Department of Health Care Policy and Financing
Department Description
FY 2011-12 Budget Request

November 1, 2010

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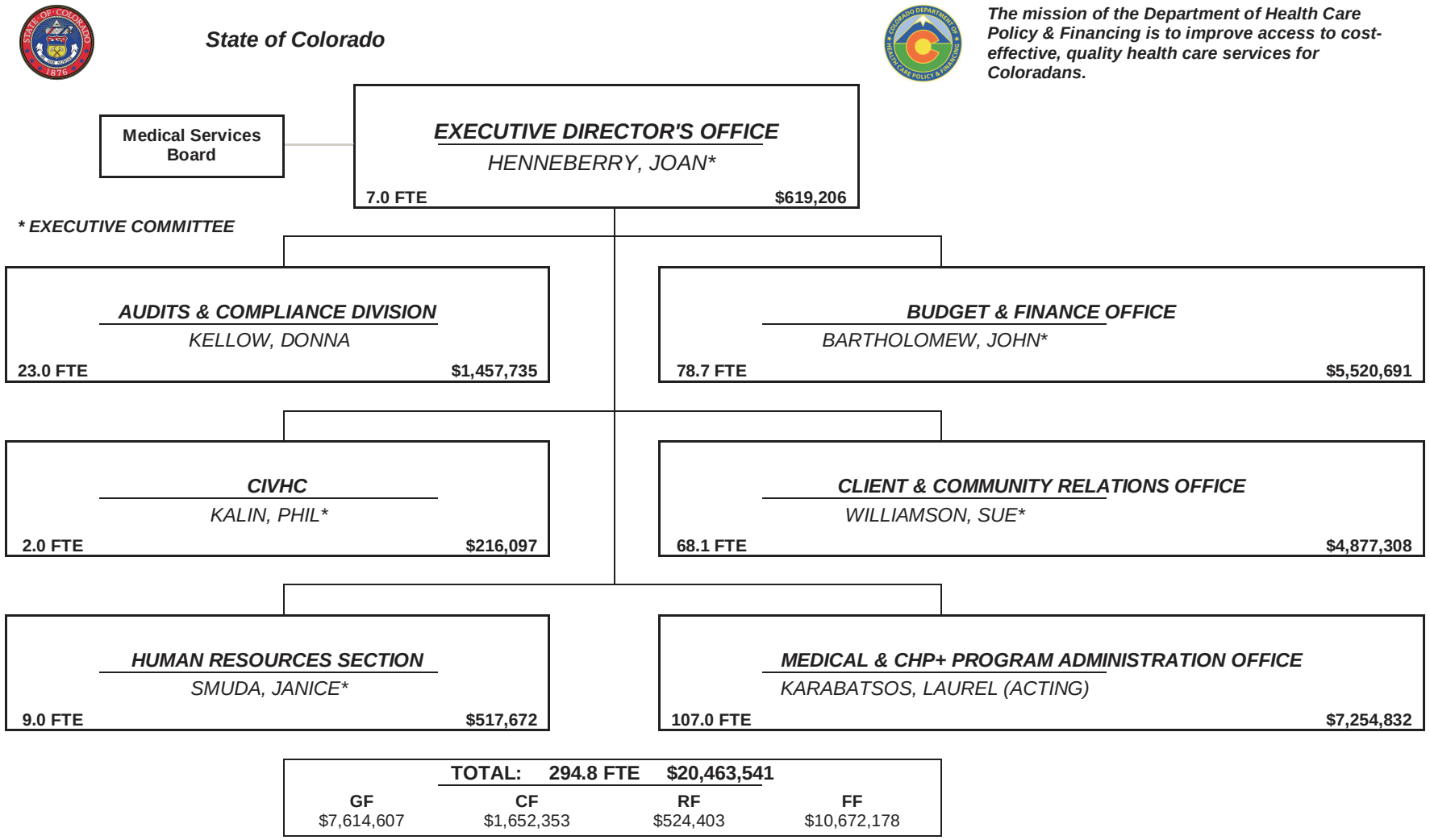


II. BACKGROUND INFORMATION

The Department of Health Care Policy and Financing (the Department) receives federal funding as the single state agency responsible for administering the Medicaid program (Title XIX) and the State Child Health Insurance Program (Title XXI), known as the Children's Basic Health Plan. In addition to these programs, the Department administers the Colorado Indigent Care Program, the Old Age Pension State Medical Program, the Comprehensive Primary and Preventive Care Grant Program, the Primary Care Fund as well as the Home and Community-Based Services Medicaid Waivers. The Department also provides health care policy leadership for the state's Executive Branch. Most of the Department's programs are funded in part by the federal Centers for Medicare and Medicaid Services. The Medicaid program receives approximately 50% of its funding from the federal government and the Children's Basic Health Plan receives approximately 65% of its funding from the federal government.

Executive Director's Office

Joan Henneberry was appointed executive director of the Department effective January 9, 2007. The Executive Director has organized the Department to allow for greater focus on key program and operational areas. Areas of responsibility for the Executive Director include general governance and financial accountability for the Department, communication with partners within and outside of state government, and research and development for current and future refinement of Department operations and programs.

The State Medical Services Board was created by the Legislature effective July 1, 1994. The Board consists of 11 members appointed by the Governor and confirmed by the Senate. The members are persons who have knowledge of medical assistance programs, experience with the delivery of health care, and experience or expertise in caring for medically underserved children. The Board has the authority to adopt rules that govern the Colorado Medicaid program and the Children's Basic Health Plan that are in compliance with state and federal regulations.

The Department is committed to providing accurate, understandable, and consistent information to the public, clients, providers, legislators, internal staff, and advocates. As such, the Department's Public Information Officer resides within the Office of the Executive Director. The Public Information Officer ensures that accurate communication is provided timely and in a consistent manner. Communication is conducted through the Department's website, client correspondence, brochures, program newsletters, and email. All materials are reviewed to ensure that communication is effective and easy to read. The Public Information Officer works closely with the Governor's Office in coordinating messages to the media and with the Lieutenant Governor's Office on outreach to eligible populations.

In March 2010, the Department formed a Strategic Workgroups and Tactics Team (SWAT Team) to improve workflow and collaboration among staff. The team consists of four members, each of whom represents a different Department office, and works to achieve cohesion across offices to assist staff with achieving successful implementation of projects that support the Department's mission and goals. The SWAT Team provides assistance by helping staff prioritize resources for competing projects, making recommendations for efficient sequencing of projects or tasks, and facilitating project management assistance and coaching. The SWAT Team also provides staff with guidance for strategic and operational planning and helps with risk-management activities. Goals of the SWAT Team in FY 2010-11 include working to achieve strategic plan benchmarks, ensuring progress is made toward operational plan objectives, increasing the percentage of resolved items on the risk management list, and developing a standard operating procedure for Department project management and implementation planning.

Audits and Compliance Division

The Audits and Compliance Division consists of the Program Integrity Section and the Audits Section. These sections ensure compliance with state and federal law, as well as identifying and recovering any improper Medicaid payments.

Program Integrity

The Program Integrity section monitors and improves provider accountability for the Medicaid program. The section identifies fraud, potentially excessive and/or improper utilization, and improper billing of the Medicaid program by providers. If aberrancies are identified, staff investigate, classify, and recover payments and/or refer the providers to legal authorities for possible prosecution when appropriate. Administrative, civil, and/or criminal sanctions may also be pursued by the Department in coordination with the Attorney General's Medicaid Fraud Control Unit or the U.S. Attorney's office.

Between July 1, 2008 and August 31, 2010, the Program Integrity section recovered approximately $21 million in improper payments. The section's goal is to have recovered $47.7 million between July 1, 2008 and June 30, 2012.

Audits Section

The Audits section exists to ensure that the Department maintains compliance with federal and state rules, laws, and regulations. The section has several different functions that assist with this, including:

- Medicaid Eligibility Quality Control Unit: The Medicaid Eligibility Quality Control unit assesses eligibility determinations to assure accuracy and timeliness of the eligibility determination to avoid inappropriate payments and client determination delays. This program is required by the federal government.

- County Audits: This function was transferred from the Department of Human Service with the passage of SB 06-219. This ensures that the Department is able to issue Management Decisions on all county Single Audits, follow-up on county audit findings and review county financial statements.
- Payment Error Rate Measurement (PERM) Program: The Payment Error Rate Measurement program is required by the federal Centers for Medicare and Medicaid Services to comply with the Improper Payments Information Act of 2002. The purpose of the program is to examine the accuracy of eligibility determinations and claims payment to ensure that the Department only pays for appropriate expenditures.
- Internal Audits/Review: Internal auditing/reviewing is an independent, objective assurance activity designed to add value and improve an organization's operations and assist with compliance with federal and state laws and regulations.
- Department Audit Coordination: The Department is routinely audited by the State Auditor's Office, the U.S. Office of the Inspector General, and the federal Centers for Medicare and Medicaid Services. The Department is committed to implementing all agreed audit findings and continually improving processes and policies. The Audits Section actively monitors the implementation of all audit findings and is responsive to all information requests from auditors.

Budget and Finance Office

The Budget and Finance Office consists of the Budget Division, the Controller Division, the Claims Systems and Operations Division, and the Safety Net Programs Section. The Budget Division includes the Financing and Indigent Care Unit, the Medical Premiums Unit, and the Personal Services and Other Agencies Unit. The Claims Systems and Operations Division is comprised of the Contracts and Monitoring Section and the Claims Systems Section. The Controller Division oversees the Accounting Section, which includes the Operations Unit, the Financial Reporting and Grants Unit, and the Medicaid and Other Programs Unit.

Budget Division

The Budget Division's five key responsibilities are to project, construct, present, monitor, and manage the Department's budget. In addition, the Budget Division presents and defends the Department's budgetary needs to the Executive and Legislative authorities. The division prepares each phase of the budget request process, including deliverables such as statistical forecasting of caseload and premiums, requests for additional funding, and recommendations for reduced funding. This division also monitors caseload and expenditures throughout the fiscal year and ensures expenditures meet legal requirements while still coinciding with the Department's objectives. The Budget Division also tracks relevant legislation as it moves through the General Assembly and prepares fiscal impact statements for proposed legislation and ballot initiatives that may affect the Department. This division is also responsible for federal reporting as well as coordinating with the Department of Human Services on budgetary issues that affect both departments.

The Budget Division is also tasked with working closely with the Centers for Medicare and Medicaid Services to ensure that the Department is maximizing federal Medicaid revenue. In addition, the Division strives to maximize available federal funding for hospital and clinic providers who participate in Medicaid and the Colorado Indigent Care Program.

Controller Division

The Controller's Division oversees the accounting functions of the Department. The division ensures the proper recording and reporting of revenues and that expenditures in the Department are in compliance with generally accepted accounting principles and state and federal rules and regulations.

- The Operations Unit is responsible for the proper recording of cash receipts, accounts receivable, accounts payable, and payroll. The Cash Receipts Accounting Technician processes and deposits checks and other receipts and properly records this information in the State's financial records system. Working with the MMIS system, the Accounts Receivable Accountant monitors receivable balance sheet accounts, adjusts vendor accounts to properly account for amounts owed the State's Medicaid program, and collects past due accounts. Timely manual payments to vendors are processed in the State's financial records system by the Accounts Payable Accountant. Working closely with the Human Resources Department, the Payroll Accounting Technician is responsible for the accurate processing of the Department's monthly and bi-weekly personnel payments through the State's central payroll system. All positions are responsible for monitoring the accurate reporting of assigned appropriations and working with Budget and Program personnel to resolve issues.
- The Financial Reporting and Grants Unit is comprised of the Children's Basic Health Plan Accountant, the Department of Human Services and County Administration Program Accountant, the Cash Management Accountant and their Supervisor. Each accountant responds to the accounting needs of their Program, and the Cash Management Accountant manages the State and Federal Cash as well as the reporting of private grants and non-Medicaid Federal grants.
- The Medicaid and Other Programs Unit is primarily responsible for all accounting entries and issues related to the Medical Services Premiums and Medicaid Mental Health Long Bill Groups, the Hospital Provider Fee, the Nursing Home Provider Fee, and Tobacco Taxes. Additional duties include recording the Departmental budget in the Colorado Financial Reporting System and performing and reconciling all entries related to the enhanced federal medical assistance percentage provided by the American Recovery and Reinvestment Act of 2009 (ARRA). All positions are responsible for monitoring the accurate reporting of assigned appropriations and working with Budget and Program personnel to resolve issues.

Claims Systems and Operations Division – Contracts and Monitoring Section

Within the Claims Systems and Operations Division, the Contracts and Monitoring Section manages the Department's Information Technology (IT) contracts and agreements, monitors IT vendors for contractual compliance, and provides IT vendor operational oversight. The section drafts and negotiates contracts and monitors contract performance as well as federal oversight of IT contracts. The primary IT contract that the section manages and monitors is the Medicaid Management Information System (MMIS) contract, which is a multi-year, multi-million-dollar contract. The section also works with the Budget Division to provide estimates for building in modifications to the system to reflect changes needed to implement legislation or shifts in policy direction.

The Contracts and Monitoring section also provides oversight of all operational aspects of the MMIS contract. This includes, but is not limited to, oversight of provider enrollment and claims processing. Claims processing responsibilities include management of claim edits, prior authorizations, claim reconsiderations, financial transactions and mass adjustments. The section is also responsible for provider call center functions and provider communication. Responsibilities regarding provider communication include:

- facilitating provider training;
- preparing training materials;
- updating and maintaining billing manuals;
- maintaining provider services web pages;
- ensuring a secured provider web portal; and
- preparing the provider bulletin.

In addition, the Contracts and Monitoring section is responsible for addressing escalated billing and provider enrollment issues that require state approval. The section also handles provider appeals that are filed with the office of administrative courts. The section works closely with the Claims Systems Section, Department policy staff, programmers, and business analysts at the fiscal agent to ensure the claims systems accurately pay for approved services to eligible clients by enrolled providers. The section provides quality assurance for written transmittals to the MMIS vendor and conducts claims payment audits through claims processing assessment system studies. The section is responsible for ensuring operational compliance and strategic planning to achieve required Health Insurance Portability and Accountability Act transaction standards for covered entities.

The Contracts and Monitoring section manages contracts for the production and issuance of medical identification cards, interagency agreements, the provider-secured Web portal, and data use agreements between the Department and other state and federal

organizations. Lastly, the section manages external audit coordination for the Claims Systems and Operations Division as well as for the Information Technology Division.

Claims and Operations Division – Claims Systems Section

The Claims Systems Section ensures timely and accurate Medicaid and Children's Basic Health Plan claims processing and reporting. The section is responsible for directing the systems maintenance and enhancement of the MMIS by working closely with the systems staff of the fiscal agent, ACS Government Solutions. The section works with Department policy staff to gather requirements for the maintenance or enhancement of the MMIS by developing requirement documentation, reviewing and approving detail system design approaches, ensuring appropriate testing of changes, and by reviewing and approving all test outputs. Further, they propose IT solutions to program staff and implement those solutions to support Department policies. The section works with policy staff at the Department and its sister agencies as well as programmers and business analysts at the fiscal agent to ensure the MMIS accurately pays for approved services to eligible clients by enrolled providers.

In addition to supporting the MMIS, the Claims Systems Section directs the claims system programs through maintenance and enhancement efforts on:

- the decision support system, housed at the fiscal agent site, that provides predefined and ad-hoc reporting capability to Department program managers, contractors, and multiple state agencies; and,
- the provider Web portal, operated by a separate vendor, which allows providers to submit claims, search for eligibility verifications, and retrieve files and reports.

The Claims Systems Section also manages several data interfaces, including data communications between the Colorado Benefits Management System (CBMS) and MMIS. For example, there are daily and monthly interface files with client eligibility and enrollment data sent to the MMIS from CBMS. Another major interface partner is the Colorado Financial Reporting System. In addition, there are weekly interfaces of data for payments (warrants and electronic funds transfers) to providers. This section is also responsible for assuring that medical identification card interfaces are sent to the designated vendor on a daily basis. Finally, this section ensures systems compliance and strategic planning to achieve required Health Insurance Portability and Accountability Act transaction and code set standards for the Department as a covered entity.

With the creation of the Governor's Office of Information Technology, the staff responsible for managing CBMS began reporting to the Governor's Office of Information Technology effective July 1, 2009. In addition, the Governor's Office of Information Technology now has oversight of the CBMS contract with the vendor Deloitte.

Safety Net Programs Section

The Safety Net Programs Section administers several programs that provide funding to hospitals and clinics that serve uninsured and underinsured individuals, and provide coverage for individuals not eligible for Medicaid or the Children's Basic Health Plan.

The Colorado Indigent Care Program distributes federal and state funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado citizens, migrant workers, and legal immigrants with limited financial resources. These individuals are uninsured or underinsured, and are not eligible for benefits under either the Medicaid Program or the Children's Basic Health Plan.

The Comprehensive Primary and Preventive Care Grant Program provides grants to health care providers in order to expand primary and preventive health care services to Colorado's low-income residents. Primary and preventive care are two of the most cost-effective means of keeping people healthy. The Comprehensive Primary and Preventive Care Grant Program is intended to expand these services to Colorado's uninsured or medically indigent populations. However, it is not intended to supplant or expand Medicaid, the Children's Basic Health Plan, or the Colorado Indigent Care Program.

The Old Age Pension State Medical Program provides limited medical care for individuals receiving Old Age Pension grants. Those eligible for this program are over age 60, but may not meet Supplemental Security Income criteria or residence requirements, and are therefore ineligible for Medicaid. This population could be disabled to some degree, but not sufficiently to qualify for Supplemental Security Income.

The School Health Services Program provides reimbursement to qualified school districts that provide health services to children enrolled in Medicaid. In order to qualify, districts or their corresponding Boards of Cooperative Educational Services (BOCES) must submit a Local Services Plan that outlines the services that the district, the community, and the BOCES would like to provide. Once a plan has been approved, the Department reimburses the district upon receipt of claims for services provided to children enrolled in Medicaid.

The Primary Care Fund, which is funded by taxes on tobacco products, provides an allocation of moneys to health care providers that qualify under a specific set of criteria. These providers must provide basic health care services in an outpatient setting to residents of Colorado who are considered medically indigent. Moneys are allocated based on the number of medically indigent patients served by one health care provider in an amount proportionate to the total number of medically indigent patients served by all health care providers who qualify for moneys from this fund.

Client and Community Relations Office

The Office of Client and Community Relations includes a diverse set of functions that promote the Department's mission of improving access to high-quality and cost-effective health care to Coloradans. Many of the activities focus on ensuring that those applying for state health care programs have the support and information they need to make the process as easy as possible. Once enrolled in a program, several activities support the client's continued retention if they remain eligible and promote access to health care services in appropriate settings. Many of the activities focus on ensuring that external partners, providers, stakeholders, and community-based organizations have opportunities to provide input regarding the implementation of programs and major initiatives of the Department. To this end, the Office of Client and Community Relations identifies ways to improve communication to further the goals of transparency and accountability.

The functions within the office that are client- and community-facing include: Medicaid eligibility operations and policy; the Early and Periodic, Screening, Diagnosis and Treatment Outreach and Case Management Unit; the County Liaison; the Americans with Disabilities Act Liaison; oversight of the medical assistance sites; and the functions of the Customer Service Center, Medical Services Board, statewide outreach, and management of the eligibility and enrollment for medical assistance programs contractor.

Eligibility Section

The Eligibility Section exists to ensure access to Medicaid for eligible families, children, the elderly, and persons with disabilities. This section defines program eligibility through policy development and training to counties and other agencies. The section also provides policy expertise on Medicaid eligibility for all categories for the rules-based eligibility computer system, serving as a liaison to the Colorado Benefits Management System, managed by OIT.

Client Services Section

The Client Services Section provides a high level of communication and assistance to all clients who contact the Department. The section acts as a major focal point for callers who require assistance with questions about eligibility and program information and who need help in navigating a complex health care system.

EPSDT Unit

The Early and Periodic Screening, Diagnosis, and Treatment Unit (EPSDT) is responsible for program outreach and case management services in a manner consistent with federal regulations. These outreach and case management services are aimed at the promotion of

health, the prevention of disease, and improved access to health care services for children on Medicaid. This unit also administers the Medical Homes for Children program which works closely with providers and families to promote the medical home model with the goal of improving health outcomes for children.

County Oversight/Outreach

The office also works closely with the county departments of social/human services and the medical assistance sites to ensure that eligibility determinations are completed accurately and timely. Communication to and from the counties and medical assistance sites is accomplished through a county liaison and medical assistance site coordinator. Further, the office coordinates all of the Department's outreach efforts with clients, providers, stakeholders, and community-based organizations to create awareness of the availability of the Department's public health insurance programs; to encourage eligible, but not enrolled people to apply for Medicaid and to determine the best strategies to maximize enrollment and retention in the Department's programs.

The office is also responsible for a number of operational components of the Department which include the Legal Division, the Contracts and Purchasing Section, and management of the Department's grant-making process.

Legal Division

The Legal Division is responsible for handling privacy and Health Insurance Portability and Accountability Act (HIPAA) training and compliance. The division also acts as records custodian and coordinates Colorado Open Records Act requests. Other responsibilities of the division include:

- managing and coordinating external data requests through the Department's data review board;
- managing the Department's privacy database;
- managing the Department's State Plan and drafting amendments to the State Plan;
- providing assistance in drafting rules;
- coordinating Department rules and Department guidance to avoid conflicts of authority;
- coordinating the Department's relationship with the Attorney General's office;
- providing analysis and guidance to Department personnel on various regulatory and legal issues; and
- monitoring the impacts of federal health care reform.

The Legal Division includes the Benefits Coordination section, whose mission is to ensure Medicaid is the payer of last resort, extending public purchasing power by pursuing third-party payment of medical costs for Medicaid-eligible persons. The Benefits Coordination Section pursues responsible payment sources to recover costs for medical care paid for by Medicaid. The sources the Benefits Coordination Section pursues include trusts, estate recoveries, and recovery of any payments for clients who were discovered to be ineligible for Medicaid retroactively.

In FY 2009-10, the Benefits Coordination Section collected $35.9 million in recoveries from trusts, estate recoveries, and recovery of any payments for clients who were discovered to be ineligible for Medicaid retroactively. This was an increase of 49.2% over the FY 2008-09 recoveries.

Contracts and Purchasing Section

The Contracts and Purchasing Section provides support for all aspects of procurement for the Department and ensures compliance with state procurement statutes and rules. The section also reviews departmental contracts for compliance with state rules, regulations, and contracting standards and processes.

Health Resources and Services Administration

The Department routinely seeks grant funding from a variety of government agencies, local health foundations as well as national non-profit organizations to implement new health care programs and policies. The management of the grants process, which includes the preparation of grant proposals and completion of the requirements for grant submission as well as financial tracking and reporting is housed within the office. The operations and oversight of the Health Resources and Services Administration (HRSA) State Health Access Program grant also resides in this office.

Human Resources Section

The Human Resources Section provides the full range of human resource services to all employees of the Department. This is a decentralized personnel function, which includes recruitment, testing, selection, classification, salary administration, diversity, training, rules interpretation, work force development, employee/manager counseling, corrective and disciplinary actions, separation analysis, dispute resolution, and maintaining personnel records within the confines of the State personnel rules. This section also provides advice, guidance, counseling, and technical assistance to Department managers and staff on the workings of the State personnel system. In addition, the Human Resources Section has taken over the reception area and has been delegated the incoming security for the department.

The Human Resources Section is responsible for all functions necessary to properly classify Department staff positions and to fill those positions in accordance with the State constitution and the State personnel rules and procedures. This includes proper classification of positions, announcing job openings, reviewing applications, testing candidates, and referring qualified candidates to departmental appointing authorities. Section staff participate in corrective action meetings, disciplinary hearings, and any appeals related to the results of those functions. The Human Resources Section staff is now trained in mediation and provides a full range of resources designed to reduce and resolve disputes within the Department.

The Human Resources Section is also responsible for the development and implementation of internal training for all Department employees. This includes career development, management enhancement, and employee assessment. The Human Resources Section is responsible for training all Department staff on Executive Orders that require training on topics such as sexual harassment, violence in the workplace, and maintaining a respectful workplace. The section provides external tracking of all trainings associated with performance measures and allocates funding for career development seminars. The Human Resources section also has the department office supply budget to provide adequate tools and resources for all staff to perform their duties. The Human Resources section must provide badges to all department visitors and ensure that no unexpected person is wandering within the department building area between 8 a.m. and 5 p.m.

Medical and Child Health Plan *Plus* Program Administration Office

This office designs, implements, and administers Medicaid, Children's Basic Health Plan, and the Long-Term Care Medicaid Programs. The office aims to improve the health status of all clients, achieve efficiencies in scarce health care resource utilization, and promote effective partnerships with providers and contractors to achieve improved health and functioning of clients. The office recognizes the diversity of geography, age, culture, ethnicity, psychosocial needs, income, and health among its clients and aims to deliver high-quality client-centered services.

Medicaid Program Division

The Medicaid Program Division is responsible for the administration and performance of Medicaid fee-for-service and managed-care services and programs. The Medicaid Program Division seeks to maximize the health, functioning, and self-sufficiency of all Medicaid clients affordably. The services and programs include both physical health and behavioral health benefits. The division is responsible for provider outreach, policy development, contract management, operations management, and overall Medicaid program performance. The division is currently implementing a hybrid Medical Home/Accountable Care Organization program aimed at becoming the dominant delivery system in the Medicaid program.

Long-Term Care Benefits Division

The Long Term Care Benefits Division oversees Medicaid-funded community-based services and nursing facilities. The division has a particular focus on affordably maximizing the health, functioning, and self-sufficiency of clients in long-term care, institutional, or community settings. The clients utilizing these services have complex health care needs, requiring coordinated and high-quality services. Community-based services are those services provided in clients' homes as an alternative to placement in a nursing facility or other institutional setting. These community-based services provide support for clients to remain at home and in the community, allowing for individual choice. This division oversees all Medicaid Home- and Community-Based Services waiver programs (HCBS) and skilled services such as home health care, private duty nursing, and hospice care that are available through the Medicaid State Plan. The division is also responsible for managing consumer-directed attendant support services which allow qualifying individual clients to direct their own in-home care.

CHP+ Division

The Children's Basic Health Plan provides basic health insurance coverage for uninsured children and pregnant women of low-income families. The CHP+ Division, which administers The Children's Basic Health Plan, focuses on affordably promoting the health and functioning of children and their mothers. The Children's Basic Health Plan is a non-entitlement, non-Medicaid program that delivers coverage in accordance with the principles of private insurance. The Children's Basic Health Plan benefit package is substantially equivalent to the level of coverage mandated by the State for small, privately insured groups. The Children's Basic Health Plan offers a wide variety of services to children including check-ups, immunizations, doctor visits, hospital services, prescribed medications, mental health services, dental services, hearing aids, and glasses.

Pharmacy Section

The Pharmacy Section oversees access to medications for Medicaid clients, including the fee-for-service and dual-eligible (Medicare and Medicaid) populations. The section ensures that medications are used in a clinically appropriate and cost-effective manner through the Preferred Drug List Program and by performing drug-utilization analysis, with input from the Drug Utilization Review Board. The section aims to improve health care quality by addressing under-utilization, over-utilization, and inappropriate utilization of pharmaceuticals. This section administers the Rx Review Program (drug therapy counseling sessions for Medicaid clients). The section collects federal and supplemental drug rebates from pharmaceutical manufacturers. The section also ensures that pharmacy benefits are provided in compliance with federal and state statutes and regulations. Finally, the section provides pharmacy benefits information and assistance to clients, pharmacies, and prescribers to facilitate clients' access to their medications.

Health Outcomes and Quality Management Unit

The Health Outcomes and Quality Management Unit is responsible for directing, conducting, and coordinating performance-improvement activities for the care and services Medicaid and Children's Basic Health Plan clients receive. The unit works across programs, offices, and divisions to promote effectiveness and efficiency initiatives that support the Department's mission. Specific functions of the unit include:

- process and outcome measurement and improvement;
- managing the external quality review of physical and behavioral managed care contractors and fee-for-service providers;
- monitoring managed care plan contract compliance;
- overseeing external review organization administration of satisfaction surveys to clients enrolled in managed care as well as clients enrolled in the Children's Basic Health Plan;
- development of long-term care quality tools and interagency quality collaborations; and,
- development and implementation of quality strategies and consulting to program managers regarding performance measurement and improvement.

Rates and Analysis Division

The Rates Section of the Rates and Analysis Division develops rate-setting methodology and implements managed care rates for health maintenance organizations, behavioral health organizations, and the Program of All Inclusive Care for the Elderly providers. The section also monitors and updates rates paid for home and community-based services. In addition, this section is responsible for rate analysis and operations for hospitals, federally qualified health centers, and rural health clinics. It is the responsibility of this section to make sure that rates comply with all applicable state statutes and federal regulations.

The Department recognizes the critical need for professional, efficient, consistent, and appropriate analysis of its statistical information, and as such, has a Data Analysis Section. The section establishes standards for appropriate analytical methodologies for use in making strategic and fiscally responsible decisions. The focus of this section is to address the difficult and complex data analysis needs of both internal and external customers. This section extracts data for research, policy formation, report writing, forecasting, and rate setting for the Department's programs.

III. PRIOR-YEAR LEGISLATION

The following is a summary of major legislation enacted in 2010 that affects Department policies and procedures.

HB 10-1005 (Massey, Foster) Telemedicine Changes

This bill makes telemedicine for Home Health and Home- and Community-Based Services (HCBS) eligible for reimbursement under Medicaid in order to comply with direction from the Centers for Medicare and Medicaid Services (CMS). The bill eliminates incorrect references to the way reimbursement payments are made under the program and deletes the requirement that reimbursement rates from telemedicine be budget neutral or result in cost savings to the program. This bill is correcting issues related to SB 07-196 and is separate from the telemedicine program established by SB 06-165 for disease management.

HB 10-1010 (Ferrandino, Morse) Public-Private Initiatives with Non-Profit Entities

This bill authorizes state agencies to enter into public-private initiative agreements with non-profit entities. The bill also provides an incentive for an agency to enter into public-private initiatives by amending an existing statutory definition of "cost savings" to include savings from these kinds of agreements, as the bill allows an agency to retain a portion of any cost savings realized from a personal services contract entered into pursuant to a public-private initiative agreement.

HB 10-1027 (Roberts, Williams) Prognosis for Hospice Care

This bill increases the required life expectancy prognosis for clients receiving Medicaid hospice services from 6 months to 9 months if the Department receives the necessary federal authorization.

HB 10-1029 (Acree, Keller) Purchase of Medical Goods

This bill directs the Department to work with non-profit organizations to develop a link on its website to approved vendors willing to sell Durable Medical Equipment at a discount to eligible clients. The bill requires the Department to provide criteria for approving vendors for the list.

HB 10-1033 (Massey, Boyd) Add Substance Abuse to Optional Medicaid Services

This bill is from the Health Care Task Force. The bill adds Screening, Brief Intervention, and Referral to Treatment (SBIRT) to the list of Medicaid optional services. This bill would allow the Department to reimburse existing providers for providing SBIRT services

– including screenings and brief interventions for alcohol and/or substance abuse and tobacco use – to identify clients at risk for substance abuse or dependence.

HB 10-1043 (Apuan, Sandoval) Remove Outdated References to AFDC

This bill was part of the Department's legislative agenda. The bill eliminates references to the former federal Aid to Families with Dependent Children (AFDC) program to bring statute in line with current Department practice. In 1996, the Personal Responsibility and Work Opportunity Act required states to base eligibility criteria for Medicaid on a person's income and resources and set the criteria at no less than those used for the AFDC program as of July 16, 1996. This bill authorizes the Medical Services Board to adopt rules for Medicaid eligibility for families using the pre-welfare reform criteria or to make adjustments to the income or resource standards as allowed under federal law.

HB 10-1146 (Hullinghorst, Tochtrop) Circumstances for Receiving Adult Foster Care and Home Care Allowance

This bill clarifies the circumstances under which recipients of Old Age Pension, Aid to the Needy Disabled, Aid to the Blind, or Supplemental Security Income benefits can receive state-funded adult foster care (AFC) and home care allowance (HCA). Old Age Pension clients receiving benefits as of June 30, 2010, would be allowed to retain their eligibility for HCA and AFC. Old Age Pension clients eligible July 2010 and thereafter will no longer be eligible for HCA and AFC; however, this provision will not become effective until 2014 due to the maintenance of effort requirements under federal health care reform. In addition, this bill would no longer allow Home and Community Based Services waiver clients to also receive HCA or AFC.

HB 10-1053 (Riesberg, Boyd) Community Long-Term Savings Study

Subject to the receipt of sufficient moneys through gifts, grants, or donations, this bill directs the Department to contract for a study of Medicaid recipients who receive services under a Home and Community Based Services waiver to evaluate whether cost savings can be realized from changes to reimbursement methods for Alternative Care Facilities. The bill also requires the Department to add requirements to its rules regarding restricted environments and egress alert devices for use in Adult Day Services centers.

HB 10-1119 (Ferrandino, Schaffer) SMART Government Act

This bill codifies current Executive Branch policy requiring state agencies to link their annual budget requests to performance-based strategic plans. In addition, the bill adds a requirement that agencies report on their performance progress annually and requires the State Auditor to conduct performance audits for two agencies per year. The bill requires the Office of State Planning and Budgeting

to publish annual performance reports for agencies and requires the Governor's Office of Information Technology to conduct a feasibility study for implementing a centralized, electronic budgeting system for the state. Lastly, the bill deletes restrictive language regarding department authority to transfer funds within its own budget for Personal Services and Operating Expenses.

HB 10-1330 (Kefalas and Kagan, Morse) All Payer Claims Database

This bill was part of the Department's legislative agenda. This bill requires the executive director of the Department to appoint an advisory committee to make recommendations regarding the creation of a Colorado all-payer health claims database for the purpose of transparent public reporting of health care information. The executive director is required to appoint an administrator to create the database. The administrator, in consultation with the advisory committee, shall create the database if sufficient gifts, grants, and donations are received on or before January 1, 2012, to pay for the creation and maintenance of the database.

SB 10-002 (Steadman, Looper) Denial of Benefits

This bill requires the Department to examine the feasibility of requiring an independent contractor to develop an additional process to identify reasons for denials for payment by private insurance carriers for which an appeal should be considered. The bill requires the Department to use this process to prioritize appeals of denials based upon the reasons for the denial in order to increase the amount of recoveries from third parties. The bill expresses the intent of the general assembly that additional recoveries from third parties be used to reduce the waiting list of persons with developmental disabilities.

SB 10-061 (Tochtrop, Soper) Medicaid Hospice Room and Board Charges

This bill requires the Department to pay a nursing facility directly for room and board charges for services provided to a Medicaid recipient who elects to receive hospice care. Currently, the Department reimburses the hospice provider who then reimburses the nursing facility for room-and-board charges. This bill also requires the Department to reimburse inpatient hospice facilities for room and board.

SB 10-117 (Foster, Primavera) Medicaid Over-the-Counter Medications

This bill adds over-the-counter medications identified through the drug utilization review process to services provided under Medicaid when the medications are prescribed by a licensed practitioner or a qualified licensed pharmacist. The bill requires the Medical Services Board to adopt rules to allow pharmacies to be reimbursed for dispensing the specified medications to Medicaid recipients

and to identify the standards for qualified pharmacists. In addition, the Department is required to annually report any savings from reimbursing over-the-counter medications to the Joint Budget Committee.

SB 10-129 (Hudak, Rice) Children with Autism Waiver

This bill was part of the Department's legislative agenda. The Department is required to contract with Community Centered Boards (CCBs) to serve as the single entry point and care planning agency for the Home- and Community-Based Services waiver for Children with Autism. This bill allows the Department to contract with a department-approved case management agency if a designated CCB is unwilling or unable to contract with the Department for these services.

SB 10-167 (Boyd, Riesberg) Medicaid Efficiencies and False Claims Act

This was a part of the Department's legislative agenda. This bill is comprised of the following elements: aligning the current State False Claims Act with the Federal False Claims Act which would increase the state share of recoveries; pre-payment Medicaid Claims Review through the National Correct Coding Initiative (NCCI); creation of a pharmacy coordination of benefits program which allows for real-time verification of third party liability; expanding the use of the Public Assistance Reporting Information System (PARIS) for data matching between states; expanding the Health Insurance Buy-In (HIBI) program; and creation of an Internal Audit unit within the Department.

IV. HOT ISSUES

Federal Health Care Reform

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (PPACA), which, along with the Health Care and Education Reconciliation Act of 2010, mandates broad, sweeping reform of the U.S. health care system that affects eligibility, administration, and delivery at both the federal and state levels. Among these changes are: requiring all citizens to carry health insurance; prohibiting health insurance providers from denying coverage for pre-existing conditions or having lifetime limits on coverage; expanding Medicaid eligibility; and creating state-, multi-state, or regional-based Exchanges that allow individuals and small businesses to purchase health insurance. These changes are scheduled to take effect over a transition period spanning between the years 2010 and 2018.

Medicaid Reform

Among the changes resulting from PPACA, Medicaid reform has the greatest impact on the Department. In particular, effective by January 1, 2014, Medicaid eligibility will be expanded to all citizens with incomes up to 133% FPL, including adults without dependent children. These newly eligible adults are guaranteed a benchmark benefit package that provides coverage equivalent to most basic private plans. To aid in this transition, the federal government plans to fund the new population of adults without dependent children, initially at 100% between 2014 and 2016, and gradually abdicating 10% of the financial burden for this population to the state by 2020. It should be noted that States have the option to phase-in the newly eligible adults prior to 2014 through a State Plan Amendment. The Department estimates that by 2020, Medicaid will cover approximately 145,000 individuals due to PPACA, in addition to the 194,000 that the Department anticipates will be covered under the Colorado Health Care Affordability Act (HB 09-1293).

Other mandatory Medicaid reform resulting from PPACA include:

- interface of Medicaid eligibility systems with these new Exchanges for individuals and small businesses;
- Maintenance of Effort Provisions (MOE) requiring states to maintain the same income eligibility levels during the reform transition to ensure clients do not lose coverage;
- eligibility of subsidies and public coverage based on Modified Adjusted Gross Income (MAGI) to eliminate differences across states;
- requiring Medicaid coverage for former foster care children up to age 26;

- the requirement that Medicaid rates for primary care services be no less than 100% of Medicare rates in 2013 and 2014, with 100% federal funding for the incremental cost from July 1, 2009;
- an increase of the Medicaid drug rebate to 23.1% for brand-name drugs and 13% of AMP for non-innovator, multiple-source drugs, and extends to include Medicaid-managed care plans;
- a reduction in Medicaid DSH payments beginning in 2014; and,
- an increase of 23 percentage points to the CHP+ enhanced match rate from FFY 2015 through FFY 2019.

In addition to these required changes, there are numerous state options to improve services, delivery systems, and payments methodologies. These include:

- increasing federal financial participation on proven preventive services by 1% if states cover all such services and prohibit cost-sharing;
- grants to states to test approaches that may encourage healthy lifestyles among Medicaid enrollees;
- option to offer Family Planning Services under the State Plan rather than a waiver;
- option to offer Home- and Community-Based Services under the State Plan rather than a waiver;
- Money-Follows-the-Person Rebalancing Demonstration, which reduces the institutional residency period for purposes of demonstration participation by requiring that individuals reside in an institutional facility for at least 90 days, as opposed to at least six months;
- option to provide Health Homes for enrollees with chronic conditions, with planning grants beginning in January 2011;
- funding for childhood obesity demonstration projects in CHP+;
- demonstration project to implement accountable care pilots;
- demonstration project for emergency psychiatric program to provide incentive payments to certain institutions for mental disease;
- options for states to implement health information technology standards and protocols;
- demonstration project to study bundled payments for hospital and physician services; and,
- requiring the Secretary of HHS to also establish a Medicaid Global Payment demonstration project under which participating states must adjust the payments made to an eligible safety net hospital system or network from fee-for-service to global capitated.

Because it is early in the implementation of health care reform, the Department does not know which optional programs may be implemented; however, the Department anticipates these changes will necessitate additional administrative and support resources to accommodate the expansive reform.

Section 1311 of PPACA provides funding assistance to the States for the planning and establishment of American Health Benefit Exchanges ("Exchanges"). PPACA provides that each State may elect to establish an Exchange that would: 1) facilitate the purchase of qualified health plans; 2) provide for the establishment of a Small Business Health Options Program ("SHOP Exchange") designed to assist qualified employers in facilitating the enrollment of their employees in Qualified Health Plans offered in the SHOP exchange; and 3) meet other requirements specified in the Act. On October 1, 2010, the Department was awarded a planning and establishment grant totaling $1,000,000 for initial planning activities related to the potential implementation of the Exchanges.

Colorado Health Care Affordability Act

On April 21, 2009, Governor Ritter signed Colorado House Bill 09-1293 "Health Care Affordability Act" into law. Once implemented, the legislation will provide health care coverage for more than 100,000 uninsured Coloradans, reduce uncompensated care costs, and benefit the state as a whole. The Colorado Hospital Association, the Department of Health Care Policy and Financing ("the Department"), and the Governor's Office worked together for nearly one year to develop House Bill 09-1293, which passed both the House and the Senate with more than 40 co-sponsors and bipartisan support.

The bill requires the Department to assess and collect a provider fee from all licensed or certified hospital providers, including providers that do not serve Medicaid clients. The provisions of the legislation prohibit shifting the fee to either clients or insurers. With many Colorado businesses and families struggling to secure affordable health insurance, this legislation will help reduce the number of uninsured individuals in Colorado. By partnering with hospitals, the Colorado Health Care Affordability Act (CHCAA) will allow Colorado to generate up to approximately $600 million in additional funding per year through a hospital provider fee and draw down approximately $600 million in federal Medicaid matching funds for the following purposes authorized under CHCAA:

- increasing hospital reimbursement rates for Medicaid inpatient and outpatient care, up to a maximum of the federal upper payment limit;
- increasing hospital reimbursement rates through the Colorado Indigent Care Program, up to a maximum 100% of cost;
- creation of hospital quality incentive payments for rewarding enhanced quality, health outcomes, and cost effectiveness;
- increasing coverage for parents with incomes of up to 100% of the federal poverty line (FPL) through Medicaid;
- increasing coverage in the Children's Basic Health Plan (CHP+) up to 250% FPL;

- initiating coverage for adults without dependent children with incomes of up to 100% FPL through Medicaid;
- creating a Medicaid buy-in program for individuals with disabilities whose family incomes are too high for Medicaid eligibility but are under 450% FPL;
- implementing continuous eligibility for Medicaid children to reduce administrative burdens on Colorado families and keep eligible kids covered on a continuing basis; and,
- covering the Department's administrative costs related to the bill.

The Hospital Provider Fee, State Plan Amendments, and Upper Payment Limit were officially approved by Centers for Medicare and Medicaid Services (CMS) on March 31, 2010. Hospital Provider Fee collections and payments were assessed and collected in four installments for FY 2009-10. At the end of the fiscal year, all the expected payments and fee collections were properly paid and collected. All providers who pay a fee are now on electronic funds transfers for payments and fee collection.

In FY 2009-10, the Department distributed approximately $300 million in fees from hospitals which, with federal matching funds, funded health coverage expansions, payments to hospitals, the Department's administrative expenses, and General Fund relief per SB 10-169. The following table outlines the Hospital Provider Fee expenditures in FY 2009-10:

FY 2009-10 Hospital Provider Fee Expenditures (Total Funds)	
Supplemental Hospital Payments	$590,238,706
Department Administration	$2,938,742
Expansion Populations	$3,241,897
SB 10-169 General Fund Offset	$46,329,410
Total Expenditures	**$642,748,755**

Through this financing mechanism, Colorado was able to draw down and distribute $140 million in additional federal dollars in FY 2009-10. The net gain to hospitals in FY 2009-10 was approximately $143 million and is estimated to increase to $159 million in FY 2010-11. These net gains represent the reduction in uncompensated costs incurred by hospitals.

On May 1, 2010, the population expansions for Medicaid Parents to 100% FPL and CHP+ to 250% FPL were implemented. As of September 30, 2010, the Department had enrolled approximately 25,000 Medicaid Parents, 2,500 CHP+ children, and 200 CHP+ pregnant women in these expansion populations. Of these enrollees, approximately 14,200 Medicaid Parents, 1,200 CHP+ children, and 160 CHP+ pregnant women were newly eligible for public assistance.

The Hospital Provider Fee Oversight and Advisory Board (OAB) extended the FY 2010-11 Hospital Provider Model to an October 1, 2010 start date. The FY 2009-10 Hospital Provider Fee Model will continue through the July-to-September quarter with no changes, except that the payments and fee collections will be made on a monthly basis rather than on a quarterly cycle.

The Department is now focused on implementing a Medicaid Buy-In Program for People with Disabilities (Summer 2011) and Adults without Dependent Children (Early 2012). As the expansion populations are implemented and continue to grow, the Department will have to closely monitor the costs of these newly eligible populations to ensure that adequate fee revenue can be collected within federal limitations. The provisions of CHCAA leave Colorado well-positioned to implement the Patient Protection and Affordable Care Act of 2010 (PPACA). The enhanced federal financial participation that will be available through PPACA beginning in January 2014 for expansion populations included in CHCAA will help ensure the viability of the Hospital Provider Fee. In addition, PPACA has numerous provisions that are anticipated to reduce the level of uncompensated care, decrease the rate of growth in health care costs, and improve health outcomes of individuals, all of which are goals of the Department in implementing CHCAA. The Department continues to explore the interplay between PPACA and CHCAA.

Colorado Accountable Care Collaborative

An extension of the Governor's Building Blocks to Health Care Reform plan, the Department has been particularly interested in how to better contain health care costs while improving the overall health and functioning of the clients served in Medicaid. The Department has learned over the years that higher health care spending is not necessarily associated with higher quality care or improved outcomes. Currently, the majority of Medicaid clients access their health care services in a fee-for-service delivery model that does not always support coordinated care and the appropriate utilization of services. Clients often seek care in emergency rooms or other sites that offer episodic services. As a result, providers may not know the clients' history or ongoing health care needs. Because clients interact with a host of Medicaid and non-Medicaid provider organizations ranging from schools and county government services to independent living centers and transportation vendors, access to and interaction between these providers and support organizations varies, and little or no data is available to facilitate coordination and continuity of care.

Two of the additional reform efforts spearheaded under the Ritter administration were the Medicaid Value-Based Care Coordination Initiative (now known as the Accountable Care Collaborative, or ACC Program) and the Colorado Healthcare Affordability Act. The Department worked simultaneously on these efforts. The Department submitted a formal budget action for the ACC Program on November 3, 2008 and in April 2009, the Colorado Healthcare Affordability Act (HB 09-1293), became law.

The passage of the Hospital Provider Fee, coupled with the unprecedented growth in Medicaid caseload due to the economic recession, reinforced the need for the Department to implement the ACC Program, a strategy that will contain costs while improving

health outcomes for Medicaid clients. Additionally, with the passage of national health care reform, the Department recognizes that significant changes to the way health care services are delivered to Medicaid clients are essential to maximize their health, functioning and independence. In response to the changing health care environment, the ACC Program plans to redesign the Medicaid program with the following goals:

- Provide a focal point of care/Medical Home for all clients;
- Develop statewide data and analytics capabilities;
- Coordinate care across all programs and providers; and,
- Develop regional accountability for client health and cost containment.

The ACC Program represents an innovative way to accomplish the Department's goals for Medicaid reform. The ACC Program differs from a capitated managed care organization by investing directly in community infrastructure to support care teams and care coordination. It also creates aligned incentives to measurably improve client health and reduce avoidable health care costs. The ACC Program makes the people and organizations that actually provide the care accountable for the quality and cost of that care. Previous health care reform initiatives involved insurers and made them ultimately accountable. The fundamental premise of the ACC Program is that communities are in the best position to make the changes that will address the cost and quality problems resulting from the existing system of fragmented care, variation in practice patterns and volume-based payment systems. While the commitment and participation of providers will be essential to driving these changes, the Department realizes that the supportive infrastructure that is necessary to make this paradigm shift is currently lacking. The ACC Programs strengthens this infrastructure.

To support these reform measures and improve health information technology in Colorado, the Department is working with stakeholders to help providers become better equipped to move to electronic health records. Under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, eligible health care professionals can qualify for Medicare and Medicaid incentive payments when they adopt certified Electronic Health Records technology and meaningfully use it to improve the quality and safety of care, improve care coordination, engage clients and families, promote public health, and promote the security of private health information. Colorado Medicaid is working with the Colorado Regional Health Information Organization (CORHIO), a public-private partnership, to implement this program and promote health information exchange across the state. The ACC Program will work with CORHIO's regional extension centers to encourage providers in each region to participate in the HITECH program and improve their health information technology.

The ACC Program provides the framework within which other health care initiatives can thrive such as the Medical Home, health information technology, and payment reform. The ACC Program is a hybrid model, adding the characteristics of an Accountable Care

Organization to the Primary Care Case Management system. While other states have structured their Accountable Care Organizations in a variety of ways, certain fundamental Accountable Care Organization characteristics are essential to the success of the ACC Program as follows:

- Provides or manages the continuum of care as a real or virtually integrated delivery system;
- Has a large enough number of clients to support comprehensive performance measurement;
- Is capable of prospectively planning budget and resource needs; and,
- Is able to develop and organize provider networks.

On August 20, 2010, the Department posted a Request For Proposals (RFP) to solicit competitive bids for the Regional Care Coordination Organizations (RCCOs), seeking experienced and innovative entities with a strong community presence that will be accountable for controlling costs and improving the health of Medicaid clients in one (or more) of seven regions statewide.

The ACC Program is designed not only to improve the client/family experience and improve access to care, but to establish accountability for cost management and health improvement. By integrating the principles of a Patient-Centered Medical Home model, applying best practices in care coordination and medical management, and combining unprecedented access to client data and resource utilization, RCCOs will become valued partners in the Department's efforts to move away from a focus on volume-driven, sick care and towards an outcomes-based, efficient, health improvement model of care. RCCOs will use both Patient-Centered Medical Home and accountable care principles, and their own expertise to help the Department control costs and reduce unwarranted variability in health care and health.

Central to the success of the ACC Program is the interaction among three (3) key roles: the RCCOs, the Statewide Data and Analytics Contractor (SDAC), and Primary Care Medical Providers (PCMPs). The RCCOs are responsible for ensuring accountable care. The SDAC (through a separate procurement) is responsible for bringing a new level of information and data analytics to the Medicaid program, providing insight into variations within and across RCCOs, benchmarking across key performance indicators, and serving as conduit for health information exchange between the Department and the RCCO. The PCMPs will contract with the RCCO to serve as Medical Homes for Members.

HITECH Incentive Payments

The passage of the American Recovery and Reinvestment Act (ARRA) of 2009 on February 17, 2009 established incentive payments to eligible professionals (EPs), eligible hospitals, critical access hospitals (CAHs), and Medicare Advantage Organizations to promote

the adoption and meaningful use of health information technology (HIT) and qualified electronic health records (EHRs). Together, these provisions comprise the Health Information Technology for Economic and Clinical Health (HITECH) program.

The Centers for Medicare and Medicaid Services (CMS) issued proposed rules to implement the HITECH program on January 13, 2010. On July 13, 2010, CMS issued the final rules for the Medicare and Medicaid EHR incentive payment programs, which are 100% funded with federal funds (42 C.F.R. §495.320, (2010)). According to the final rules and federal statute at 42 C.F.R. §495.304, (2010), the following Medicaid providers are eligible to voluntarily participate in the HITECH program: Medicaid EPs, acute care hospitals, and children's hospitals. Of the Medicaid EPs, payment is limited to the following provider types: physicians, dentists, certified nurse-midwife, nurse-practitioner, and physician-assistants practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

Medicaid EPs must meet one of the following criteria:

- minimum of 30% Medicaid patient volume;
- minimum of 20% Medicaid patient volume if a pediatrician;
- not be hospital-based; or,
- practice predominately in a FQHC or RHC and have a minimum 30% patient volume attributable to needy individuals, which include individuals receiving assistance from Medicaid, CHP, or uncompensated care programs.

According to HITECH provisions, Medicaid EPs may not begin receiving incentive payments any later than calendar year 2016 and can only receive a maximum of five incentive payments after their first-year incentive payment (42 C.F.R. §495.310 (a)(2)(i) and (a)(2)(ii), (2010)). Therefore, the total eligibility period is limited to six years (42 C.F.R. §495.310 (a)(3), (2010)). If a Medicaid EP satisfies all participation requirements, then they may receive the maximum incentive payment of $63,750 over the entire six-year eligibility period.

Eligible hospitals must meet additional requirements which include:

- Acute care hospitals must have at least 10% Medicaid patient volume for each year the hospital is seeking incentive payments.
- Children's hospitals are exempt from meeting a patient volume threshold.

The incentive payments to eligible hospitals require the submission of information from auditable data sources (e.g., provider's Medicare cost reports, state specific Medicaid cost reports, payment and utilization, and hospital financial statements and accounting

records) before payments are issued. Unlike the calculation to determine EP incentive payments, the incentive payments to hospitals require calculation using numerous data sources; therefore, the Department cannot estimate an individual hospital's payment at this time. While the base amount for hospitals is $2,000,000, this level may be exceeded depending on the auditable data sources and statutory formula. Eligible hospitals may participate in both the Medicare and Medicaid incentive programs, depending on successful demonstration of meaningful use and other requirements under both programs.

In order to implement the HITECH incentive program in Colorado, the Department must first seek approval from the Regional CMS Office, whereby the Department must describe how the state intends to initiate planning and implementation activities in support of the Medicaid-provider incentive payments. The first phase in the approval process is the Medicaid Health Information Technology (HIT) Phase 1 Planning Project. The Department submitted a state Medicaid HIT plan and Planning Advanced Planning Document, as required under 42 C.F.R. §495.332 and §495.336, (2010), to CMS's regional office on January 25, 2010.

On February 10, 2010, the Department received approval from CMS granting 90% federal financial participation, as required under 42 C.F.R. §495.322, (2010), for initial planning, assessment, and analysis activities to implement the HITECH provisions in Colorado. The Phase 1 activities shall include the development of Colorado's State Medicaid Health Information Technology Plan which will provide a plan for: 1) administration of the Medicaid provider incentive payment program; 2) provider adoption and meaningful use of EHR; and 3) how the plan will work in conjunction with the larger statewide HIT goal.

After Phase 1 activities are completed and the Regional CMS Office approves the Department's Implementation Advanced Planning Document, the Department will begin Phase 2 activities (42 C.F.R. §495.338, (2010)). Some of the Phase 2 activities include software and system development changes to both its Provider Web Portal and Medicaid Management Information System. In response to final rules for the Medicare and Medicaid EHR incentive payment programs issued by CMS on July 13, 2010, the Department repurposed an existing General Fund appropriation to leverage the 90% federal financial participation and received spending authority of $2,500,000 total funds for the systems changes in FY 2010-11. Once these system development changes are completed, the Department may begin issuing incentive payments to eligible professionals and hospitals that meet all the participation requirements.

The Department has contracted with CORHIO to assist in efforts to align the Medicaid ARRA HITECH implementation with other initiatives around the state and assure that federal dollars are maximized. CORHIO has also provided a conduit for engaging safety net providers in the process of preparing for appropriate methods to not only implement but assure appropriate allocations and use of the "Meaningful Use of an EHR" incentives by Medicaid EPs and Medicaid eligible hospitals. In CORHIO's role as the Colorado Regional Extension Center (CO-REC), CORHIO is facilitating the work of a number of organizations to help health care providers and hospitals to reach the federal standards for "Meaningful use of an EHR" in a user-friendly way – irrespective of whether those providers are eligible for Medicaid or Medicare incentive payments. The CO-REC's expert knowledge of both the Medicaid and

Medicare incentive programs assists eligible providers in applying and receiving support from the correct programs, thereby improving efficient allocation of resources on behalf of Colorado health care providers and the state. Additionally, the federal definition of Meaningful Use includes component objectives requiring health information exchange (HIE), and future stages are anticipated to rely even more heavily upon the exchange of electronic health information between unaffiliated entities. Governor Ritter appointed CORHIO as the State-Designated Entity for HIE, and the organization is rapidly developing statewide exchange on a community-by-community basis. Many synergies and interdependencies exist, and will continue to amplify, between CORHIO and the Medicaid EHR Incentive program as requirements for Meaningful Use develop even further into the HIE domain. The Department will continue to work with CORHIO to assure these efficiencies and alignments are utilized to maximize federal funding, leverage current state and philanthropic investments, and minimize state expenditures as appropriate.

Colorado's All-Payer Claims Database

On May 26, 2010, Governor Ritter signed House Bill 10-1330, authorizing the creation of a state-wide APCD. This legislation grants the Department's Executive Director authority to do the following:

- Compel insurers to provide claims data for use in an APCD.
- Appoint an administrator to lead the planning, implementation, and operation of the APCD. The Center for Improving Value in Health Care (CIVHC) has been appointed.
- Appoint an Advisory Committee which will make recommendations to the Administrator regarding developing and operating the APCD and to the Executive Director regarding the ongoing oversight of the APCD. Additionally, since no general funds are allocated for this project, the Executive Director will direct the Administrator to raise the necessary gifts, grants and donations to create the database and to give final implementation approval once the funds are raised (to be no later than January 1, 2012).

Generally all-payer claims databases (APCD) include data derived from medical, eligibility, provider, pharmacy, and/or dental files from private and public payers, including insurance companies, third-party administrators, Medicaid, and Medicare. These databases include covered services for the population, a unique member identification number, patient demographics, plan and member payments, clinical information (diagnoses, CPT codes, ICD-9 procedure codes), date of service, and servicing providers.

There are several reasons that policymakers, researchers, and public health officials would value the data contained in APCD. This data can: inform public policy decisions and help determine how best to use public funds; identify opportunities for improvements within the health care system; determine utilization patterns and rates; identify gaps in needed disease prevention and health promotion services; evaluate access to care; assist with benefit design and planning; analyze state-wide and local health care

expenditures by provider, employer, geography, etc.; and establish clinical guideline measurements related to quality, safety, and continuity of care.

At this time, CIVHC has received approval from The Colorado Trust on a grant for $180,000 to fund the planning stage of the process. The funding will begin at the end of September.

Members of the APCD Advisory Committee were announced in mid August of 2010. The advisory committee is directed to: 1) develop recommendations on data collection, reporting, scope of APCD, governance, and data elements, and 2) discuss alignment with other state and federal data standards, reporting standards, and data security.

The advisory committee will submit a report to the Colorado General Assembly by March 1, 2011 that will include recommended data elements and plans for ensuring HIPAA compliance. This report is for information only. Upon submission of the advisory committee's recommendations to the state legislature and the go-ahead of the Executive Director of HCPF, CIVHC will move forward on steps toward full implementation of the APCD. It is anticipated that data will become available for initial extraction in July of 2011.

Colorado's Comprehensive Health Access Modernization Program

In June 2009, the Department applied to receive grant funding from the federal Health Resources and Services Administration (HRSA) State Health Access Program (SHAP) for the Colorado Comprehensive Health Access Modernization Program (CO-CHAMP). The purpose of this additional grant funding is to augment the funding appropriated under House Bill 09-1293 "Colorado Health Care Affordability Act" and ensure its successful and full implementation. In September 2009, the Department received notice that its application was approved to fund seven comprehensive and interrelated projects totaling $42,773,029 over the next five years beginning in FY 2009-10.

The CO-CHAMP grant program reflects the Department's responsibility as leaders to "champion" policies leading to greater access to health care, increased positive health outcomes, and reduced cost-shifting. In the context of the delivery of health care services, the Department's modernization efforts include making investments in prevention, health information technology, infrastructure, and in understanding which treatments work best for any given health condition.

In the context of the CO-CHAMP grant, modernization refers to changing the way the Department conducts business to expand access to benefits and improve efficiency by working smarter and more effectively in managing limited resources. It includes making investments in infrastructure and technology and also includes implementing new strategies around benefit design and cost-sharing.

In fulfilling the coverage expansions authorized in 2009 under HB 09-1293 "Colorado Health Care Affordability Act," it is essential to ensure that the Department's systems work as well as possible to support the increased caseload.

The common thread underlying all of the CO-CHAMP grant projects is making the health care delivery system and access to programs more outcomes-focused and client-centered. The additional funding Colorado will receive for this project will elevate the health care system and Colorado to a new level, and position the State well for engaging in the national discussion on health reform.

The original projects funded under the CO-CHAMP grant program include:

- Maximizing Outreach, Retention, and Enrollment (MORE): The purpose of this project is to design, develop, and implement an enhanced outreach plan for the HB 09-1293 expansion populations that generates awareness of the availability of health care coverage programs and the expanded eligibility and teaches families how to access health care in appropriate settings.
- Eligibility Modernization - Streamlining the Application Process: The purpose of this project is to further streamline the application process by replacing paper documentation with electronic data where possible, develop Web-based services for clients, and create interfaces to other state and federal systems to ease data exchange for the HB 09-1293 expansion populations making it easier for clients to apply for public health insurance programs.
- Adults without Dependent Children and Buy-in for Individuals with Disabilities Implementation: The purpose of this project is to develop potential program designs, including models for premium structures and cost-sharing provisions, for adults without dependent children and buy-in for individuals with disabilities expansion populations.
- Premium Assistance Program: The purpose of this project is to expand the CHP+ at Work program statewide to expand coverage to children eligible for the Children's Basic Health Plan who have access to employer-sponsored insurance.
- Health Access Pueblo Community Share Expansion: The purpose of this project is to design, develop, and implement an outreach and marketing plan to new businesses on the availability of Pueblo County's community-share program, known as the Health Access Program to expand coverage to the working uninsured.
- San Luis Valley Three-Share Community Start-Up: The purpose of this project is to replicate Pueblo County's Health Access Program and create health care coverage for the working uninsured through the San Luis Valley Health Access Program.
- Weld County Evidence-Based Benefit Design Pilot: The purpose of this project is to create an innovative benefit design tool that can be implemented easily and administered efficiently for carriers to develop new insurance products targeted at previously uninsured populations.

HRSA also recently approved an additional CO-CHAMP project as described below:

- Colorado Multi-Stakeholder Adult Patient Centered Medical Home Pilot (Adult PCMH Pilot): The pilot will focus on a systems approach to delivering health care. One of the guiding principles of the pilot is to bring together public and private payer systems to collaborate on payment structures that promote proactive, comprehensive, evidence-based patient-centered care delivery. This collaboration starts to build systems that are independent of the payer and are focused on delivering care to all Coloradoans, reducing disparities and providing a comprehensive system whether insured or uninsured.

One of the first CO-CHAMP initiatives to be launched is the Colorado Program Eligibility and Application Kit (PEAK), a web-based portal designed to provide clients and community partners with a modern and easily accessible tool to apply for public assistance benefits. In October 2009, Phase I of PEAK was implemented that allows new applicants to screen themselves for potential program eligibility ("Am I Eligible?") and allows existing clients to check on their benefits ("Check My Benefits"). In early 2011, applicants will be able to apply for the Department's family and children's programs online ("Apply for Benefits") and existing clients will be able to report changes, such as changes in their address online ("Report My Changes"). Future phases of PEAK will permit clients to process their redeterminations online and functionality will be expanded to adult programs, the Colorado Indigent Care Program, and all of the expansion populations under the Health Care Affordability Act.

As the Department begins to implement the eligibility modernization components of CO-CHAMP, electronic interfaces with other state and federal databases will be created so that citizenship, identity and income documentation are electronically verified so that clients do not have to submit paper documents as part of the application process. Over time, the Department will create a streamlined, seamless process that makes it easier for applicants to enroll and retain eligibility in the Department's programs if they meet all requirements.

Another exciting project associated with PEAK is focused on outreach efforts. The Department's objective is to build a coordinated outreach campaign that includes building awareness about PEAK through a host of channels, identifying technology access points for clients who wish to use PEAK; and training community-based organizations on using PEAK as a way to assist clients with the application submission process.

PEAK puts control of application process back in the hands of the clients and increases client self-sufficiency. Through this, the State is able to improve customer service, improve statewide accountability for our public health insurance programs, and ensure that the performance of the Colorado Benefits Management System is being enhanced to meet increasing and changing client needs.

FY 2010-11 and FY 2011-12 Budget Reductions

Significant increases in Colorado's unemployment rate led to substantial increases in Medicaid caseload beginning in FY 2008-09. These increases in caseload are projected to continue through FY 2012-13. Coupled with the current economic situation, the Department has had to meet this increased need with resources that are increasingly limited. In response to declining state revenue, the Department proposed reduction items totaling nearly $300 million total funds in FY 2009-10, some of which were permanent cuts that would have annualized to a total reduction of approximately $380 million in FY 2010-11. Subsequent revenue forecasts from Legislative Council indicated that some of the reductions were not needed, but as part of budget balancing, the Department imposed a permanent 4.5% provider rate cut in FY 2009-10. In response to continuing anemic revenue forecasts, the Department has proposed and implemented several budget reduction ideas for FY 2010-11 that are incremental to the permanent FY 2009-10 reductions. As with prior budget reduction, the Department continues to attempt to reduce costs while minimizing the impact of the reductions on clients and providers. A summary of these reductions are described below.

MEDICAL SERVICES PREMIUMS		
Estimated Impact on FY 2010-11 Expenditures		
JBC Actions: Utilization and Provider Rate Reductions	**Effective Date**	**Total Funds**
1.0% Provider Rate Reductions	July 2010	($17,274,357)
Restrictions to Durable Medical Equipment	July 2010	($637,311)
Utilization Review- Outlier Days	July 2010	($360,300)
Utilization Review- Frequent Utilizers of Emergency Departments	July 2010	($671,039)
Expansion of State Maximum Allocable Cost Pharmacy Rate Methodology	January 2011	($1,057,450)
Total		**($20,000,457)**

The majority of the reductions for FY 2010-11 come in the form of 1.0% reductions to provider rates paid to Medicaid physical health fee-for-service and managed care providers effective July 1, 2010. This reduction affects all providers and services paid within the Department's Medical Services Premiums line item, with the following exceptions: prescription drugs; federally qualified health centers; rural health centers; and, prepaid inpatient health plan (PIHP) administration.

The Department also received authority to implement evidence guided utilization review (EGUR) that focuses on high-growth, high-cost medical spending categories, including radiology, hospital outpatient services, selected outpatient therapies, ancillary services, emerging technologies, and selected client groups such as high risk deliveries and pre-term newborns. The Department received funding to increase medical review hours to allow for expanded review by the Department's Quality Improvement Organization (QIO)

contractor. In addition to additional prospective and retrospective review hours, EGUR funding allows for concurrent review selected activities such as inpatient outlier days.

The expansion of utilization review under EGUR involves continuing the work of the Benefits Collaborative and Accountable Care Collaborative. As provider panels and client and stakeholder sessions yield newly documented best practices and community standards, the Department will require its QIO to integrate these standards with evidence-based clinical guidelines – such as the Milliman Care Guidelines and McKesson's InterQual decision support criteria – and adjudicate its reviews based on those standards through the technology system. The expansion of utilization review is not only anticipated to yield savings, but also lead to enhanced quality and improved health outcomes.

In addition to these Department initiated requests, several bills were passed during the 2010 Legislative Session that impacted the Department's budget. These include:

- HB 10-1378 "2010 Transfers For Health Care Services": Eliminates the Primary Care Fund Program for FY 2010-11, which allocates monies to health care providers who make basic health care services available in an outpatient setting to residents of Colorado who are considered medically indigent. This bill requires the redistribution of tobacco tax funds appropriated to the Primary Care Fund to offset General Fund expenditures in Medicaid and to minimize the losses to community health clinics.
- HB 10-1379 "2010 Nursing Facility Rate Reductions": Reduces the per diem rate paid to nursing facilities under Medicaid by 2.5% for FY 2010-11 and limits the annual increase in the General Fund share of the per diem rate to 1.9% from the prior fiscal year.
- HB 10-1380 "Use Supplemental OAP Health Fund For Medicaid": Allows moneys in the Supplemental Old Age Pension and Medical Care Fund to be used to offset General Fund expenditures for Medicaid for persons 65 years of age and older. A General Fund offset from the cash fund of up to $4.85 million is allowed in FY 2010-11 and up to $3.0 million in FY 2011-12.

With the expiration of the enhanced Federal Medical Assistance Percentage provided through the American Recovery and Reinvestment Act of 2009 (ARRA) on June 30, 2011 and the continuing anemic economic conditions, the Department is requesting further budget reductions in the FY 2011-12 Budget Submission. These initiatives include:

- Implementation of a provider incentive payment and a lock-in system to expand the Client Overutilization Program (COUP), in which clients are locked in with one primary care physician, pharmacy, or managed care organization when there is evidence that the client has improperly or excessively utilized Medicaid benefits that are not medically necessary.
- Shift the final week of fee-for-service payments in FY 2011-12 into FY 2012-13.

- Similar to HB 10-1378, the Department is proposing to redistribute the tobacco tax funds appropriated to the Primary Care Fund to offset General Fund expenditures in Medicaid and to minimize the losses to community health clinics.
- A permanent reduction to the General Fund appropriation to the Pediatric Specialty Hospital line item, which was established to increase reimbursement to the state's only Pediatric Specialty Hospital, The Children's Hospital, to help defray the cost of providing care to large numbers of Medicaid and indigent clients.
- A number of initiatives to reduce costs in the Children's Basic Health Plan, including: eliminating reimbursement for out-of-network, non-emergent care without prior authorization; eliminating the pre-HMO period of eligibility and begin HMO enrollment the first day of the month following eligibility determination; eliminating reinsurance; 3.0% CHP+ HMO rate reduction; and, eliminating inpatient coverage for CHP+ prenatal presumptive eligibility.
- A number of Medicaid initiatives, including: expanding utilization of the state maximum allowable cost (SMAC) pricing for pharmaceuticals; reduce adult oral nutrition benefit or clients 5 years of age or older; reduce the reimbursement level for blood glucose/reagent strips; reduce the reimbursement amount paid to facilities for an uncomplicated cesarean section (C-section) delivery to the same amount that the Department pays for complicated vaginal deliveries; reduce the amount paid for inpatient renal dialysis; deny payment to hospitals for clients who are readmitted within 48 hours to the same hospital for a related condition; require prior authorization in outpatient hospital departments for certain procedures which currently require prior authorization in free-standing imaging (radiology) facilities; set a maximum rate of 95% of the equivalent Medicare rate for procedure codes; impose a cap on the wage rate that a client enrolled in the Consumer Directed Attendant Support Services (CDASS) program is allowed to pay attendants; reduce Federally Qualified Health Center rates to remove unsupported pharmacy costs; enforce limitations on Acute Home Health services; and, reduce the Medicaid Mental Health Capitation program by 2.0%.

In proposing new budget reductions, the Department continues to collaborate with providers and stakeholders to develop innovative cost reduction plans which generate savings while minimizing the impact to providers, clients, and the quality of care.

Health Care Expansion Fund

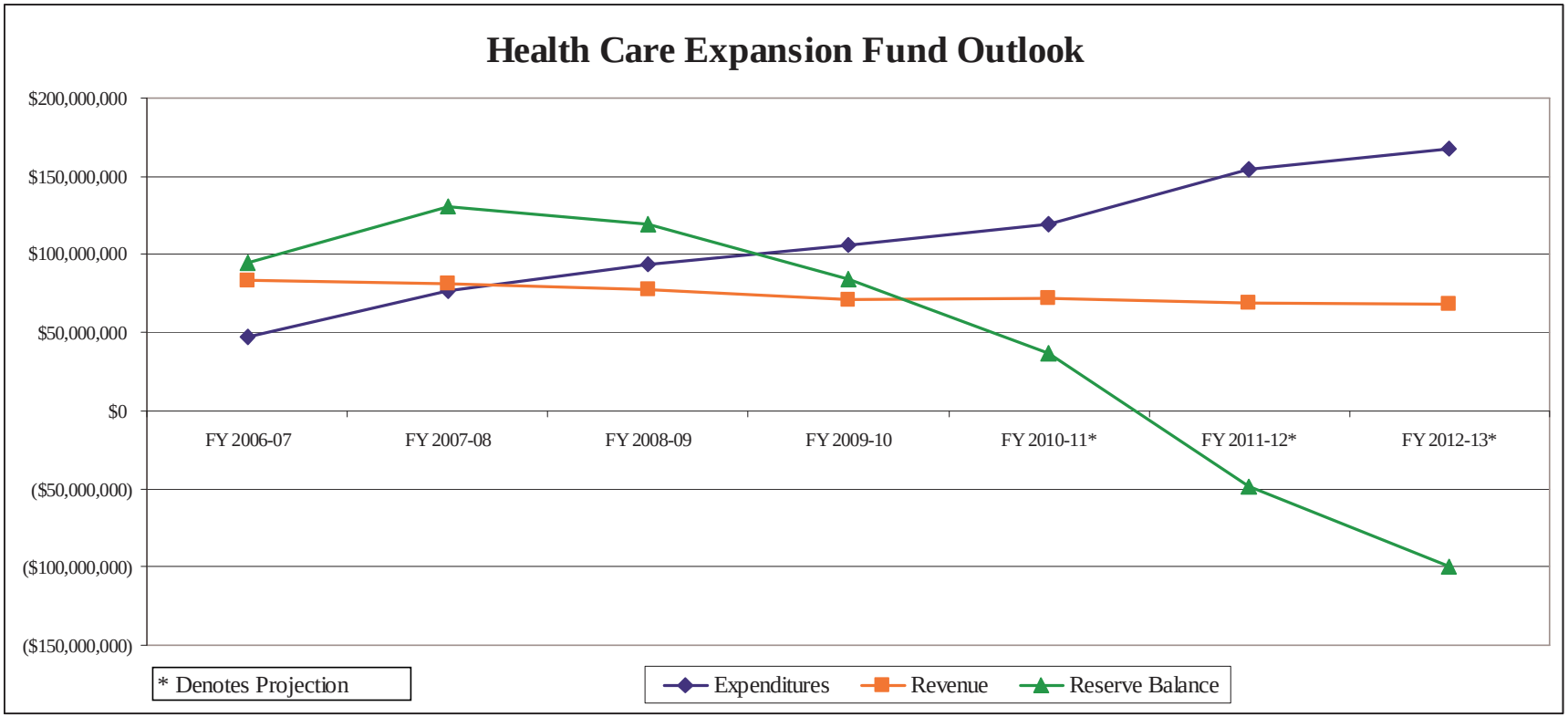
The Health Care Expansion Fund receives 46% of annual Tobacco Tax revenues as stipulated in HB 05-1262, the Tobacco Tax Implementation bill. This legislation requires that Health Care Expansion Fund monies be used to expand eligibility for low-income individuals through Medicaid or the Children's Basic Health Plan. The funds are used to pay for services provided to the following expanded eligibility groups:

- Children's Basic Health Plan eligibility to 200% of the federal poverty line;
- Children's Basic Health Plan enrollment above the FY 2003-04 levels;

- removal of the Medicaid asset test;
- reduction of the Children's Extensive Support and Children's Home and Community Based Services waitlists;
- increase the eligibility of parents of enrolled children to at least 60% of the federal poverty line;
- Medicaid coverage for optional legal immigrants;
- presumptive eligibility for pregnant women on Medicaid;
- expand Medicaid eligibility to age 21 for Foster Care children (SB 07-002 and SB 08-099); and,
- Children's Basic Health Plan Outreach.

On average, annual Amendment 35 Tobacco Tax revenues have been declining since the implementation of HB 05-1262, and expenditures out of the Health Care Expansion Fund have been increasing each year. See the chart below which displays revenues into the fund, expenditures, and the reserve fund balance.

As can be seen in the chart below, in FY 2007-08, expenditures began to outpace the revenue coming into the fund and began dipping into the reserve fund balance. Also illustrated, revenue has been continuously trending downward, while the expenditures continue to grow. Projections into the future display the same trends, which will continue to increase the gap between revenue and expenditures, increasing the amount that must be taken from the reserve fund to support the expenditures.



Going forward, assuming equal monthly expenditures in FY 2011-12, it can be expected that the reserve fund balance will be exhausted in mid FY 2011-12. The passage of the Patient Protection and Affordable Care Act of 2010 (PPACA) imposed Maintenance of Effort provisions on Medicaid. As such, Colorado cannot apply more restrictive eligibility standards, methodologies, or procedures than were under the State Plan as of the passage of PPACA on March 23, 2010. The MOE applies to adults until the major components of health reform go into effect on January 1, 2014, and to children (in both Medicaid and the Children's Basic Health Plan) until September 30, 2019. Due to these MOEs, the Department will not be able to rescind any of the eligibility expansions provided under HB 05-1262 in order to address the Health Care Expansion Fund deficit. The Department has submitted DI-9 in the FY 2011-12 Budget Request to balance the Health Care Expansion Fund using temporary financing and General Fund. With this in mind, long-term options must soon be evaluated and a solution be created in order for the Health Care Expansion Fund to be able to support the Medicaid and Children's Basic Health Plan clients in the same way it currently does.

Long-Term Care Reform

The Department continues to pursue long-term care reform with input from interested stakeholders. Long-Term Benefits management is in the process of reconstituting the Department's Long-Term Care Advisory Committee to help set the strategic direction for Long-Term Care Reform.

During the 2009 Legislative Session, the General Assembly enacted House Bill 09-1103, granting the Department authority to pursue long-term care presumptive eligibility. The Long-Term Care Division within the Department has organized a project team to plan the implementation of this legislation in the next six months. Next steps include pursuing additional legislative action to amend the set plan to allow for presumptive eligibility

The Department was one of seven states awarded a technical assistance grant from the Center for Health Care Strategies to test innovative care models for people who are dually eligible for Medicare and Medicaid (referred to as "dual-eligibles"). The Department will work with the grantors and other states to address program design, care models, financing mechanisms, and contracting strategies. This grant ends in Fall 2010. Staff will continue to develop programs and strategies to better serve dual-eligibles while at the same time containing costs.

A recent state audit found that there is an inherent conflict of interest in the way Community Centered Boards (CCBs) are structured, in that they determine eligibility and also provide case management and services. Consequently, the Department engaged stakeholders to develop a set of recommendations on how to address this conflict of interest. The draft recommendations are currently being considered by the Department of Human Services (DHS) and the Department. The Department's decisions will redefine the roles and responsibilities of the CCBs and Single Entry Points.

Another outcome of the State Auditor's report is the scheduling of joint meetings between the Department and DHS to consider the future of the long-term care system. From these meetings, two initiatives are emerging. First, it has become clear to both departments that it may be more efficient of the administration of Home-and Community-Based Services (HCBS) waivers currently administered by the Division of Developmental Disabilities were transferred to the Department. Transferring administration of HCBS waivers from DHS to the Department requires legislative approval, and DHS staff currently responsible for administering the four waivers in question would move to the Department. The Department continues to work with DHS to assess this option.

The second initiative that the Department will pursue is the consolidation of waivers. The end goal is that the Department would have anywhere between one and four waivers to administer, rather than eleven. The array of services currently available through the

various waivers would be available under the minimum number of waivers required. The Department will be engaging stakeholders and seeking federal approval over the next year to gather their recommendations. The target date for consolidation is July 1, 2012.

The Department will also work towards implementing Olmstead policy recommendations resulting from the Long-Term Care Advisory Committee to build a strategy towards improving upon the existing infrastructure of services for people with disabilities. The Committee worked with a core team of stakeholders including people receiving services, case management and service providers, mental health professionals, home health providers, academics, state staff and advocacy organizations to develop recommendations and policy options to further promote community-based long-term care services. Enabling individuals with disabilities and the elderly to live in the least restrictive settings possible is one step toward the Department's goal to improve the health and functioning of all clients.

Additionally, the Department has numerous opportunities to reform Long-Term Care through the Patient Protection and Affordable Care Act (PPACA). The first opportunity is the extension of the Money Follows the Person Rebalancing (MFP) Demonstration Program for an additional five years and allowing additional states to join the Demonstration project. This is a significant grant opportunity to build systems and infrastructure needed to improve the quality of HCBS services, increase the availability of HCBS, and support the deinstitutionalization of several target populations. This grant will allow modernization of Single Entry Points, Information Management Systems, and Quality Assurance Programs for HCBS services, and the Department would receive a 75% federal match on HCBS services for every person transferred from institutions to the community settings. The average grant size to other states in previous rounds of funding for this purpose was $46 million over 5 years.

The grant solicitation for new states was released July 26, 2010, and the application deadline is January 7, 2011. As part of the application, the Department is required to create a detailed Operational Plan. This will require substantial resources to develop and submit the operational plan. Consequently, planning grants have been made available with funding awarded to secure the resources needed produce the operational plan. The Department was awarded a planning grant totaling $200,000 on October 1, 2010.

There are other opportunities through PPACA that the Department may pursue as guidance from CMS becomes available. These opportunities include:

- HCBS as a state plan benefit rather than a waiver;
- Consumer Directed Attendant Support Services (CDASS) as a state plan benefit; and,
- Enhanced federal financial participation for HCBS services provided that the Department is working towards a single assessment process for all publicly funded long term care services, state-wide adoption of Aging & Disability Resource Centers and conflict-free case management.

V. WORKLOAD REPORTS

The Department collects data from various sources that provide information on consumer satisfaction, the number of clients served, as well as demographics. This information is provided below.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) [4] is a nationally recognized survey that measures client satisfaction within a given health plan and may be used to compare satisfaction across health plans. The goal of the CAHPS surveys is to effectively and efficiently obtain client information.

The Department requires Medicaid physical health plans to conduct client satisfaction surveys to ascertain whether clients are satisfied with their care, as well as to ascertain differences among clients enrolled in Medicaid managed care, the Primary Care Physician Program, and Medicaid fee-for-service. As part of a comprehensive quality improvement effort, the Department required physical health plans to conduct the CAHPS 4.0H Survey of Adults and 4.0H Survey of Children with Medicaid clients that had been continuously enrolled in a managed care plan for at least five of the last six months of calendar year 2008. The survey period for this questionnaire was July through December 2008. The data were collected between February and May 2009. National averages for 2008 (the most recent comparative data available) are included.

A minimum of 100 responses to each measure are required in order to report the measure as a CAHPS Survey Result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (N/A). Health Services Advisory Group, the contracted External Quality Review Organization that calculates CAHPS, has advised that plan ratings should not be compared to national averages. Using a national average would not be practicable due its statistical sensitivity in comparison to plan results. It is equally impractical to use a statewide average which is calculated by the National Committee for Quality Assurance because plan results have case mix differences factored into the numbers while the statewide average does not factor case mix differences.

[4] CAHPS is a registered trademark of the Agency for Health Care Research and Quality.

FY 2009-10 CAHPS Results				
	Fee-For-Service	**Primary Care Physician Program**	**Denver Health Medical Plan**	**Rocky Mountain Health Plan**
Adult Medicaid				
Global Ratings				
Rating of Health Plan	★	★★	★	★★★★
Rating of All Health Care	★	★★★	★	★★★★★
Rating of Personal Doctor	★★★	★★★★	★★★★	★★★★
Rating of Specialist Seen Most Often	★★★★	★★★	★★	★★★
Composite Measures				
Getting Needed Care	★★★	★★★★	★	★★★★★
Getting Care Quickly	★★	★★★★	★	★★★★★
How Well Doctors Communicate	★★★	★★★★	★★★	★★★★
Customer Service	NA	NA	NA	★★★★★
Shared Decision Making	★★★★	★★★★★	★★★★	★★★★★
★★★★★90th Percentile or Above ★★★★75th-89th Percentiles ★★★50th-74th Percentiles				
★★25th-49th Percentiles ★Below 25th Percentile **NA** Not Applicable				
	Fee-For-Service	**Primary Care Physician Program**	**Denver Health MP**	**Rocky Mountain Health Plan**
Child Medicaid				
Global Ratings				
Rating of Health Plan	★★	★★	★★	★★★★
Rating of All Health Care	★★	★★★	★	★★★★★
Rating of Personal Doctor	★★	★★★	★★★★★	★★★★★
Rating of Specialist Seen Most Often	★★	★★★	NA	NA
Composite Measures				
Getting Needed Care	★★	★★	NA	★★★★★
Getting Care Quickly	★★★	★★	★	★★★★★
How Well Doctors Communicate	★★★	★★★★	★★	★★★★★
Customer Service	★	★★	NA	NA
Shared Decision Making	★★★★★	★★★★★	★	★★★★★
★★★★★80th Percentile or Above ★★★★60th-79th Percentiles ★★★40th-59th Percentiles				
★★20th-39th Percentiles ★Below 20th Percentile **NA** Not Applicable				

Health Effectiveness Data and Information Set (HEDIS)

The Health Effectiveness Data and Information Set (HEDIS®)[5] is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans. The performance measures address many significant health care issues such as access to care, effectiveness of care, and use of services. Each year, different HEDIS measures are selected that relate to quality initiatives outlined in the State Quality Improvement Work Plan. Since different measures are selected annually, variations may occur in data presentation and reported level of detail.

The Department requires Medicaid health plans to report HEDIS measure rates each year. The Department uses this information to track the health plans' performance in providing care and services to Medicaid clients and to identify and prioritize improvement efforts. As part of a comprehensive quality initiative, the Department required health plans to report rates on HEDIS measures for adults and children. The data presented in the following tables show performance rates on measures ranging from child immunization rates to cholesterol management. The 2010 rates reflect services provided January 1, 2009 through December 31, 2009.

It was discovered that not all federally qualified health centers (FQHCs) submit the codes needed to accurately calculate some HEDIS measures, although FQHCs clients are included in percentage denominators. This means that some fee-for-service rates are artificially low. The Department is working with the FQHCs to submit the required codes. Where applicable, the measures that may be affected by this data are marked with an asterisk (*).

[5] HEDIS is a registered trademark of the National Committee for Quality Assurance.

2010 HEDIS Colorado Medicaid (Calendar Year 2009 Data Collection) HEDIS Rates for All Medicaid Health Plans HEDIS is a registered trademarked product of the National Committee for Quality Assurance								
HEDIS Measure	**Denver Health**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Fee-for-Service**	**HMO Weighted Average**	**Primary Care Physician Program & Fee-for-Service Weighted Average***	**Colorado Medicaid Weighted Average**	**2009 HEDIS National Medicaid Mean**
Childhood Immunization Status (H) (Percentage of children with immunization)								
4 Diptheria, Tetanus, Pertussis	86.60%	91.00%	84.80%	82.00%	87.80%	82.10%	82.80%	78.60%
1 Measles, Mumps and Rubella	93.90%	94.90%	94.90%	91.50%	94.20%	91.60%	91.90%	90.90%
3 Polio Virus immunizations	95.60%	97.60%	91.60%	91.70%	96.10%	91.70%	92.30%	87.90%
2 Haemophilus Influenza Type b	96.60%	97.80%	96.90%	91.70%	96.90%	91.90%	92.50%	93.40%
3 Hepatitis B immunizations	95.40%	96.80%	93.80%	92.70%	95.80%	92.70%	93.10%	88.30%
1 Chicken Pox vaccine	93.70%	95.60%	94.10%	90.80%	94.20%	90.80%	91.30%	89.70%
Pneumococcal Conjugate	88.60%	89.80%	87.30%	80.10%	88.90%	80.30%	81.30%	75.60%
Combo Rate 2 – 4 DTP or DTaP, 3OPV or IPV, 1 MMR, 2 hepatitis B, 1 Hib and VZV	86.10%	89.30%	81.10%	74.70%	87.00%	74.90%	76.40%	73.70%
Combo Rate 3 – 4 DTP or DTaP, 3OPV or IPV, 1 MMR, 2 hepatitis B, 1 Hib, VZV and pneumococcal congugate	85.20%	85.90%	78.00%	69.80%	85.40%	70.10%	71.90%	67.60%
Percentage of children with well child visits in the first 15 months of life (H)								
0 visits (lower is better)	0.70%	0.00%	4.10%	6.10%	0.60%	6.10%	5.60%	2.70%
6 or more visits	86.10%	72.60%	62.20%	55.00%	83.00%	55.10%	57.20%	58.80%
Percentage of well child visits in the 3rd, 4th, 5th and 6th years of life (H)	63.30%	70.50%	63.50%	59.90%	65.00%	60.00%	60.60%	69.70%
Percentage of adolescents receiving a well care visit (H)	46.00%	48.20%	50.10%	35.00%	46.60%	36.00%	37.10%	45.90%
Percentage of children and adolescents who access primary care practitioners*								
12-24 months	93.60%	98.80%	97.50%	92.90%	94.80%	93.00%	93.20%	95.00%
25 months – 6 years	79.20%	91.80%	85.80%	80.80%	82.30%	81.00%	81.10%	87.20%
7-11 years	85.10%	91.70%	86.90%	82.10%	86.80%	82.50%	83.00%	87.80%
12-19 years	85.80%	92.70%	88.20%	81.40%	87.90%	82.00%	82.60%	85.30%

2010 HEDIS Colorado Medicaid (Calendar Year 2009 Data Collection) HEDIS Rates for All Medicaid Health Plans HEDIS is a registered trademarked product of the National Committee for Quality Assurance								
HEDIS Measure	**Denver Health**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Fee-for-Service**	**HMO Weighted Average**	**Primary Care Physician Program & Fee-for-Service Weighted Average***	**Colorado Medicaid Weighted Average**	**2009 HEDIS National Medicaid Mean**
Percentage of deliveries in which the mother received prenatal and postpartum care (H)								
Percentage obtaining care within first trimester	83.50%	95.00%	66.90%	62.50%	88.70%	62.60%	65.10%	81.90%
Percentage obtaining care between 21 and 56 days postpartum	58.40%	73.70%	57.00%	59.60%	65.30%	59.60%	60.10%	62.60%
Percentage of Adults accessing preventive care*								
Percentage of clients age 20-44 accessing care	74.90%	87.70%	83.90%	79.40%	79.00%	79.70%	79.60%	79.80%
Percentage of clients age 45-64 accessing care	78.70%	90.40%	88.10%	83.40%	82.00%	84.00%	83.80%	85.50%
Percentage of clients age 65+ accessing care	69.50%	95.60%	85.50%	77.30%	77.80%	78.00%	78.00%	83.90%
Weight assessment and counseling for children								
Percentage with BMI documented	77.10%	58.20%	35.50%	21.40%	71.80%	22.30%	31.90%	21.30%
Percentage counseled for nutrition	71.80%	60.10%	44.50%	44.30%	68.50%	44.30%	49.00%	35.50%
Percentage counseled for activity	48.20%	53.00%	38.00%	26.30%	49.50%	27.00%	31.40%	26.50%
Antidepressant medication management								
Percentage with effective acute treatment	51.20%	Not a RMHP benefit	55.40%	53.40%	51.20%	53.50%	53.30%	48.20%
Percentage with effective ongoing treatment	38.00%	Not a RMHP benefit	37.80%	34.90%	38.00%	35.00%	35.30%	31.80%
Percentage with no imaging studies initially done for low back pain (higher score indicates appropriate treatment)	79.40%	72.60%	81.80%	78.10%	76.90%	78.20%	78.10%	75.70%
Percentage of adults with high blood pressure controlled	64.70%	74.10%	41.10%	40.20%	67.30%	40.30%	44.60%	55.80%

2010 HEDIS Colorado Medicaid (Calendar Year 2009 Data Collection) HEDIS Rates for All Medicaid Health Plans HEDIS is a registered trademarked product of the National Committee for Quality Assurance								
HEDIS Measure	**Denver Health**	**Rocky Mountain Health Plans**	**Primary Care Physician Program**	**Fee-for-Service**	**HMO Weighted Average**	**Primary Care Physician Program & Fee-for-Service Weighted Average***	**Colorado Medicaid Weighted Average**	**2009 HEDIS National Medicaid Mean**
Percentage of adults who did not receive antibiotics for bronchitis (higher rate indicates appropriate treatment)	64.60%	35.90%	50.20%	41.10%	49.00%	42.10%	42.50%	25.80%
Pharmacotherapy management of COPD exacerbation								
Systemic corticosteroid	49.60%	34.30%	27.90%	17.50%	46.50%	18.60%	23.80%	61.70%
Bronchodilator	55.60%	62.90%	31.70%	25.60%	57.10%	26.20%	32.00%	78.20%
Chlamydia screening in women	78.50%	45.50%	33.90%	54.80%	67.50%	54.00%	55.40%	54.90%
Adult BMI assessment	83.70%	48.70%	28.50%	27.70%	72.30%	27.80%	33.20%	24.00%
Percentage of clients on persistent medications receiving annual monitoring*	84.70%	75.30%	82.00%	83.50%	82.40%	83.20%	83.00%	82.60%
ACE inhibitors or ARBs	88.80%	75.40%	87.40%	86.40%	85.80%	86.60%	86.40%	84.80%
Digoxin	N/A	N/A	77.80%	88.60%	N/A	86.50%	86.50%	88.50%
Diuretics	88.40%	75.10%	85.80%	87.40%	85.30%	87.20%	86.70%	84.20%
Anticonvulsants	60.20%	73.90%	71.30%	69.70%	64.80%	70.10%	69.20%	68.70%
Percentage of antibiotic utilization for antibiotics of concern*	26.30%	37.20%	40.70%	39.60%	31.50%	38.00%	37.50%	41.50%
Number of ambulatory care visits/1000 member months*								
Outpatient*	296.8	470.5	461.6	385.0	341.8	389.2	383.6	347.3
ED	63.1	63.3	66.4	71.0	63.1	70.7	69.8	60.2
Ambulatory surgery	22.5	14.5	15.4	11.4	20.5	11.6	12.7	9.2
Observation stays	1.0	1.8	1.1	1.5	1.2	1.5	1.4	1.8
Inpatient Utilization								
Number of discharges/1000 mm	12.9	12.1	11.5	13.3	12.7	13.2	13.1	8.4
Number of days/1000 mm	69.4	33.5	56.6	52.2	60.1	52.4	53.4	30.1
Average Length of Stay	5.4	2.8	4.9	3.9	4.7	4.0	4.1	3.6

***May not include data from Colorado Federally Qualified Health Centers**

Demographics and Expenditures

Demographic statistics provide valuable insight on the demand for medical care within each region. More populated areas tend to have a greater demand for medical care. Therefore, a region that is more populated is likely to have higher medical expenditures and caseloads. Likewise, as Colorado's population increases, the demand for medical care will also increase. The Department collected 2008 demographic data from the United States Census Report, "2008 American Community Survey" for: 1) population; and 2) percent of total Colorado population. However, this survey does not present data for all geographic areas.

The United States Census Bureau derives its definition of poverty from the Office of Management and Budget's Strategic Policy Directive 14. This definition of poverty accounts for family size, income, and the age of each family member. As the percentage of families living below poverty increases, the demand for medical care provided by the State will increase. Similarly, as the percentage of female-headed households increases, utilization of State provided medical care may increase. Conversely, a higher percent of the population in the labor force should result in a reduction of State provided medical care.

Medicaid

Using the Department's decision support system database, FY 2009-10 Medicaid data was collected for the following statistics and reported for the State in the following table, and reported by county:

- Medicaid Clients;
- Medicaid Expenditures; and
- Percentage Share of Medicaid Premium Expenditures, Statewide Total

Please note that monthly expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System. The decision support system extracts data on a different time span and from a different source (i.e., Medicaid Management Information System) than the Colorado Financial Reporting System. Therefore, total expenditures presented in this document will not reconcile with the actual medical services expenditures reported in Exhibit M in the November 1, 2010 FY 2011-12 Budget Request.

Children's Basic Health Plan

Using FY 2009-10 expenditures and caseload data for the Children's Basic Health Plan (CHP+), the Department compiled the following data and reported it by county in the following table:

- Average Number of Children per Month;

- Number of Deliveries for Women; and
- Children's Basic Health Plan Expenditures.

CHP+ provides medical and dental services to children under age 19, and provides prenatal care and delivery for adult pregnant women who are at or below 250% of the federal poverty level. The total CHP+ expenditures presented in the statewide table below include Children's Basic Health Plan Premium Costs and Children's Basic Health Plan Dental Benefit Costs.

Please note that all data included in prior Budget Submissions were aggregated at the Health Insurance Portability and Accountability Act (HIPAA) region level. HIPAA requires that the Department release client information in a larger aggregation in order to maintain client confidentiality and anonymity in smaller counties. To do this, twenty "HIPAA Regions" were developed for the provision of Department information. However, beginning with the FY 2011-12 Budget Submission, the Department will be reporting data at the county level, and suppressing data for small counties. For data at the HIPAA region level, please contact Matt Ivy at 303-866-6077.

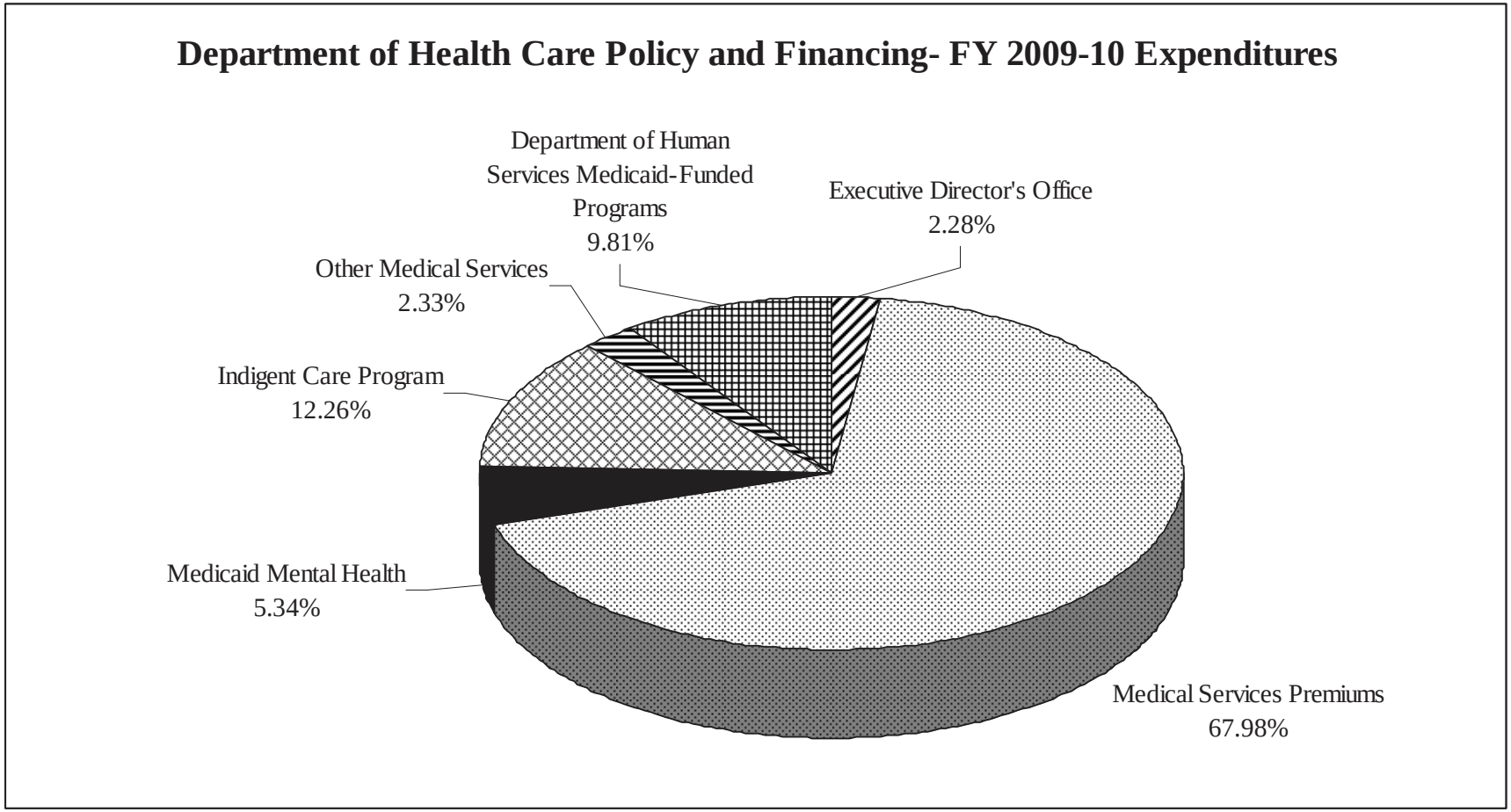
Colorado's Demographics, Medicaid, and the Children's Basic Health Plan - A Statewide View	
Characteristics	**State Totals**
Demographic Characteristics	
Colorado Population Forecast, 2009[6]	5,109,699
Percent of Population in the Labor Force, 2008[7]	70.99%
Percent of Homes where Language Other Than English is Spoken[7]	15.10%
Percent of Families Below Poverty, 2008	7.80%
Percent of Female Headed Households, 2008	9.65%
Medicaid Characteristics, FY 2009-10	
Average Number of Medicaid Clients[8]	498,189
Medical Services Premiums Expenditures[9]	$2,877,812,219
Total Department Expenditures[9]	$4,233,221,564
Medical Services Premiums as a percentage of the total services expenditures	67.98%
Children's Basic Health Plan Characteristics, FY 2009-10	
Average Number of Children per Month[8]	68,725
Average Prenatal Caseload per Month[8]	1,561
Children's Basic Health Plan Expenditures[9]	$178,495,021

[6] Colorado Division of Local Government, Demography Office, November 2008 - Table 3a. Preliminary Population Forecasts for Colorado Regions 2000-2010. http://dola.colorado.gov/demog/population/forecasts/substate1yr.pdf

[7] Per the '2008 American Community Survey' from the Unites States Census Bureau. The percents listed are not relative to the total population http://factfinder.census.gov/servlet/IPGeoSearchByListServlet?ds_name=ACS_2008_1YR_G00_&_lang=en&_ts=301332950782

[8] Department of Health Care Policy and Financing June 2010 Premiums, Caseload, and Expenditures Report dated July 15, 2010. http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251643751700&ssbinary=true

[9] Expenditures from the Department's November 1, 2010 FY 2011-12 Budget Request, Schedule 3.



Medicaid and the Children's Basic Health Plan

The following table provides insight on the variations of Medicaid and the Children's Basic Health Plan (CHP+) usage across counties. Some important caveats must be mentioned concerning the Medicaid and CHP+ data presented in the county table. Overall, Medicaid and CHP+ expenditure figures by county will not equal the year-to-date FY 2009-10 appropriated or actual amounts. This is due to several factors:

1. The Medicaid and CHP+ data were pulled from a different source than the rest of the Budget's exhibits to obtain county numbers. However, Medicaid caseload, pulled from the Decision Support System will match the official caseload count as reported in the "Exhibit B – Medicaid Caseload Forecast," page EB-1.

2. County Medicaid expenditures represent actual fiscal year totals for Medical Services Premiums only.

3. Individuals for whom no county code had been attributed yet were not included in the county caseload or in the county expenditures. Typically, this accounts for less than 1% of the average number of the Medicaid client population.

4. Expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System, whereas the Decision Support System database extracts its data from the Medicaid Management Information System (MMIS). Therefore, total Medicaid and CHP+ expenditures presented in the table below will not exactly reconcile with the numbers for actual medical services reported in the June 2010 Premiums, Caseload, and Expenditure Report to the Joint Budget Committee. Some Medicaid expenditures are not linked to an eligibility type or to a unique client identification number for the following reasons:

    a. These expenditures are financial transaction payments made to individual providers, health maintenance organizations, service organizations, such as cost settlements or lump sum payments;

    b. Clients had no recorded eligibility type, gender, and/or county code.

5. Expenditures for drug rebates, Single Entry Point, and Supplemental Medicare Insurance Beneficiaries are not included in expenditure amounts by region since they are not processed in the MMIS.

County Level Medicaid and CHP+ Data				
Characteristics	**Adams**	**Alamosa**	**Arapahoe**	**Archuleta**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	455,134	16,392	583,854	14,107
Percent of Total Colorado Population (2010)[1]	8.72%	0.31%	11.19%	0.27%
Colorado Population (2000)[2]	363,857	14,966	487,967	9,898
Percent of Population in the Labor Force (2000)[2]	70.57%	66.29%	73.27%	63.22%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	21.64%	28.34%	15.51%	11.95%
Percent of Families Below Poverty (2000)[2]	6.46%	15.56%	4.18%	9.05%
Percent of Female Headed Households (2000)[2]	12.11%	11.65%	10.64%	8.17%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	56,405	3,421	52,444	1,154
Percent of County Population that are Medicaid Clients	12.39%	20.87%	8.98%	8.18%
Medicaid Expenditures	$317,371,693	$20,991,943	$324,444,965	$4,814,138
Percent of Total Medicaid Expenditures	10.29%	0.68%	10.51%	0.16%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	9,449	531	7,703	272
Percent of County Population that are CHP+ Clients	2.08%	3.24%	1.32%	1.93%
CHP+ Expenditures	$19,590,514	$1,069,178	$16,005,645	$629,961
Percent of Total CHP+ Expenditures	13.07%	0.71%	10.68%	0.42%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	1,468	7,485	11,435	0
Number of Colorado Indigent Care Program Providers in County	1	2	1	0
Colorado Indigent Care Program Expenditures	$1,741,014	$3,972,872	$4,015,962	$0
Percent of Total Colorado Indigent Care Program Expenditures	0.86%	1.96%	1.98%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Baca**	**Bent**	**Boulder**	**Broomfield**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	4,067	5,693	303,277	58,196
Percent of Total Colorado Population (2010)[1]	0.08%	0.11%	5.81%	1.12%
Colorado Population (2000)[2]	4,517	5,998	291,288	-
Percent of Population in the Labor Force (2000)[2]	57.64%	48.60%	73.36%	-
Percent of Homes where Language Other Than English is Spoken (2000)[2]	5.81%	16.83%	13.62%	-
Percent of Families Below Poverty (2000)[2]	12.89%	16.58%	4.59%	-
Percent of Female Headed Households (2000)[2]	7.51%	11.43%	7.70%	-
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	571	1,032	18,367	2,574
Percent of County Population that are Medicaid Clients	14.04%	18.13%	6.06%	4.42%
Medicaid Expenditures	$5,194,608	$7,110,575	$126,029,064	$18,962,286
Percent of Total Medicaid Expenditures	0.17%	0.23%	4.08%	0.61%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	119	99	2,654	535
Percent of County Population that are CHP+ Clients	2.93%	1.74%	0.88%	0.92%
CHP+ Expenditures	$253,853	$198,678	$5,434,563	$1,104,729
Percent of Total CHP+ Expenditures	0.17%	0.13%	3.63%	0.74%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	0	2,527	11,559	0
Number of Colorado Indigent Care Program Providers in County	0	3	4	0
Colorado Indigent Care Program Expenditures	$0	$2,389,014	$4,933,760	$0
Percent of Total Colorado Indigent Care Program Expenditures	0.00%	1.18%	2.43%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Chaffee**	**Cheyenne**	**Clear Creek**	**Conejos**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	17,525	1,911	9,769	8,411
Percent of Total Colorado Population (2010)[1]	0.34%	0.04%	0.19%	0.16%
Colorado Population (2000)[2]	16,242	2,231	9,322	8,400
Percent of Population in the Labor Force (2000)[2]	52.97%	63.45%	77.30%	55.11%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	8.70%	7.61%	3.51%	42.11%
Percent of Families Below Poverty (2000)[2]	7.37%	8.72%	2.99%	18.64%
Percent of Female Headed Households (2000)[2]	6.85%	5.68%	6.89%	12.68%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	1,327	157	559	1,824
Percent of County Population that are Medicaid Clients	7.57%	8.22%	5.72%	21.69%
Medicaid Expenditures	$9,527,499	$1,056,428	$2,906,859	$8,471,478
Percent of Total Medicaid Expenditures	0.31%	0.03%	0.09%	0.27%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	340	54	97	384
Percent of County Population that are CHP+ Clients	1.94%	2.83%	0.99%	4.57%
CHP+ Expenditures	$790,242	$140,469	$204,710	$796,579
Percent of Total CHP+ Expenditures	0.53%	0.09%	0.14%	0.53%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	405	0	0	345
Number of Colorado Indigent Care Program Providers in County	1	0	0	1
Colorado Indigent Care Program Expenditures	$413,746	$0	$0	$288,303
Percent of Total Colorado Indigent Care Program Expenditures	0.20%	0.00%	0.00%	0.14%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Costilla**	**Crowley**	**Custer**	**Delta**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	3,529	8,524	4,550	33,372
Percent of Total Colorado Population (2010)[1]	0.07%	0.16%	0.09%	0.64%
Colorado Population (2000)[2]	3,663	5,518	3,503	27,834
Percent of Population in the Labor Force (2000)[2]	45.67%	31.92%	56.27%	54.87%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	59.47%	14.65%	3.65%	10.32%
Percent of Families Below Poverty (2000)[2]	21.26%	15.20%	9.76%	8.55%
Percent of Female Headed Households (2000)[2]	11.31%	11.05%	5.41%	7.87%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	881	770	386	3,865
Percent of County Population that are Medicaid Clients	24.96%	9.03%	8.48%	11.58%
Medicaid Expenditures	$3,876,078	$4,583,576	$1,292,710	$20,453,486
Percent of Total Medicaid Expenditures	0.13%	0.15%	0.04%	0.66%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	98	85	67	628
Percent of County Population that are CHP+ Clients	2.78%	1.00%	1.47%	1.88%
CHP+ Expenditures	$189,638	$168,210	$120,241	$1,272,496
Percent of Total CHP+ Expenditures	0.13%	0.11%	0.08%	0.85%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	0	0	34	1,079
Number of Colorado Indigent Care Program Providers in County	0	0	1	1
Colorado Indigent Care Program Expenditures	$0	$0	$21,559	$866,906
Percent of Total Colorado Indigent Care Program Expenditures	0.00%	0.00%	0.01%	0.43%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Denver**	**Dolores**	**Douglas**	**Eagle**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	621,430	1,998	304,234	57,942
Percent of Total Colorado Population (2010)[1]	11.91%	0.04%	5.83%	1.11%
Colorado Population (2000)[2]	554,636	1,844	175,766	41,659
Percent of Population in the Labor Force (2000)[2]	67.65%	58.03%	79.01%	80.90%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	26.96%	5.71%	7.20%	24.68%
Percent of Families Below Poverty (2000)[2]	10.63%	10.22%	1.62%	3.94%
Percent of Female Headed Households (2000)[2]	10.84%	8.54%	5.74%	5.55%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	88,953	187	7,174	2,557
Percent of County Population that are Medicaid Clients	14.31%	9.36%	2.36%	4.41%
Medicaid Expenditures	$518,417,204	$867,805	$48,470,123	$8,626,016
Percent of Total Medicaid Expenditures	16.80%	0.03%	1.57%	0.28%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	8,876	41	1,480	442
Percent of County Population that are CHP+ Clients	1.43%	2.05%	0.49%	0.76%
CHP+ Expenditures	$17,782,767	$82,102	$3,249,204	$979,240
Percent of Total CHP+ Expenditures	11.86%	0.05%	2.17%	0.65%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	52,837	67	0	0
Number of Colorado Indigent Care Program Providers in County	6	1	0	0
Colorado Indigent Care Program Expenditures	$114,988,900	$88,517	$0	$0
Percent of Total Colorado Indigent Care Program Expenditures	56.74%	0.04%	0.00%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Elbert**	**El Paso**	**Fremont**	**Garfield**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	23,606	622,858	50,168	67,321
Percent of Total Colorado Population (2010)[1]	0.45%	11.94%	0.96%	1.29%
Colorado Population (2000)[2]	19,872	516,929	46,145	43,791
Percent of Population in the Labor Force (2000)[2]	75.45%	71.94%	45.07%	71.05%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	4.79%	11.36%	7.37%	15.46%
Percent of Families Below Poverty (2000)[2]	2.54%	5.69%	8.35%	4.60%
Percent of Female Headed Households (2000)[2]	5.66%	10.22%	9.18%	7.79%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	1,149	59,095	5,771	5,053
Percent of County Population that are Medicaid Clients	4.87%	9.49%	11.50%	7.51%
Medicaid Expenditures	$5,582,107	$357,710,694	$45,970,535	$29,664,460
Percent of Total Medicaid Expenditures	0.18%	11.59%	1.49%	0.96%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	229	6,764	715	962
Percent of County Population that are CHP+ Clients	0.97%	1.09%	1.43%	1.43%
CHP+ Expenditures	$457,241	$15,523,166	$1,463,102	$2,165,104
Percent of Total CHP+ Expenditures	0.31%	10.36%	0.98%	1.44%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	0	31,509	1,651	341
Number of Colorado Indigent Care Program Providers in County	0	3	1	1
Colorado Indigent Care Program Expenditures	$0	$23,651,247	$570,458	$828,526
Percent of Total Colorado Indigent Care Program Expenditures	0.00%	11.67%	0.28%	0.41%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Gilpin**	**Grand**	**Gunnison**	**Hinsdale**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	5,332	15,336	15,506	903
Percent of Total Colorado Population (2010)[1]	0.10%	0.29%	0.30%	0.02%
Colorado Population (2000)[2]	4,757	12,442	13,956	790
Percent of Population in the Labor Force (2000)[2]	81.33%	77.09%	73.36%	70.51%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	4.73%	6.11%	6.60%	4.85%
Percent of Families Below Poverty (2000)[2]	1.00%	5.39%	6.01%	4.45%
Percent of Female Headed Households (2000)[2]	5.73%	5.20%	5.42%	4.74%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	309	697	833	40
Percent of County Population that are Medicaid Clients	5.80%	4.54%	5.37%	4.43%
Medicaid Expenditures	$1,661,155	$2,533,238	$5,274,029	$77,796
Percent of Total Medicaid Expenditures	0.05%	0.08%	0.17%	0.00%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	71	180	226	22
Percent of County Population that are CHP+ Clients	1.33%	1.17%	1.46%	2.44%
CHP+ Expenditures	$151,696	$474,804	$586,480	$52,004
Percent of Total CHP+ Expenditures	0.10%	0.32%	0.39%	0.03%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	0	70	92	0
Number of Colorado Indigent Care Program Providers in County	0	1	1	0
Colorado Indigent Care Program Expenditures	$0	$43,252	$105,227	$0
Percent of Total Colorado Indigent Care Program Expenditures	0.00%	0.02%	0.05%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Huerfano**	**Jackson**	**Jefferson**	**Kiowa**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	8,299	1,472	551,617	1,426
Percent of Total Colorado Population (2010)[1]	0.16%	0.03%	10.57%	0.03%
Colorado Population (2000)[2]	7,862	1,577	527,056	1,622
Percent of Population in the Labor Force (2000)[2]	48.81%	66.75%	73.43%	60.63%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	18.17%	3.83%	9.23%	3.54%
Percent of Families Below Poverty (2000)[2]	14.10%	10.27%	3.35%	9.64%
Percent of Female Headed Households (2000)[2]	10.35%	7.87%	9.13%	6.62%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	1,455	119	34,934	169
Percent of County Population that are Medicaid Clients	17.53%	8.08%	6.33%	11.85%
Medicaid Expenditures	$11,498,408	$399,949	$311,890,154	$1,202,421
Percent of Total Medicaid Expenditures	0.37%	0.01%	10.11%	0.04%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	129	35	5,338	36
Percent of County Population that are CHP+ Clients	1.55%	2.38%	0.97%	2.52%
CHP+ Expenditures	$279,435	$71,767	$11,470,760	$70,508
Percent of Total CHP+ Expenditures	0.19%	0.05%	7.65%	0.05%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	88	0	0	0
Number of Colorado Indigent Care Program Providers in County	1	0	0	0
Colorado Indigent Care Program Expenditures	$230,220	$0	$0	$0
Percent of Total Colorado Indigent Care Program Expenditures	0.11%	0.00%	0.00%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Kit Carson**	**Lake**	**La Plata**	**Larimer**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	8,156	10,296	51,517	306,176
Percent of Total Colorado Population (2010)[1]	0.16%	0.20%	0.99%	5.87%
Colorado Population (2000)[2]	8,011	7,812	43,941	251,494
Percent of Population in the Labor Force (2000)[2]	60.98%	72.65%	69.04%	71.92%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	13.22%	26.35%	9.45%	8.47%
Percent of Families Below Poverty (2000)[2]	9.39%	9.52%	6.65%	4.26%
Percent of Female Headed Households (2000)[2]	6.29%	8.40%	8.66%	7.87%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	907	865	3,720	22,569
Percent of County Population that are Medicaid Clients	11.12%	8.40%	7.22%	7.37%
Medicaid Expenditures	$5,443,649	$3,590,607	$20,315,592	$139,378,102
Percent of Total Medicaid Expenditures	0.18%	0.12%	0.66%	4.52%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	292	147	872	3,476
Percent of County Population that are CHP+ Clients	3.58%	1.43%	1.69%	1.14%
CHP+ Expenditures	$622,297	$343,778	$1,987,201	$7,679,660
Percent of Total CHP+ Expenditures	0.42%	0.23%	1.33%	5.12%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	0	28	396	12,504
Number of Colorado Indigent Care Program Providers in County	0	1	1	4
Colorado Indigent Care Program Expenditures	$0	$36,139	$958,910	$10,808,623
Percent of Total Colorado Indigent Care Program Expenditures	0.00%	0.02%	0.47%	5.33%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Las Animas**	**Lincoln**	**Logan**	**Mesa**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	17,353	5,712	22,923	153,457
Percent of Total Colorado Population (2010)[1]	0.33%	0.11%	0.44%	2.94%
Colorado Population (2000)[2]	15,207	6,087	20,504	116,255
Percent of Population in the Labor Force (2000)[2]	54.67%	52.43%	60.75%	64.20%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	20.79%	6.89%	8.21%	7.97%
Percent of Families Below Poverty (2000)[2]	14.00%	8.15%	8.99%	7.03%
Percent of Female Headed Households (2000)[2]	11.65%	8.36%	8.56%	9.78%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	2,746	630	2,415	17,252
Percent of County Population that are Medicaid Clients	15.82%	11.03%	10.54%	11.24%
Medicaid Expenditures	$22,968,036	$4,839,431	$17,556,785	$107,632,307
Percent of Total Medicaid Expenditures	0.74%	0.16%	0.57%	3.49%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	298	86	379	2,778
Percent of County Population that are CHP+ Clients	1.72%	1.51%	1.65%	1.81%
CHP+ Expenditures	$664,624	$175,675	$785,436	$6,325,237
Percent of Total CHP+ Expenditures	0.44%	0.12%	0.52%	4.22%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	1,255	5,579	1,036	5,876
Number of Colorado Indigent Care Program Providers in County	2	1	2	3
Colorado Indigent Care Program Expenditures	$338,120	$23,737	$855,826	$2,056,797
Percent of Total Colorado Indigent Care Program Expenditures	0.17%	0.01%	0.42%	1.01%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Mineral**	**Moffat**	**Montezuma**	**Montrose**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	1,043	17,650	26,645	44,675
Percent of Total Colorado Population (2010)[1]	0.02%	0.34%	0.51%	0.86%
Colorado Population (2000)[2]	831	13,184	23,830	33,432
Percent of Population in the Labor Force (2000)[2]	62.30%	69.27%	63.35%	62.60%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	1.89%	8.37%	13.34%	11.57%
Percent of Families Below Poverty (2000)[2]	9.30%	6.89%	13.12%	8.88%
Percent of Female Headed Households (2000)[2]	5.84%	8.17%	10.56%	8.69%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	48	1,547	3,743	5,684
Percent of County Population that are Medicaid Clients	4.60%	8.76%	14.05%	12.72%
Medicaid Expenditures	$205,167	$8,412,266	$23,043,532	$27,335,591
Percent of Total Medicaid Expenditures	0.01%	0.27%	0.75%	0.89%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	6	285	697	1,281
Percent of County Population that are CHP+ Clients	0.58%	1.61%	2.62%	2.87%
CHP+ Expenditures	$12,975	$707,053	$1,441,664	$2,763,753
Percent of Total CHP+ Expenditures	0.01%	0.47%	0.96%	1.84%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	0	427	315	1,133
Number of Colorado Indigent Care Program Providers in County	0	2	1	1
Colorado Indigent Care Program Expenditures	$0	$170,570	$1,443,212	$1,106,491
Percent of Total Colorado Indigent Care Program Expenditures	0.00%	0.08%	0.71%	0.55%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Morgan**	**Otero**	**Ouray**	**Park**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	28,990	18,991	4,864	18,748
Percent of Total Colorado Population (2010)[1]	0.56%	0.36%	0.09%	0.36%
Colorado Population (2000)[2]	27,171	20,311	3,742	14,523
Percent of Population in the Labor Force (2000)[2]	62.41%	58.35%	62.98%	70.30%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	25.64%	21.90%	5.70%	4.24%
Percent of Families Below Poverty (2000)[2]	8.50%	14.20%	6.03%	3.36%
Percent of Female Headed Households (2000)[2]	8.97%	11.96%	6.54%	4.45%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	3,916	4,113	205	896
Percent of County Population that are Medicaid Clients	13.51%	21.66%	4.21%	4.78%
Medicaid Expenditures	$23,022,913	$27,313,170	$644,151	$3,639,904
Percent of Total Medicaid Expenditures	0.75%	0.89%	0.02%	0.12%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	540	462	87	187
Percent of County Population that are CHP+ Clients	1.86%	2.43%	1.79%	1.00%
CHP+ Expenditures	$1,177,609	$913,935	$200,326	$380,389
Percent of Total CHP+ Expenditures	0.79%	0.61%	0.13%	0.25%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	1,448	0	0	0
Number of Colorado Indigent Care Program Providers in County	2	0	0	0
Colorado Indigent Care Program Expenditures	$466,680	$0	$0	$0
Percent of Total Colorado Indigent Care Program Expenditures	0.23%	0.00%	0.00%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Phillips**	**Pitkin**	**Prowers**	**Pueblo**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	4,589	17,149	13,191	164,783
Percent of Total Colorado Population (2010)[1]	0.09%	0.33%	0.25%	3.16%
Colorado Population (2000)[2]	4,480	14,872	14,483	141,472
Percent of Population in the Labor Force (2000)[2]	59.65%	79.92%	65.42%	58.31%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	10.94%	12.10%	24.37%	16.13%
Percent of Families Below Poverty (2000)[2]	8.81%	3.03%	14.46%	11.18%
Percent of Female Headed Households (2000)[2]	5.56%	5.32%	10.95%	13.33%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	493	247	2,626	30,218
Percent of County Population that are Medicaid Clients	10.74%	1.44%	19.91%	18.34%
Medicaid Expenditures	$3,100,457	$1,062,530	$14,742,559	$202,163,745
Percent of Total Medicaid Expenditures	0.10%	0.03%	0.48%	6.55%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	87	64	406	2,475
Percent of County Population that are CHP+ Clients	1.90%	0.37%	3.08%	1.50%
CHP+ Expenditures	$182,152	$136,282	$809,232	$5,166,813
Percent of Total CHP+ Expenditures	0.12%	0.09%	0.54%	3.45%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	0	218	0	26,262
Number of Colorado Indigent Care Program Providers in County	0	1	0	3
Colorado Indigent Care Program Expenditures	$0	$324,211	$0	$10,400,793
Percent of Total Colorado Indigent Care Program Expenditures	0.00%	0.16%	0.00%	5.13%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**Rio Blanco**	**Rio Grande**	**Routt**	**Saguache**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	9,792	12,492	24,728	7,174
Percent of Total Colorado Population (2010)[1]	0.19%	0.24%	0.47%	0.14%
Colorado Population (2000)[2]	5,986	12,413	19,690	5,917
Percent of Population in the Labor Force (2000)[2]	67.58%	61.50%	80.39%	59.84%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	6.58%	27.57%	6.10%	36.48%
Percent of Families Below Poverty (2000)[2]	6.74%	11.26%	2.77%	18.73%
Percent of Female Headed Households (2000)[2]	7.81%	11.17%	5.78%	11.00%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	592	2,508	934	1,089
Percent of County Population that are Medicaid Clients	6.05%	20.08%	3.78%	15.18%
Medicaid Expenditures	$3,532,373	$14,400,622	$7,080,916	$4,405,044
Percent of Total Medicaid Expenditures	0.11%	0.47%	0.23%	0.14%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	103	498	295	179
Percent of County Population that are CHP+ Clients	1.05%	3.99%	1.19%	2.50%
CHP+ Expenditures	$278,770	$1,067,802	$797,212	$365,644
Percent of Total CHP+ Expenditures	0.19%	0.71%	0.53%	0.24%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	0	261	379	0
Number of Colorado Indigent Care Program Providers in County	0	1	1	0
Colorado Indigent Care Program Expenditures	$0	$228,787	$466,665	$0
Percent of Total Colorado Indigent Care Program Expenditures	0.00%	0.11%	0.23%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data				
Characteristics	**San Juan**	**San Miguel**	**Sedgwick**	**Summit**
Demographic Characteristics				
Colorado Population Estimate (2010)[1]	557	8,471	2,468	30,937
Percent of Total Colorado Population (2010)[1]	0.01%	0.16%	0.05%	0.59%
Colorado Population (2000)[2]	558	6,594	2,747	23,548
Percent of Population in the Labor Force (2000)[2]	69.56%	83.76%	60.88%	86.09%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	9.02%	10.85%	9.33%	13.58%
Percent of Families Below Poverty (2000)[2]	13.46%	6.59%	7.80%	3.09%
Percent of Female Headed Households (2000)[2]	8.92%	5.44%	6.61%	4.36%
Medicaid Characteristics, FY 2009-10				
Average Number of Medicaid Clients per Month	55	302	297	1,120
Percent of County Population that are Medicaid Clients	9.87%	3.57%	12.03%	3.62%
Medicaid Expenditures	$133,752	$733,617	$2,744,808	$3,500,543
Percent of Total Medicaid Expenditures	0.00%	0.02%	0.09%	0.11%
CHP+ Characteristics, FY 2009-10				
Average Number of CHP+ Clients per Month	21	105	58	287
Percent of County Population that are CHP+ Clients	3.77%	1.24%	2.35%	0.93%
CHP+ Expenditures	$39,473	$269,569	$120,796	$789,836
Percent of Total CHP+ Expenditures	0.03%	0.18%	0.08%	0.53%
Colorado Indigent Care Program Characteristics, FY 2008-09				
Unduplicated Client Count	0	543	0	0
Number of Colorado Indigent Care Program Providers in County	0	1	0	0
Colorado Indigent Care Program Expenditures	$0	$105,851	$0	$0
Percent of Total Colorado Indigent Care Program Expenditures	0.00%	0.05%	0.00%	0.00%

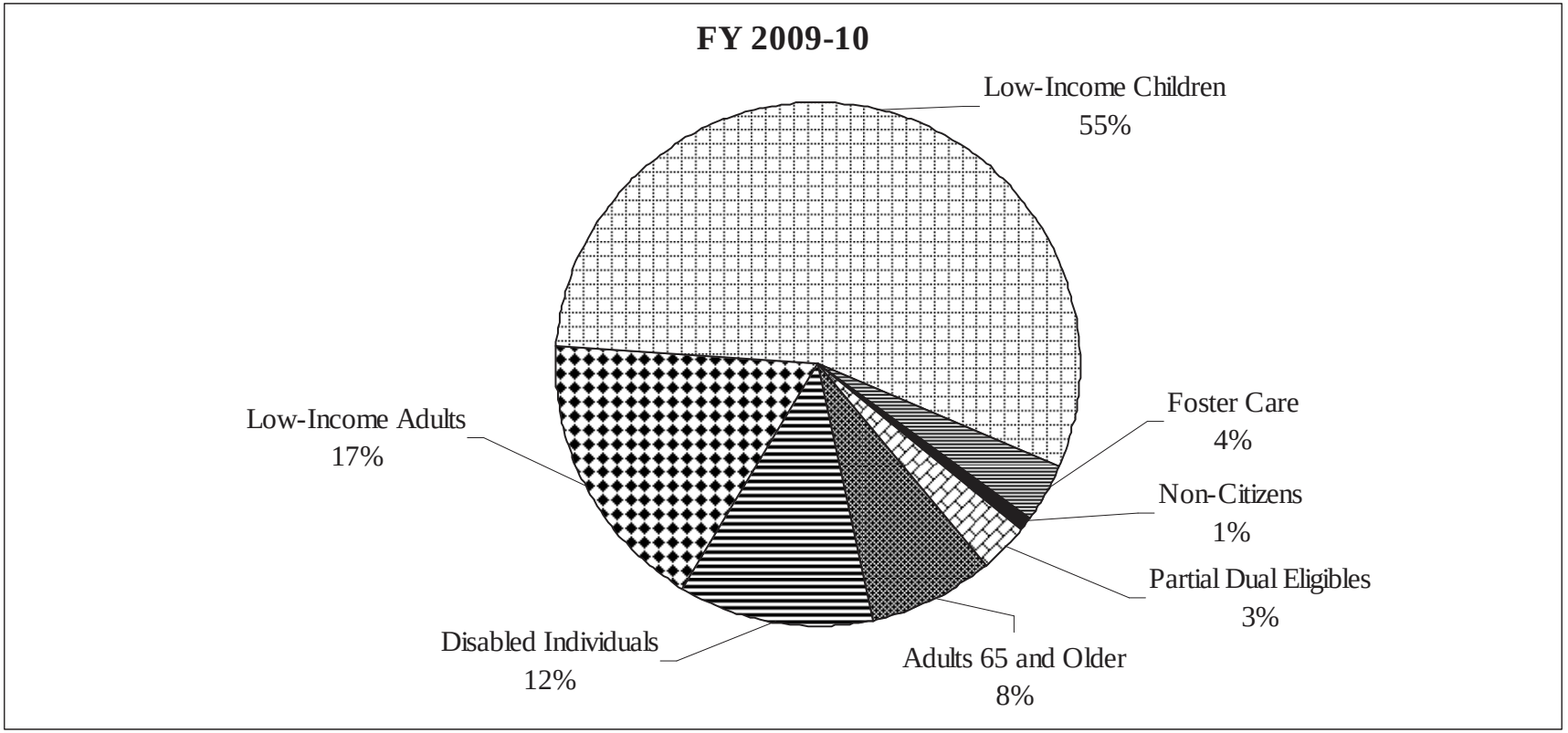
Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

County Level Medicaid and CHP+ Data					
Characteristics	**Teller**	**Washington**	**Weld**	**Yuma**	**Statewide**
Demographic Characteristics					
Colorado Population Estimate (2010)[1]	24,096	4,758	267,938	10,066	5,218,144
Percent of Total Colorado Population (2010)[1]	0.46%	0.09%	5.13%	0.19%	100.00%
Colorado Population (2000)[2]	20,555	4,926	180,936	9,841	4,301,261
Percent of Population in the Labor Force (2000)[2]	72.36%	62.84%	68.61%	66.20%	70.99%
Percent of Homes where Language Other Than English is Spoken (2000)[2]	4.00%	5.24%	20.25%	11.47%	15.10%
Percent of Families Below Poverty (2000)[2]	3.40%	8.58%	8.04%	8.83%	7.80%
Percent of Female Headed Households (2000)[2]	6.56%	6.44%	9.42%	6.76%	9.65%
Medicaid Characteristics, FY 2009-10					
Average Number of Medicaid Clients per Month	1,725	452	28,787	1,259	498,192
Percent of County Population that are Medicaid Clients	7.16%	9.50%	10.74%	12.51%	9.55%
Medicaid Expenditures	$8,356,112	$2,750,298	$146,637,255	$8,007,300	$3,085,626,615
Percent of Total Medicaid Expenditures	0.27%	0.09%	4.75%	0.26%	100.00%
CHP+ Characteristics, FY 2009-10					
Average Number of CHP+ Clients per Month	339	93	4,385	254	70,183
Percent of County Population that are CHP+ Clients	1.41%	1.95%	1.64%	2.52%	1.34%
CHP+ Expenditures	$720,425	$193,839	$9,434,763	$489,906	$149,873,211
Percent of Total CHP+ Expenditures	0.48%	0.13%	6.29%	0.33%	99.99%
Colorado Indigent Care Program Characteristics, FY 2008-09					
Unduplicated Client Count	153	389	16,252	151	197,597
Number of Colorado Indigent Care Program Providers in County	1	1	4	1	64
Colorado Indigent Care Program Expenditures	$55,613	$369,123	$13,159,983	$136,920	$202,662,534
Percent of Total Colorado Indigent Care Program Expenditures	0.03%	0.18%	6.49%	0.07%	100.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2010); Colorado State Demography Website for population and demographic numbers.
Notes:
1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based.
2) Expenditures are by county in which the client lived in FY 2009-10.
3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Colorado Indigent Care Providers (CICP) data by county includes CICP hospitals, clinics, and satellite facilities.
5) Medicaid Expenditures include Drug Rebates, Single Entry Point (SEP), Consumer Directed Attendant Support Services (CDASS), Special Low Income Medicare Beneficiaries (SLIMB), Disease Management, and Other Adjustments.

Medicaid Caseload

Medicaid caseload trends are influenced by a number of factors including: population trends, in-State migration, age of the population, length of stay, economic conditions, and State and federal policy changes. Projecting annual caseload is complicated by the fact that each of these factors can contribute to categorical changes, some of which may be contradictory. For example, the State may enact legislation that removes clients from a Medicaid category who are aged 65 and older, while the population of adults aged 65 and older is increasing. The chart below shows Medicaid caseload by category as a percentage of the overall caseload for FY 2009-10.[7]



[7] Source: November 1, 2010 FY 2011-12 Budget Request, Exhibit B, "Medicaid Caseload Forecast."

A. Clients

A1. 2010 Federal Poverty Levels

The table below reports the federal poverty levels for all states except Hawaii and Alaska from the Department of Health and Human Services. For family units of more than eight members, add $4,300 for each additional family member.

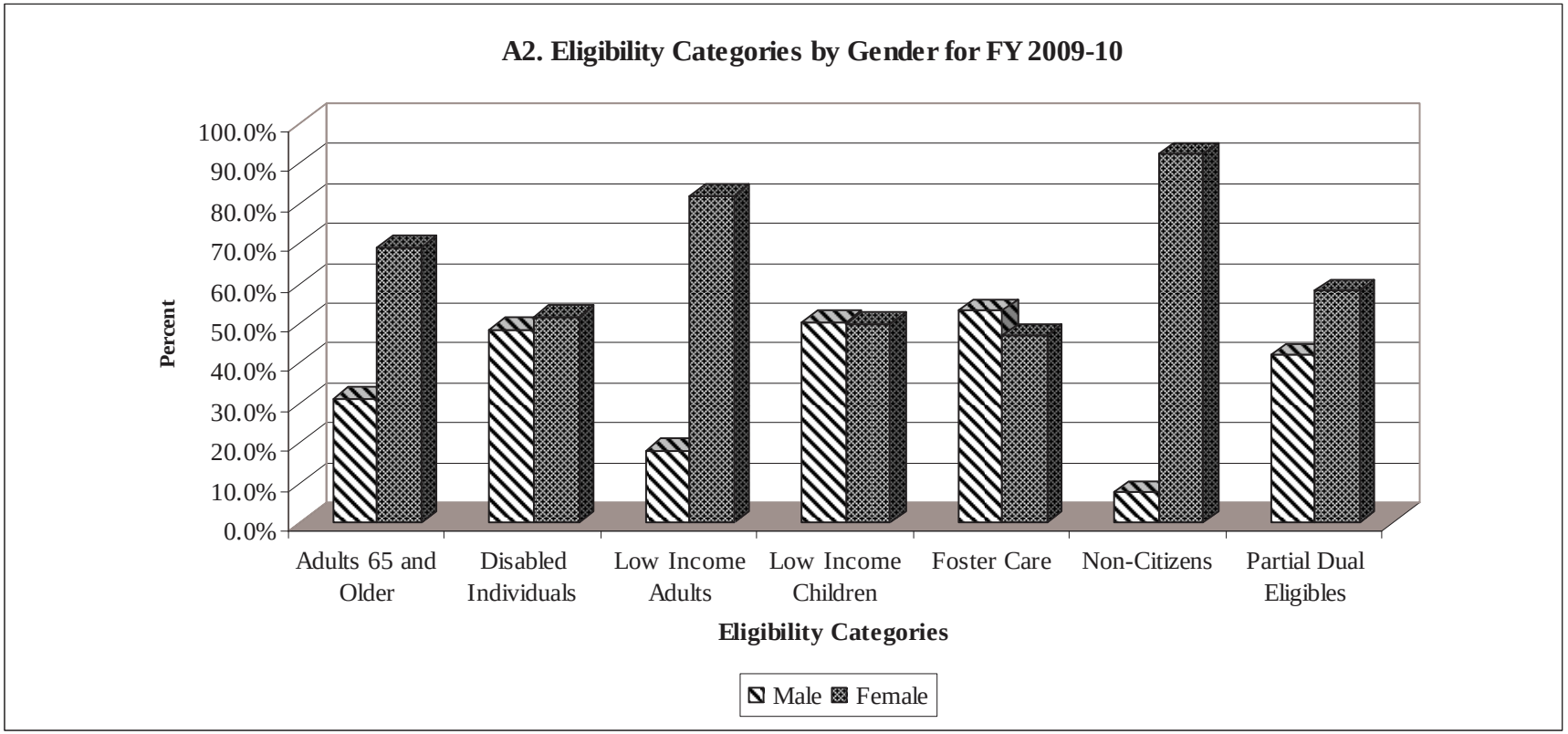
A supplemental poverty measure to complement, but not replace, the existing official poverty statistic is in development at the U.S. Commerce Department. Census Bureau analysts will develop the supplemental/experimental poverty measure, which will use the best new data and methodologies to obtain an improved understanding of the economic well-being of American families and of how federal policies affect those living in poverty.

The supplemental poverty measure report will be released in the fall of 2011, at the same time that the official income and poverty measures for 2010 are released by the Census Bureau. Until this is released, the 2009 poverty levels are being used. The first report will be based on the March 2011 Current Population Survey that will feature some new questions on medical out-of-pocket expenses, child care, and a few additional issues, all designed to improve an NAS-type measure for the nation.

Federal Poverty Guidelines for Annual Income

Family Size	100%	120%	133%	150%	175%	185%	190%	200%	250%
1	$10,830	$12,996	$14,404	$16,245	$18,953	$20,036	$20,577	$21,660	$27,075
2	$14,570	$17,484	$19,378	$21,855	$25,498	$26,955	$27,683	$29,140	$36,425
3	$18,310	$21,972	$24,352	$27,465	$32,043	$33,874	$34,789	$36,620	$45,775
4	$22,050	$26,460	$29,327	$33,075	$38,588	$40,793	$41,895	$44,100	$55,125
5	$25,790	$30,948	$34,301	$38,685	$45,133	$47,712	$49,001	$51,580	$64,475
6	$29,530	$35,436	$39,275	$44,295	$51,678	$54,631	$56,107	$59,060	$73,825
7	$33,270	$39,924	$44,249	$49,905	$58,223	$61,550	$63,213	$66,540	$83,175
8	$37,010	$44,412	$49,223	$55,515	$64,768	$68,469	$70,319	$74,020	$92,525

A2. Eligibility Categories by Gender for FY 2009-10[8]



[8] Source: Business objects of America Query
1) Disabled Individuals includes Disabled Adults 60 to 64 and Disabled Individuals to 59.
2) Low-Income Adults also includes Baby Care Program-Adults and Breast and Cervical Cancer Program Clients.
3) Partial Dual Eligibles includes Qualified and Supplemental Low Income Medicare Beneficiaries.
4) Percent based on member months in each category.

A3. Medicaid Enrollment by Type of Managed Care Provider

The following table shows the breakdown by client count for FY 2005-06 through FY 2009-10 for clients enrolled in health maintenance organizations, prepaid inpatient health plan, Primary Care Physician Program, and unassigned fee-for-service. Health maintenance organizations, prepaid inpatient health plan and Primary Care Physician Program enrollment figures were subtracted from total caseload numbers (without retroactivity) to calculate the fee-for-service enrollment figures, and as a result may cause the fee-for-service counts to be underrepresented[9].

Average Medicaid Enrollment for FY 2005-06 through FY 2009-10

Membership Category	FY 2005-06 Count	FY 2006-07 Count	FY 2007-08 Count	FY 2008-09 Count	FY 2009-10 Count
Health Maintenance Organizations and Prepaid Inpatient Health Plans	71,799	35,985	36,701	54,510	61,047
Primary Care Physician Program	36,563	29,243	25,875	22,717	23,240
Fee-for-Service	291,343	327,849	325,492	359,585	413,902
TOTALS	**399,705**	**393,077**	**388,068**	**436,812**	**498,189**

[9] Department of Health Care Policy and Financing June 2010 Premiums, Caseload, and Expenditures Report dated July 15, 2010. http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251643751700&ssbinary=true Fee-for-service enrollment is derived by the total enrollment minus enrollment in administrative service organizations, health maintenance organizations, and the Primary Care Physician Program.
Note: The Department developed a new caseload report in FY 2007-08 that it believes measures caseload more accurately. Because of the differences between the methodologies used in the original and new caseload reports, the Department restated historical Medicaid caseload through FY 2002-03. The numbers above through FY 2007-08 are based on the old methodologies and will not match restated caseload totals because the Department does not have a methodology for restating caseload by provider type.

B. Services

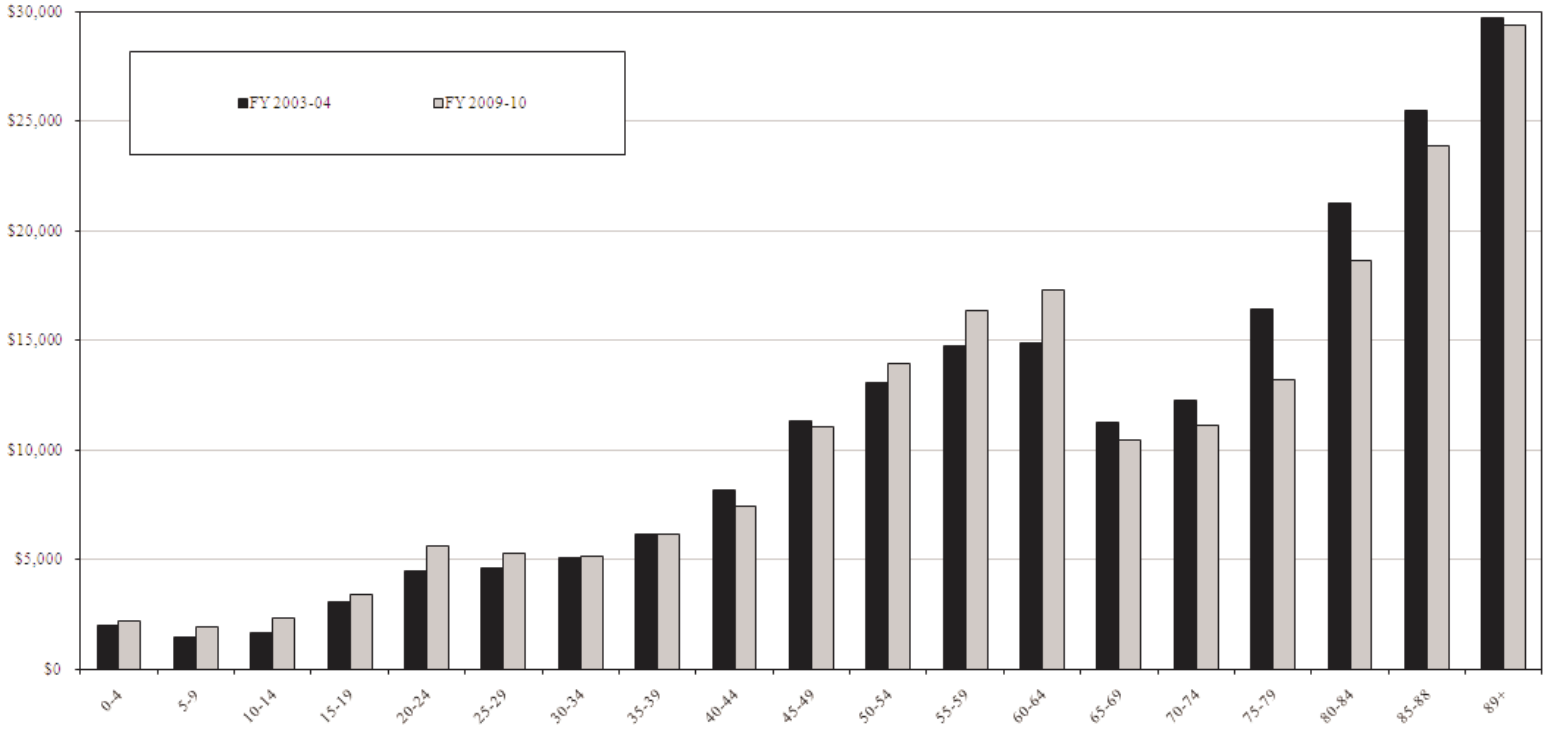
B1. Paid Medical Services Per Capita Costs (from all claims) Across Age Groups[10]

The graph below represents Medicaid per capita costs by client age as of first date of service as reported on his or her most recent claim in FY 2009-10. The graph also contains all clients in the following caseload categories:

- Adults 65 and Older (OAP-A): This includes persons with Supplemental Security Income for persons 65 years of age or older (Old Age Pension-A).
- Disabled Adults 60 to 64 (OAP-B): This includes Supplemental Security Income for disabled persons 60-64 years of age (Old Age Pension-B).
- Disabled Individuals to 59 (AND/AB): This includes Supplemental Security Income for disabled individuals up to the age of 59 (Aid to the Needy Disabled/Aid to the Blind).
- CE Low Income Adults: Categorically Eligible Low Income Adults (Aid to Families with Dependent Children - Adults)
- BCCP: Breast and Cervical Cancer Program
- Health Care Expansion Fund: Low-Income Adults
- Eligible Children: Eligible Children (Aid to Families with Dependent Children - Children/Baby Care Children)
- Foster Children: Foster care (Aid to Families with Dependent Children - Foster Care)
- Baby Care Adults: A Medicaid eligibility category appropriated in the Long Bill that deals only with pregnant women
- Non Citizens: Adults and/or children who have not established legal residency in the US and certain qualifications of legal immigrants who meet certain eligibility requirements
- Partial Dual Eligibles (QMBs/SLMBs): Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries

[10] Source: Medicaid paid claims. Financial transactions and other accounting adjustments are not included in the expenditures by age group.

Per-Capita Costs for All Medicaid Clients by Age Group:
FY 2003-04 and FY 2009-10



Source: Medicaid paid claims. Note: Financial transactions and other accounting adjustments are not included in the expenditures by age group.

B2. FY 2009-10 Services by County

Exhibits B2a - B2b show client counts, expenditures, and average costs of the following medical services county by average monthly client count and average cost per full time equivalent client.

Acute Care, including:

Federal Qualified Health Centers

Physician and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

Prescription Drugs

Inpatient Hospital

Outpatient Hospital

B3. Client Counts for Long-Term Care and Home and Community-Based Services

Exhibit B3a - B3c shows client counts, expenditures, and average costs for Long-term Care and Home Health and Long-term Care Services, including:

Home and Community-Based Services (HCBS)

Program for All-Inclusive Care for the Elderly (PACE)

Home Health

Nursing Facilities

B4. Deliveries

Exhibit B4a – B4e show client counts, expenditures, and average costs for various deliveries in Medicaid, including:

Deliveries by County

Delivery Types

Age Group of Mother

Low Birthweight, Preterm, and Neonatal Intensive Care Unit

Neonatal Intensive Care Unit

B5. Top Tens

Exhibits B5a – B5j shows expenditure and utilization for the top ten diagnoses and procedures for the following:

Inpatient Hospital

Outpatient Hospital

Federal Qualified Health Centers

Rural Health Centers

Physician and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

Dental

Laboratory

Durable Medical Equipment and Supplies

Exhibits B5k and B5l show the top 10 prescription drug expenditures and the top ten prescription drugs by number of prescriptions filled, in total and pre and post implementation of Medicare Part D.

The following should be noted:

- Clients with no county designation are not included.
- The Department's decision support system (MMIS-DSS), extracts data on a different time span and from a different source (i.e., the MMIS) than the Colorado Financial Reporting System. This decision support system contains a full extract of all county level data in the MMIS.
- The Department administers the following Home and Community-Based Services waivers: Elderly, Blind and Disabled; Persons with Mental Illness; Persons Living with AIDS; Persons with Brain Injury; Children's; Children with Autism and Consumer Directed Care for the Elderly.
- The Department of Human Services administers the following Home and Community-Based Services waivers: Developmentally Disabled, Supported Living Services, Children's Extensive Support, and Children's Habilitation Residential Program.
- The inpatient diagnosis related groups (DRGs) were categorized to improve the interpretation and evaluation of services (tables B5a and B5b). Research and reasonableness were used to determine the DRG categories. The naming of DRG categories was completed through consultation of the ICD-10 (International Classification of Diseases). There is a group called Non-Specific Symptoms, Disorders or Procedures which was created to minimize the number of DRG categories. Since the DRG descriptions were sometimes referring to diseases and sometimes to procedures, the term 'Disorders or Procedures' was often included in the names of categories, or groups.
- The tables exhibit the top 10 client counts, top 10 service utilizations, and top 10 expenditures by types of commonly used medical services. It should be noted that sometimes the ranking of top client counts and service utilizations are the same, but the expenditures rankings differ.
- The outpatient diagnosis groupings are based on the first three digits of the ICD-9 codes.
- For the top ten prescription drug tables, the number of prescriptions filled was used instead of the number of prescriptions because it provides better insight on the frequency of pharmacy Medicaid payments. In addition, claims where the payment was zero were excluded from the analysis.
- The totals at the bottom of each of the top ten tables reflect the sum of unique client count/count of services/expenditures for the top ten groupings only. These sums should not be mistaken for the totals of clients, services and expenditures for a type of medical service.

B2a: FY 2009-10 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	20,811	48,136	36,925	5,978	28,633
Alamosa	2,694	2,562	2,524	353	1,589
Arapahoe	8,663	46,916	34,220	5,581	26,557
Archuleta	32	929	653	101	459
Baca	62	342	387	39	256
Bent	614	795	766	94	527
Boulder	8,793	13,797	11,268	1,865	8,502
Broomfield	689	2,192	1,802	230	1,200
Chaffee	*	969	860	106	548
Cheyenne	*	83	123	*	64
Clear Creek	144	466	410	59	207
Conejos	1,049	1,359	1,441	178	829
Costilla	567	444	551	52	313
Crowley	286	594	561	82	397
Custer	*	228	278	34	120
Delta	*	2,050	1,475	136	994
Denver	26,725	47,621	36,253	7,138	27,683
Dolores	94	132	111	20	85
Douglas	292	6,837	5,262	689	3,071
Eagle	254	2,653	1,550	455	1,067
Elbert	264	979	842	104	529
El Paso	23,821	48,821	41,954	5,831	31,284
Fremont	323	4,204	4,448	492	2,730
Garfield	1,680	4,159	3,209	678	2,531
Gilpin	186	217	216	23	127
Grand	*	678	497	77	243
Gunnison	*	777	510	79	363
Hinsdale	*	*	*	*	*
Huerfano	67	1,118	942	98	666
Jackson	*	87	82	*	44
Jefferson	5,477	29,903	23,544	3,337	15,690

B2a: FY 2009-10 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Kiowa	41	115	118	*	73
Kit Carson	174	580	675	89	451
Lake	*	937	685	106	514
La Plata	166	3,453	2,515	394	1,846
Larimer	7,432	19,715	15,927	2,177	10,776
Las Animas	80	2,027	1,896	243	1,390
Lincoln	403	428	457	54	271
Logan	927	1,784	1,893	231	1,264
Mesa	64	8,350	5,502	595	3,393
Mineral	*	*	*	*	*
Moffat	413	1,391	1,137	186	753
Montezuma	382	2,865	2,592	334	1,877
Montrose	161	2,664	1,729	192	1,119
Morgan	1,388	3,089	2,745	404	2,039
Otero	1,888	3,277	2,959	324	2,128
Ouray	*	114	77	14	38
Park	69	785	621	70	311
Phillips	112	372	305	47	223
Pitkin	89	198	130	45	102
Prowers	1,541	2,268	2,088	260	1,564
Pueblo	8,037	25,779	22,648	2,763	16,001
Rio Blanco	*	341	319	40	246
Rio Grande	1,646	1,833	1,844	230	1,167
Routt	42	964	662	123	375
Saguache	891	685	727	92	437
San Juan	*	*	*	*	*
San Miguel	82	208	113	*	43
Sedgwick	37	205	219	31	128
Summit	*	1,278	765	165	448
Teller	846	1,368	1,194	156	770
Washington	111	364	317	49	202

B2a: FY 2009-10 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Weld	13,532	24,816	20,600	3,133	14,326
Yuma	128	987	801	111	520
Suppressed Counties	163	111	78	68	52
STATEWIDE	**141,544**	**371,361**	**299,351**	**46,335**	**217,320**

Source: Medicaid Paid Claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific county only. Statewide totals represent an unduplicated client count for the entire state. Statewide totals are not a sum of the county as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple counties.
* Denotes county included in "suppressed county data" category

B2b: FY 2009-10 Expenditures for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$10,791,114	$32,148,739	$23,041,991	$43,642,449	$25,196,263
Alamosa	$1,680,188	$1,458,763	$1,528,486	$2,403,962	$1,002,250
Arapahoe	$3,801,585	$31,270,503	$23,263,284	$40,605,139	$23,153,404
Archuleta	$9,299	$415,043	$286,800	$505,521	$256,225
Baca	$18,574	$144,193	$420,437	$275,306	$221,124
Bent	$329,514	$378,297	$1,004,649	$596,734	$341,896
Boulder	$4,410,893	$9,178,530	$9,177,740	$11,027,037	$6,947,703
Chaffee	*	$670,730	$839,204	$704,072	$508,629
Cheyenne	*	$26,985	$78,255	*	$61,678
Clear Creek	$86,025	$369,907	$370,087	$495,921	$211,209
Conejos	$566,761	$732,245	$987,099	$1,602,982	$709,329
Costilla	$343,905	$228,921	$414,261	$347,593	$239,109
Crowley	$138,916	$316,723	$621,138	$521,064	$280,311
Custer	*	$147,659	$139,404	$237,184	$120,198
Delta	*	$764,746	$690,167	$974,706	$522,166
Denver	$13,391,308	$31,269,282	$26,154,249	$65,351,707	$25,293,469
Dolores	$51,412	$75,651	$76,830	$103,717	$65,354

B2b: FY 2009-10 Expenditures for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Douglas	$115,106	$5,169,106	$4,424,755	$4,903,548	$2,970,936
Eagle	$134,171	$1,429,880	$871,729	$2,664,494	$934,864
Elbert	$114,737	$658,794	$642,444	$583,096	$487,592
El Paso	$14,852,122	$33,024,698	$34,012,423	$35,607,481	$27,088,369
Fremont	$188,683	$2,578,436	$4,533,836	$2,987,447	$1,865,243
Garfield	$999,126	$2,146,520	$1,766,386	$3,639,934	$1,919,765
Gilpin	$99,410	$150,749	$189,502	$272,169	$118,625
Grand	*	$425,726	$249,550	$454,066	$290,205
Gunnison	*	$416,147	$266,036	$663,263	$379,820
Hinsdale	*	*	*	*	*
Huerfano	$52,551	$729,114	$1,163,063	$737,815	$605,514
Jackson	*	$47,767	$50,815		$44,117
Jefferson	$2,665,058	$22,326,268	$23,090,331	$24,342,978	$14,930,088
Kiowa	$16,066	$60,037	$142,994	*	$59,544
Kit Carson	$65,860	$298,090	$459,920	$579,538	$444,801
Lake	*	$532,604	$428,053	$705,567	$461,527
La Plata	$43,421	$2,154,839	$1,640,771	$2,015,085	$1,382,910
Larimer	$3,488,265	$13,285,621	$14,051,691	$13,224,543	$8,462,686
Las Animas	$54,136	$1,306,098	$1,707,067	$1,504,168	$966,498
Lincoln	$211,820	$294,870	$541,231	$361,842	$380,182
Logan	$541,372	$850,800	$1,570,978	$1,468,083	$986,781
Mesa	$24,687	$3,160,888	$1,897,543	$4,921,544	$2,496,930
Mineral	*	*	*	*	*
Moffat	$196,630	$866,807	$647,263	$918,297	$709,451
Montezuma	$138,230	$1,430,623	$1,862,068	$1,804,668	$1,356,477
Montrose	$55,163	$916,168	$757,923	$1,155,080	$669,576
Morgan	$724,472	$1,716,453	$1,959,173	$1,994,776	$1,691,148
Otero	$1,001,886	$1,755,638	$2,958,455	$2,162,257	$1,587,814

B2b: FY 2009-10 Expenditures for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Ouray	*	$47,528	$38,947	$100,802	$45,396
Park	$31,096	$487,039	$467,025	$359,515	$282,249
Phillips	$44,400	$122,479	$179,848	$206,059	$214,252
Pitkin	$48,444	$94,275	$78,524	$253,712	$102,371
Prowers	$762,732	$1,177,490	$1,432,193	$1,505,148	$1,240,330
Pueblo	$5,400,270	$16,940,430	$23,396,206	$16,946,907	$12,467,343
Rio Blanco	*	$218,875	$127,700	$334,818	$291,173
Rio Grande	$958,151	$958,375	$1,107,638	$1,303,014	$826,440
Routt	$16,683	$609,312	$368,305	$813,847	$416,181
Saguache	$593,408	$371,995	$442,658	$806,168	$320,486
San Juan	*	*	*	*	*
San Miguel	$33,821	$103,630	$80,507		$50,429
Sedgwick	$13,309	$107,698	$247,735	*	$125,710
Summit	*	$782,257	$453,190	$854,129	$318,017
Teller	$438,084	$795,644	$1,056,753	$758,494	$591,601
Washington	$47,237	$189,142	$207,807	$366,789	$259,601
Weld	$7,472,599	$16,041,736	$14,833,807	$20,908,324	$11,795,130
Yuma	$48,745	$430,549	$630,097	$926,102	$713,750
Broomfield	$339,473	$1,676,305	$1,332,231	$1,458,194	$1,075,505
Suppressed Counties	$54,714	$63,026	$61,701	$391,619	$96,275
STATEWIDE	**$77,705,632**	**$248,547,443**	**$237,522,952**	**$327,360,474**	**$189,654,018**

Source: Medicaid Paid Claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific county only. Statewide totals represent an unduplicated client count for the entire state. Statewide totals are not a sum of the county as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple counties.

* Denotes county included in "suppressed county data" category

B2c: FY 2009-10 Average Cost per Full Time Equivalent Client for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$519	$668	$624	$7,301	$880
Alamosa	$624	$569	$606	$6,810	$631
Arapahoe	$439	$667	$680	$7,276	$872
Archuleta	$291	$447	$439	$5,005	$558
Baca	$300	$422	$1,086	$7,059	$864
Bent	$537	$476	$1,312	$6,348	$649
Boulder	$502	$665	$814	$5,913	$817
Broomfield	$493	$765	$739	$6,340	$896
Chaffee	$507	$692	$976	$6,642	$928
Cheyenne	$288	$325	$636	$4,717	$964
Clear Creek	$597	$794	$903	$8,405	$1,020
Conejos	$540	$539	$685	$9,006	$856
Costilla	$607	$516	$752	$6,684	$764
Crowley	$486	$533	$1,107	$6,354	$706
Custer	$453	$648	$501	$6,976	$1,002
Delta	$369	$373	$468	$7,167	$525
Denver	$501	$657	$721	$9,155	$914
Dolores	$547	$573	$692	$5,186	$769
Douglas	$394	$756	$841	$7,117	$967
Eagle	$528	$539	$562	$5,856	$876
Elbert	$435	$673	$763	$5,607	$922
El Paso	$623	$676	$811	$6,107	$866
Fremont	$584	$613	$1,019	$6,072	$683
Garfield	$595	$516	$550	$5,369	$759
Gilpin	$534	$695	$877	$11,833	$934
Grand	$485	$628	$502	$5,897	$1,194
Gunnison	$297	$536	$522	$8,396	$1,046
Hinsdale	$142	$373	$654	$1,487	$5,639

B2c: FY 2009-10 Average Cost per Full Time Equivalent Client for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Huerfano	$784	$652	$1,235	$7,529	$909
Jackson	$373	$549	$620	$8,896	$1,003
Jefferson	$487	$747	$981	$7,295	$952
Kiowa	$392	$522	$1,212	$4,467	$816
Kit Carson	$379	$514	$681	$6,512	$986
Lake	$325	$568	$625	$6,656	$898
La Plata	$262	$624	$652	$5,114	$749
Larimer	$469	$674	$882	$6,075	$785
Las Animas	$677	$644	$900	$6,190	$695
Lincoln	$526	$689	$1,184	$6,701	$1,403
Logan	$584	$477	$830	$6,355	$781
Mesa	$386	$379	$345	$8,272	$736
Mineral	$355	$810	$1,124	$2,345	$614
Moffat	$476	$623	$569	$4,937	$942
Montezuma	$362	$499	$718	$5,403	$723
Montrose	$343	$344	$438	$6,016	$598
Morgan	$522	$556	$714	$4,938	$829
Otero	$531	$536	$1,000	$6,674	$746
Ouray	$69	$417	$506	$7,200	$1,195
Park	$451	$620	$752	$5,136	$908
Phillips	$396	$329	$590	$4,384	$961
Pitkin	$544	$476	$604	$5,638	$1,004
Prowers	$495	$519	$686	$5,789	$793
Pueblo	$672	$657	$1,033	$6,134	$779
Rio Blanco	$291	$642	$400	$8,370	$1,184
Rio Grande	$582	$523	$601	$5,665	$708
Routt	$397	$632	$556	$6,617	$1,110
Saguache	$666	$543	$609	$8,763	$733

B2c: FY 2009-10 Average Cost per Full Time Equivalent Client for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
San Juan	$0	$388	$405	$4,576	$3,380
San Miguel	$412	$498	$712	$6,840	$1,173
Sedgwick	$360	$525	$1,131	$9,786	$982
Summit	$420	$612	$592	$5,177	$710
Teller	$518	$582	$885	$4,862	$768
Washington	$426	$520	$656	$7,485	$1,285
Weld	$552	$646	$720	$6,674	$823
Yuma	$381	$436	$787	$8,343	$1,373
STATEWIDE	**$549**	**$669**	**$793**	**$7,072**	**$873**

B3a: FY 2009-10 Unduplicated Client Count					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Classes I and II)**
Adams	1,476	740	315	872	1,236
Alamosa	308	61	0	139	118
Arapahoe	2,062	1,025	342	990	1,073
Archuleta	80	*	0	*	47
Baca	77	*	0	*	73
Bent	89	*	0	*	55
Boulder	1,032	487	*	526	665
Broomfield	166	59	0	72	132
Chaffee	117	46	0	49	75
Cheyenne	*	*	0	0	*
Clear Creek	53	*	0	*	*
Conejos	174	*	0	74	*
Costilla	140	*	0	60	*
Crowley	77	*	0	*	31
Custer	*	0	0	*	0
Delta	293	58	93	123	136
Denver	3,722	694	573	1,387	1,747
Dolores	*	*	0	*	0
Douglas	396	164	*	177	188
Eagle	*	*	0	32	*
Elbert	41	*	0	*	*
El Paso	2,116	890	94	1,473	1,347
Fremont	550	112	*	169	390
Garfield	214	103	0	33	175
Gilpin	*	*	0	*	0
Grand	43	*	0	*	*
Gunnison	62	0	0	34	40

B3a: FY 2009-10 Unduplicated Client Count					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Classes I and II)**
Hinsdale	*	0	0	0	0
Huerfano	125	36	0	33	106
Jackson	*	0	0	*	*
Jefferson	2,007	1,033	454	934	1,552
Kiowa	*	0	0	*	*
Kit Carson	44	*	0	*	*
Lake	*	*	0	*	*
La Plata	290	62	0	96	114
Larimer	1,173	490	0	586	807
Las Animas	388	69	0	39	109
Lincoln	66	*	0	*	36
Logan	200	87	0	32	102
Mesa	1,416	398	0	273	448
Mineral	*	*	0	*	*
Moffat	76	34	0	*	47
Montezuma	323	39	0	91	162
Montrose	340	122	111	106	182
Morgan	241	53	*	94	226
Otero	330	93	0	135	185
Ouray	*	*	0	*	*
Park	*	*	0	*	0
Phillips	48	0	0	*	43
Pitkin	*	0	0	*	*
Prowers	147	48	0	47	84
Pueblo	1,768	587	*	1,150	801
Rio Blanco	43	*	0	*	37
Rio Grande	184	0	0	85	133

B3a: FY 2009-10 Unduplicated Client Count					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Classes I and II)**
Routt	30	33	0	*	45
Saguache	106	*	0	55	*
San Juan	*	0	0	0	0
San Miguel	*	*	0	*	*
Sedgwick	33	*	0	*	*
Summit	*	*	0	*	*
Teller	82	*	0	39	34
Washington	30	*	0	*	*
Weld	1,041	376	0	715	554
Yuma	126	*	0	*	89
Suppressed Counties	3,804	2,491	659	3,447	197
TOTAL	**27,749**	**10,490**	**2,641**	**14,167**	**13,424**

Source: Medicaid Paid Claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific county only. Statewide totals represent an unduplicated client count for the entire state. Statewide totals are not a sum of the counties as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple counties.

* Denotes county included in "suppressed county data" category

B3b: FY 2009-10 Total Expenditures					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Classes I and II)**
Adams	$13,039,321	$28,265,036	$11,441,684	$13,957,528	$46,907,916
Alamosa	$1,728,171	$2,884,622	$0	$448,603	$3,948,709
Arapahoe	$22,849,726	$39,807,852	$11,719,238	$15,585,297	$39,026,662
Archuleta	$804,159	*	$0	*	$1,451,545
Baca	$222,725	*	$0	*	$2,830,144
Bent	$271,310	*	$0	*	$1,898,480
Boulder	$8,527,167	$20,321,661	*	$6,382,498	$23,667,228
Broomfield	$1,549,630	$2,525,145	$0	$1,341,337	$4,079,267

B3b: FY 2009-10 Total Expenditures					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Classes I and II)**
Chaffee	$572,254	$1,505,341	$0	$434,461	$2,284,403
Cheyenne	*	*	$0	$0	*
Clear Creek	$213,094	*	$0	*	*
Conejos	$1,529,236	*	$0	$257,318	*
Costilla	$922,279	*	$0	$209,967	*
Crowley	$287,623	*	$0	*	$1,124,860
Custer	*	$0	$0	*	$0
Delta	$2,251,668	$1,918,349	$2,776,271	$1,025,822	$4,729,274
Denver	$45,765,793	$22,248,433	$20,286,870	$18,381,649	$73,626,365
Dolores	*	*	$0	*	$0
Douglas	$3,974,374	$4,535,529	*	$3,648,077	$7,172,419
Eagle	*	*	$0	$49,254	*
Elbert	$437,471	*	$0	*	*
El Paso	$21,991,500	$31,171,255	$2,901,244	$35,694,445	$50,978,416
Fremont	$4,631,079	$4,955,470	*	$1,858,673	$13,243,732
Garfield	$1,335,912	$4,774,856	$0	$150,761	$8,001,111
Gilpin	*	*	$0	*	$0
Grand	$344,363	*	$0	*	*
Gunnison	$390,963	$0	$0	$78,977	$1,951,365
Hinsdale	*	$0	$0	$0	$0
Huerfano	$1,425,414	$1,140,723	$0	$83,393	$3,652,517
Jackson	*		$0	*	*
Jefferson	$21,066,300	$45,792,958	$16,019,160	$16,870,741	$60,124,156
Kiowa	*	$0	$0	*	*
Kit Carson	$379,572	*	$0	*	*
Lake	*	*	$0	*	*
La Plata	$2,461,774	$2,237,367	$0	$937,945	$3,430,640

B3b: FY 2009-10 Total Expenditures					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Classes I and II)**
Larimer	$7,779,218	$20,959,110	$0	$6,462,757	$27,532,450
Las Animas	$5,556,211	$2,209,942	$0	$155,187	$4,936,708
Lincoln	$526,279	*	$0	*	$1,686,988
Logan	$1,458,205	$3,980,356	$0	$477,686	$2,887,924
Mesa	$16,493,862	$27,289,641	$0	$2,583,895	$14,461,316
Mineral	*	*	$0	*	*
Moffat	$417,490	$1,547,449	$0	*	$1,542,976
Montezuma	$3,196,555	$1,083,641	$0	$1,356,958	$4,991,625
Montrose	$1,734,658	$4,670,319	$3,237,754	$1,311,083	$6,635,328
Morgan	$1,267,763	$1,732,141	*	$307,497	$7,614,214
Otero	$1,387,898	$4,330,873	$0	$1,834,384	$5,712,207
Ouray	*	*	$0	*	*
Park	*	*	$0	*	$0
Phillips	$280,030	$0	$0	*	$1,401,300
Pitkin	*	$0	$0	*	*
Prowers	$718,386	$1,793,351	$0	$151,655	$3,222,818
Pueblo	$14,910,154	$33,113,975	*	$16,326,096	$26,182,463
Rio Blanco	$189,334	*	$0	*	$1,773,697
Rio Grande	$979,970	$0	$0	$233,154	$4,331,503
Routt	$82,034	$1,451,570	$0	*	$2,340,128
Saguache	$488,227	*	$0	$122,294	*
San Juan	*	$0	$0	$0	$0
San Miguel	*	*	$0	*	*
Sedgwick	$242,213	*	$0	*	*
Summit	*	*	$0	*	*
Teller	$612,886	*	$0	$640,998	$1,184,758
Washington	$137,365	*	$0	*	*

B3b: FY 2009-10 Total Expenditures					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Classes I and II)**
Weld	$8,904,685	$14,492,412	$0	$7,856,038	$18,623,041
Yuma	$720,861	*	$0	*	$2,711,670
Suppressed Counties	$1,630,185	$6,557,702	$370,837	$1,829,800	$5,469,709
TOTAL	**$228,687,348**	**$339,297,080**	**$68,753,056**	**$159,046,227**	**$499,372,030**

Source: Medicaid Paid Claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to one and one-half months after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category in that specific county only. Statewide totals represent an unduplicated client count for the entire state. Statewide totals are not a sum of the counties as a specific client may receive a service in one or multiple service categories, or may have received the same service in the same service category in one or multiple counties.
* Denotes county included in "suppressed county data" category

B3c: FY 2009-10 Expenditures per Client					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Classes I and II)**
Adams	$8,834	$38,196	$36,323	$16,006	$37,951
Alamosa	$5,611	$47,289	$0	$3,227	$33,464
Arapahoe	$11,081	$38,837	$34,267	$15,743	$36,372
Archuleta	$10,052	$12,815	$0	$8,190	$30,884
Baca	$2,893	$8,807	$0	$46,677	$38,769
Bent	$3,048	$53,491	$0	$5,155	$34,518
Boulder	$8,263	$41,728	$22,514	$12,134	$35,590
Broomfield	$9,335	$42,799	$0	$18,630	$30,904
Chaffee	$4,891	$32,725	$0	$8,867	$30,459
Cheyenne	$3,476	$7,056	$0	$0	$34,031
Clear Creek	$4,021	$14,064	$0	$5,662	$1,263
Conejos	$8,789	$11,954	$0	$3,477	$24,226
Costilla	$6,588	$30,517	$0	$3,499	$10,809
Crowley	$3,735	$8,559	$0	$7,088	$36,286
Custer	$9,507	$0	$0	$3,010	$0
Delta	$7,685	$33,075	$29,852	$8,340	$34,774

B3c: FY 2009-10 Expenditures per Client					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Classes I and II)**
Denver	$12,296	$32,058	$35,405	$13,253	$42,144
Dolores	$23,728	$889	$0	$5,609	$0
Douglas	$10,036	$27,656	$10,697	$20,611	$38,151
Eagle	$6,496	$24,701	$0	$1,539	$19,615
Elbert	$10,670	$7,753	$0	$12,962	$33,066
El Paso	$10,393	$35,024	$30,864	$24,232	$37,846
Fremont	$8,420	$44,245	$31,926	$10,998	$33,958
Garfield	$6,243	$46,358	$0	$4,569	$45,721
Gilpin	$6,432	$10,903	$0	$13,738	$0
Grand	$8,008	$4,608	$0	$6,920	$11,245
Gunnison	$6,306	$28,229	$0	$2,323	$48,784
Hinsdale	$370	$0	$0	$0	$0
Huerfano	$11,403	$31,687	$0	$2,527	$34,458
Jackson	$1,123	$0	$0	$1,780	$1,921
Jefferson	$10,496	$44,330	$35,284	$18,063	$38,740
Kiowa	$4,987	$0	$0	$2,992	$26,642
Kit Carson	$8,627	$41,681	$0	$1,385	$32,948
Lake	$1,780	$5,822	$0	$3,180	$44,838
La Plata	$8,489	$36,087	$0	$9,770	$30,093
Larimer	$6,632	$42,774	$0	$11,029	$34,117
Las Animas	$14,320	$32,028	$0	$3,979	$45,291
Lincoln	$7,974	$28,247	$0	$17,561	$46,861
Logan	$7,291	$45,751	$0	$14,928	$28,313
Mesa	$11,648	$68,567	$0	$9,465	$32,280
Mineral	$5,552	$485	$0	$285	$4,626
Moffat	$5,493	$45,513	$0	$6,269	$32,829
Montezuma	$9,896	$27,786	$0	$14,912	$30,812

B3c: FY 2009-10 Expenditures per Client					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Classes I and II)**
Montrose	$5,102	$38,281	$29,169	$12,369	$36,458
Morgan	$5,260	$32,682	$5,863	$3,271	$33,691
Otero	$4,206	$46,569	$0	$13,588	$30,877
Ouray	$4,149	$7,161	$0	$21,640	$17,581
Park	$3,997	$50,167	$0	$24,408	$0
Phillips	$5,834	$7,708	$0	$26,372	$32,588
Pitkin	$21,840	$0	$0	$2,485	$5,182
Prowers	$4,887	$37,361	$0	$3,227	$38,367
Pueblo	$8,433	$56,412	$9,287	$14,197	$32,687
Rio Blanco	$4,403	$9,671	$0	$1,612	$47,938
Rio Grande	$5,326	$47,602	$0	$2,743	$32,568
Routt	$2,734	$43,987	$0	$653	$52,003
Saguache	$4,606	$57,777	$0	$2,224	$16,822
San Juan	$3,783	$0	$0	$0	$0
San Miguel	$7,206	$28,221	$0	$37,284	$574
Sedgwick	$7,340	$56,421	$0	$5,832	$24,649
Summit	$8,156	$27,548	$0	$1,839	$23,906
Teller	$7,474	$14,424	$0	$16,436	$34,846
Washington	$4,579	$42,724	$0	$2,965	$30,783
Weld	$8,554	$38,544	$0	$10,987	$33,616
Yuma	$5,721	$20,341	$0	$2,680	$30,468
AVERAGE	**$7,289**	**$31,012**	**$25,954**	**$9,957**	**$30,710**

B3d: HCBS Waiver Programs Administered by the Department of Health Care Policy and Financing (HCPF)								
Fiscal Year	Elderly Blind and Disabled; and Consumer Directed Care for the Elderly*	Children's Home and Community-Based Services	Persons with Brain Injury	Persons with Mental Illness	Persons Living with AIDS	Children with Autism	Pediatric Hospice	Total HCPF
FY 2004-05	14,833	618	322	1,844	66	0	0	**17,407**
FY 2005-06	16,415	1,049	297	1,948	58	0	0	**19,534**
FY 2006-07	17,019	1,254	306	2,160	62	17	0	**20,553**
FY 2007-08	17,627	1,360	264	2,312	71	73	0	**21,522**
FY 2008-09	18,618	1,334	264	2,489	71	89	42	**22,756**
FY 2009-10	19,848	1,314	253	2,641	67	113	84	**24,163**

*The Consumer Directed Care for the Elderly waiver ended in December 2007, coinciding with the implementation of the Consumer Directed Attendant Support Services benefit in the Elderly, Blind and Disabled waiver. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B3e: HCBS Waiver Programs Administered by Department of Human Services (DHS)					
Fiscal Year	Children's Habilitation Residential Program	Supported Living Services	Developmentally Disabled	Children's Extensive Support	Total DHS
FY 2004-05	204	2,935	3,688	220	**6,927**
FY 2005-06	191	3,092	3,690	375	**7,212**
FY 2006-07	165	2,982	4,112	381	**7,521**
FY 2007-08	149	3,057	4,207	430	**7,692**
FY 2008-09	156	3,285	4,379	423	**8,053**
FY 2009-10	165	3,270	4,482	431	**8,223**

Unduplicated client counts represent the number of unique clients who received a service in each category only.

B3f: Long-Term Care Programs Administered by Department of Health Care Policy and Financing					
Fiscal Year	Home Health	Program for All-Inclusive Care for the Elderly	Class I Nursing Facilities	Class II Nursing Facilities	Total Nursing Facilities (Classes I and II)
FY 2004-05	8,687	1,187	13,919	17	13,936
FY 2005-06	9,430	1,271	14,287	20	14,299
FY 2006-07	10,161	1,376	14,045	21	14,066
FY 2007-08	10,272	1,501	13,886	21	13,907
FY 2008-09	10,902	1,794	13,614	22	13,636
FY 2009-10	10,982	2,013	13,583	38	13,621

Source: Medicaid paid claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months (FY 2003-06) one and one-half months (FY 2006-07) after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Totals are not the sum of categories.

B4a: FY 2009-10 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County of Residence on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Adams	3,639	$25,876,227	$7,111
Alamosa	172	$1,210,164	$7,036
Arapahoe	3,276	$23,563,129	$7,193
Archuleta	68	$412,020	$6,059
Baca	*	*	$8,361
Bent	40	$388,807	$9,720
Boulder	1,032	$7,101,203	$6,881
Broomfield	122	$855,219	$7,010
Chaffee	58	$433,840	$7,480
Cheyenne	*	*	$6,240
Clear Creek	*	*	$9,352
Conejos	82	$672,443	$8,201
Costilla	*	*	$7,755
Crowley	*	*	$7,702
Custer	*	*	$7,105
Delta	66	$300,657	$4,555
Denver	4,062	$29,420,323	$7,243
Dolores	*	*	$8,411
Douglas	365	$2,705,730	$7,413
Eagle	366	$1,981,463	$5,414
El Paso	3,065	$23,824,632	$7,773
Elbert	48	$351,959	$7,332
Fremont	226	$1,730,188	$7,656
Garfield	448	$2,639,766	$5,892
Gilpin	*	*	$6,720
Grand	46	$299,048	$6,501
Gunnison	55	$306,967	$5,581

B4a: FY 2009-10 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County of Residence on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Hinsdale	*	*	$5,624
Huerfano	39	$404,259	$10,366
Jackson	*	*	$3,772
Jefferson	1,707	$12,836,333	$7,520
Kiowa	*	*	$6,991
Kit Carson	58	$495,272	$8,539
La Plata	250	$1,504,879	$6,020
Lake	57	$343,567	$6,027
Larimer	1,230	$8,728,514	$7,096
Las Animas	111	$776,447	$6,995
Lincoln	30	$239,407	$7,980
Logan	120	$1,126,760	$9,390
Mesa	575	$2,120,926	$3,689
Mineral	*	*	$5,278
Moffat	111	$745,537	$6,717
Montezuma	186	$1,298,193	$6,980
Montrose	122	$629,366	$5,159
Morgan	252	$1,699,284	$6,743
Otero	137	$1,131,083	$8,256
Ouray	*	*	$3,720
Park	32	$211,640	$6,614
Phillips	*	*	$6,971
Pitkin	36	$169,856	$4,718
Prowers	125	$1,107,549	$8,860
Pueblo	1,293	$10,397,278	$8,041
Rio Blanco	*	*	$6,889
Rio Grande	130	$1,015,993	$7,815
Routt	76	$510,048	$6,711

B4a: FY 2009-10 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County of Residence on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Saguache	43	$332,652	$7,736
San Juan	*	*	$4,638
San Miguel	*	*	$2,959
Sedgwick	*	*	$8,108
Summit	111	$594,251	$5,354
Teller	81	$627,926	$7,752
Washington	*	*	$6,957
Weld	1,620	$12,214,881	$7,540
Yuma	65	$429,171	$6,603
Suppressed Counties	268	$1,905,300	$7,109
Total Colorado Medicaid	**26,101**	**$187,670,157**	**$7,190**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B4b: FY 2009-10 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Type			
Delivery Type	**Unique Deliveries**	**Total Payments**	**Average Payment**
Caesarian	5,738	$60,157,826	$10,484
Vaginal	19,244	$124,334,851	$6,461
Unknown	1,119	$3,177,481	$2,840
Total	**26,101**	**$187,670,157**	**$7,190**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Deliveries not classified (unknown) were identified via antepartum/stand-alone claims; delivery method could not be ascertained with this data.

B4c: FY 2009-10 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's Age on Delivery Date			
Age Group	**Unique Deliveries**	**Total Payments**	**Average Payment**
<=14	52	$386,433	$7,431
15-19	4,357	$30,802,580	$7,070
20	1,953	$14,432,415	$7,390
21-24	6,987	$50,775,217	$7,267
25-34	10,523	$74,135,233	$7,045
35+	2,229	$17,138,279	$7,689
Total	**26,101**	**$187,670,157**	**$7,190**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Age groups below selected so Medicaid data may be used in conjunction with the CDC's PRAMS survey data. Age 20 separate so total EPSDT children may be obtained. Age 20 may also be added to 21-24 age group to match PRAMS age groups.

B4d: FY 2009-10 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit Claims by Severity of Condition and Needy Newborn Status							
	Most Severe Classification*	**Unique Clients**	**Unique Clients: Not Needy Newborn**	**Unique Clients: Needy Newborn**	**Total LBW / Preterm / NICU Payments**	**Payments: Not Needy Newborn**	**Payments: Needy Newborn**
Low Birthweight Infants							
	Extremely Low BW (<1000 grams)	336	148	188	$10,263,472	$2,312,970	$7,950,502
	Very Low BW (1000 - 1499 grams)	297	77	220	$5,492,625	$469,093	$5,023,531
	Low BW (1500-2499 grams)	2,492	620	1,872	$9,560,437	$1,390,318	$8,170,119
	All LBW Clients	3,125	845	2,280	$25,316,534	$4,172,381	$21,144,153
Preterm Infants Not Classified as Low Birthweight							
	Very Preterm (<32 weeks gestation)	385	164	221	$3,638,506	$731,938	$2,906,568
	Moderately Preterm (32 to 36 weeks gestation)	560	126	434	$1,625,412	$511,356	$1,114,056
	All Preterm Infants not identified via LBW	945	290	655	$5,263,918	$1,243,294	$4,020,625
Infants Treated in the NICU Not Due to LBW or Preterm							
	NICU - Other	999	88	911	$2,921,536	$243,669	$2,677,867
	Total	**5,069**	**1,223**	**3,846**	**$33,501,988**	**$5,659,344**	**$27,842,644**

* Individuals assigned to classifications according to the most severe diagnosis code associated with his or her claims during the fiscal year.
Source: Medicaid paid claims from MMIS-DSS. Notes: Data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent clients who received a service in each category only. Needy Newborns are infants born to mothers who had Medicaid eligibility at the time of the infant's birth. Needy Newborns are identified via Program Aid Code H2.

B4e: FY 2009-10 Clients and Costs Associated with Neonatal Intensive Care Unit Claims		
DRG Description	**Unique Clients with DRG***	**NICU Payments**
Neonates, Died Or Transferred To Another Facility	36	$102,618
Full Term Neonate With Major Problems	574	$2,394,254
Neonate With Other Significant Problems	1,086	$2,356,489
Neonates < 1,000 grams	93	$6,778,127
Neonates 1,000 - 1,499 grams	143	$3,909,598
Neonates 1500 - 1,999 grams	348	$4,100,297
Neonates > 2,000 grams With RDS	174	$2,093,048
Neonates > 2,000 grams, Premature with Major Problems	228	$1,452,520
Neonates Low Birthweight Diagnosis, Over 28 Days	NR	$256,346
Total NICU Payments		**$23,443,297**

B5a: FY 2009-10 Top 10 Major Diagnostic Categories (Inpatient) Ranked by Expenditures					
Rank	**MDC**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	14	Pregnancy, childbirth and the puerperium	$93,970,997	24,102	$3,899
2	4	Respiratory system	$37,691,374	5,831	$6,464
3	15	Conditions of newborns	$24,825,466	3,331	$7,453
4		Pre-MDC Other	$24,771,769	281	$88,156
5	5	Circulatory system	$19,754,671	1,566	$12,615
6	6	Digestive system	$18,780,181	2,676	$7,018
7	8	Musculoskeletal system and connective tissue	$17,603,873	1,779	$9,895
8	1	Nervous System	$16,352,032	1,725	$9,479
9	11	Kidney and urinary tract	$11,912,609	1,146	$10,395
10	18	Infectious & parasitic diseases	$9,937,802	1,090	$9,117
		Top Ten Totals	**$275,600,773**	**43,527**	**$6,332**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5b: FY 2009-10 Top 10 Inpatient Hospital Diagnosis Related Groups Ranked by Expenditures					
Rank	**DRG**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	373	Vaginal Delivery without Complicating Diagnoses	$40,294,300	14,517	$2,776
2	371	Cesarean Section without Complicating Diagnoses	$16,850,351	3,131	$5,382
3	370	Cesarean Section with Complicating Diagnoses	$16,114,114	2,280	$7,068
4	541	Tracheotomy with Mechanical Ventilator with Major Operating Room Procedure	$13,703,916	141	$97,191
5	372	Vaginal Delivery with Complicating Diagnoses	$11,092,672	2,902	$3,822
6	801	Neonates < 1,000 Grams	$7,275,810	100	$72,758
7	898	Bronchitis and Asthma, Age < 17 with Complicating Diagnoses	$7,042,993	1,978	$3,561
8	565	Respiratory System Diagnosis with Ventilator Support 96+ Hours	$6,052,661	165	$36,683
9	317	Admit for Renal Dialysis	$4,838,037	42	$115,191
10	542	Tracheotomy with Mechanical Ventilator without Major Operating Room Procedure	$4,582,576	87	$52,673
		Top Ten Totals	**$127,847,430**	**25,343**	**$5,045**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5c: FY 2009-10 Top 10 Outpatient Hospital Principal Diagnosis Categories Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	789	Other Symptoms Involving Abdomen and Pelvis	$10,108,720	14,905	$678
2	521	Diseases of Hard Tissues of Teeth	$7,470,655	4,195	$1,781
3	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$6,288,800	14,650	$429
4	780	General Symptoms	$5,546,091	16,658	$333
5	585	Chronic Renal Failure	$3,904,464	320	$12,201
6	V58	Other and Unspecified Aftercare	$3,626,751	2,533	$1,432
7	784	Symptoms Involving Head and Neck	$3,172,092	6,890	$460
8	787	Symptoms Involving Digestive System	$3,056,780	11,275	$271
9	493	Asthma	$2,995,888	6,281	$477
10	474	Chronic Disease of Tonsils and Adenoids	$2,746,493	2,336	$1,176
		Top Ten Totals	**$48,916,734**	**80,043**	**$611**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5d: FY 2009-10 Top 10 Outpatient Surgical Procedures Ranked by Expenditures					
Rank	**Surgical Procedure Code**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	23.41	Application of crown	$2,042,077	856	$2,386
2	28.3	Tonsillectomy with adenoidectomy	$1,195,797	509	$2,349
3	96.54	Dental scaling, polishing, and debridement	$932,838	353	$2,643
4	23.09	Extraction of other tooth	$932,058	364	$2,561
5	89.17	Polysomnogram	$857,594	531	$1,615
6	93.54	Application of splint	$604,286	1,905	$317
7	66.29	Other bilateral endoscopic destruction or occlusion of fallopian tubes	$595,332	390	$1,526
8	20.01	Myringotomy with insertion of tube	$575,517	355	$1,621
9	37.23	Combined right and left heart cardiac catheterization	$564,549	54	$10,455
10	23.70	Root canal, not otherwise specified	$459,956	195	$2,359
		Top Ten Totals	**$8,760,004**	**5,512**	**$1,589**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5e: FY 2009-10 Top 10 Federally Qualified Health Center (FQHC) Principal Diagnosis Categories Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	V20	Health Supervision of Infant or Child	$14,670,670	56,060	$262
2	V72	Special Investigations and Examinations	$9,950,205	31,628	$315
3	V22	Normal Pregnancy	$6,290,279	7,519	$837
4	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$3,444,119	17,156	$201
5	V04	Need For Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	$1,528,348	10,794	$142
6	382	Suppurative and Unspecified Otitis Media	$1,469,635	7,002	$210
7	V25	Encounter For Contraceptive Management	$1,168,038	4,161	$281
8	V70	General Medical Examination	$1,112,537	5,560	$200
9	V05	Need For Other Prophylactic Vaccination and Inoculation Against Single Diseases	$1,053,070	6,204	$170
10	250	Diabetes Mellitus	$1,015,512	2,730	$372
		Top Ten Totals	**$41,702,414**	**148,814**	**$280**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5f: FY 2009-10 FY 08-09 Top 10 Rural Health Center (RHC) Principal Diagnosis Categories Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	V20	Health Supervision of Infant or Child	$834,205	4,804	$174
2	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$391,357	2,461	$159
3	382	Suppurative and Unspecified Otitis Media	$350,094	1,893	$185
4	V22	Normal Pregnancy	$296,168	508	$583
5	V72	Special Investigations and Examinations	$215,404	695	$310
6	462	Acute Pharyngitis	$169,912	1,369	$124
7	V04	Need For Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	$169,622	1,051	$161
8	780	General Symptoms	$159,212	1,212	$131
9	724	Other and Unspecified Disorders of Back	$151,691	758	$200
10	789	Other Symptoms Involving Abdomen and Pelvis	$139,674	903	$155
		Top Ten Totals	**$2,877,338**	**15,654**	**$184**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5g: FY 2009-10 Top 10 Physician and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program Principal Diagnosis Categories, Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	V20	Health Supervision of Infant or Child	$16,393,716	99,546	$165
2	650	Normal Delivery	$8,838,006	12,416	$712
3	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$5,825,499	52,184	$112
4	315	Specific Delays in Development	$5,736,534	4,392	$1,306
5	V25	Encounter For Contraceptive Management	$5,680,834	19,155	$297
6	367	Disorders of Refraction and Accommodation	$5,661,647	44,573	$127
7	789	Other Symptoms Involving Abdomen and Pelvis	$5,639,614	32,405	$174
8	780	General Symptoms	$5,624,680	44,746	$126
9	783	Symptoms Concerning Nutrition, Metabolism, and Development	$3,879,891	9,261	$419
10	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$3,842,073	47,538	$81
		Top Ten Totals	**$67,122,495**	**366,216**	**$183**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5h: FY 2009-10 Top 10 Dental Procedures Ranked by Expenditures					
Rank	**Procedure Code**	**Procedure Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	D8090	Comprehensive Ortho Adult Dentition	$7,722,226	2,551	$3,027
2	D2930	Prefabricated Stainless Steel Crown Primary	$6,247,307	20,465	$305
3	D1120	Prophylaxis Child	$4,690,436	122,276	$38
4	D2391	Resin Based Comp One Surface Posterior	$3,968,388	29,585	$134
5	D1330	Oral Hygiene Instructions	$3,865,352	127,704	$30
6	D7140	Extraction Erupted Tooth/Exposed Root	$3,555,410	25,420	$140
7	D2392	Resin Based Comp Two Surfaces Posterior	$3,101,275	21,306	$146
8	D2150	Amalgam Two Surfaces Permanent	$2,966,551	20,544	$144
9	D0120	Periodic oral evaluation	$2,739,248	98,773	$28
10	D2140	Amalgam One Surface Permanent	$2,524,939	21,597	$117
		Top Ten Totals	**$41,381,133**	**490,221**	**$84**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5i: FY 2009-10 Top 10 Laboratory Procedures Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	87491	Chlamydia Tracholmatis, DNA, Amplified Probe Technique	$2,041,064	34,651	$59
2	87591	Neisseria Gonorrhea, DNA, Amplified Probe Technique	$2,016,656	34,395	$59
3	80101	Drug screen, single	$1,950,204	9,459	$206
4	85025	Complete Blood Count with Automated White Blood Cells Differentials	$1,306,377	76,480	$17
5	80053	Comprehensive etabolic panel	$1,066,560	48,479	$22
6	84443	Thyroid Stimulus Hormone	$972,431	35,638	$27
7	87086	Urine culture/colony count	$638,295	42,885	$15
8	80050	General health panel	$616,510	12,713	$48
9	88305	Tissue exam by pathologist	$581,308	9,323	$62
10	80061	Lipid Panel	$569,851	26,953	$21
		Top Ten Totals	**$11,759,256**	**330,976**	**$36**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5j: FY 2009-10 Top 10 Durable Medical Equipment and Supplies Procedures Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	E1390	Oxygen concentrator	$10,607,990	11,503	$922
2	S8121	O2 contents liquid lb	$8,388,946	5,538	$1,515
3	B5160	Enteral Formula for Pediatrics, Calorie Dense	$4,138,071	1,380	$2,999
4	T4527	Adult Large Sized Disposable Incontinence Product	$1,976,750	2,843	$695
5	B5161	EF pediatric hydrolyzed/amino acid	$1,859,552	402	$4,626
6	A4253	Blood glucose/reagent strips	$1,768,833	6,556	$270
7	B5035	Enteral feed supp pump per day	$1,756,935	982	$1,789
8	E0434	Portable Liquid Oxygen	$1,635,839	4,512	$363
9	T4526	Adult Medium Sized Disposable Incontinence Product	$1,485,171	2,914	$510
10	T4535	Disposable liner/shield/pad	$1,435,725	4,591	$313
		Top Ten Totals	**$35,053,812**	**41,221**	**$850**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.

B5k: FY 2009-10 Top 10 Prescription Drugs Ranked by Expenditures					
Rank	**Drug Name**	**Therapeutic Class**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	Abilify	Antipsychotic	$13,818,245	4,946	$2,794
2	Seroquel	Antipsychotic	$12,170,941	5,207	$2,337
3	Zyprexa	Antipsychotic	$7,689,477	1,905	$4,036
4	Synagis	Monoclonal Antibody (prevention/treatment of respiratory virus in infants)	$5,895,133	616	$9,570
5	Prevacid	Proton-Pump Inhibitor	$5,619,438	11,096	$506
6	Advair	Bronchodilator and Corticosteroid	$4,431,908	6,981	$635
7	Singulair	Leukotreine Receptor Antagonist	$4,144,203	9,639	$430
8	Lipitor	Anti-Hyperlipidemic	$3,797,128	4,908	$774
9	Concerta	Treatment for Attention Deficit-Hyperactivity (ADHD) and Narcolepsy	$3,757,094	4,134	$909
10	Oxycodone	Analgesic	$3,728,577	30,773	$121
		Top Ten Total	**$65,052,145**	**80,205**	**$811**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service

B5l: FY 2009-10 Top 10 Prescription Drugs Ranked by Number of Prescriptions Filled					
Rank	**Drug Name**	**Therapeutic Class**	**Total Prescriptions Filled**	**Expenditures**	**Average Cost**
1	Hydrocodone	Analgesic	126,126	$1,865,081	$15
2	Amoxicillin	Antibiotic	106,069	$895,803	$8
3	Oxycodone	Analgesic	99,185	$3,728,577	$38
4	Proair	Beta-Adrenergic Agent	56,537	$2,505,056	$44
5	Azithromycin	Macrolide	55,653	$1,357,206	$24
6	Lorazepam	Anti-Anxiety Drug	52,888	$438,816	$8
7	Lisinopril	ACE Inhibitor	45,913	$318,890	$7
8	Levothyroxine	Thyroid Hormone	44,556	$341,305	$8
9	Clonazepam	Anti-Convulsant	43,544	$368,228	$8
10	Ibuprofen	NSAID	41,887	$247,955	$6
		Top Ten Total	**672,358**	**$12,066,917**	**$18**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and prescriptions filled presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within