COLORADO

Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
Medical Services Premiums

FY 2021-22, FY 2022-23, and FY 2023-24 Budget Request

November 2021

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I. BACKGROUND

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible older adults, 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 supports 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, a 90.0% FMAP. 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%.

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. . An enhanced federal match was authorized through the Families First Coronavirus Response Act and is currently projected to end December 31, 2021 which would mean an FMAP of 53.10% in FY 2021-22. Through the American Rescue Plan Act, the Department may also claim a 10-percentage point FMAP bump on certain Medicaid Home and Community-Based Services (HCBS) from April 1, 2021 through March 31, 2022. Data from the Colorado Population Forecast, the U.S. Census, and the Legislative Council is used to estimate the FMAP for FY 2022-23 and FY 2023-24 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 2020-21 actuals contained within this request reflect data for FY 2020-21 as of August 13, 2021.

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: Brain Injury
- Home-and Community-Based Services: Children with Life Limiting Illness
- Home-and Community-Based Services: Spinal Cord Injury Adult
- 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. 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%, summarized in the table below. Members who transitioned from CHP+ to Medicaid under SB 11-008 and SB 11-250 and members in BCCP receive the enhanced FMAP, which is approximately 65%. The State's FMAP for Medicaid services for members receiving the enhanced match is currently 69.34% due to enhancements authorized through the Families First Coronavirus Response Act The expansion populations, MAGI Parents/Caretakers 69% to 133% and MAGI Adults, receive a match of 90.00% 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%. The Disabled Buy-In population receives the standard match for expenditure net of patient premiums.

The Department can also claim an enhanced FMAP on certain Home- and Community- Based (HCBS) services based on a provision in Section 9817 of the American Rescue Plan Act. Section 9817 of the American Rescue Plan Act provides the Department with a temporary 10 percentage point increase to the FMAP for certain HCBS services from April 1, 2021 through March 31, 2022. To receive the increased FMAP, states and territories must meet certain requirements. The increased FMAP for HCBS cannot exceed 95%. As required by section 9817 of the American Rescue Plan Act, the temporary increased FMAP is only available for expenditures for certain services, including HCBS waivers, the Program of All Inclusive Care for the Elderly (PACE), Home Health, Private Duty Nursing, Case Management, and Rehabilitative Services. The Department included the enhanced FMAP bump for these services in Exhibit A.

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 2021-22	67.17%	Qualifying clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	67.17%	Clients in the BCCP program	Please see Exhibit F
	90.00%	MAGI Parents/Caretakers 69% to 133% FPL, MAGI Adults	Please see Exhibit J
	80.78%	MAGI Adult Non-Newly Eligible	Please see Exhibit J
	53.10%	Disabled Buy-In, MAGI Parents/Caretakers 60-68% FPL	HAS Fee portion matched at 53.10%, Medicaid Buy-In Fund 0%
FY 2022-23	65.00%	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%
FY 2023-24	65.00%	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 2021-22	100.00%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	54.10%	ACA Preventive Services	Please see Exhibit A
	90.00%	Family Planning Services	Please see Exhibit F
	100.00%	Indian Health Services	Please see Exhibit F
FY 2022-23	100.00%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51.00%	ACA Preventive Services	Please see Exhibit A
	90.00%	Family Planning Services	Please see Exhibit F
	100.00%	Indian Health Services	Please see Exhibit F
FY 2023-24	100.00%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51.00%	ACA Preventive Services	Please see Exhibit A
	90.00%	Family Planning Services	Please see Exhibit F
	100.00%	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 50.00% 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 at the enhanced match.

- 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 enhanced FMAP 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".

- 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 ensured 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.

- 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.

- 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 under a Random Moment Time Study (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.

- 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.

- 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 $1,400,000 total funds, with the State share being transferred through Denver Health & Hospital Authority.

- 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.

- 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: Originally approved under SB 17-254, the Colorado Legislature approved a transfer from the University of Colorado School of Medicine (UCSOM) to the Department to gain access to federal matching funds. The Department then would reimburse UCSOM through a UPL payment for physician services.

- Public School Health Services: Approved as part of the FY 2019-20 S-7, BA-7 "Public School Health Services Funding Adjustment", this request allowed the Department to use certified public expenditure spent on Public School Health Services (SHS) programs to claim a federal match. Part of the claimed federal funds are applied as a General Fund offset in the Medical Services Premiums line.

- SB 21-213 Use of Increased Medicaid match accounts for the transfer of savings from cash fund financed services to the General Fund as a result of the enhanced federal match was authorized through the Families First Coronavirus Response Act.

- 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.

  The table below shows the impact by cash fund for FY 2021-22, FY 2022-23, and FY 2023-24.

Cash and Reappropriated Funds	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**
Tobacco Tax Cash Fund (SB 11-210)	$1,996,170	$1,924,065	$1,902,5400
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)	$9,897,464	$9,897,464	$9,897,464
Service Fee Fund (SB 13-167)	$200,460	$200,460	$200,460
Total	**$27,593,634**	**$27,521,529**	**$27,500,004**

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Page EB-1 contains historical and projected caseload for all eligibility types. Pages EB-2 through EB-5 provide historical monthly caseload without retroactivity for each of the eligibility types. 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 letter note 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.

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.

The table below describes the trend selections for FY 2021-22, FY 2022-23, and FY 2023-24. The selected trend factors for each year, with the rationale for selection, are as follows:

Aid Category	FY 2021-22 Trend Selection	FY 2022-23 Trend Selection	FY 2023-24 Trend Selection	Justification
Adults 65 and Older (OAP-A)	4.61%	16.50%	6.44%	The Department kept the same trend from the February request in FY 2021-22. The Department increased the FY 2022-23 trend anticipating an increase in per capita costs corresponding to the disenrollment of lower cost members who were on continuous coverage during the PHE.
Disabled Adults 60 to 64 (OAP-B)	8.23%	8.23%	4.12%	The Department kept the trend from the February request.
Disabled Individuals to 59 (AND/AB)	7.76%	2.82%	7.76%	The Department kept the same trend from the February request due to an increase in pharmacy expenditure for this population.
Disabled Buy-in	0.00%	2.49%	3.79%	The Department kept the trend from the February Request in FY 2021-22. The Department increased the FY 2022-23 trend anticipating an increase in per capita costs corresponding to the disenrollment of lower cost members who were on continuous coverage during the PHE.

Aid Category	FY 2021-22 Trend Selection	FY 2022-23 Trend Selection	FY 2023-24 Trend Selection	Justification
MAGI Parents/ Caretakers to 68% FPL	0.56%	5.82%	5.82%	The Department decreased the trend from the February request due to a decrease in utilization across many service categories in FY 2021-22. The Department increased the FY 2022-23 trend anticipating an increase in per capita costs corresponding to the disenrollment of lower cost members who were on continuous coverage during the PHE.
MAGI Parents/ Caretakers 69% to 133% FPL	2.20%	5.27%	4.35%	The Department increased the trend from the February request due to an increase in utilization across many service categories. The Department anticipates the per capita of this population will continue to grow based on historical growth in per capita costs. The Department increased the FY 2022-23 trend anticipating an increase in per capita costs corresponding to the disenrollment of lower cost members who were on continuous coverage during the PHE.
MAGI Adults	0.00%	5.72%	0.00%	The Department decreased the trend from the February forecast due to a decrease in utilization across many service categories. The Department increased the FY 2022-23 trend anticipating an increase in per capita costs corresponding to the disenrollment of lower cost members who were on continuous coverage during the PHE.

Aid Category	FY 2021-22 Trend Selection	FY 2022-23 Trend Selection	FY 2023-24 Trend Selection	Justification
Breast and Cervical Cancer Program	5.82%	0.00%	7.96%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program Per Capita Detail and Fund Splits" for a description of this trend factor.
Eligible Children (AFDC-C/ BCKC-C)	3.64%	12.83%	4.02%	The Department kept the trend from the February request in FY 2021-22. The Department increased the FY 2022-23 trend anticipating an increase in per capita costs corresponding to the disenrollment of lower cost members who were on continuous coverage during the PHE.
SB 11-008 Eligible Children	1.61%	5.00%	1.61%	The Department kept the same trend from the February request. The Department increased the FY 2022-23 trend anticipating an increase in per capita costs corresponding to the disenrollment of lower cost members who were on continuous coverage during the PHE.
Foster Care	2.13%	0.00%	3.42%	The Department increased the trend relative to the February request due to increased utilization.
MAGI Pregnant Adults	0.00%	36.45%	6.65%	The Department decreased the trend from the February request due to a decrease in utilization of services. The Department increased the FY 2022-23 trend anticipating an increase in per capita costs corresponding to the disenrollment of lower cost members who were on continuous coverage during the PHE.

Aid Category	FY 2021-22 Trend Selection	FY 2022-23 Trend Selection	FY 2023-24 Trend Selection	Justification
SB 11-250 Eligible Pregnant Adults	0.00%	44.55%	6.65%	The Department kept the same trend from the February request in FY 2021-22. The Department increased the FY 2022-23 trend anticipating an increase in per capita costs corresponding to the disenrollment of lower cost members who were on continuous coverage during the PHE.
Non-Citizens	1.23%	48.00%	1.23%	The Department kept the same trend from the February request in FY 2021-22. The Department increased the FY 2022-23 trend anticipating an increase in per capita costs corresponding to the disenrollment of lower cost members who were on continuous coverage during the PHE.
Partial Dual Eligibles	2.90%	24.00%	2.90%	The Department kept the same trend from the February request in FY 2021-22. The Department increased the FY 2022-23 trend anticipating an increase in per capita costs corresponding to the disenrollment of lower cost members who were on continuous coverage during the PHE.

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:

- FY 2019-20 R-6 Local Administration Transformation – The Department received $700,000 for FY 2019-20 and $1,966,848 in FY 2020-21 to implement three initiatives that would improve county performance and accountability, increasing incentive funding and oversight, removing NEMT administration from county administration responsibilities, and consolidating returned mail processing.

- Annualization of 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.
- Annualization of 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 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.
- Annualization of Accountable Care Collaborative (ACC) savings accounts for reductions in Acute Care expenditure resulting from ACC program activities. Additional detail can be found in Exhibit I.
- 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.
- FY 2020-21 R-10 Community Provider Rate Decrease (1.0% Across-the-Board) incorporates the acute care impact of the 1.0% across-the-board decreases approved during the 2020 legislative session.
- COVID-19 Utilization incorporates the estimated increase in utilization of hospital services and laboratory services associated with COVID-19. The Department estimated the impact using projections of hospitalizations from the Colorado Department of Public Health and Environment for the state, and by estimating the proportion of hospitalizations that for Medicaid members of the total COVID-19 hospitalizations based on the most recent data on Medicaid members with a hospitalization related to COVID-19.
- R-12 Work Number Verification provides funding in order to implement a robust income verification process for Medicaid and CHP+ eligibility determinations based on real-time verifications. The Department will set up contract with a vendor to obtain work number verification data and anticipates costs avoided from a reduction in Medicaid caseload.
- R-6 Local Administration, the NEMT program is now centrally administered to alleviate the need for 55 counties to use local funds and streamline the system.
- R-7 Pharmacy Pricing and Technology Request incorporates savings for rate changes to the departments prescription drug reimbursement methodology and the Department's physician drug administered drug methodology.
- SB 20-212 Telehealth Services this bill increase costs associated with telehealth services being provided and reimbursed at the in-person rate.
- COVID-19 Vaccine Administration cost incorporates costs associated with the administration of the COVID-19 vaccine.

- Continuous Glucose Monitor Policy Clarification Bottom Line Impact incorporates increase in cost associated with clarifying the Department's policy for Continuous Glucose Monitors.
- SB 21-137 Behavioral Health Recovery Act increased the number of perinatal mood screenings from 3 to 4.
- SB 21-194 Maternal Health Providers expanded postpartum coverage from sixty days to 12 months.
- SB 21-009 Reproductive Health Care Program created a state only program to provide reproductive services to non-citizens. The Department expects to see savings in the emergency services populations.
- FY 2022 R-16 Provider Rate Adjustments - Allergy Testing Rates accounts for a reduction to allergen testing rates. The Department changed allergen testing to be based on the commercial benchmark.
- FY 2022 R-16 Provider Rate Adjustments - Benchmark Certain Rates to Medicare accounts for a rebalancing of DME and ambulatory rates to 80 to 100% of the Medicare rates.
- FY 2022 R-16 Provider Rate Adjustments - Outpatient Hospital Physician Administered Drugs accounts for reducing the Enhanced Ambulatory Patient Grouping (EAPG) weights by 35.00% from 20.00% for claims associated with 340B drugs in FY 2021-22 and ongoing.
- FY 2022 R-16 Provider Rate Adjustments - Lab Testing Code Rate Reduction accounts for increases in the lab testing code rates to 80% of Medicare's rates and aligns the rates with the Medicare Definitive drug testing policy.
- FY 2021-22 BA-15 Implement eConsult Program authorizes the Department to implement a Medicaid statewide eConsult platform. The adjustment accounts for the net effect of reimbursements to providers and savings from avoided face-to-face specialist visits.
- FY 2020-21 JBC Action 2.5% ATB Rate Increase accounts for the increase in expenditure associated with increasing- rates for all eligible services by 2.5%.
- HB 21-1085 Secure Transportation for Behavioral Health Crisis accounts for a new service within Non Emergency Medical Transportation that provides transportation to members in a behavioral health crisis.
- HB 21-1275 Medicaid Reimbursement for Pharmacists Rendered Services accounts for an increase in services that can be rendered by pharmacists under a collaborative agreement with a physician. This policy change allows pharmacists to render some primary care services as long as they are in collaboration with a physician.
- SB 21-211 (Adult Dental Benefit $1500 Cap reinstatement) This bill repeals the $1,000 annual Medicaid adult dental benefit cap and also reverses and repeals fund transfers previously enacted in HB 20-1361.
- Estimated Increase in Flu Expenditure accounts for an increase in costs associated with an increase in flu expenditure relative to FY 2020-21.
- Reduction to Blood Clotting Medication accounts for a decrease in rates associated with blood clotting medications.
- Per Capita Damper for New Enrollees accounts for the decrease in per capita costs for certain populations due to lower cost member's being locked into Medicaid.

- Estimated Increase in Respiratory Syncytial Virus (RSV) accounts for expected increases in treating RSV. There were virtually no expenditures associated with treatment of RSV in FY 2020-21 due to increased social distancing during the regular RSV season between October 2020 and March 2021. The Department is already seeing an uptick in reimbursement of these expenditures starting in August 2021.

Breast and Cervical Cancer Program Per Capita Detail and Fund Splits

In 2001, the General Assembly passed SB 01-012, which established a Breast and Cervical Cancer Treatment Program within the Department. In 2019, the General Assembly passed HB 19-1302 which extended the repeal date of the program to 2029. 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 2020-21. 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 2019-20. Therefore, the Department adjusted the per capita up for FY 2021-22, FY 2022-23, and FY 2023-24.

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 forecasted expenditure based on the most recent actuals, which were lower than previously forecasted. Therefore, the Department has lowered the forecast for FY 2021-22, FY 2022-23, and FY 2023-24.

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 most recent actuals. The Department decreased costs in FY 2021-22 from previous forecasts based on FY 2020-21 data. The Department carried the forecasted growth from FY 2018-19 to FY 2020-21 into the FY 2021-22 ongoing.

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 understated and artificially low in FY 2016-17. The Department has trended forward the FY 2020-21 expenditure by a fraction of previous growth rates to reach FY 2021-22, FY 2022-23, and FY 2023-24 estimates.

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.

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

Home- and Community-Based Services (HCBS) Waivers

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 2019 through the June 2020, the Department paid HCBS-LTSS waiver claims for an average of 30,865 clients per month.

Clients receiving CBLTC services currently have access to 10 HCBS waivers, each targeted to specific populations. Of the 10 waivers administered by the Department, 6 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 and the Consumer Directed Attendant Support (CDASS) State Plan Waiver ended operation effective January 1, 2019. Information for the CDASS State Plan waiver and CWA waiver 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]
- Children's Home-and Community-Based Services Waiver
- Brain Injury Adult Waiver
- Children with Life Limiting Illness Waiver[2]
- Spinal Cord Injury Adult Waiver[3]

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.

Since the Department is using an enrollment-based methodology to define caseload, a utilization adjustment must be used prior to developing final projected expenditure. This utilization adjustment is determined by taking the ratio of paid claims in given month to the number of PARs in the same month. The Department has chosen to incorporate actual data on average monthly utilizers to average monthly enrollments to select a utilization adjustment that aligns with the last six months of FY 2021-22. The Department then used this adjustment factor to estimate the FPE and adjust projected expenditure for each waiver in FY 2021-22, FY 2022-23, and FY 2023-24.

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

The selected enrollment, utilization adjustments, and cost per utilizer trend factors for FY 2021-22, FY 2022-23, and FY 2023-24 with the rationale for selection, are below. In most cases, the Department increased trends for both enrollment and cost per utilizer from the February forecast for each of the three years based on the last six months of FY 2020-21.

Home- and Community-Based Long-Term Services and Supports Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Cost Per Utilizer Trend Selection**	**Justification**
Elderly, Blind and Disabled Waiver	FY 2021-22 through FY 2023-24: 2.89%, 2.90%, 2.90% respectively	FY 2021-22 through FY 2023-24: 8.49%, 5.29%, 3.16% respectively	The last six months of FY 2020-21 showed a slightly higher average enrollment of 26,407 members which is higher than previous enrollment estimates for the EBD waiver. The Department projects an increase in enrollment of about 2.89% in FY 2021-22 and 2.90% in the future years. Per utilizer costs for this waiver increased in the last six months of FY 2020-21 compared to the Department's previous forecast. The Department predicts cost per utilizer will grow in FY 2021-22 by approximately 8.49% to around 5.29% in FY 2022-23, and 3.16% in FY 2023-24.
Community Mental Health Supports Waiver	FY 2021-22 through FY 2023-24: 2.03%, 2.02%, 2.01% respectively	FY 2021-22 through FY 2023-24: 2.44%, 2.26%, 0.05% respectively	The last six months of FY 2021-22 showed higher average enrollment of 3,688 members which is higher than previous enrollment estimates for the CMHS waiver. The Department projects an increase in enrollment of about 2.03% in FY 2021-22, 2.02% in FY 2022-23, and 2.01% in FY 2023-24. Per utilizer cost for the CMHS waiver increased slightly in the last six months of FY 2020-21 compared to the Department's previous forecast. The Department predicts cost per utilizer will grow slightly

			in FY 2021-22 by approximately 2.44% in FY 2021-22, to 2.26% in FY 2022-23, and 0.05% in FY 2023-24.
Children's Home and Community Based Services Waiver	FY 2021-22 through FY 2023-24: 8.32%, 7.63%, 2.64% respectively	FY 2021-22 through FY 2023-24: 12.64%, 7.27%, 7.49% respectively	Since FY 2011-12, average annual enrollment growth is around 5.78% with large increases in the past three fiscal years. The last six months of FY 2020-21 showed slightly higher average enrollment compared to previous estimates for the CHCBS waiver. The Department is projecting enrollment growth of 8.32% in FY 2021-22, 7.63% in FY 2022-23, and 2.64% in FY 2023-24. 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. Per utilizer costs continue to grow as new people join the waiver and existing waiver enrollees shift to IHSS.
Brain Injury Waiver	FY 2021-22 through FY 2023-24: 5.61%, 7.48%, 7.42% respectively	FY 2021-22 through FY 2023-24: 6.84%, 2.16%, 0.24% 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. Average enrollment in FY 2020-21 was only slightly higher than previously anticipated and the Department projects a growth trend of 5.61% FY 2021-22, 7.48% in FY 2022-23, and 7.42% in FY 2023-24. In the last half of FY 2020-21, the actual cost per utilizer was only slightly higher, but very close to what was predicted in the previous forecast. Because of this the Department projects cost per utilizer will remain almost constant, with a small growth trend of 6.84% in FY 2021-22, 2.16% in FY 2022-23, and 0.24% in FY 2023-24.

Children with Life Limiting Illness Waiver	FY 2021-22 through FY 2023-24: 9.90%, 12.32%, 6.75% respectively	FY 2021-22 through FY 2023-24: 6.46%, 6.73%, 2.44% respectively	The last six months of FY 2020-21 showed almost no increase in the average enrollment compared to the February forecast. The Department projects enrollment will grow by 9.90% in FY 2021-22, 12.32% in FY 2022-23, and 6.75% in FY 2023-24. Per utilizer cost for this waiver was lower in the last six months of FY 2020-21 compared to the Department's previous forecast. The Department predicts cost per utilizer will grow only slightly in FY 2021-22 by approximately 6.46%, 6.73% in FY 2022-23, and 2.44% in FY 2023-24.
Spinal Cord Injury Waiver	FY 2021-22 through FY 2023-24: 6.57%, 10.43%, 62.66% respectively	FY 2021-22 through FY 2023-24: 2.17%, 5.01%, -0.14% respectively	Senate Bill 19-197 "Spinal Cord Pilot Alterative Med" reauthorized the waiver for five more years. After removal of the enrollment cap, annual enrollment growth has averaged 22.82% in the last three fiscal years. The Department believes growth will continue to increase in FY 2021-22, and throughout FY 2022-23, and FY 2023-24. Cost per utilizer in the last half of FY 2020-21 was slightly lower than what was previously forecasted FY 2019-20 with an increase in the number of waiver utilizers. A positive growth trend of 2.17% was selected in FY 2021-22 followed by a trend of 5.01%in FY 2022-23, and -0.14% FY 2022-24.

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. 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, 2020. 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. CCT clients enrolling into LTSS waivers are captured in the enrollment trends. These clients, however, are eligible for five services, in addition to waiver services, to aid in their transitions. This bottom line impact accounts for expenditure on those five transition services that clients have access to during their one year of transitioning.
- SB 20-212 "Reimbursement for Telehealth Services": The bill expands Medicaid reimbursement for telehealth services to new providers and establishes requirements for state-regulated health insurance carriers and home care agencies related to the delivery of telehealth services.
- FY 2021-22 Across the Board 2.5% Rate Increase – The Join Budget Committee approve a 2.5% across the board rate increase, effective July 1, 2021.
- Local Minimum Wage: In the 2020 legislative session, the JBC approved an action to increase rates for certain HCBS services in the Denver metro area in response to Denver increasing its minimum wage starting on January 1, 2020 with subsequent increases each January through January 1, 2022. This bottom line impact includes the expenditure impact of three years of rate increases.
- FY 2020-21 R-10 Community Provider Rate Decrease incorporates the HCBS waiver impact of the 1.0% across-the-board decreases approved during the 2020 legislative session.
- FY 2020-21 R-13 Long-Term Care Utilization Management CDASS - accounts for savings that will result from the Department increasing utilization management activities for In-Home Support Services (IHSS) population.
- FY 2020-21 R-13 Long-Term Care Utilization Management IHSS - accounts for savings that will result from the Department increasing utilization management activities for Consumer Directed Attendant Support Services (CDASS) population.

- Executive Order D 2021 010 – OSPB approved a 3-month rate increase for Alternative Care Facility services (ACF), Adult Day services, Non-Medical Transportation (NMT), and Supported Living Program (SLP) services.
- FY 2021-22 R-6 Remote Supports for HCBS Programs – The Department requested to add a remote support option to existing electronic monitoring services for the EBD, CMHS, BI and SCI waivers. Remote supports are a method of service that joins technology and direct care to support people with disabilities and should reduce the use of in-person services.
- SB 21-038 "Expansion of Complementary and Alternative Medicine" – This bill requires the Department to implement a pilot program that would allow an eligible person with to receive complementary or alternative medicine. The purpose of the pilot program is to expand the choice of therapies available to eligible persons with disabilities and to study the success of complementary and alternative medicine. This bill expanded the pilot program to include persons with specific spinal cord injuries along with the total inability for independent ambulation directly resulting from one of these injuries. This bill expands the pilot program to all eligible individuals in Colorado.
- JBC Authorization of 667 enrollments onto the HCBS - DD waiver –the General Assembly authorized an additional 667 enrollments to be placed onto the HCBS-DD waiver from the waiting list. The Department assumes that if these enrollments were not authorized by the General Assembly, these individuals would have sought alternative care by enrolling on the HCBS Elderly, Blind and Disabled waiver.

Hospice

Hospice expenditure for FY 2021-22, FY 2022-23, and FY 2023-24 is forecasted as the sum of two primary categories of services. The first category – Nursing Facility Room and Board expenditure – is for expenses incurred on a per-diem basis for clients receiving hospice services in a full-time capacity within a nursing facility. This expenditure represented approximately 76% of total hospice expenditure in FY 2020-21. 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 rate for hospice services, and the per diem for hospice clients is prescribed at approximately 95% of the per diem rate 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 rate, 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 2021-22 patient days. Due to COVID-19, the Department's data showed members spending less time within nursing facilities receiving hospice services. Therefore, the number of claims incurred in FY 2020-21 were low compared to previous fiscal years and compared to the February forecast. The Department assumes that hospice utilization will slowly ramp back up to levels seen prior to the pandemic. 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 2% per-year following HB 20-1362 which limits the annual increase in the general fund share of per diem rates for nursing facilities to 2% for FY 2020-21 and FY 2021-22. 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 2020-21, Hospice Routine Home Care expenditure was approximately $14.5 million and thus represented approximately 83% of Hospice Services expenditure and 24% 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 patient days by increasing the total patient days in FY 2021-22 by 0.92%. Starting from FY 2021 – 22, Routine Home Care patient days were increased by another 0.92% for FY 2022-23 and 0.92% in FY 2023-24; the trends were selected with the assumption that patient days would grow more slowly compared to the February forecast due to the COVID-19 pandemic. The Hospice Routine Home Care per diem is forecasted by applying approximately a 2.50% trend to daily rates in FY 2020-21 based on the YTD average rate. Starting on January 1, 2016, the Department was instructed by CMS to implement a tiered rate system for Routine Home Care Services. [4] 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 2020-21, the Department paid approximately $2.8

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

million for Hospice General Inpatient Care. The Department estimated FY 2021-22, FY 2022-23, and FY 2023-24 service costs by trending FY 2020-21 expenditure by the percentage change in growth from FY 2018-19, FY 2019-20 to FY 2020-21.

The remaining components of hospice services expenditure in total represent approximately $127,000 of expenditure based on FY 2020-21 actual expenditure. There is significant variation in these remaining services by fiscal year. The Department estimated that expenditure would remain steady going into FY 2021-22, FY 2023-24 and FY 2024-25.

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 rates for Hospice services by 2.50%. This increase does not apply to Nursing Facility Room and Board.

Private Duty Nursing

Private Duty Nursing (PDN) services are face-to-face skilled nursing services provided in a more individualized fashion than comparable services available under the home health benefit or in hospitals or nursing facilities and are generally provided in a client's home. PDN services are billed hourly; maximum daily eligibility is 16 hours for adults and 24 hours for pediatric clients. There are five categories of PDN expenditure: individual services provided by a registered nurse (RN), group services provided by a registered nurse (RN-group), individual services provided by a licensed practical nurse (LPN), group services provided by a licensed practical nurse (LPN-group), and blended services. RN services are associated with the highest hourly rate and LPN-group services with the lowest. The remaining three services – RN-group, LPN, and blended – charge similar rates. PDN rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change. During the FY 2021-22 Legislative Session, PDN services received a 2.5% across the board rate increase which was implemented on July 1, 2021.

The Department expects rates to remain constant, expenditure forecasts for FY 2021-22, FY 2022-23and FY 2023-24 are directly from the Department fee schedule for each service.

Private Duty Nursing Utilization Trends and Justification

Service	Average Month Utilizer Trend Selection	Units Per Client Trend Selection
Registered Nursing (RN)	FY 2021-22: 5.61% FY 2022-23: 2.81% FY 2023-24: 2.89%	FY 2021-22: 1.06% FY 2022-23: 0.50% FY 2023-24: 0.54%
Licensed Practical Nursing (LPN)	FY 2021-22: 0.00% FY 2022-23: 0.00% FY 2023-24: 0.00%	FY 2021-22: 3.78% FY 2022-23: 3.80% FY 2023-24: 3.80%
Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN	FY 2021-22: 13.74% FY 2022-23: 2.68% FY 2023-24: 1.96%	FY 2021-22: 4.30% FY 2022-23: 3.47% FY 2023-24: 4.64%

Registered Nursing (RN):
In FY 2020-21, average monthly clients reverted back to higher positive growth trends compared to in FY 2019-20. The Department anticipates that the growth trend will slow; therefore, the Department chose a positive trend of 5.61% for the current fiscal year and lowered the trend for the request year and out year.

FY 2019-20 units per clients included a 53rd payment week and because of this the trend in FY 2020-21 actuals appeared to be lower. The Department applied a small increase in units per client in the current year and then leveled off the trend. To keep in line with this expectation the Department placed a small positive trend of 1.06% on units per client for FY 21-22 and then assumed half of this growth for the request and out year.

Licensed Practical Nursing (LPN):
LPN average utilizers per month has had strong negative trends for the last three fiscal years. The Department believes that the number of clients has started to level off. The Department chose a trend of 0.00% for the current year and the out years.

FY 2019-20 units per clients included a 53rd payment week and because of this the trend in FY 2020-21 actuals appears to be lower; because of the additional payment period in the last fiscal year. LPN units per client have increased the past two years, and the

Department assumes that this trend will continue on into the future. The Department assumed a 3.78% growth rate for the current year units per client, as well as the request and out year.

Registered Nursing (RN) Group/Licensed Practical Nursing Group (LPN) and Blended RN/LPN*:*
LPN-group, RN-group, and Blended RN/LPN drove 17.31% of total expenditure in FY 2020-21 and represent the smallest number of average utilizers per month. Due to large growth in the Department, the Department assumes a high growth trend that will level off. The Department in FY 2021-22 selected a trend of 22.06% and then decrease in future fiscal years to 4.38% and 4.31%.

FY 2019-20 units per clients included a 53rd payment week and because of this the trend for FY 2020-21 actuals appeared lower; because of the additional payment period in the last fiscal year. For the grouped and blended PDN services, the growth of units per client has fluctuated between negative and positive the last few years. The department chose a 4.30% growth rate for the current year, changing only slightly to 3.47% for the request year, and then increasing slightly to 4.64% for the out year.

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. The following impacts have been included in the Request for Long-Term Home Health:

Expenditure

- FY 2021-22 Private Duty Nursing Targeted Rate Increase – The Joint Budget Committee approved targeted rate increases for Private Duty Nursing. Registered Nursing received a rate increase of 5.86% and Licensed Practical Nursing received a rate increase of 10.5%.

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 per-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. During the FY 2021-22 Legislative Session, LTHH services received a 2.50% across the board rate increase effective July 1, 2021.

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.

LTHH Trends and Justifications

Service	Average Monthly Utilizer Trend Selection	Average Units Per Client Trend Selection
Home Health Aid Basic	FY 2021-22: 5.14% FY 2022-23: 5.14% FY 2023-24: 5.15%	FY 2021-22: 2.74% FY 2022-23: 2.94% FY 2023-24: 2.94%
Home Health Aid Extended	FY 2021-22: 3.19% FY 2022-23: 3.19% FY 2023-24: 3.20%	FY 2021-22: 0.78% FY 2022-23: 0.39% FY 2023-24: 0.39%
Registered Nursing/Licensed Practical Nurse	FY 202122: 0.30% FY 2022-23: 0.00% FY 2023-24: 0.00%	FY 2021-22: 0.00% FY 2022-23: 0.00% FY 2023-24: 0.00%
RN Brief First of Day	FY 2021-22: 1.98% FY 2022-23: 0.88% FY 2023-24: 0.87%	FY 2021-22: 0.00% FY 2022-23: 0.00% FY 2023-24: 0.00%
RN Brief Second or more	FY 2021-22: 0.00% FY 2022-23: 0.00% FY 2023-24: 0.00%	FY 2021-22: 0.00% FY 2022-23: 0.00% FY 2023-24: 0.00%
Physical (PT)	FY 2021-22: 12.17% FY 2022-23: 12.20% FY 2023-24: 6.10%	FY 2021-22: -10.34% FY 2022-23: 0.00 FY 2023-24: 0.00%
Occupational (OT)	FY 2021-22: 15.61% FY 2022-23: 15.60% FY 2023-24: 7.81%	FY 2021-22: -10.34% FY 2022-23: 0.00% FY 2023-24: 0.00%
Speech/Language Therapy (S/LT)	FY 2021-22: 16.64% FY 2022-23:12.57% FY 2023-24: 12.58%	FY 2021-22: -11.86% FY 2022-23: 0.00% FY 2023-24: 0.00%

Home Health Aid Basic and Home Health Aid Extended:
Average utilizers per month for HHA Basic and Extended have steadily increased since FY 2012-13, with a large increase in FY 2017-18 and continued growth through FY 2020-21. The Department believes that this trend will continue to increase but is assuming a steady level of growth of 5.14%.

FY 2019-20 units per clients included a 53rd payment week and because of this the trend in FY 2020-21 actuals appears lower; because of the additional payment period in the last fiscal year. HHA Basic units per utilizer growth has been historically positive which the Department continued in the current forecast. Besides in FY 2019-20, HHA Extended units per utilizer have decreased since FY 2017-18. As a result, the Department assumed small and consistent growth trends in the current, request, and out year.

Registered Nursing/Licensed Practical Nurse:
In FY 2019-20 average monthly utilizers decreased, then increased again in FY 2020-21. The Department assumes a small increase in utilizers of 0.30% for the current year, which will level off in the request year and out year.

The Department assumed no growth for units per utilizer to align with the fluctuation in growth trends over the past few years.

RN Brief First of Day and RN Brief Second or more:
For RN Brief 1st Visit of Day, the Department chose a trend of 1.98% for average monthly utilizers. There was a large increase in the number of utilizers because of the claims system implementation in FY 2017-18 followed by a large decrease in FY 2018-19 and an increase through FY 2020-21. The Department assumes client count will return to a more normal growth rate of 1.98% in FY 2021-22, 0.88% in FY 2022-23, and 0.87% in FY 2023-24. Utilizers for Second or More Visit of the day had a positive growth occur in the last fiscal years. The Department assumed that utilization would level out for the current and future fiscal years.

FY 2019-20 units per clients included a 53rd payment week and because of this the actual trends appear lower in FY 2020-21; because of the additional payment period in the last fiscal year. The Department assumes units per utilizer are leveling off; therefore, the Department has chosen 0.00% growth for the current year, request year, and out year.

Physical (PT), Occupational (OT), and Speech/Language Therapy (S/LT):
Growth in all the therapy services has been high over the past few fiscal years. The Department has seen significant growth in average monthly utilizers with most services in the second half probably due to increased telehealth options during the COVID-19 pandemic. The Department selected strong positive trends for the current year and expected strong growth in the out-years.

The Department believes that the units per client is relatively stable and selected trends that maintained current client utilization levels and put a negative trend on out year units per user for all therapy services.

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. The following impacts have been included in the Request for Long-Term Home Health:

Expenditure

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 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 once implemented.
- FY 2021-22 Across the Board 2.5% Rate Increase – The Join Budget Committee approve a 2.5% across the board rate increase, effective July 1, 2021.
- FY 2021-22 Long-Term Home Health Targeted Rate Increase – The Joint Budget Committee approved targeted rate increases for Long-Term Home Health. The rate increases differ by Long-Term Home Health service and range from 7.31% and 7.35%.

Enrollment

- N/A

EXHIBIT H - LONG-TERM CARE AND INSURANCE SERVICES

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

- Class I Nursing Facilities
- Class II Nursing Facilities

- Program of All-Inclusive Care for the Elderly (PACE)
- Supplemental Medicare Insurance Benefits
- Health Insurance Buy-In

Summary of Long-Term Care and Insurance Request

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

Class I Nursing Facilities

Class I Nursing Facility costs are a function of the application and interpretation of rate reimbursement methodology specified in detail in State statute, the utilization of the services by Medicaid clients, and the 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 through FY 2016-17, while leveling off in FY 2017-18 and FY 2018-19 and FY 2019-20. However, patient days and expenditure significantly decreased in FY 2020-21 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.

The methodology for the Class I request in Exhibit H is as follows[5]:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2021-22.
- 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 2021-22. 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 2021-22 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2021-22.
- The product of the estimated Medicaid per diem reimbursement rate for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2020-21.
- Of the estimated total reimbursement for claims incurred in FY 2021-22, only a portion of those claims will be paid in FY 2020-21. The remainder is assumed to be paid in FY 2021-22. The Department estimates that 93.41% of claims incurred in FY 2020-21 will also be paid during FY 2021-22. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2021-22.
- During FY 2021-22, the Department will also pay for some claims incurred during FY 2020-21 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2020-21 to calculate an estimate of outstanding claims to be paid in FY 2021-22.
- The sum of the current year claims and the prior year claims is the estimated expenditure in FY 2021-22, prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in Footnotes 6 and 7.
- Legislative impacts are added as bottom-line adjustments. For FY 2021-22, 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 2020-21 expenditure.

[5] For clarity, FY 2020-21 is used as an example. The estimates for FY 2021-22 and FY 2022-23 are based on the estimate for FY 2020-21, and follow the same methodology.

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. The following impacts have been included in the FY 2021-22, FY 2022-23, and FY 2023-24 calculations for Class I Nursing Facilities:

- Expenditure for the Hospital Backup Program are included as bottom-line adjustments for FY 2021-22 through FY 2023-24. Please refer to Footnote 6 on page EH-7 for more detail. The Department increased estimates from the November forecast based on YTD actuals and recent growth trends.
- 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 2021-22, FY 2022-23, and FY 2023-24. 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.
- The JBC appropriated funding for the Department of Local Affairs to increase housing vouchers for people transitioning from a nursing home to a community setting. The increase in housing vouchers is projected to decrease nursing home costs by lowering patient days and utilization of nursing home services. The savings from this increase in housing vouchers are included as bottom-line adjustments for FY 2021-22 and beyond.
- HB 20-1362 Limits annual increase in the general fund share of per diem rates to nursing facilities to 2% for 2020-21 and 2021-22 state fiscal years.
- SB 20-212: The bill expands Medicaid reimbursement for telehealth services and allowed for LTHH supervisory visits to be provided in a telehealth setting instead of in-person. The Department chose to incorporate the increase in utilization due to the rule change through trends in nursing services forecast instead of a bottom line impact.

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 2020-21 that will be paid in FY 2021-22 and the percentage of claims incurred in FY 2021-22 that will be paid in FY 2022-23 and subsequent years. The Department applies the same factor to the FY 2022-23 and FY 2023-24 estimates.

The Department uses the IBNR adjustment calculation for the November 2021 Request using paid claims data through April 2020. 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:
February 2017	93.17%
November 2017	93.16%
February 2018	92.71%
November 2018	92.06%
February 2019	92.55%
November 2019	98.57%
February 2020	93.09%
November 2020	92.89%
February 2021	93.41%
November 2021	93.88

Patient Days Forecast

The Department observed a decrease in patient days in FY 2020-21 due to the COVID-19 pandemic. The Department lowered its assumptions in nursing facility utilization for the patient days forecast. The Department is continuing to expect slow to modest growth

in patient days based on a growing elderly population. The Department used fiscal year-to-date actual patient days to inform its forecast for the remainder of the year.

Patient Payment Forecast Model

The Department utilizes a seasonally adjusted model that accounts for cost of living adjustment (COLA). 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 expects patient payments to increase steadily based on recent increases in COLA and updated patient payment information from FY 2020-21 YTD.

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 cost over FY 2016-17. For FY 2021-22 the Department increased the forecast due to higher than anticipated cost per utilizer and increased the forecast in each of the forecast years as the Department believes this growth will continue at a historical rate. The Department has kept this forecast the same as the November forecast as actuals are coming in close to the forecasted amount.

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. TRU Community Care opened in February 2017 and serves Boulder and Weld counties. Most recently, Hope West, opened in Spring of 2021 and will serve clients in Mesa county.

Expenditure estimates for PACE in FY 2021-22, FY 2022-23, and FY 2023-24 are the product of two pieces: projected enrollment and cost per enrollee. PACE enrollment was estimated by taking actual enrollment census numbers reported by PACE facilities and applying the average change in monthly enrollment over the last year and applying that trend to FY 2021-22. For enrollment in FY 2022-23 and FY 2023-24, the average change in month-to-month enrollment from August 2019 to November 2019, was applied at the end of FY 2021-22 and continued. The Department assumes that monthly PACE enrollment will return to levels prior to the onset of COVID-19 in FY 2022-23. This method was used to estimate future enrollment on an aggregate-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 is closely monitoring these systems issues going forward. Actual enrollment in PACE programs was slightly lower than the enrollment forecasted in the February 2021-22 request, but the Department assumes that enrollment for FY 2021-22 will not grow as quickly due to client and provider concerns with COVID-19. As a result, the enrollment forecast in the November 2022-23 request was decreased in the request year and out year.

Per-enrollee costs for FY 2021-22 are determined by cross-walking the actual FY 2021-22 rates net of patient payment for PACE services with an eligibility-type distribution estimate derived from FY 2021-22 enrollment projections. Per enrollee costs only represent an estimate to the extent that the exact eligibility type and exact provider distributions for FY 2021-22 are unknown.

SB 19-209 repealed previous statute directing the Department to apply a grade of membership method in determining the upper payment limit methodology. It also requires the Department to meet with PACE organizations to negotiate an appropriate contracted rate for PACE program services for the FY 2021-22 fiscal year. Until the new rates are negotiated, the Department will continue to use the current rate setting methodology, without the Grade of Membership methodology.

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.[6] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

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

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:[7]

History of Medicare Premiums

Calendar Year	Part A	% Change	Part B	% Change
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%
2019	$437.00	3.55%	$135.50	0.75%
2020	$458.00	4.81%	$144.60	6.72%
2021	$478.00	4.37%	$148.50	2.07%

[6] 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.

[7] Premium information taken from the Centers for Medicare and Medicaid Services, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf Tables V.E1 and IV.B1.

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

To forecast FY 2021-22, FY 2022-23, and FY 2023-24, the Department estimated enrollment growth based on the forecasted growth in the relevant Medicaid populations and used the following projected premiums from the CMS 2020 Medicare Trustees Report: $157.70 in CY 2022, $166.70 in CY 2023, and 176.60 in CY 2024. Additionally, the Department assumed small amounts of retroactive payments and recoupments for newly added or disenrolled clients based on the most recent actuals.

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). 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.

The Department estimates expenditure based directly on the contractor's program enrollment estimates to calculate provider and premiums payments for clients enrolled in HIBI.

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 July 1, 2020 the Department revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, SEPs were paid through a fixed contract amount for each year. However, the Department has developed and implemented a rates methodology that pays the SEPs for administrative deliverables as well as for Case Management functions.

Effective with the approval of the Department's FY 2021-22 R-14, "Technical Adjustments," funding for SEP agencies and Community Centered Boards (CCBs) has been consolidated into a new line item. Both SEPs and CCBs provide case management and administrative functions for individuals in the Department's HCBS waiver programs. As of FY 2021-22, the Department will report estimates for SEP expenditure in the Department's R-5 Office of Community Living, alongside the forecast for CCB expenditure for services for individuals with intellectual or developmental disabilities (IDD). In effect, starting in FY 2021-22, there will be no fiscal impact of SEPs on R-1 Medical Services Premiums expenditures.

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 February 2021 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 cost savings estimated for this program are included in Acute Care; please see Exhibit F for more information on its impact to Acute Care. The monthly management fees are estimated in the Accountable Care Collaborative exhibit.

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 increased from $15.50 to $15.76 in July 2021, 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 did.

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 fell to 93%, and on January 1, 2020 it fell 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. However, the Public Health Emergency locked several members into this population who are not eligible for the enhanced match because they are over 65 years of age and receiving Medicare benefits. To account for this the Department dampened the assumed FMAP by less than 1%. 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 has suspended collecting premiums from this population during the public health emergency.

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 actuals that was not present previously. The data presented in this request is based on information available as of August 13, 2021.

EXHIBIT N - EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2008-09 through FY 2020-21 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 2020-21 final actual total expenditure for Medical Services Premiums, including fund splits, the remaining balance of the FY 2020-21 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 2020-21 and 2021-22 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 2021-22 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, 2021. Therefore, FMAP for FY 2021-22 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 2022-23 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.

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.