COLORADO

Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
Children's Basic Health Plan

FY 2023-24 and FY 2024-25 Budget Request

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CHILDREN'S BASIC HEALTH PLAN

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

Points of Interest

- Federal funding for the CHIP program was reauthorized, retroactive to October 1, 2017. The program has been reauthorized for six years initially then an additional four years, expiring September 30, 2027.
- Federal financial participation was also reauthorized at the additional 23% increase for FFY 2017-18 and FFY 2018-19. Beginning in FFY 2019-20, the federal match rate was reduced by 11.50% and in FFY 2020-21 the federal match rate was reduced to 65.00%.
- With the passage of the ACA and the enhanced federal financial participation, the Department has been able to pay for the state's share of costs entirely with cash funds. With the expiration of the enhanced match in FY 2020-21, the Department started funding a portion of the expenses with General Fund due to the exhaustion of the CHP+ Trust fund.
- In the 2017 legislative session, SB 17-267 "Sustainability of Rural Colorado" was passed and creates the Colorado Healthcare Affordability and Sustainability Enterprise within the Department to manage the Healthcare Affordability and Sustainability (HAS) Fee, which replaces the Hospital Provider Fee assess under current law. Beginning in FY 2017-18, the state share of the populations with FPL greater than 205% will be paid with the HAS Fee.
- Beginning January 2014, an income rating code used to identify clients from 201%-205% changed to 201%-213% as part of the MAGI conversion. Clients under 205% FPL receive funding from the CHP Trust Fund while clients over 205% FPL receive funding from the Healthcare Affordability and Sustainability (HAS) fee fund. With the implementation of the interChange, the Department is now able to identify discrete FPLs for CHP+ members. Between January 2014 and March 2017, the Department used a distribution of clients over 200% FPL prior to January 2014 to assign clients with that income rating code to the appropriate cohorts.
- Following the declaration of a public health emergency by the Secretary of Health and Human Services during the COVID-19 pandemic, CMS notified states that an increased FMAP would be available for each calendar quarter occurring during the public health emergency, including retroactively to January 1, 2020. To be eligible to receive the 6.2 percentage point FMAP increase (4.34 percentage points in CHIP), states were required to adhere to a set of requirements that included, but were not limited to, maintaining eligibility standards, methodologies, and procedures; covering medical costs related to the testing, services, and treatment of COVID-19; and not terminating individuals from Medicaid if such individuals were enrolled in the Medicaid program as of the date of the beginning

of the emergency period or during the emergency period. The Consolidated Appropriations Act of 2023 decoupled the continuous coverage requirement and the additional federal match from the public health emergency declaration. The continuous coverage requirement and additional federal match ended on March 31, 2023. The 6.2 percent additional match steps down to 5.0 percent from April 2023 through June 2023, 2.5 percent from July through September 2023, and 1.5 percent from October through December 2023, after which there is no more additional match. For CHIP, the 4.34 percent additional match steps down to 3.5 percent from April 2023 through June 2023, 1.75 percent from July through September 2023, and 1.05 percent from October through December 2023, after which there is no additional match.

- As part of the effort to modernize the CHP+ program, the Department ended the State Managed Care Network (SMCN), the administrative service organization (ASO) for the CHP+ program, at the end of SFY 2020-21. Moving forward, all CHP+ eligible members will be enrolled into a managed care organization (MCO). The goals of expanding the managed care delivery model within the CHP+ program are to improve continuity of care for members and reduce duplicative administrative tasks through leveraging the Department's existing capabilities and infrastructure.

History and Background Information

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

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

The number of CHP+ enrollees and their per capita costs fluctuate due to changes in economic conditions, federal and state policies, and a number of other factors, resulting in changes in CHP+ program expenditures. Changes in funding from sources such as the Tobacco Master Settlement Agreement and Tobacco Taxes also increase the volatility in funding needs. Thus, the Department periodically updates its caseload and expenditure forecast based on recent experience and

submits funding requests to the General Assembly. This ensures that the Department has sufficient spending authority to cover expenditures for CHP+ clients and the program's administration.

The eligible CHP+ populations are:

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

CBHP CAPITATION PAYMENTS

The CBHP Capitation Payments line item reflects the appropriation that funds CBHP services throughout Colorado through managed care providers contracted by the Department. CHP+ children and prenatal members are served by a health maintenance organization (HMO) at a fixed monthly cost. Actual and estimated caseload ratios between HMOs and the self-funded network are used to develop blended capitation rates and per capita costs.

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

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

Analysis of Historical Expenditure Allocations across Eligibility Categories

Historical expenditure allocations across eligibility categories reflects the expenditures reported in the Colorado Financial Reporting System (COFRS). Beginning July 1, 2014, the Department transitioned from COFRS to Colorado

Operations Resource Engine (CORE). Historical expenditure through FY 2013-14 is from COFRS and historical expenditure from FY 2014-15 and ongoing is from CORE.

Description of Transition to New Methodology

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

In estimating the future per capita costs, the Department incorporates claims distribution and retroactivity adjustments to the projected rates. The adjustments are described in further detail in Exhibit H.

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

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

EXHIBIT A - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

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

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

EXHIBIT B - CALCULATION OF FUND SPLITS

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

The Patient Protection and Affordable Care Act (Sec. 2101 (a)) enhanced the CHP+ FMAP 23 percentage points beginning October 1, 2015 through September 30, 2019 (SSA 2105 (b)). This enhanced FMAP from the ACA fully expired as of September 30, 2020 and beginning in FY 2020-21, the Department began funding the program with a combination of General Fund and CHP+ Trust Fund for members to 205% FPL.

The Families First Coronavirus Response Act passed in response to the COVID-19 pandemic allows states to claim an enhanced FMAP through the end of the calendar quarter in which the Secretary of Health and Human Services has declared a public health emergency (PHE) or extended that emergency. The Consolidated Appropriations Act of 2023 decoupled the continuous coverage requirement and the additional federal match from the public health emergency declaration. The continuous coverage requirement and additional federal match now both end on March 31, 2023. The current 4.34 percent additional match steps down to 3.5 percent from April 2023 through June 2023, 1.75 percent from July through September 2023, and 1.05 percent from October through December 2023, after which there is no more

additional match. In addition, the Department is also expecting to recover payments in FY 2023-24, FY 2024-25, and FY 2025-26 for prior year dates of service. The recovery amount for FY 2023-24 is available in Exhibit B. The amounts for FY 2024-25 and FY 2025-26 are not known at this time. Additionally, there may be additional recoveries that will be received in FY 2023-24 that are not currently known. Due to state fiscal rules, the Department is unable to offset current year expenditure for prior year recoveries, and therefore, the recoveries are counted as revenue to cash funds.

EXHIBIT C – CHILDREN'S BASIC HEALTH PLAN SUMMARY

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

EXHIBIT D – CBHP CASELOAD

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

Children's Basic Health Plan Caseload by Fiscal Year

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

Children's Basic Health Plan Caseload by Month

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

From January 2013 to January 2014, caseload decreased steadily for populations under 205% FPL due to the implementation of SB 11-008 and SB 11-250 and the MAGI conversion and increasing for populations above 205% FPL. The most recent months (January 2023 – June 2023) have seen caseload declining due to the continuous coverage policy associated with the Families First Coronavirus Response Act. A graph of recent caseload can be found in Exhibit D-4. As a condition of claiming a higher FMAP under the Act, the Department was required to maintain continuous coverage for clients, meaning it could not disenroll members if they were enrolled in the program as of the beginning of the emergency period or becomes enrolled during the emergency period. This continuous coverage policy effectively ceased all churn of children from Medicaid onto CHP+. However, because CHP+ clients can still churn onto Medicaid, this has caused caseload to fall as families lose income and qualify for Medicaid. The Department anticipates caseload to grow in FY 2023-24 due to churn from Medicaid to CHP+ as a result of the PHE unwind process.

Children's Basic Health Plan Per Capita Historical Summary

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

Children's Basic Health Plan Historical Expenditures Summary

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

EXHIBIT E – CHILDREN'S BASIC HEALTH PLAN FUNDING SOURCES

Traditional Population Expenditures and Funding

This exhibit shows expenditures for the traditional population in isolation and provides additional detail to the calculation of fund splits. Traditional populations include those from 0%-205% FPL. These populations receive the enhanced CHP+ Federal Match and receive cash funds from the CHP Trust Fund, CO Immunization Fund, and Health Care Expansion Fund. Once the available cash funds have been used, the General Fund covers the remaining State share of expenditures for clients under 205% FPL. The available funding from the CHP Trust Fund and the CO Immunization Fund is forecasted using the published projections in the March 2023 Tobacco MSA Payment Forecast, allocation changes from HB 16-1408 "Cash Fund Allocations for Health-related Programs", and the actual expenditures from prior years. Calculations can be found in Exhibit E.

As described above for exhibit B, the CHP+ Federal Match increased by 23 percentage points in October 2015 and remained in effect until September 30, 2019. Beginning October 1, 2020 when the enhanced federal match rate stepped down, the Department began using General Fund for this population as there was not enough revenue in the CHP+ Trust Fund to support expenditures.

Expansion Population Expenditures and Funding

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

Children's Health Plan Plus Enrollment Fees

The Department no longer collects enrollment fees per HB 22-1289. A historical summary of enrollment fees can be found in Exhibit E.

EXHIBIT F - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

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

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

The forecasted capitation rate is derived from Exhibits H through J and will be presented in more detail below. The caseload is the same as displayed in Exhibit D.

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

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

Actuarially Certified Capitation Rates

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

Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit F. The methodology for determining the forecasted capitation rate is the subject of Exhibits H through J.

Incurred-but-not-Reported Estimates

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

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

EXHIBIT G – CHILDREN'S BASIC HEALTH PLAN BOTTOM LINE IMPACTS TO EXPENDITURE

Delta Dental MLR Reconciliation

The Department requires its dental contractor to maintain a medical loss ratio (MLR) of 80% or greater. In the past, the Department has recouped funds from the contractor due to having a ratio of less than 80%.

Manual Enrollment "Capitation Gap" Payments

The Department makes reconciliation payments for members that were manually enrolled. Previously, these were projected by applying growth rates from projected caseload (Exhibit D) and rate inflation (Exhibit I) to the expenditure for reconciliation payments for manual enrollments in the previous fiscal year. Due to the introduction of the interChange system these manual enrollment reconciliation can now be handled in the capitation payments each month, within a lookback period of four months. This forecast adjustment captures the missing payments for members outside the four-month window.

Newborn Delivery "Kick" Payments

The Department issues a case rate ("kick") payment for the newborn delivery services rendered by the MCOs for members 19 or older and who are eligible and enrolled at the time of service. This kick payment rate is developed during the capitation rate setting process and presented to the CHP+ MCOs at each rate setting cycle. This payment is processed quarterly.

Newborn Reinsurance

Beginning in FY 2021-22, the Department implemented a reinsurance model for newborns enrolled to CHP+ MCOs. Under the reinsurance model, MCOs will cover all newborn costs up to an agreed upon maximum threshold. Costs that exceed that maximum threshold will be shared between the MCO and the Department in a predetermined risk-sharing arrangement.

COVID Vaccinations

Per section 9811 of The American Rescue Plan Act (ARPA), a 100% FFP is available for COVID-19 vaccines and their administration through the last day of the first calendar quarter following the end of the public health emergency (PHE). The PHE declared by the Secretary of Health and Human Services expired on May 11, 2023. Therefore, the 100% FFP for COVID-19 vaccinations and their administration is effective through September 30, 2024.

Respiratory Syncytial Virus (RSV) Vaccines

On July 17, 2023, the U.S. Food and Drug Administration (FDA) approved the biologics license application for a single dose of Nirsevimab for prevention of RSV-associated lower respiratory tract infection (LRTI) in infants born during or entering their first RSV season and in children up to 24 months of age who remain vulnerable to severe RSV disease through their second RSV season. The RSV vaccines will be available to eligible children enrolled in CHP+ beginning October 1, 2023.

FY 2023-24 R-09 Advancing Birthing Equity

This request expanded perinatal services to include coverage for doula services.

HB 23-1136 Prosthetic Devices for Recreational Activity

Beginning January 1, 2025, this bill requires state-regulated insurance plans, including CHP+, to cover an alternative prosthetic limb if the patient's physician determines that it is necessary to engage in physical and recreational activity.

HB 23-1300 Continuous Eligibility Medical Coverage

Upon receipt of maximum federal financial participation, by January 1, 2026, the bill requires the Department to extend the continuous eligibility population to children under three years of age, including those who will be eligible under HB 22-1289 at the time of implementation. Under the bill, this population will not be disenrolled from CHP+ until they reach the age of three.

Implement Juvenile Justice Release Services

The Consolidated Appropriations Act, 2023 (CCA 2023) mandates that starting January 1, 2025, states must provide a limited set of benefits, including screenings, diagnostic services, referrals, and targeted case management services, for Medicaid and CHP+-eligible juveniles in public institutions. This obligation begins 30 days prior to release following adjudication.

EXHIBIT H - CBHP RETROACTIVITY ADJUSTMENT AND CLAIMS DISTRIBUTION ADJUSTMENT MULTIPLIER

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

Additionally, claims-based data (as it is derived from the actual money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the health maintenance organizations (HMOs) to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can trend similarly, but any difference in

trends needs to be captured to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the CBHP Capitation program. This difference is captured through a partial-month adjustment multiplier.

Retroactivity Adjustment Multiplier

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

Claims Distribution Adjustment Multiplier

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

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

EXHIBIT I - CBHP CAPITATION RATE TRENDS AND FORECASTS

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e., the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual

health maintenance organization or state managed care network) was examined. Exhibit I presents historical data as well as the forecasted weighted rates. Rates are first presented by poverty level and age group, and then aggregated by poverty level for all ages.

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

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

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

Exhibit I presents the weighted point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit F to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years.

EXHIBIT J - FORECAST MODEL COMPARISONS

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

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

Final Forecasts

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

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

Then the claims-based rate is adjusted a second time, this time by the retroactivity adjustment. From Exhibit H, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit H, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep CBHP caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to derive the expenditure calculation presented in Exhibit F. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

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

For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the

future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

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

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

CBHP CASELOAD

CBHP Caseload Models

The Department's caseload projections utilize statistical forecasting methodologies to predict CBHP caseload by eligibility category. Historical monthly caseload data is used from July 2007 to June 2020. CBHP caseload increased significantly in FY 2016-17 and coincides with the implementation of the interChange. A large percentage of the growth experienced are for members that are not tied to an HMO. For the purpose of forecasting caseload, the Department has chosen to forecast based on those clients that are actively tied to an HMO because that appears to be the best representation of actual enrollment and expenditure. As a result, caseload figures in the exhibits may not tie directly to those mentioned below for forecasting. The following forecasting models are used to forecast CBHP caseload: average growth model, two-period moving average model, exponential growth model, and linear growth model.

For each eligibility category, four different trend model forecasts were performed: an average growth model, a constant growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the

capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period. The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

Model Selection

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

CHILDREN'S BASIC HEALTH PLAN CASELOAD FORECAST

Children's Caseload Projections (Exhibit D)

CHP Kids 0% to 205% FPL

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

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

CHP Kids 206% to 260% FPL

- This population before the COVID-19 pandemic was mostly flat with either little growth or declines, and since the start of the pandemic this population has maintained this trend. There has been less churn into Medicaid from this

eligibility group. The Department expects that once the continuous coverage policy expires, there will be some shift of members from Medicaid to CHP+.

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

Prenatal Caseload Projections (Exhibit D)

CHP Prenatal 0% to 205% FPL

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

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

CHP Prenatal 206% to 260% FPL

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

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