Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-06

Request Titles

R-06 Medicaid & CHP+ Enrollment Simplification

Dept. Approval By:	Josh Block		**Supplemental FY 2014-15**
		X	**Change Request FY 2015-16**
OSPB Approval By:			**Base Reduction FY 2015-16**
			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16 FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	**Total**	**$6,475,631,759**	**$0**	**$6,538,626,483**	**$1,050,191**	**$17,386,751**
	FTE	-	-	-	-	-
	GF	$1,803,693,171	$0	$1,847,305,341	$147,729	$1,818,579
	CF	$675,722,073	$0	$682,275,581	$213,004	$299,241
	RF	$23,910	$0	$23,910	$0	$0
	FF	$3,996,192,605	$0	$4,009,021,651	$689,458	$15,268,931

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16 FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - Operating Expenses	**Total**	**$3,345,159**	**$0**	**$1,946,037**	**$150,000**	**$0**
	CF	$62,577	$0	$62,577	$0	$0
	FF	$1,681,676	$0	$976,139	$75,000	$0
	GF	$1,576,996	$0	$883,411	$75,000	$0
	RF	$23,910	$0	$23,910	$0	$0
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	**Total**	**$5,724,352,770**	**$0**	**$5,768,568,225**	**$0**	**$12,281,696**
	CF	$622,898,368	$0	$628,705,349	$0	$45,663
	FF	$3,492,641,948	$0	$3,485,278,253	$0	$10,825,525
	GF	$1,608,812,454	$0	$1,654,584,623	$0	$1,410,508
03. Behavioral Health Community Programs - Behavioral Health Capitation Payments	**Total**	**$548,101,614**	**$0**	**$548,263,817**	**$0**	**$3,924,077**
	CF	$4,534,586	$0	$4,500,945	$0	$0
	FF	$372,562,308	$0	$373,428,468	$0	$3,577,923
	GF	$171,004,720	$0	$170,334,404	$0	$346,154
05. Indigent Care Program - Children's Basic Health Plan Medical and Dental Costs	**Total**	**$199,832,216**	**$0**	**$219,848,404**	**$900,191**	**$1,180,978**
	CF	$48,226,542	$0	$49,006,710	$213,004	$253,578
	FF	$129,306,673	$0	$149,338,791	$614,458	$865,483
	GF	$22,299,001	$0	$21,502,903	$72,729	$61,917

Letternote Text Revision Required?	Yes X No	**If Yes, describe the Letternote Text Revision:**

In Medical Services Premiums $45,663 is from the Adult Dental Fund (28C0) in FY 2016-17. For Children's Basic Health Plan $40,396 is from the CHP Trust Fund (11G0) and $172,608 is from the Hospital Provider Fee (24A0) in FY 2015-16 and $50,875 is from the CHP Trust Fund and $202,703 is from the Hospital Provider Fee for FY 2016-17.

Cash or Federal Fund Name and CORE Fund Number: CF: Adult Dental Fund (28C0), CHP Trust Fund (11G0), Hospital Provider Fee (24A0) FF: Title XIX, Title XXI

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? Yes ___ No ___ **Not Required:** X

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Cost and FTE

- The Department requests $1,050,191 total funds, $147,729 General Fund, in FY 2015-16 and $17,386,751 total funds, $1,818,579 General Fund in FY 2016-17 to change income determination to an annualized income and implement a one-month grace period for CHP+ enrollment fees in order to reduce gaps in coverage and improve access to benefits.

Current Program

- Continuous eligibility has been made available for children enrolled in either Medicaid or CHP+, but not for Medicaid eligible adults.
- Both Medicaid and CHP+ eligibility are determined based on an individual's current or prior month income, rather than an annualized income.
- Clients that are eligible for CHP+ with incomes 157% above the federal poverty levels or higher are responsible for paying an enrollment fee. These clients are not enrolled immediately and benefits cannot be accessed until the enrollment fee is paid and processed.

Problem or Opportunity

- Clients lose and regain coverage from Medicaid and CHP+ due to changes in income. This is particularly difficult for clients with seasonal income, such as farmers. Clients with consistent seasonal changes in their income could have seasonal gaps in coverage as their income levels change each month. These gaps occur because State programs determine income eligibility based on prior or current month's income instead of an annualized income.
- Individuals that qualify for CHP+ cannot receive a real-time determination when they apply online because determination requires additional manual processing, noticing, and the enrollment fee calculation is based on income, which occurs after the client is otherwise eligible.

Consequences of Problem

- Continuing to determine clients eligible by monthly income means clients with seasonal income would continue to have seasonal gaps in coverage. This would perpetuate churn that is potentially harmful to the well-being of the client.
- Not allowing a one-month grace period for CHP+ clients prevents clients from receiving immediate access to benefits upon being determined eligible.

Proposed Solution

- While continuous eligibility for adults is not an immediate option, changing monthly income determination to an annualized income determination could greatly reduce the gaps in coverage and improve the client experience. Clients with seasonal income would gain more continuous coverage if their income were averaged for the year, rather than used for determination each month. This would also improve consistency between state programs and the Marketplace, since the Marketplace currently annualizes an applicant's income.
- Allow a one-month grace period for CHP+ clients owing an enrollment fee, giving clients immediate access to benefits upon being determined eligible.

Department Priority: R-6
Request Detail: Medicaid & CHP+ Enrollment Simplification

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Medicaid & CHP+ Enrollment Simplification	$1,050,191	$147,729

Problem or Opportunity:

Medicaid and the Children's Basic Health Plan Plus (CHP+) clients face unnecessary complexities when enrolled or when applying for benefits, resulting in either gaps in coverage or a delay in the clients' access to benefits. The Department has identified three sources of delayed access to benefits and significant burden for applicants. First, the treatment of income for Medicaid eligibility determinations is incongruent with other state processes and fails to adequately address issues related to seasonal variation in income. Second, clients churn on and off of Medicaid with fluctuations in income resulting in potential coverage gaps. Last, pregnant women and children have delayed access to care due to processes related to enrollment fee collection.

Both Medicaid and the CHP+ eligibility are determined based on an individual's current or prior month income. This methodology fails to account for applicants that have highly variable or seasonal incomes, such as farmers. Consequently, individuals must consistently make updates to their income based on the time of year that they work, which can result in interruption in benefits since they may be eligible in one month but over income the following month. Additionally, under the current methodology for evaluating income, individuals with very high, but seasonal, annual income can receive public assistance when it is genuinely not appropriate for them given their high income.

Monthly income determinations also create disconnects with other programs. Specifically, eligibility determination for Connect for Health Colorado (C4HCO), Colorado's insurance marketplace (the Marketplace), is based on projected annualized income. Having a different methodology for state programs causes eligibility for the Insurance Affordability Programs (IAPs), Marketplace tax subsidies and public assistance programs that ensure individuals have access to affordable coverage, to be out of sync. The implication is that individuals are potentially not receiving the correct subsidies or coverage to which they are entitled.

Fluctuations in income at any point in a year can result in loss of Medicaid eligibility. Moving back and forth between the Marketplace and public assistance can result in coverage gaps and excessive burden for clients needing to constantly reapply for different types of coverage when their income fluctuates. Further,

discontinuity in coverage, frequently referred to as "churn", can result in negative impacts on client health outcomes. Because different insurance providers contract with different provider networks, churn can result in breakage of critical connections between an individual and their primary care provider. To reduce churn and help ensure continuity of care, Colorado has implemented continuous eligibility for children. However, the Department would need a demonstration waiver to implement continuous eligibility for adults, which would require meeting federal budget neutrality requirements. Because the effects of churn on short and long run costs are not fully understood for adults in Medicaid, the Department perceives an opportunity to perform a study on the possible benefits of implementing a solution such as continuous eligibility for adults, as well as investigating other strategies for reducing disruptive churn in a cost effective manner.

The last factor identified by the Department as creating undue burden for clients is delayed eligibility for pregnant women and children pending processing of enrollment fees. After the CBMS Lawsuit in 2005 (Anna Davis et. al. v. Joan Henneberry and Karen Beye), the standard for CHP+ application processing was set at 45 days. Clients that are determined eligible for CHP+ with incomes 157% above the federal poverty levels (FPL) or higher are responsible for paying an enrollment fee within 30 days. With these time frames, an applicant may wait up to 75 days after submitting their application before they may access benefits. These clients with incomes above 157% FPL are not enrolled immediately and benefits cannot be accessed until the enrollment fee is paid and processed. As a result, individuals that will qualify for CHP+ will never receive a real time determination when they apply online because determination requires additional manual processing and noticing and the enrollment fee calculation is based on income, which occurs after the client is otherwise eligible.

Addressing the aforementioned issues presents a significant opportunity to improve client experience by reducing coverage gaps, reduce administrative burden, and improve consistency between state programs and the Marketplace.

Proposed Solution:

The Department requests $1,050,191 total funds, including $147,729 General Fund in FY 2015-16, and $17,386,751 total funds, including $1,818,579 General Fund in FY 2016-17 to address three critical issues impacting clients' eligibility to ensure seamless and efficient coverage and access to care.

The Department requests funding to implement standardization of Medicaid income calculation to align more closely with that of the Marketplace. This would essentially change the income assessment for public health care coverage from a monthly income determination to an annualized income determination. While the Marketplace annualizes income for the entire year, the State would annualize the applicant's income for the remainder of the year. Federal regulations at 42 CFR 435.603(h) do not allow the State to annualize for a full year, but the regulations do provide the option of annualizing for the remainder of the year. Basing income eligibility on an annualized income would prevent gaps in coverage for clients with seasonal income as well as maintain consistency for the IAPs by utilizing a similar methodology as the Marketplace.

To develop a long term solution for addressing churn, the Department requests funding to study on the potential benefits of implementing continuous eligibility for Medicaid eligible adults, as well as other options that could potentially reduce churn.

Lastly, to address delayed access to health care for pregnant women in need of prenatal care and children in CHP+, the Department requests funding to allow CHP+ eligible clients a one-month grace period to pay their enrollment fee; this would allow CHP+ clients immediate access to benefits. Should the applicant fail to pay enrollment fees by the end of the grace period, eligibility would be terminated.

Anticipated Outcomes:

Replacing monthly income determination with an annualized income determination would permit clients who have an annual income below the income threshold to maintain benefits continuously throughout the year. For clients remaining on Medicaid, they would do so without having to continuously reapply and enduring coverage gaps or potential churn between Medicaid and the Marketplace. Closing coverage gaps addresses the Department's FY 2014-15 performance goal for eligibility and enrollment by improving client access and supporting continuous enrollment. Supporting more continuous coverage could improve the client experience, has the potential to help client outcomes, which could lower per capita costs. Only those applicants with relatively high annual income will be determined ineligible for public assistance. Absent a change in methodology, populations with seasonal income would continue to churn on and off of Medicaid, and high income populations would remain enrolled. Lastly, inconsistencies between eligibility policy and IAPs through the Marketplace would remain unresolved.

Should income determination change from monthly to an annualized income, there would still be clients who churn on and off of Medicaid due to income changes. Through a study of options to address churn, the Department anticipates it would be able to develop a long term strategy that would support a seamless continuum of coverage in Colorado that significantly reduces the negative impacts of eligibility churn on costs and client outcomes.

Allowing a one-month grace period to pay enrollment fees will allow CHP+ clients immediate access to benefits, ensuring timely access to care for children. Implementing the one-month grace period for CHP+ clients addresses the Department's FY 2014-15 performance goal for client experience and timely eligibility determinations. The delayed access to benefits after eligibility determination can be reduced by up to 30 days by giving these clients a grace period for the enrollment fee. Failure to pay the enrollment fee within the first month would still result in termination of benefits.

Assumptions and Calculations:

The Department's calculations are shown in the appendix.

<u>Fiscal impact of annualized income determinations</u>:

The current system determines an applicant eligible base upon their monthly income, changes would need to be made for MAGI eligibilities so that income eligibility is based on the applicant's income that has been annualized for the remainder of the year. The Department assumes these hours can be covered by the current scheduled workload for CBMS changes.

In order to identify the number of clients that will be affected by the annualization of income, the Department has analyzed client history for Medicaid and CHP+ from FY 2012-13. The clients of interest are assumed to

be those that experienced gaps in their Medicaid or CHP+ eligibility of at least one month, but because not all clients would be affected, the Department has only considered clients who have an eligibility gap that is less than one standard deviation above the average gap in eligibility spans. These clients have a minimum gap in coverage of 1 month and a maximum gap in coverage of approximately 6 months, so the sample has a gap in coverage lasting half of the fiscal year or less. The Department assumes clients with coverage gaps lasting longer than 6 months are not facing predictable income changes since seasonal employment does not typically last longer than 6 months. A weighted average of the results for MAGI Parents/Caretakers to 68% FPL and MAGI Parents/Caretakers to 69% to 133% FPL was used to estimate the impact for MAGI Adults.

The Department assumes that MAGI Eligible Children and CHP+ Children would not be affected from the annualization of income because continuous eligibility has already been implemented for these categories. The Department also assumes that the annualization of income will have no impact on prenatal clients.

To account for the fact that per capita costs decline as clients are eligible for longer periods of time, the per capita costs used in the estimate are those projected in the FY 2014-15 S-1: "Medical Services Premiums" request, Exhibit C, multiplied by 50%. This is based on the analysis done to estimate the cost of implementing continuous eligibility for children. The estimated per capita used to predict the costs of continuous eligibility for children was approximately 50% of the actual per capita. This same proportion was applied to the per capita for MAGI Parents/Caretakers and MAGI Adults.

The Department assumes that this change could be implemented in July 2016.

Churn study:

After reviewing the costs of studies done in the past, the Department requests funding of $150,000 in FY 2015-16 to study the potential benefits of implementing continuous eligibility for Medicaid eligible adults, as well as other options that could potentially reduce churn.

One-month grace period for enrollment fees in CHP+:

Currently, CBMS determines a client ineligible for not paying the enrollment fee; the Department would require system changes to change system rules to allow a client to be enrolled immediately and only terminate for lack of payment after one month. The Department assumes these hours can be covered by the current scheduled workload for CBMS changes.

The Department identified a total of 5,383 clients (3,326 cases) that were denied eligibility in CY 2013 due to failure to pay the enrollment fee. This number was used to find the average monthly number of clients that did not qualify for benefits due to failure to pay enrollment fee. The Department assumes that 90% of cases that failed to pay the enrollment fee would have paid the fee within the one-month grace period, and would remain eligible for the remainder of the fiscal year. The remaining 10% of clients would fail to pay within the one-month grace period and would receive one month of coverage. The Department applied the projected growth trend for CHP+ caseload, from S-3 February 2014, to the average monthly clients and average monthly cases from CY 2013 to estimate the average monthly number of clients that will gain CHP+ eligibility when granted the one-month grace period and estimate the newly obtained enrollment fees.

While there is potential for clients to seek out their one month of benefits and still be terminated due to lack of payment, the Department assumes that this will not be a frequent occurrence as clients are more likely to be seeking continuous coverage and not simply one month of services. If implemented, the Department would track how often clients fail to pay the enrollment fee within the grace period to determine if additional policy changes would be necessary. For this analysis, the Department has assumed that 90% of all clients will have paid the enrollment fee within the one-month grace period.

The new enrollment fees collected after this change must be estimated in order to correctly calculate the federal match. The CHP+ program receives a federal match on all expenditures, minus the amount collected in enrollment fees. Enrollment fees are based on the FPL on the application and the number of children listed on the application, fees are listed in the table below. Because enrolling two or more children receives a flat fee, the Department uses the observed average fee owed in CY 2013 instead of estimating the number of children on each application. The Department assumes the average enrollment fee would equal the average observed fee in CY 2013 for all projected years. For clients under 205% FPL the average fee is $31.58, and the average enrollment fee for clients over 205% FPL is $94.42. The average enrollment fee is then multiplied by the projected number of cases (applications) that will pay the enrollment fee for the entire fiscal year. The projected number of cases is based on the 3,326 cases identified in CY 2013 as failing to pay the enrollment fee.

CHP+ Enrollment Fees		
	Children 150%-205%	**Children 206%-250%**
Fee to enroll one child(1)	$25.00	$75.00
Fee to enroll more than one child(1)	$35.00	$105.00

The Department assumes that this change could be implemented in September 2015.

R-6 Medicaid & CHP+ Enrollment Simplification - Summary of Request

Table 1.1
Summary of Request
FY 2015-16

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes
Total Request	**$1,050,191**	**$147,729**	**$213,004**	**$0**	**$689,458**	
(1) Executive Director's Office; (A) General Administration, Personal Services	$150,000	$75,000	$0	$0	$75,000	Narrative
(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	$900,191	$72,729	$213,004	$0	$614,458	Table 3.1 Row F

Table 1.2
Summary of Request
FY 2016-17

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes
Total Request	**$17,386,751**	**$1,818,579**	**$299,241**	**$0**	**$15,268,931**	
(2) Medical Services Premiums	$12,281,696	$1,410,508	$45,663	$0	$10,825,525	Table 2.1 Row E
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	$3,924,077	$346,154	$0	$0	$3,577,923	Table 2.1 Row H
(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	$1,180,978	$61,917	$253,578	$0	$865,483	Table 3.2 Row F

R-6 Medicaid & CHP+ Enrollment Simplification - Summary of Request

Table 1.3
Request Components by Line Item
FY 2015-16

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**$1,050,191**	**$147,729**	**$213,004**	**$0**	**$689,458**	
(1) Executive Director's Office; (A) General Administration, Personal Services	**$150,000**	**$75,000**	**$0**	**$0**	**$75,000**	
Continuous Eligibility Study	$150,000	$75,000	$0	$0	$75,000	Narrative
(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	**$900,191**	**$72,729**	**$213,004**	**$0**	**$614,458**	
One-Month Grace Period for CHP+ Enrollment Fees	$900,191	$72,729	$213,004	$0	$614,458	Table 3.1 Row F

Table 1.4
Request Components by Line Item
FY 2016-17

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**$17,386,751**	**$1,818,579**	**$299,241**	**$0**	**$15,268,931**	
(2) Medical Services Premiums	**$12,281,696**	**$1,410,508**	**$45,663**	**$0**	**$10,825,525**	
Annualization of Income	$12,281,696	$1,410,508	$45,663	$0	$10,825,525	Table 2.1 Row E
(3) Behavioral Health Community Programs	**$3,924,077**	**$346,154**	**$0**	**$0**	**$3,577,923**	
Annualization of Income	$3,924,077	$346,154	$0	$0	$3,577,923	Table 2.1 Row H
(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	**$1,180,978**	**$61,917**	**$253,578**	**$0**	**$865,483**	
One-Month Grace Period for CHP+ Enrollment Fees	$1,180,978	$61,917	$253,578	$0	$865,483	Table 3.2 Row F

Determining Income Eligibility Through Annualized Income - Fund Splits

Table 2.1 Summary of Projected Expenditures for Annualized Income FY 2016-17

(2) Medical Services Premiums

Row		Total Funds	General Fund	Cash Funds*	Reappropriated Funds	Federal Funds	FMAP	Notes
A	Standard FMAP Expenditures - Medical	$2,846,061	$1,410,508	$0	$0	$1,435,553	*50.44%*	Table 2.4 Row I
B	Standard FMAP Expenditures - Dental	$92,136	$0	$45,663	$0	$46,473	*50.44%*	Table 2.4 Row L
C	Enhanced ACA FMAP Expenditures - Medical	$9,168,927	$0	$0	$0	$9,168,927	*100.00%*	Table 2.4 Row I
D	Enhanced ACA FMAP Expenditures - Dental	$174,572	$0	$0	$0	$174,572	*100.00%*	Table 2.4 Row L
E	**Total MSP Expenditure FY 2016-17**	**$12,281,696**	**$1,410,508**	**$45,663**	**$0**	**$10,825,525**	***88.14%***	**Row A + Row B + Row C + Row D**

*Of this amount, $45,663 is from the Adult Dental Fund.

(3) Behavioral Health Community Programs

Row		Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
F	Standard FMAP Expenditures	$698,455	$346,154	$0	$0	$352,301	*50.44%*	Table 2.4 Row O
G	Enhanced ACA FMAP Expenditures	$3,225,622	$0	$0	$0	$3,225,622	*100.00%*	Table 2.4 Row O
H	**Total BH Expenditure FY 2016-17**	**$3,924,077**	**$346,154**	**$0**	**$0**	**$3,577,923**	***91.18%***	**Row F + Row G**

Determining Income Eligibility Through Annualized Income - Calculations

Table 2.2 Projected Costs for Annualized Income FY 2016-17						
Row	**Item**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Total**	**Notes**
A	FY 2016-17 Projected Caseload	187,003	65,764	209,346	462,113	Revised caseload estimates based on data through June 2014
B	Estimated Percentage of Clients Affected	3.81%	6.13%	4.43%	4.43%	Historical Medicaid and CHP+ Data
C	Estimated Clients Affected by Annualized Income	7,125	4,031	9,274	20,430	Row E * Row F
D	Estimated Months Added to Eligibility	3.45	3.54	3.48	3.48	Historical Medicaid and CHP+ Data
E	Annualize for Implementation Date	100.00%	100.00%	100.00%	100.00%	Projected Implementation of July 2016
F	Estimated Additional Member Months	24,581	14,270	32,304	71,155	Row C * Row D * Row E
G	Estimated PMPM for Medical Services Premiums - Medical	$115.78	$100.28	$239.53	$168.86	S-1 February 2014 Exhibit C1, divided by 12, multiplied by 50%
H	Estimated Additional Member Months	24,581	14,270	32,304	71,155	Row F
I	**Estimated MSP Expenditure - Medical**	**$2,846,061**	**$1,431,041**	**$7,737,886**	**$12,014,988**	**Row G * Row H**
J	Estimated PMPM for Medical Services Premiums - Dental	$3.75	$3.75	$3.75	$3.75	S-1 February 2014 Exhibit B1 & Exhibit D1, divided by 12, multiplied by 50%
K	Estimated Additional Member Months	24,581	14,270	32,304	71,155	Row F
L	**Estimated MSP Expenditure - Dental**	**$92,136**	**$53,488**	**$121,084**	**$266,708**	**Row J * Row K**
M	Estimated PMPM for Mental Health	$28.41	$28.41	$87.30	$55.15	S-2 February 2014 Exhibit DD, divided by 12, multiplied by 50%
N	Estimated Additional Member Months	24,581	14,270	32,304	71,155	Row F
O	**Estimated BH Expenditure**	**$698,455**	**$405,474**	**$2,820,148**	**$3,924,077**	**Row M * Row N**
P	**Total Expenditure FY 2016-17**	**$3,636,652**	**$1,890,003**	**$10,679,118**	**$16,205,773**	**Row I + Row L + Row O**

Implementing One-Month Grace Period for CHP+ Clients Owing Enrollment Fee - Fund Splits

Table 3.1 Summary of Costs of One-Month Grace Period FY 2015-16								
(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs								
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds***	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Notes**
A	***FY 2015-16 Expenditure to be Matched***	***$740,668***	***$126,210***	***$0***	***$0***	***$614,458***	*82.96%*	Row D - (Row B + Row C)
B	*Children 0%-205% FPL Enrollment Fees*	*$40,396*	*$0*	*$40,396*	*$0*	*$0*	*NA*	Table 3.3 Row T
C	*Children 206%-250% FPL Enrollment Fees*	*$119,127*	*$0*	*$119,127*	*$0*	*$0*	*NA*	Table 3.3 Row T
D	**FY 2015-16 Total Expenditure**	**$900,191**	**$126,210**	**$159,523**	**$0**	**$614,458**	*68.26%*	Table 3.3 Row K
E	Children 206%-250% FPL	$0	($53,481)	$53,481	$0	$0	*NA*	Table 3.3 Row N
F	**Estimated CHP+ Expenditure FY 2015-16**	**$900,191**	**$72,729**	**$213,004**	**$0**	**$614,458**	*68.26%*	Row D + Row E

*Of this amount, $40,396 is from the CHP Trust Fund and $172,608 is from the Hospital Provider Fee.

Table 3.2 Summary of Costs of One-Month Grace Period FY 2016-17								
(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs								
Row	**Item**	**Total Funds**	**General Fund**	**Cash Funds***	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Notes**
A	***FY 2016-17 Expenditure to be Matched***	***$975,632***	***$110,149***	***$0***	***$0***	***$865,483***	*88.71%*	Row D - (Row B + Row C)
B	*Children 0%-205% FPL Enrollment Fees*	*$50,875*	*$0*	*$50,875*	*$0*	*$0*	*NA*	Table 3.4 Row T
C	*Children 206%-250% FPL Enrollment Fees*	*$154,471*	*$0*	*$154,471*	*$0*	*$0*	*NA*	Table 3.4 Row T
D	**FY 2016-17 Total Expenditure**	**$1,180,978**	**$110,149**	**$205,346**	**$0**	**$865,483**	*73.29%*	Table 3.4 Row K
E	Children 206%-250% FPL	$0	($48,232)	$48,232	$0	$0	*NA*	Table 3.3 Row N
F	**Estimated CHP+ Expenditure FY 2016-17**	**$1,180,978**	**$61,917**	**$253,578**	**$0**	**$865,483**	*73.29%*	Row D + Row E

*Of this amount, $50,875 is from the CHP Trust Fund and $202,703 is from the Hospital Provider Fee.

Implementing One-Month Grace Period for CHP+ Clients Owing Enrollment Fee - Calculations

Table 3.3 Cost of Covering Clients Who Failed to Pay Enrollment Fee FY 2015-16

Projected Cost of Covering Clients

Row		CHP+ Children 0%-205% FPL	CHP+ Children 206%-250% FPL	Total	Source
A	Clients Denied Eligibility - Per Month	229	225	454	Historical CHP+ Data
B	Proportion of Clients That Will Pay the Fee	90.00%	90.00%	90.00%	See Narative
C	Clients That Will Maintain Eligibility After One Month	206	203	409	Row A * Row B
D	Projected Unadjusted Per Capita (Medical + Dental)	$2,696.51	$2,536.60	$2,617.14	S-3 February 2014 Exhibit C4
E	Annualize for Implementation Date	83.33%	83.33%	83.33%	Projected Implementation of September 2015
F	**Expenditure for clients that pay the fee FY 2015-16**	**$462,901**	**$429,108**	**$892,009**	**Row C * Row D * Row E**
G	Clients That Will Lose Eligibility After One Month	23	22	45	Row A - Row C
H	Projected Unadjusted Per Capita for One Month of Coverage	$224.71	$211.38	$218.19	Row D divided by 12
I	Annualize for Implementation Date	83.33%	83.33%	83.33%	Projected Implementation of September 2015
J	**Expenditure for clients that fail to pay the fee FY 2015-16**	**$4,307**	**$3,875**	**$8,182**	**Row G * Row H * Row I**
K	**Total Expenditure FY 2015-16**	**$467,208**	**$432,983**	**$900,191**	**Row F + Row J**
L	Projected Fees Collected	$40,396	$119,127	$159,523	Row T
M	Expenditures to be Matched	$426,812	$313,856	$740,668	Row K - Row L
N	State Funds / Hospital Provider Fee*	$72,729	$53,481	$126,210	Row M * (1-82.96%)

*Children 0%-205% FPL are funded with state funds, children 206%-250% FPL are funded with the Hospital Provider Fee.

Projected Enrollment Fees Collected

Row		CHP+ Cases 0%-205% FPL	CHP+ Cases 206%-250% FPL	Total	Source
O	Cases Denied Eligibility - Per Year	1,705	1,682	3,387	Projected Based on Historical CHP+ Data
P	Proportion that will pay fee	90.00%	90.00%	90.00%	Row B
Q	Cases that will pay the fee within one month	1,535	1,514	3,049	Row O * Row P
R	Average Fee	$31.58	$94.42	$62.79	Projected Based on Historical CHP+ Data
S	Annualize for Implementation Date	83.33%	83.33%	83.33%	Projected Implementation of September 2015
T	**Total Fees Collected FY 2015-16**	**$40,396**	**$119,127**	**$159,523**	**Row Q * Row R * Row S**

Implementing One-Month Grace Period for CHP+ Clients Owing Enrollment Fee - Calculations

Table 3.4 Cost of Covering Clients Who Failed to Pay Enrollment Fee FY 2016-17					
Projected Cost of Covering Clients					
Row		**CHP+ Children 0%-205% FPL**	**CHP+ Children 206%-250% FPL**	**Total**	**Source**
A	Clients Denied Eligibility	240	243	483	Historical CHP+ Data
B	Proportion of Clients that will pay the Fee	90.00%	90.00%	90.00%	See Narative
C	Clients that will maintain eligibility after one month	216	219	435	Row A * Row B
D	Projected Unadjusted Per Capita (Medical + Dental)	$2,749.07	$2,632.04	$2,690.19	S-3 February 2014 Exhibit C4
E	Annualize for Implementation Date	100.00%	100.00%	100.00%	Projected Implementation of September 2015
F	**Expenditure for clients that pay the fee FY 2015-16**	**$593,799**	**$576,417**	**$1,170,216**	**Row C * Row D * Row E**
G	Clients that will lose eligibility after one month	24	24	48	Row A - Row C
H	Projected Unadjusted Per Capita for one month of coverage	$229.09	$219.34	$224.22	Row D divided by 12
I	Annualize for Implementation Date	100.00%	100.00%	100.00%	Projected Implementation of September 2015
J	**Expenditure for clients that fail to pay the fee FY 2015-16**	**$5,498**	**$5,264**	**$10,762**	**Row G * Row H * Row I**
K	**Total Expenditure FY 2016-17**	**$599,297**	**$581,681**	**$1,180,978**	**Row F + Row J**
L	Projected Fees Collected	$50,875	$154,471	$205,346	Row T
M	Expenditures to be Matched	$548,422	$427,210	$975,632	Row K - Row L
N	State Funds / Hospital Provider Fee*	$61,917	$48,232	$110,149	Row K * (1-88.71%)
*Children 0%-205% FPL are funded with state funds, children 206%-250% FPL are funded with the Hospital Provider Fee.					
Projected Enrollment Fees Collected					
Row		**CHP+ Cases 0%-205% FPL**	**CHP+ Cases 206%-250% FPL**	**Total**	**Source**
O	Cases Denied Eligibility	1,790	1,818	3,608	Historical CHP+ Data
P	Proportion that will pay fee	90.00%	90.00%	90.00%	Row B
Q	Cases that will pay the fee within one month	1,611	1,636	3,247	Row O * Row P
R	Average Fee	$31.58	$94.42	$63.24	Historical CHP+ Data
S	Annualize for Implementation Date	100.00%	100.00%	100.00%	Projected Implementation of September 2015
T	**Total Fees Collected FY 2016-17**	**$50,875**	**$154,471**	**$205,346**	**Row Q * Row R * Row S**