stable before the pandemic and there has been little growth since the start of the pandemic. In contrast to the CHP+ children, the Department does not forecast the same caseload changes in pregnant women due to the COVID-19 pandemic. As clients in this population are disenrolled from CHP+ when the pregnancy comes to term, total caseload of CHP+ pregnant women will not experience the same degree of churn as in the CHP+ children's populations. Instead, the Department expects women with completed pregnancies would either fall off public medical assistance or churn into a non-pregnant eligibility group on Medicaid.

- Along with the children's expansion to 205% FPL, this population includes the subpopulation that was created through SB 07-097 and was implemented beginning March 1, 2008. Prenatal women in this subpopulation have family incomes between 201 and 205% of the federal poverty level.

CHP+ Prenatal 206% to 260% FLP: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-17	230	-	-
Jul-17	503	273	118.70%
Aug-17	509	6	1.19%
Sep-17	512	3	0.59%
Oct-17	523	11	2.15%
Nov-17	565	42	8.03%
Dec-17	568	3	0.53%
Jan-18	575	7	1.23%
Feb-18	564	(11)	-1.91%
Mar-18	554	(10)	-1.77%
Apr-18	534	(20)	-3.61%
May-18	533	(1)	-0.19%
Jun-18	507	(26)	-4.88%
Jul-18	509	2	0.39%
Aug-18	552	43	8.45%
Sep-18	560	8	1.45%
Oct-18	534	(26)	-4.64%
Nov-18	574	40	7.49%
Dec-18	580	6	1.05%
Jan-19	606	26	4.48%
Feb-19	620	14	2.31%
Mar-19	623	3	0.48%
Apr-19	582	(41)	-6.58%
May-19	578	(4)	-0.69%
Jun-19	531	(47)	-8.13%

February 2019 Forecast	
Forecasted June 2019 Level	581

Base trend from June 2019 level			
FY 2019-20	531	-7.01%	(40)

	Caseload	% Change	Level Change
FY 2010-11	272	24	-
FY 2011-12	448	64.51%	176
FY 2012-13	463	3.46%	16
FY 2013-14	502	8.26%	38
FY 2014-15	460	-8.23%	(41)
FY 2015-16	469	1.96%	9
FY 2016-17	431	-8.17%	(38)
FY 2017-18	537	24.62%	106
FY 2018-19	571	6.28%	34
FY 2019-20	564	-1.18%	(7)
FY 2020-21	625	10.82%	61
FY 2021-22	693	10.88%	68

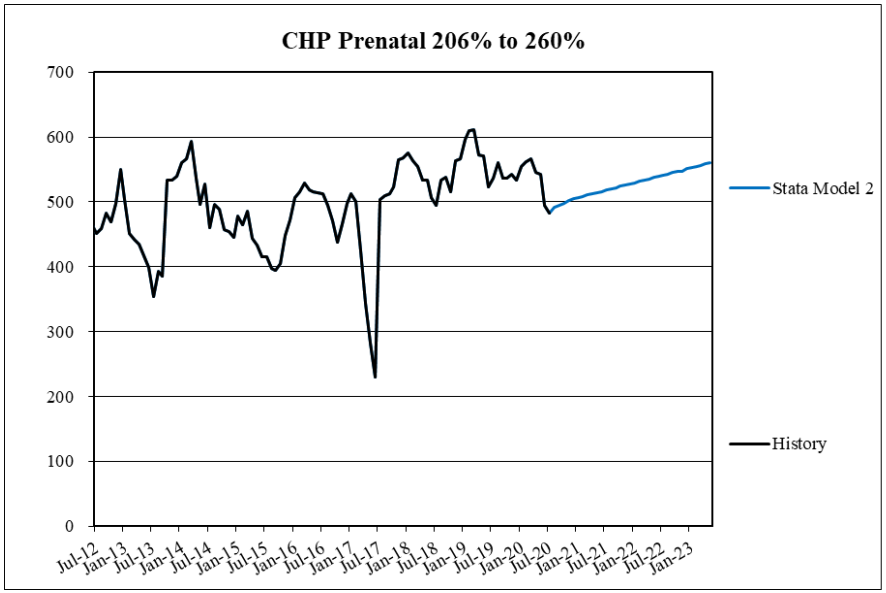
Actuals		
	Monthly Change	% Change
6-month average	(8)	-1.35%
12-month average	2	0.51%
18-month average	(2)	-0.28%
24-month average	13	5.26%

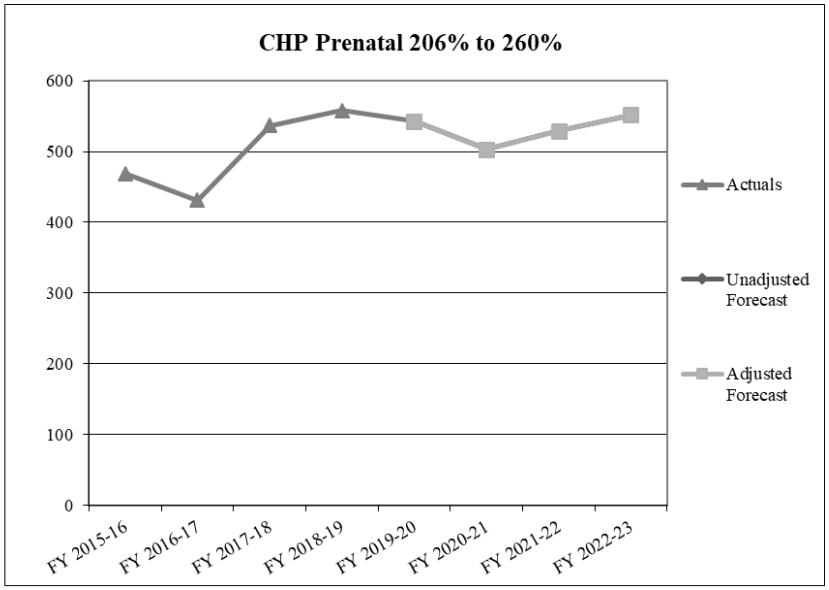
February 2019 Projection Before Adjustments			
FY 2017-18	537	24.59%	106
FY 2018-19	575	7.08%	38
FY 2019-20	598	4.00%	23
FY 2020-21	632	5.69%	34

Monthly Average Growth Actuals		
FY 2013-14 1st Half	24	6.24%
FY 2013-14 2nd Half	(2)	-0.21%
FY 2013-14	11	3.02%
FY 2014-15 1st Half	(14)	-2.54%
FY 2014-15 2nd Half	(5)	-1.02%
FY 2014-15	(9)	-1.78%
FY 2015-16 1st Half	9	2.24%
FY 2015-16 2nd Half	7	1.47%
FY 2015-16	8	1.86%
FY 2016-17 1st Half	(3)	-0.42%
FY 2016-17 2nd Half	(45)	-11.64%
FY 2016-17	(24)	-6.03%
FY 2017-18 1st Half	56	21.86%
FY 2017-18 2nd Half	(10)	-1.85%
FY 2017-18	23	10.00%
FY 2018-19 1st Half	12	2.36%
FY 2018-19 2nd Half	(8)	-1.35%
FY 2018-19	2	0.51%

Monthly Average Growth Comparisons

Request	Monthly Change		Percent Change	
	S-3	R-3	S-3	R-3
FY 2019-20 1st Half	3	5	1.24%	0.92%
FY 2019-20 2nd Half	3	5	1.24%	0.86%
FY 2019-20	3	5	1.24%	0.89%
FY 2020-21 1st Half	3	5	1.24%	0.86%
FY 2020-21 2nd Half	3	5	1.24%	0.86%
FY 2020-21	3	5	1.24%	0.86%
FY 2021-22 1st Half	#DIV/0!	6	#DIV/0!	0.86%
FY 2021-22 1st Half	#DIV/0!	6	#DIV/0!	0.86%
FY 2021-22 1st Half	#DIV/0!	6	#DIV/0!	0.86%





- The caseload of prenatal clients with FPL 0% to 205% was stable before the pandemic and there has been little growth since the start of the pandemic. In contrast to the CHP+ children, the Department does not forecast the same caseload changes in pregnant women due to the COVID-19 pandemic. As clients in this population are disenrolled from CHP+ when the pregnancy comes to term, total caseload of CHP+ pregnant women will not experience the same degree of churn as in the CHP+ children's populations. Instead, the Department expects women with completed pregnancies would either fall off public medical assistance or churn into a non-pregnant eligibility group on Medicaid.

- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Pregnant women in this population have family incomes between 206% and 260% of the federal poverty level.

CHP+ Prenatal 206% to 260% FLP: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-18	507	-	-
Jul-18	494	(13)	-2.56%
Aug-18	534	40	8.10%
Sep-18	538	4	0.75%
Oct-18	515	(23)	-4.28%
Nov-18	563	48	9.32%
Dec-18	566	3	0.53%
Jan-19	596	30	5.30%
Feb-19	610	14	2.35%
Mar-19	612	2	0.33%
Apr-19	572	(40)	-6.54%
May-19	571	(1)	-0.17%
Jun-19	523	(48)	-8.41%
Jul-19	537	14	2.68%
Aug-19	561	24	4.47%
Sep-19	537	(24)	-4.28%
Oct-19	536	(1)	-0.19%
Nov-19	543	7	1.31%
Dec-19	533	(10)	-1.84%
Jan-20	554	21	3.94%
Feb-20	562	8	1.44%
Mar-20	566	4	0.71%
Apr-20	545	(21)	-3.71%
May-20	542	(3)	-0.55%
Jun-20	495	(47)	-8.67%

May 2020 Forecast	
Forecasted June 2020 Level	548

Base trend from June 2019 level			
FY 2020-21	495	-8.84%	(48)

	Caseload	% Change	Level Change
FY 2011-12	448	1	176
FY 2012-13	463	3.35%	15
FY 2013-14	502	8.42%	39
FY 2014-15	460	-8.37%	(42)
FY 2015-16	469	1.96%	9
FY 2016-17	431	-8.10%	(38)
FY 2017-18	537	24.59%	106
FY 2018-19	558	3.91%	21
FY 2019-20	543	-2.69%	(15)
FY 2020-21	503	-7.37%	(40)
FY 2021-22	529	5.17%	26
FY 2022-23	552	4.35%	23

Actuals		
	Monthly Change	% Change
6-month average	(6)	-1.14%
12-month average	(2)	-0.39%
18-month average	(4)	-0.66%
24-month average	(1)	0.00%

May 2020 Projection			
FY 2018-19	558	3.91%	21
FY 2019-20	547	-1.97%	(11)
FY 2020-21	597	9.14%	50
FY 2021-22	625	4.61%	28

Monthly Average Growth Actuals		
FY 2014-15 1st Half	(10)	-2.08%
FY 2014-15 2nd Half	(1)	0.08%
FY 2014-15	(6)	-1.12%
FY 2015-16 1st Half	5	1.19%
FY 2015-16 2nd Half	7	1.47%
FY 2015-16	6	1.33%
FY 2016-17 1st Half	(3)	-0.42%
FY 2016-17 2nd Half	(45)	-11.64%
FY 2016-17	(24)	-6.03%
FY 2017-18 1st Half	56	21.86%
FY 2017-18 2nd Half	(10)	-1.85%
FY 2017-18	23	10.00%
FY 2018-19 1st Half	10	1.98%
FY 2018-19 2nd Half	(7)	-1.19%
FY 2018-19	1	0.39%
FY 2019-20 1st Half	2	0.36%
FY 2019-20 2nd Half	(6)	-1.14%
FY 2019-20	(2)	-0.39%

Monthly Average Growth Comparisons

Request	Monthly Change		Percent Change	
	S-3	R-3	S-3	R-3
FY 2020-21 1st Half	19	3	3.20%	0.67%
FY 2020-21 2nd Half	(12)	2	-1.67%	0.38%
FY 2020-21	4	3	0.77%	0.52%
FY 2021-22 1st Half	5	2	0.83%	0.37%
FY 2021-22 2nd Half	5	2	0.79%	0.36%
FY 2021-22	5	2	0.81%	0.37%
FY 2022-23 1st Half	0	2	0.00%	0.35%
FY 2022-23 2nd Half	0	2	0.00%	0.35%
FY 2022-23	0	2	0.00%	0.35%