DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(A) General Administration							
Personal Services							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$21,775,206	312.2	$7,817,694	$0	$2,054,145	$448,289	$11,455,078
SB 11-076 "PERA Contribution Rates"	($508,843)	0.0	($166,362)	$0	($56,118)	$0	($286,363)
SB 11-177 "Repeal Sunset Teen Pregnancy & Dropout Program"	$47,817	1.0	$23,909	$0	$0	$0	$23,908
SB 11-216 "Children's Basic Health Plan General Fund Appropriation"	($23,494)	(0.2)	$0	$0	($23,494)	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$21,290,686**	**313.0**	**$7,675,241**	**$0**	**$1,974,533**	**$448,289**	**$11,192,623**
Annualization of FY 2011-12 DI#8: "Prenatal Plus Administration Transfer"	$11,643	0.0	$5,822	$0	$0	$0	$5,821
SB 10-061 Annualization "Medicaid Hospice Room And Board Charges"	$31,692	0.5	$15,846	$0	$0	$0	$15,846
SB 11-076 Annualization "PERA Contribution Rates"	$508,843	0.0	$166,362	$0	$56,118	$0	$286,363
SB 11-177 Annualization "Repeal Sunset Teen Pregnancy & Dropout Program"	$4,345	0.0	$2,172	$0	$0	$0	$2,173
Statewide Indirect Cost Allocation	$0	0.0	$88,624	$0	$27,698	($67,879)	($48,443)
FY 2012-13 Base Request	**$21,847,209**	**313.5**	**$7,954,067**	**$0**	**$2,058,349**	**$380,410**	**$11,454,383**
FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$116,204	1.8	$58,102	$0	$0	$0	$58,102
FY 2012-13 February 15 Request	**$21,963,413**	**315.3**	**$8,012,169**	**$0**	**$2,058,349**	**$380,410**	**$11,512,485**
Health, Life, and Dental							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$2,024,577	0.0	$627,749	$0	$255,164	$0	$1,141,664
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$2,024,577**	**0.0**	**$627,749**	**$0**	**$255,164**	**$0**	**$1,141,664**
FY 2012-13 Common Policy Adjustment	($54,511)	0.0	$98,221	$0	($95,681)	$49,661	($106,712)
FY 2012-13 Base Request	**$1,970,066**	**0.0**	**$725,970**	**$0**	**$159,483**	**$49,661**	**$1,034,952**
FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$8,106	0.0	$4,053	$0	$0	$0	$4,053
FY 2012-13 February 15 Request	**$1,978,172**	**0.0**	**$730,023**	**$0**	**$159,483**	**$49,661**	**$1,039,005**
Short-term Disability							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$32,206	0.0	$12,334	$0	$2,521	$0	$17,351
SB 11-216 "Children's Basic Health Plan General Fund Appropriation"	($18)	0.0	$0	$0	($18)	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$32,188**	**0.0**	**$12,334**	**$0**	**$2,503**	**$0**	**$17,351**
FY 2012-13 Common Policy Adjustment	$6,940	0.0	$3,492	$0	$454	$629	$2,365
FY 2012-13 Base Request	**$39,128**	**0.0**	**$15,826**	**$0**	**$2,957**	**$629**	**$19,716**
FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$184	0.0	$92	$0	$0	$0	$92
FY 2012-13 February 15 Request	**$39,312**	**0.0**	**$15,918**	**$0**	**$2,957**	**$629**	**$19,808**
S.B. 04-257 Amortization Equalization Disbursement							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$533,397	0.0	$190,728	$0	$53,691	$0	$288,978
SB 11-216 "Children's Basic Health Plan General Fund Appropriation"	($543)	0.0	$0	$0	($543)	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$532,854**	**0.0**	**$190,728**	**$0**	**$53,148**	**$0**	**$288,978**
FY 2012-13 Common Policy Adjustment	$174,565	0.0	$95,393	$0	$320	$11,380	$67,472
FY 2012-13 Base Request	**$707,419**	**0.0**	**$286,121**	**$0**	**$53,468**	**$11,380**	**$356,450**
FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$3,718	0.0	$1,859	$0	$0	$0	$1,859
FY 2012-13 February 15 Request	**$711,137**	**0.0**	**$287,980**	**$0**	**$53,468**	**$11,380**	**$358,309**
S.B. 06-235 Supplemental Amortization Equalization Disbursement							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$427,633	0.0	$151,785	$0	$42,790	$0	$233,058
SB 11-216 "Children's Basic Health Plan General Fund Appropriation"	($308)	0.0	$0	$0	($308)	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$427,325**	**0.0**	**$151,785**	**$0**	**$42,482**	**$0**	**$233,058**
FY 2012-13 Common Policy Adjustment	$180,613	0.0	$94,100	$0	$3,467	$9,780	$73,266
FY 2012-13 Base Request	**$607,938**	**0.0**	**$245,885**	**$0**	**$45,949**	**$9,780**	**$306,324**
FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$3,196	0.0	$1,598	$0	$0	$0	$1,598
FY 2012-13 February 15 Request	**$611,134**	**0.0**	**$247,483**	**$0**	**$45,949**	**$9,780**	**$307,922**
Workers' Compensation							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$29,652	0.0	$14,826	$0	$0	$0	$14,826
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$29,652**	**0.0**	**$14,826**	**$0**	**$0**	**$0**	**$14,826**
FY 2012-13 Common Policy Adjustment	$3,932	0.0	$1,966	$0	$0	$0	$1,966
FY 2012-13 Base Request	**$33,584**	**0.0**	**$16,792**	**$0**	**$0**	**$0**	**$16,792**
FY 2012-13 February 15 Request	**$33,584**	**0.0**	**$16,792**	**$0**	**$0**	**$0**	**$16,792**
Operating Expenses							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$1,580,579	0.0	$677,168	$0	$101,248	$13,461	$788,702
SB 11-177 "Repeal Sunset Teen Pregnancy & Dropout Program"	$5,653	0.0	$2,826	$0	$0	$0	$2,827
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$1,586,232**	**0.0**	**$679,994**	**$0**	**$101,248**	**$13,461**	**$791,529**
Annualization of FY 2010-11 BA#17: "General Operating Expenses Reduction"	$69,140	0.0	$34,570	$0	$0	$0	$34,570
Annualization of FY 2011-12 DI#8: "Prenatal Plus Administration Transfer"	($10,086)	0.0	($5,043)	$0	$0	$0	($5,043)
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	($96,398)	0.0	$0	$0	($48,199)	$0	($48,199)
SB 10-061 Annualization "Medicaid Hospice Room And Board Charges"	$2,375	0.0	$1,187	$0	$0	$0	$1,188
SB 11-177 Annualization "Repeal Sunset Teen Pregnancy & Dropout Program"	($4,703)	0.0	($2,351)	$0	$0	$0	($2,352)
FY 2012-13 Base Request	**$1,546,560**	**0.0**	**$708,357**	**$0**	**$53,049**	**$13,461**	**$771,693**
FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$11,306	0.0	$5,653	$0	$0	$0	$5,653
FY 2012-13 February 15 Request	**$1,557,866**	**0.0**	**$714,010**	**$0**	**$53,049**	**$13,461**	**$777,346**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Legal Services and Third Party Recovery Legal Services for 11,893 hours							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$956,823	0.0	$347,930	$0	$130,482	$0	$478,411
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$956,823**	**0.0**	**$347,930**	**$0**	**$130,482**	**$0**	**$478,411**
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$72,232	0.0	$0	$0	$36,116	$0	$36,116
FY 2012-13 Base Request	**$1,029,055**	**0.0**	**$347,930**	**$0**	**$166,598**	**$0**	**$514,527**
FY 2012-13 February 15 Request	**$1,029,055**	**0.0**	**$347,930**	**$0**	**$166,598**	**$0**	**$514,527**
Administrative Law Judge Services							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$422,830	0.0	$186,717	$0	$24,698	$0	$211,415
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$422,830**	**0.0**	**$186,717**	**$0**	**$24,698**	**$0**	**$211,415**
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$41,602	0.0	$0	$0	$20,801	$0	$20,801
FY 2012-13 Common Policy Adjustment	$71,679	0.0	$35,840	$0	$0	$0	$35,839
FY 2012-13 Base Request	**$536,111**	**0.0**	**$222,557**	**$0**	**$45,499**	**$0**	**$268,055**
FY 2012-13 February 15 Request	**$536,111**	**0.0**	**$222,557**	**$0**	**$45,499**	**$0**	**$268,055**
Purchase of Services from Computer Center							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$835,843	0.0	$414,566	$0	$0	$3,375	$417,902
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$835,843**	**0.0**	**$414,566**	**$0**	**$0**	**$3,375**	**$417,902**
FY 2012-13 Common Policy Adjustment	$185,874	0.0	$94,605	$0	$0	$0	$91,269
FY 2012-13 Base Request	**$1,021,717**	**0.0**	**$509,171**	**$0**	**$0**	**$3,375**	**$509,171**
FY 2012-13 February 15 Request	**$1,021,717**	**0.0**	**$509,171**	**$0**	**$0**	**$3,375**	**$509,171**
Multiuse Network Payments							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$227,900	0.0	$113,950	$0	$0	$0	$113,950
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$227,900**	**0.0**	**$113,950**	**$0**	**$0**	**$0**	**$113,950**
FY 2012-13 Common Policy Adjustment	$3,433	0.0	$1,717	$0	$0	$0	$1,716
FY 2012-13 Base Request	**$231,333**	**0.0**	**$115,667**	**$0**	**$0**	**$0**	**$115,666**
FY 2012-13 February 15 Request	**$231,333**	**0.0**	**$115,667**	**$0**	**$0**	**$0**	**$115,666**
Management and Administration of OIT							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$631,234	0.0	$315,617	$0	$0	$0	$315,617
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$631,234**	**0.0**	**$315,617**	**$0**	**$0**	**$0**	**$315,617**
FY 2012-13 Common Policy Adjustment	($631,234)	0.0	($315,617)	$0	$0	$0	($315,617)
FY 2012-13 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 February 15 Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Payment to Risk Management and Property Funds							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$77,888	0.0	$38,944	$0	$0	$0	$38,944
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$77,888**	**0.0**	**$38,944**	**$0**	**$0**	**$0**	**$38,944**
FY 2012-13 Common Policy Adjustment	$6,427	0.0	$3,214	$0	$0	$0	$3,213
FY 2012-13 Base Request	**$84,315**	**0.0**	**$42,158**	**$0**	**$0**	**$0**	**$42,157**
FY 2012-13 February 15 Request	**$84,315**	**0.0**	**$42,158**	**$0**	**$0**	**$0**	**$42,157**
Leased Space							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$696,564	0.0	$197,119	$0	$151,164	$0	$348,281
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$696,564**	**0.0**	**$197,119**	**$0**	**$151,164**	**$0**	**$348,281**
FY 2012-13 Base Request	**$696,564**	**0.0**	**$197,119**	**$0**	**$151,164**	**$0**	**$348,281**
FY 2012-13 February 15 Request	**$696,564**	**0.0**	**$197,119**	**$0**	**$151,164**	**$0**	**$348,281**
Capitol Complex Leased Space							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$397,928	0.0	$198,964	$0	$0	$0	$198,964
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$397,928**	**0.0**	**$198,964**	**$0**	**$0**	**$0**	**$198,964**
FY 2012-13 Common Policy Adjustment	$45,070	0.0	$22,535	$0	$0	$0	$22,535
FY 2012-13 Base Request	**$442,998**	**0.0**	**$221,499**	**$0**	**$0**	**$0**	**$221,499**
FY 2012-13 February 15 Request	**$442,998**	**0.0**	**$221,499**	**$0**	**$0**	**$0**	**$221,499**
General Professional Services and Special Projects							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$6,422,552	0.0	$1,400,918	$0	$665,000	$0	$4,356,634
HB 11-1242 "Medicaid Provider Integration Of Service"	$113,500	0.0	$0	$0	$56,750	$0	$56,750
SB 11-125 "Nursing Home Fees & Order of Payments"	$60,000	0.0	$30,000	$0	$0	$0	$30,000
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$6,596,052**	**0.0**	**$1,430,918**	**$0**	**$721,750**	**$0**	**$4,443,384**
Annualization of FY 2010-11 BA#13: "Coordinated Payment and Payment	$112,500	0.0	$56,250	$0	$0	$0	$56,250
Annualization of the First Conference Committee Report on SB 09-259, Council for Affordable Health Insurance (CAHI)[1]	($150,000)	0.0	$0	$0	($150,000)	$0	$0
HB 10-1027 Annualization "Medicaid Hospice Life Expectancy"	($25,000)	0.0	$0	$0	($12,500)	$0	($12,500)
SB 10-061 Annualization "Medicaid Hospice Room And Board Charges"	($10,000)	0.0	$0	$0	($5,000)	$0	($5,000)
HB 11-1242 Annualization "Medicaid Provider Integration Of Service"	($113,500)	0.0	$0	$0	($56,750)	$0	($56,750)
FY 2012-13 Base Request	**$6,410,052**	**0.0**	**$1,487,168**	**$0**	**$497,500**	**$0**	**$4,425,384**
FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($52,000)	0.0	($26,000)	$0	$0	$0	($26,000)
FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	$30,000	0.0	$15,000	$0	$0	$0	$15,000
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	($120,000)	0.0	$0	$0	($60,000)	$0	($60,000)
FY 2012-13 February 15 Request	**$6,268,052**	**0.0**	**$1,476,168**	**$0**	**$437,500**	**$0**	**$4,354,384**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(B) Transfers to Other Departments							
Transfer to Department of Public Health and Environment Facility for Survey and Certification							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$5,024,611	0.0	$1,567,498	$0	$0	$0	$3,457,113
SB 11-076 "PERA Contribution Rates"	($79,170)	0.0	($27,710)	$0	$0	$0	($51,460)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$4,945,441**	**0.0**	**$1,539,788**	**$0**	**$0**	**$0**	**$3,405,653**
SB 11-076 Annualization "PERA Contribution Rates"	$79,170	0.0	$27,710	$0	$0	$0	$51,460
Align Fund Splits for Federal Allocation	$190,518	0.0	($3,567)	$0	$0	$0	$194,085
FY 2012-13 Common Policy Adjustment	$17,554	0.0	$8,777	$0	$0	$0	$8,777
FY 2012-13 Base Request	**$5,232,683**	**0.0**	**$1,572,708**	**$0**	**$0**	**$0**	**$3,659,975**
FY 2012-13 February 15 Request	**$5,232,683**	**0.0**	**$1,572,708**	**$0**	**$0**	**$0**	**$3,659,975**
Transfer to Department of Public Health and Environment for Nurse Home Visitor Program							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$3,010,000	0.0	$0	$0	$0	$1,505,000	$1,505,000
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$3,010,000**	**0.0**	**$0**	**$0**	**$0**	**$1,505,000**	**$1,505,000**
FY 2012-13 Base Request	**$3,010,000**	**0.0**	**$0**	**$0**	**$0**	**$1,505,000**	**$1,505,000**
FY 2012-13 February 15 Request	**$3,010,000**	**0.0**	**$0**	**$0**	**$0**	**$1,505,000**	**$1,505,000**
Transfer to Department of Public Health and Environment for Prenatal Statistical Information							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$6,000	0.0	$3,000	$0	$0	$0	$3,000
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$6,000**	**0.0**	**$3,000**	**$0**	**$0**	**$0**	**$3,000**
FY 2012-13 Common Policy Adjustment	($90)	0.0	($45)	$0	$0	$0	($45)
FY 2012-13 Base Request	**$5,910**	**0.0**	**$2,955**	**$0**	**$0**	**$0**	**$2,955**
FY 2012-13 February 15 Request	**$5,910**	**0.0**	**$2,955**	**$0**	**$0**	**$0**	**$2,955**
Transfers to the Department of Regulatory Agencies for Nurse Aide Certification							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$324,041	0.0	$147,369	$0	$0	$14,652	$162,020
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$324,041**	**0.0**	**$147,369**	**$0**	**$0**	**$14,652**	**$162,020**
FY 2012-13 Base Request	**$324,041**	**0.0**	**$147,369**	**$0**	**$0**	**$14,652**	**$162,020**
FY 2012-13 February 15 Request	**$324,041**	**0.0**	**$147,369**	**$0**	**$0**	**$14,652**	**$162,020**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Transfers to the Department of Regulatory Agencies for Reviews							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$14,000	0.0	$7,000	$0	$0	$0	$7,000
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$14,000**	**0.0**	**$7,000**	**$0**	**$0**	**$0**	**$7,000**
FY 2012-13 Base Request	**$14,000**	**0.0**	**$7,000**	**$0**	**$0**	**$0**	**$7,000**
FY 2012-13 February 15 Request	**$14,000**	**0.0**	**$7,000**	**$0**	**$0**	**$0**	**$7,000**
Transfer to Department of Education for Public School Health Services Administration							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$142,073	0.0	$0	$0	$0	$0	$142,073
SB 11-076 "PERA Contribution Rates"	($1,685)	0.0	$0	$0	$0	$0	($1,685)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$140,388**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$140,388**
SB 11-076 Annualization "PERA Contribution Rates"	$1,685	0.0	$0	$0	$0	$0	$1,685
Annualization of FY 2011-12 BA#5: "School Based Health Program Refinancing"	$7,926	0.0	$0	$0	$0	$0	$7,926
FY 2012-13 Base Request	**$149,999**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$149,999**
FY 2012-13 February 15 Request	**$149,999**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$149,999**
(C) Information Technology Contracts and Projects							
Information Technology Contracts							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$32,412,990	0.0	$6,581,901	$0	$1,479,670	$100,328	$24,251,091
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$32,412,990**	**0.0**	**$6,581,901**	**$0**	**$1,479,670**	**$100,328**	**$24,251,091**
Annualization of FY 2010-11 BA#15: "MMIS Adjustments"	($1,064,400)	0.0	($106,440)	$0	$0	$0	($957,960)
Annualization of FY 2011-12 BRI#1: "Client Overutilization Program Expansion"	($207,900)	0.0	($51,975)	$0	$0	$0	($155,925)
Annualization of FY 2011-12 BRI#5: "Medicaid Reductions"	($189,000)	0.0	($47,250)	$0	$0	$0	($141,750)
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$482,383	0.0	$0	$0	$218,770	$0	$263,613
SB 10-061 Annualization "Medicaid Hospice Room And Board Charges"	$319,284	0.0	$79,821	$0	$0	$0	$239,463
SB 11-008 "Aligning Children's Medicaid Eligibility"	$6,930	0.0	$1,733	$0	$0	$0	$5,197
SB 11-250 "Pregnant Women Medicaid Eligibility"	$6,930	0.0	$1,681	$0	$73	$0	$5,176
FY 2012-13 Base Request	**$31,767,217**	**0.0**	**$6,459,471**	**$0**	**$1,698,513**	**$100,328**	**$23,508,905**
FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	$523,964	0.0	$130,991	$0	$0	$0	$392,973
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	($613,974)	0.0	$0	$0	($356,987)	$0	($256,987)
FY 2012-13 BA#6: "MMIS Technical Adjustments"	$1,065,358	0.0	$0	$0	$225,140	$0	$840,218
FY 2012-13 February 15 Request	**$32,742,565**	**0.0**	**$6,590,462**	**$0**	**$1,566,666**	**$100,328**	**$24,485,109**
Fraud Detection Software Contract							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$250,000	0.0	$62,500	$0	$0	$0	$187,500
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$250,000**	**0.0**	**$62,500**	**$0**	**$0**	**$0**	**$187,500**
FY 2012-13 Base Request	**$250,000**	**0.0**	**$62,500**	**$0**	**$0**	**$0**	**$187,500**
FY 2012-13 February 15 Request	**$250,000**	**0.0**	**$62,500**	**$0**	**$0**	**$0**	**$187,500**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Centralized Eligibility Vendor Contract Project							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$2,221,482	0.0	$0	$0	$964,169	$0	$1,257,313
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$2,221,482**	**0.0**	**$0**	**$0**	**$964,169**	**$0**	**$1,257,313**
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$2,363,166	0.0	$0	$0	$1,165,298	$0	$1,197,868
FY 2012-13 Base Request	**$4,584,648**	**0.0**	**$0**	**$0**	**$2,129,467**	**$0**	**$2,455,181**
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$514,139	0.0	$0	$0	$404,737	$0	$109,402
FY 2012-13 February 15 Request	**$5,098,787**	**0.0**	**$0**	**$0**	**$2,534,204**	**$0**	**$2,564,583**
(D) Eligibility Determinations and Client Services							
Medical Identification Cards							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$120,000	0.0	$59,203	$0	$0	$1,593	$59,204
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$120,000**	**0.0**	**$59,203**	**$0**	**$0**	**$1,593**	**$59,204**
FY 2012-13 Base Request	**$120,000**	**0.0**	**$59,203**	**$0**	**$0**	**$1,593**	**$59,204**
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$9,240	0.0	$0	$0	$4,620	$0	$4,620
FY 2012-13 February 15 Request	**$129,240**	**0.0**	**$59,203**	**$0**	**$4,620**	**$1,593**	**$63,824**
Contracts for Special Eligibility Determinations							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$7,761,238	0.0	$828,091	$0	$2,806,268	$0	$4,126,879
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$7,761,238**	**0.0**	**$828,091**	**$0**	**$2,806,268**	**$0**	**$4,126,879**
FY 2012-13 Base Request	**$7,761,238**	**0.0**	**$828,091**	**$0**	**$2,806,268**	**$0**	**$4,126,879**
FY 2012-13 February 15 Request	**$7,761,238**	**0.0**	**$828,091**	**$0**	**$2,806,268**	**$0**	**$4,126,879**
County Administration							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$33,547,878	0.0	$10,300,790	$0	$6,513,282	$0	$16,733,806
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$33,547,878**	**0.0**	**$10,300,790**	**$0**	**$6,513,282**	**$0**	**$16,733,806**
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$219,570	0.0	$0	$0	$109,785	$0	$109,785
SB 11-008 "Aligning Children's Medicaid Eligibility"	$241,325	0.0	$72,398	$0	$48,265	$0	$120,662
FY 2012-13 Base Request	**$34,008,773**	**0.0**	**$10,373,188**	**$0**	**$6,671,332**	**$0**	**$16,964,253**
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	($2,581,071)	0.0	$0	$0	($1,290,536)	$0	($1,290,535)
FY 2012-13 February 15 Request	**$31,427,702**	**0.0**	**$10,373,188**	**$0**	**$5,380,796**	**$0**	**$15,673,718**
Hospital Provider Fee County Administration *(new line item)*							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$2,581,071	0.0	$0	$0	$1,290,536	$0	$1,290,535
FY 2012-13 February 15 Request	**$2,581,071**	**0.0**	**$0**	**$0**	**$1,290,536**	**$0**	**$1,290,535**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Administrative Case Management							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$869,744	0.0	$434,872	$0	$0	$0	$434,872
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$869,744**	**0.0**	**$434,872**	**$0**	**$0**	**$0**	**$434,872**
FY 2012-13 Base Request	**$869,744**	**0.0**	**$434,872**	**$0**	**$0**	**$0**	**$434,872**
FY 2012-13 February 15 Request	**$869,744**	**0.0**	**$434,872**	**$0**	**$0**	**$0**	**$434,872**
Customer Outreach							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$5,213,157	0.0	$2,550,470	$0	$56,109	$0	$2,606,578
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$5,213,157**	**0.0**	**$2,550,470**	**$0**	**$56,109**	**$0**	**$2,606,578**
Annualization of FY 2011-12 BA#9: "Medicaid Budget Balancing Reductions"	($387,358)	0.0	($193,679)	$0	$0	$0	($193,679)
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$30,447	0.0	$0	$0	$15,224	$0	$15,223
SB 11-008 "Aligning Children's Medicaid Eligibility"	$39,715	0.0	$19,858	$0	$0	$0	$19,857
FY 2012-13 Base Request	**$4,895,961**	**0.0**	**$2,376,649**	**$0**	**$71,333**	**$0**	**$2,447,979**
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$31,057	0.0	$0	$0	$15,528	$0	$15,529
FY 2012-13 February 15 Request	**$4,927,018**	**$0**	**$2,376,649**	**$0**	**$86,861**	**$0**	**$2,463,508**
(E) Utilization and Quality Review Contracts							
Professional Services Contracts							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$7,670,839	0.0	$2,100,370	$0	$60,537	$0	$5,509,932
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$7,670,839**	**0.0**	**$2,100,370**	**$0**	**$60,537**	**$0**	**$5,509,932**
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$130,883	0.0	$0	$0	$40,117	$0	$90,766
FY 2012-13 Base Request	**$7,801,722**	**0.0**	**$2,100,370**	**$0**	**$100,654**	**$0**	**$5,600,698**
FY 2012-13 R#6: "Medicaid Budget Reductions"	$500,000	0.0	$125,000	$0	$0	$0	$375,000
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$112,729	0.0	$0	$0	$13,678	$0	$99,051
FY 2012-13 February 15 Request	**$8,414,451**	**0.0**	**$2,225,370**	**$0**	**$114,332**	**$0**	**$6,074,749**
(F) Provider Audits and Services							
Professional Audit Contracts							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$2,463,406	0.0	$969,283	$0	$262,420	$0	$1,231,703
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$2,463,406**	**0.0**	**$969,283**	**$0**	**$262,420**	**$0**	**$1,231,703**
FY 2012-13 Base Request	**$2,463,406**	**0.0**	**$969,283**	**$0**	**$262,420**	**$0**	**$1,231,703**
FY 2012-13 February 15 Request	**$2,463,406**	**0.0**	**$969,283**	**$0**	**$262,420**	**$0**	**$1,231,703**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(G) Recoveries and Recoupment Contract Costs							
Estate Recovery							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$700,000	0.0	$0	$0	$350,000	$0	$350,000
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$700,000**	**0.0**	**$0**	**$0**	**$350,000**	**$0**	**$350,000**
FY 2012-13 Base Request	**$700,000**	**0.0**	**$0**	**$0**	**$350,000**	**$0**	**$350,000**
FY 2012-13 February 15 Request	**$700,000**	**0.0**	**$0**	**$0**	**$350,000**	**$0**	**$350,000**
(1) Executive Director's Office							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$138,824,271	312.2	$38,319,356	$0	$15,973,358	$2,086,698	$82,444,859
HB 11-1242 "Medicaid Provider Integration Of Service"	$113,500	0.0	$0	$0	$56,750	$0	$56,750
SB 11-076 "PERA Contribution Rates"	($589,698)	0.0	($194,072)	$0	($56,118)	$0	($339,508)
SB 11-125 "Nursing Home Fees & Order of Payments"	$60,000	0.0	$30,000	$0	$0	$0	$30,000
SB 11-177 "Repeal Sunset Teen Pregnancy & Dropout Program"	$53,470	1.0	$26,735	$0	$0	$0	$26,735
SB 11-216 "Children's Basic Health Plan General Fund Appropriation"	($24,363)	(0.2)	$0	$0	($24,363)	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$138,437,180**	**313.0**	**$38,182,019**	**$0**	**$15,949,627**	**$2,086,698**	**$82,218,836**
Annualization of FY 2010-11 BA#13: "Coordinated Payment and Payment	$112,500	0.0	$56,250	$0	$0	$0	$56,250
Annualization of FY 2010-11 BA#15: "MMIS Adjustments"	($1,064,400)	0.0	($106,440)	$0	$0	$0	($957,960)
Annualization of FY 2010-11 BA#17: "General Operating Expenses Reduction"	$69,140	0.0	$34,570	$0	$0	$0	$34,570
Annualization of FY 2011-12 BRI#1: "Client Overutilization Program Expansion"	($207,900)	0.0	($51,975)	$0	$0	$0	($155,925)
Annualization of FY 2011-12 BRI#5: "Medicaid Reductions"	($189,000)	0.0	($47,250)	$0	$0	$0	($141,750)
Annualization of FY 2011-12 DI#8: "Prenatal Plus Administration Transfer"	$1,557	0.0	$779	$0	$0	$0	$778
Annualization of FY 2011-12 BA#5: "School Based Health Program Refinancing"	$7,926	0.0	$0	$0	$0	$0	$7,926
Annualization of FY 2011-12 BA#9: "Medicaid Budget Balancing Reductions"	($387,358)	0.0	($193,679)	$0	$0	$0	($193,679)
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$3,243,885	0.0	$0	$0	$1,557,912	$0	$1,685,973
HB 11-1242 Annualization "Medicaid Provider Integration Of Service"	($113,500)	0.0	$0	$0	($56,750)	$0	($56,750)
HB 10-1027 Annualization "Medicaid Hospice Life Expectancy"	($25,000)	0.0	$0	$0	($12,500)	$0	($12,500)
SB 10-061 Annualization "Medicaid Hospice Room And Board Charges"	$343,351	0.5	$96,854	$0	($5,000)	$0	$251,497
SB 11-076 Annualization "PERA Contribution Rates"	$589,698	0.0	$194,072	$0	$56,118	$0	$339,508
SB 11-177 Annualization "Repeal Sunset Teen Pregnancy & Dropout Program"	($358)	0.0	($179)	$0	$0	$0	($179)
Annualization of the First Conference Committee Report on SB 09-259, Council for Affordable Health Insurance (CAHI)[1]	($150,000)	0.0	$0	$0	($150,000)	$0	$0
Align Fund Splits for Federal Allocation	$190,518	0.0	($3,567)	$0	$0	$0	$194,085
SB 11-008 "Aligning Children's Medicaid Eligibility"	$287,970	0.0	$93,989	$0	$48,265	$0	$145,716
SB 11-250 "Pregnant Women Medicaid Eligibility"	$6,930	0.0	$1,681	$0	$73	$0	$5,176
Statewide Indirect Cost Allocation	$0	0.0	$88,624	$0	$27,698	($67,879)	($48,443)
FY 2012-13 Common Policy Adjustment	$10,252	0.0	$144,198	$0	($91,440)	$71,450	($113,956)

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Base Request	**$141,163,391**	**313.5**	**$38,489,946**	**$0**	**$17,324,003**	**$2,090,269**	**$83,259,173**
FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$90,714	1.8	$45,357	$0	$0	$0	$45,357
FY 2012-13 R#6: "Medicaid Budget Reductions"	$500,000	0.0	$125,000	$0	$0	$0	$375,000
FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	$553,964	0.0	$145,991	$0	$0	$0	$407,973
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	($66,809)	0.0	$0	$0	$21,576	$0	($88,385)
FY 2012-13 BA#6: "MMIS Technical Adjustments"	$1,065,358	0.0	$0	$0	$225,140	$0	$840,218
FY 2012-13 February 15 Request	**$143,306,618**	**315.3**	**$38,806,294**	**$0**	**$17,570,719**	**$2,090,269**	**$84,839,336**

[1]Note that the "Annualization of the First Conference Committee Report on SB 09-259, Council for Affordable Health Insurance (CAHI)" includes the FY 10-11 annualization of the FY 2009-10 First Conference Comittee Action. (First Conference Committee Report on SB 09-259, April 23, 2009, page 16)

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(2) Medical Services Premiums

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Medical Services Premiums							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$3,521,401,973	0.0	$1,004,304,853	$284,175,417	$495,061,484	$3,101,708	$1,734,758,511
SB 11-125 "Nursing Home Fees & Order of Payments"	$30,994,411	0.0	$0	$0	$15,497,206		$15,497,205
SB 11-177 "Repeal Sunset Teen Pregnancy & Dropout Program"	$333,195	0.0	($26,735)	$0	$38,666	$0	$321,264
SB 11-210 "Phase Out Supplemental OAP Health Fund"	$0	0.0	($2,230,500)	$0	$2,230,500	$0	$0
SB 11-211 "Tobacco Revenues Offset Medical Services"	$0	0.0	($33,000,000)	$0	$29,713,649	$3,286,351	$0
SB 11-212 "Use Provider Fee Offset GF Medicaid"	$0	0.0	($50,000,000)	$0	$50,000,000	$0	$0
SB 11-215 "2011 Nursing Facility Rate Reduction"	($8,865,830)	0.0	($4,432,915)	$0	$0	$0	($4,432,915)
SB 11-219 "2011 Transfers For Health Care Services"	$0	0.0	($15,775,670)	$0	$15,775,670	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$3,543,863,749**	**0.0**	**$898,839,033**	**$284,175,417**	**$608,317,175**	**$6,388,059**	**$1,746,144,065**
Annualization of FY 2011-12 BRI#1: "Client Overutilization Program Expansion"	($1,098,200)	0.0	($549,100)	$0	$0	$0	($549,100)
Annualization of FY 2011-12 BRI#5: "Medicaid Reductions"	($3,887,075)	0.0	($1,764,302)	$0	($179,235)	$0	($1,943,538)
Annualization of FY 2011-12 BA#9: "Medicaid Budget Balancing Reductions"	($4,602,736)	0.0	($1,887,737)	$0	($407,078)	$0	($2,307,921)
HB 10-1380 Annualization "Use Supplemental OAP Health Fund for Medicaid"	$0	0.0	$3,000,000	$0	($3,000,000)	$0	$0
SB 11-125 Annualization "Nursing Home Fees & Order of Payments"	$466,905	0.0	$0	$0	$233,452	$0	$233,453
SB 11-177 Annualization "Repeal Sunset Teen Pregnancy & Dropout Program"	$542,168	0.0	($2,025)	$0	$54,622	$0	$489,571
SB 11-211 Annualization "Tobacco Revenues Offset Medical Services"	$0	0.0	$33,000,000	$0	($29,713,649)	($3,286,351)	$0
SB 11-212 Annualization "Use Provider Fee Offset GF Medicaid"	$0	0.0	$25,000,000	$0	($25,000,000)	$0	$0
SB 11-215 Annualization "2011 Nursing Facility Rate Reduction"	$8,865,830	0.0	$4,432,915	$0	$0	$0	$4,432,915
SB 11-219 Annualization "2011 Transfers For Health Care Services"	$0	0.0	$15,775,670	$0	($15,775,670)	$0	$0
SB 11-008 "Aligning Children's Medicaid Eligibility"	$8,298,832	0.0	$2,904,591	$0	$0	$0	$5,394,241
SB 11-250 "Pregnant Women Medicaid Eligibility"	$7,346,456	0.0	$2,571,260	$0	$0	$0	$4,775,196
FY 2012-13 Base Request	**$3,559,795,929**	**0.0**	**$981,320,305**	**$284,175,417**	**$534,529,617**	**$3,101,708**	**$1,756,668,882**
FY 2012-13 R#1: "Request for Medical Services Premiums"	$330,806,255	0.0	$129,303,556	$0	$36,238,486	$303,982	$164,960,231
FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($1,935,744)	0.0	($910,826)	$0	($57,047)	$0	($967,871)
FY 2012-13 R#6: "Medicaid Budget Reductions"	($30,199,322)	0.0	($30,596,105)	$0	$15,496,446	$0	($15,099,663)
FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	($2,171,793)	0.0	($1,060,682)	$0	($25,214)	$0	($1,085,897)
FY 2012-13 R#10: "Utilize Supplemental Payments for General Fund Relief"	$14,889,488	0.0	($1,006,752)	$0	$7,948,120	$0	$7,948,120
FY 2012-13 BA#1: "Medical Services Premiums Request"	$110,910,674	0.0	($4,016,472)	$0	$61,179,404	($190,350)	$53,938,092
FY 2012-13 BA#3: "Smoking Cessation Quitline for Medicaid Clients"	$1,373,470	0.0	$0	$0	$686,735	$0	$686,735
FY 2012-13 BA#4: "Utilize Supplemental Payments for General Fund Relief"	($10,527,400)	0.0	$400,246	$0	($5,946,273)	$0	($4,981,373)
FY 2012-13 February 15 Request	**$3,972,941,557**	**0.0**	**$1,073,433,270**	**$284,175,417**	**$650,050,274**	**$3,215,340**	**$1,962,067,256**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(2) Medical Services Premiums

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(2) Medical Services Premiums							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$3,521,401,973	0.0	$1,004,304,853	$284,175,417	$495,061,484	$3,101,708	$1,734,758,511
SB 11-125 "Nursing Home Fees & Order of Payments"	$30,994,411	0.0	$0	$0	$15,497,206	$0	$15,497,205
SB 11-177 "Repeal Sunset Teen Pregnancy & Dropout Program"	$333,195	0.0	($26,735)	$0	$38,666	$0	$321,264
SB 11-210 "Phase Out Supplemental OAP Health Fund"	$0	0.0	($2,230,500)	$0	$2,230,500	$0	$0
SB 11-211 "Tobacco Revenues Offset Medical Services"	$0	0.0	($33,000,000)	$0	$29,713,649	$3,286,351	$0
SB 11-212 "Use Provider Fee Offset GF Medicaid"	$0	0.0	($50,000,000)	$0	$50,000,000	$0	$0
SB 11-215 "2011 Nursing Facility Rate Reduction"	($8,865,830)	0.0	($4,432,915)	$0	$0	$0	($4,432,915)
SB 11-219 "2011 Transfers For Health Care Services"	$0	0.0	($15,775,670)	$0	$15,775,670	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$3,543,863,749**	**0.0**	**$898,839,033**	**$284,175,417**	**$608,317,175**	**$6,388,059**	**$1,746,144,065**
Annualization of FY 2011-12 BRI#1: "Client Overutilization Program Expansion"	($1,098,200)	0.0	($549,100)	$0	$0	$0	($549,100)
Annualization of FY 2011-12 BRI#5: "Medicaid Reductions"	($3,887,075)	0.0	($1,764,302)	$0	($179,235)	$0	($1,943,538)
Annualization of FY 2011-12 BA#9: "Medicaid Budget Balancing Reductions"	($4,602,736)	0.0	($1,887,737)	$0	($407,078)	$0	($2,307,921)
HB 10-1380 Annualization "Use Supplemental OAP Health Fund for Medicaid"	$0	0.0	$3,000,000	$0	($3,000,000)	$0	$0
SB 11-125 Annualization "Nursing Home Fees & Order of Payments"	$466,905	0.0	$0	$0	$233,452	$0	$233,453
SB 11-177 Annualization "Repeal Sunset Teen Pregnancy & Dropout Program"	$542,168	0.0	($2,025)	$0	$54,622	$0	$489,571
SB 11-211 Annualization "Tobacco Revenues Offset Medical Services"	$0	0.0	$33,000,000	$0	($29,713,649)	($3,286,351)	$0
SB 11-212 Annualization "Use Provider Fee Offset GF Medicaid"	$0	0.0	$25,000,000	$0	($25,000,000)	$0	$0
SB 11-215 Annualization "2011 Nursing Facility Rate Reduction"	$8,865,830	0.0	$4,432,915	$0	$0	$0	$4,432,915
SB 11-219 Annualization "2011 Transfers For Health Care Services"	$0	0.0	$15,775,670	$0	($15,775,670)	$0	$0
SB 11-008 "Aligning Children's Medicaid Eligibility"	$8,298,832	0.0	$2,904,591	$0	$0	$0	$5,394,241
SB 11-250 "Pregnant Women Medicaid Eligibility"	$7,346,456	0.0	$2,571,260	$0	$0	$0	$4,775,196
FY 2012-13 Base Request	**$3,559,795,929**	**0.0**	**$981,320,305**	**$284,175,417**	**$534,529,617**	**$3,101,708**	**$1,756,668,882**
FY 2012-13 R#1: "Request for Medical Services Premiums"	$330,806,255	0.0	$129,303,556	$0	$36,238,486	$303,982	$164,960,231
FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($1,935,744)	0.0	($910,826)	$0	($57,047)	$0	($967,871)
FY 2012-13 R#6: "Medicaid Budget Reductions"	($30,199,322)	0.0	($30,596,105)	$0	$15,496,446	$0	($15,099,663)
FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	($2,171,793)	0.0	($1,060,682)	$0	($25,214)	$0	($1,085,897)
FY 2012-13 R#10: "Utilize Supplemental Payments for General Fund Relief"	$14,889,488	0.0	($1,006,752)	$0	$7,948,120	$0	$7,948,120
FY 2012-13 BA#1: "Medical Services Premiums Request"	$110,910,674	0.0	($4,016,472)	$0	$61,179,404	($190,350)	$53,938,092
FY 2012-13 BA#3: "Smoking Cessation Quitline for Medicaid Clients"	$1,373,470	0.0	$0	$0	$686,735	$0	$686,735
FY 2012-13 BA#4: "Utilize Supplemental Payments for General Fund Relief"	($10,527,400)	0.0	$400,246	$0	($5,946,273)	$0	($4,981,373)
FY 2012-13 February 15 Request	**$3,972,941,557**	**0.0**	**$1,073,433,270**	**$284,175,417**	**$650,050,274**	**$3,215,340**	**$1,962,067,256**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(3) Medicaid Mental Health Community Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Mental Health Capitation Payments							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$272,492,157	0.0	$125,823,308		$10,510,223	$13,544	$136,145,082
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$272,492,157**	**0.0**	**$125,823,308**	**$0**	**$10,510,223**	**$13,544**	**$136,145,082**
SB 11-008 "Aligning Children's Medicaid Eligibility"	$1,009,781	0.0	$353,423	$0	$0	$0	$656,358
SB 11-250 "Pregnant Women Medicaid Eligibility"	$180,133	0.0	$63,047	$0	$0	$0	$117,086
FY 2012-13 Base Request	**$273,682,071**	**0.0**	**$126,239,778**	**$0**	**$10,510,223**	**$13,544**	**$136,918,526**
FY 2012-13 R#2: "Medicaid Mental Health Community Programs"	$36,100,428	0.0	$21,131,301	$0	($3,087,673)	($13,544)	$18,070,344
FY 2012-13 BA#2: "Medicaid Mental Health Community Programs"	$2,798,213	0.0	($4,658,107)	$0	$6,226,382	$0	$1,229,938
FY 2012-13 February 15 Request	**$312,580,712**	**0.0**	**$142,712,972**	**$0**	**$13,648,932**	**$0**	**$156,218,808**
Medicaid Mental Health Fee for Service Payments							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$3,908,827	0.0	$1,954,414	$0	$0	$0	$1,954,413
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$3,908,827**	**0.0**	**$1,954,414**	**$0**	**$0**	**$0**	**$1,954,413**
FY 2012-13 Base Request	**$3,908,827**	**0.0**	**$1,954,414**	**$0**	**$0**	**$0**	**$1,954,413**
FY 2012-13 R#2: "Medicaid Mental Health Community Programs"	$513,880	0.0	$256,939	$0	$0	$0	$256,941
FY 2012-13 BA#2: "Medicaid Mental Health Community Programs"	($71,312)	0.0	($35,656)	$0	$0	$0	($35,656)
FY 2012-13 February 15 Request	**$4,351,395**	**0.0**	**$2,175,697**	**$0**	**$0**	**$0**	**$2,175,698**
(3) Medicaid Mental Health Community Programs							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$276,400,984	0.0	$127,777,722	$0	$10,510,223	$13,544	$138,099,495
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$276,400,984**	**0.0**	**$127,777,722**	**$0**	**$10,510,223**	**$13,544**	**$138,099,495**
SB 11-008 "Aligning Children's Medicaid Eligibility"	$1,009,781	0.0	$353,423	$0	$0	$0	$656,358
SB 11-250 "Pregnant Women Medicaid Eligibility"	$180,133	0.0	$63,047	$0	$0	$0	$117,086
FY 2012-13 Base Request	**$277,590,898**	**0.0**	**$128,194,192**	**$0**	**$10,510,223**	**$13,544**	**$138,872,939**
FY 2012-13 R#2: "Medicaid Mental Health Community Programs"	$36,614,308	0.0	$21,388,240	$0	($3,087,673)	($13,544)	$18,327,285
FY 2012-13 BA#2: "Medicaid Mental Health Community Programs"	$2,726,901	0.0	($4,693,763)	$0	$6,226,382	$0	$1,194,282
FY 2012-13 February 15 Request	**$316,932,107**	**0.0**	**$144,888,669**	**$0**	**$13,648,932**	**$0**	**$158,394,506**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Safety Net Provider Payments							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$309,825,106	0.0	$0	$0	$154,912,553	$0	$154,912,553
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$309,825,106**	**0.0**	**$0**	**$0**	**$154,912,553**	**$0**	**$154,912,553**
FY 2012-13 Base Request	**$309,825,106**	**0.0**	**$0**	**$0**	**$154,912,553**	**$0**	**$154,912,553**
FY 2012-13 R#10: "Utilize Supplemental Payments for General Fund Relief"	($15,896,240)	0.0	$0	$0	($7,948,120)	$0	($7,948,120)
FY 2012-13 February 15 Request	**$293,928,866**	**0.0**	**$0**	**$0**	**$146,964,433**	**$0**	**$146,964,433**
Clinic Based Indigent Care							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$6,119,760	0.0	$3,059,880	$0	$0	$0	$3,059,880
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$6,119,760**	**0.0**	**$3,059,880**	**$0**	**$0**	**$0**	**$3,059,880**
FY 2012-13 Base Request	**$6,119,760**	**0.0**	**$3,059,880**	**$0**	**$0**	**$0**	**$3,059,880**
FY 2012-13 February 15 Request	**$6,119,760**	**0.0**	**$3,059,880**	**$0**	**$0**	**$0**	**$3,059,880**
Health Care Services Fund Programs							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$0	0.0	$0	$0	$0	$0	$0
SB 11-219 "2011 Transfers For Health Care Services"	$23,510,000	0.0	$0	$0	$11,755,000	$0	$11,755,000
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$23,510,000**	**0.0**	**$0**	**$0**	**$11,755,000**	**$0**	**$11,755,000**
SB 11-219 Annualization "2011 Transfers For Health Care Services"	($23,510,000)	0.0	$0	$0	($11,755,000)	$0	($11,755,000)
FY 2012-13 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 February 15 Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
Pediatric Specialty Hospital							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$13,285,882	0.0	$5,899,969	$0	$296,872	$446,100	$6,642,941
SB 11-216 "Children's Basic Health Plan General Fund Appropriation"	($1,485,944)	0.0	$0	$0	($296,872)	($446,100)	($742,972)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$11,799,938**	**0.0**	**$5,899,969**	**$0**	**$0**	**$0**	**$5,899,969**
FY 2012-13 Base Request	**$11,799,938**	**0.0**	**$5,899,969**	**$0**	**$0**	**$0**	**$5,899,969**
FY 2012-13 February 15 Request	**$11,799,938**	**0.0**	**$5,899,969**	**$0**	**$0**	**$0**	**$5,899,969**
Appropriation from General Fund to Pediatric Specialty Hospital Fund							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$446,100	0.0	$0	$446,100	$0	$0	$0
SB 11-216 "Children's Basic Health Plan General Fund Appropriation"	($446,100)	0.0	$0	($446,100)	$0	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 February 15 Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Appropriation from Tobacco Tax Cash Fund to the General Fund							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$446,100	0.0	$0	$0	$446,100	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$446,100**	**0.0**	**$0**	**$0**	**$446,100**	**$0**	**$0**
FY 2012-13 Base Request	**$446,100**	**0.0**	**$0**	**$0**	**$446,100**	**$0**	**$0**
FY 2012-13 February 15 Request	**$446,100**	**0.0**	**$0**	**$0**	**$446,100**	**$0**	**$0**
Primary Care Fund Program							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$28,253,000	0.0	$0	$0	$28,253,000	$0	$0
SB 11-219 "2011 Transfers For Health Care Services"	($28,253,000)	0.0	$0	$0	($28,253,000)	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
SB 11-219 Annualization "2011 Transfers For Health Care Services"	$28,253,000	0.0	$0	$0	$28,253,000	$0	$0
FY 2012-13 Base Request	**$28,253,000**	**0.0**	**$0**	**$0**	**$28,253,000**	**$0**	**$0**
FY 2012-13 February 15 Request	**$28,253,000**	**0.0**	**$0**	**$0**	**$28,253,000**	**$0**	**$0**
Primary Care Grant Program Special Distribution							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$0	0.0	$0	$0	$0	$0	$0
SB 11-219 "2011 Transfers For Health Care Services"	$2,135,830	0.0	$0	$0	$2,135,830	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$2,135,830**	**0.0**	**$0**	**$0**	**$2,135,830**	**$0**	**$0**
SB 11-219 Annualization "2011 Transfers For Health Care Services"	($2,135,830)	0.0	$0	$0	($2,135,830)	$0	$0
FY 2012-13 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 February 15 Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
H.B. 97-1304 Children's Basic Health Plan Trust							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 February 15 Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
Comprehensive Primary Care Grants Program							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$2,706,995	0.0	$0	$0	$2,706,995	$0	$0
SB 11-216 "Children's Basic Health Plan General Fund Appropriation"	($2,706,995)	0.0	$0	$0	($2,706,995)	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 February 15 Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Children's Basic Health Plan Administration							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$4,894,410	0.0	$272,494	$0	$1,948,454	$0	$2,673,462
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$4,894,410**	**0.0**	**$272,494**	**$0**	**$1,948,454**	**$0**	**$2,673,462**
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$1,912	0.0	$0	$0	$669	$0	$1,243
SB 11-008 "Aligning Children's Medicaid Eligibility"	$1,000	0.0	$0	$0	$350	$0	$650
SB 11-250 "Pregnant Women Medicaid Eligibility"	$1,000	0.0	$0	$0	$350	$0	$650
FY 2012-13 Base Request	**$4,898,322**	**0.0**	**$272,494**	**$0**	**$1,949,823**	**$0**	**$2,676,005**
FY 2012-13 R#8: "Federally Mandated CHIPRA Quality Measures"	$236,671	0.0	$82,835	$0	$0	$0	$153,836
FY 2012-13 February 15 Request	**$5,134,993**	**0.0**	**$355,329**	**$0**	**$1,949,823**	**$0**	**$2,829,841**
Children's Basic Health Plan Medical and Dental Costs							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$213,086,149	0.0	$33,001,775	$0	$41,578,378	$0	$138,505,996
SB 11-216 "Children's Basic Health Plan General Fund Appropriation"	$0	0.0	($3,449,967)	$446,100	$3,003,867	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$213,086,149**	**0.0**	**$29,551,808**	**$446,100**	**$44,582,245**	**$0**	**$138,505,996**
Annualization of FY 2011-12 BRI#4: "CHP+ Program Reductions"	($4,003,077)	0.0	($1,200,204)	$0	($200,873)	$0	($2,602,000)
SB 11-008 "Aligning Children's Medicaid Eligibility"	($11,929,097)	0.0	$0	$0	($4,175,184)	$0	($7,753,913)
SB 11-250 "Pregnant Women Medicaid Eligibility"	($9,387,101)	0.0	($3,285,485)	$0	$0	$0	($6,101,616)
FY 2012-13 Base Request	**$187,766,874**	**0.0**	**$25,066,119**	**$446,100**	**$40,206,188**	**$0**	**$122,048,467**
FY 2012-13 R#3: "Children's Basic Health Plan Medical Premium and Dental Benefit Costs"	($3,434,456)	0.0	$0	$0	($862,887)	$0	($2,571,569)
FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	($1,789,365)	0.0	($523,329)	$0	$117,055	$0	($1,383,091)
FY 2012-13 R#9: "CHP+ Eligibility for Children of State Employees"	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 February 15 Request	**$182,543,053**	**0.0**	**$24,542,790**	**$446,100**	**$39,460,356**	**$0**	**$118,093,807**
(4) Indigent Care Program							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$579,063,502	0.0	$42,234,118	$446,100	$230,142,352	$446,100	$305,794,832
SB 11-216 "Children's Basic Health Plan General Fund Appropriation"	($4,639,039)	0.0	($3,449,967)	$0	$0	($446,100)	($742,972)
SB 11-219 "2011 Transfers For Health Care Services"	($2,607,170)	0.0	$0	$0	($14,362,170)	$0	$11,755,000
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$571,817,293**	**0.0**	**$38,784,151**	**$446,100**	**$215,780,182**	**$0**	**$316,806,860**
Annualization of FY 2011-12 BRI#4: "CHP+ Program Reductions"	($4,003,077)	0.0	($1,200,204)	$0	($200,873)	$0	($2,602,000)
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$1,912	0.0	$0	$0	$669	$0	$1,243
SB 11-219 Annualization "2011 Transfers For Health Care Services"	$2,607,170	0.0	$0	$0	$14,362,170	$0	($11,755,000)
SB 11-008 "Aligning Children's Medicaid Eligibility"	($11,928,097)	0.0	$0	$0	($4,174,834)	$0	($7,753,263)
SB 11-250 "Pregnant Women Medicaid Eligibility"	($9,386,101)	0.0	($3,285,485)	$0	$350	$0	($6,100,966)
FY 2012-13 Base Request	**$549,109,100**	**0.0**	**$34,298,462**	**$446,100**	**$225,767,664**	**$0**	**$288,596,874**
FY 2012-13 R#3: "Children's Basic Health Plan Medical Premium and Dental Benefit Costs"	($3,434,456)	0.0	$0	$0	($862,887)	$0	($2,571,569)
FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	($1,789,365)	0.0	($523,329)	$0	$117,055	$0	($1,383,091)
FY 2012-13 R#8: "Federally Mandated CHIPRA Quality Measures"	$236,671	0.0	$82,835	$0	$0	$0	$153,836
FY 2012-13 R#9: "CHP+ Eligibility for Children of State Employees"	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 R#10: "Utilize Supplemental Payments for General Fund Relief"	($15,896,240)	0.0	$0	$0	($7,948,120)	$0	($7,948,120)
FY 2012-13 February 15 Request	**$528,225,710**	**0.0**	**$33,857,968**	**$446,100**	**$217,073,712**	**$0**	**$276,847,930**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(5) Other Medical Services

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Services for Old Age Pension State Medical Program Clients							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$11,000,000	0.0	$0	$0	$11,000,000	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$11,000,000**	**0.0**	**$0**	**$0**	**$11,000,000**	**$0**	**$0**
FY 2012-13 Base Request	**$11,000,000**	**0.0**	**$0**	**$0**	**$11,000,000**	**$0**	**$0**
FY 2012-13 February 15 Request	**$11,000,000**	**0.0**	**$0**	**$0**	**$11,000,000**	**$0**	**$0**
Transfer of Tobacco Tax Cash Fund into the Supplemental Old Age Pension State Medical Fund							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$2,230,500	0.0	$0	$0	$2,230,500	$0	$0
SB 11-210 "Phase Out Supplemental OAP Health Fund"	($2,230,500)	0.0	$0	$0	($2,230,500)	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 February 15 Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
Commission on Family Medicine Residency Training Programs							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$1,391,077	0.0	$695,538	$0	$0	$0	$695,539
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$1,391,077**	**0.0**	**$695,538**	**$0**	**$0**	**$0**	**$695,539**
FY 2012-13 Base Request	**$1,391,077**	**0.0**	**$695,538**	**$0**	**$0**	**$0**	**$695,539**
FY 2012-13 February 15 Request	**$1,391,077**	**0.0**	**$695,538**	**$0**	**$0**	**$0**	**$695,539**
State University Teaching Hospitals - Denver Health and Hospital Authority							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$1,831,714	0.0	$915,857	$0	$0	$0	$915,857
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$1,831,714**	**0.0**	**$915,857**	**$0**	**$0**	**$0**	**$915,857**
FY 2012-13 Base Request	**$1,831,714**	**0.0**	**$915,857**	**$0**	**$0**	**$0**	**$915,857**
FY 2012-13 February 15 Request	**$1,831,714**	**0.0**	**$915,857**	**$0**	**$0**	**$0**	**$915,857**
State University Teaching Hospitals - University of Colorado Hospital Authority							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$633,314	0.0	$316,657	$0	$0	$0	$316,657
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$633,314**	**0.0**	**$316,657**	**$0**	**$0**	**$0**	**$316,657**
FY 2012-13 Base Request	**$633,314**	**0.0**	**$316,657**	**$0**	**$0**	**$0**	**$316,657**
FY 2012-13 February 15 Request	**$633,314**	**0.0**	**$316,657**	**$0**	**$0**	**$0**	**$316,657**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(5) Other Medical Services

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Medicare Modernization Act of 2003 State Contribution Payment							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$91,156,720	0.0	$66,146,615	$0	$0	$0	$25,010,105
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$91,156,720**	**0.0**	**$66,146,615**	**$0**	**$0**	**$0**	**$25,010,105**
Annualization of FY 2011-12 BA#11: "Cash Fund Insolvency True-Up"	$0	0.0	($6,018,686)	$0	$0	$0	$6,018,686
FY 2012-13 Base Request	**$91,156,720**	**0.0**	**$60,127,929**	**$0**	**$0**	**$0**	**$31,028,791**
FY 2012-13 R#4: "Medicare Modernization Act State Contribution Payment"	$5,518,142	0.0	$5,518,142	$0	$0	$0	$0
FY 2012-13 R#11: "CHIPRA Bonus Payment True-up"	$0	0.0	($15,036,785)	$0	$0	$0	$15,036,785
FY 2012-13 February 15 Request	**$96,674,862**	**0.0**	**$50,609,286**	**$0**	**$0**	**$0**	**$46,065,576**
Public School Health Services Contract Administration							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$1,138,549	0.0	$0	$0	$0	$0	$1,138,549
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$1,138,549**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$1,138,549**
Annualization of FY 2011-12 BA#5: "School Based Health Program Refinancing"	$262,231	0.0	$0	$0	$0	$0	$262,231
FY 2012-13 Base Request	**$1,400,780**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$1,400,780**
FY 2012-13 February 15 Request	**$1,400,780**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$1,400,780**
Public School Health Services							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$30,446,344	0.0	$0	$0	$16,010,155	$0	$14,436,189
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$30,446,344**	**0.0**	**$0**	**$0**	**$16,010,155**	**$0**	**$14,436,189**
Annualization of FY 2011-12 BA#5: "School Based Health Program Refinancing"	$4,290,860	0.0	$0	$0	$2,103,154	$0	$2,187,706
FY 2012-13 Base Request	**$34,737,204**	**0.0**	**$0**	**$0**	**$18,113,309**	**$0**	**$16,623,895**
FY 2012-13 February 15 Request	**$34,737,204**	**0.0**	**$0**	**$0**	**$18,113,309**	**$0**	**$16,623,895**
(5) Other Medical Services							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$139,828,218	0.0	$68,074,667	$0	$29,240,655	$0	$42,512,896
SB 11-210 "Phase Out Supplemental OAP Health Fund"	($2,230,500)	0.0	$0	$0	($2,230,500)	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$137,597,718**	**0.0**	**$68,074,667**	**$0**	**$27,010,155**	**$0**	**$42,512,896**
Annualization of FY 2011-12 BA#5: "School Based Health Program Refinancing"	$4,553,091	0.0	$0	$0	$2,103,154	$0	$2,449,937
Annualization of FY 2011-12 BA#11: "Cash Fund Insolvency True-Up"	$0	0.0	($6,018,686)	$0	$0	$0	$6,018,686
FY 2012-13 Base Request	**$142,150,809**	**0.0**	**$62,055,981**	**$0**	**$29,113,309**	**$0**	**$50,981,519**
FY 2012-13 R#4: "Medicare Modernization Act State Contribution Payment"	$5,518,142	0.0	$5,518,142	$0	$0	$0	$0
FY 2012-13 R#11: "CHIPRA Bonus Payment True-up"	$0	0.0	($15,036,785)	$0	$0	$0	$15,036,785
FY 2012-13 February 15 Request	**$147,668,951**	**0.0**	**$52,537,338**	**$0**	**$29,113,309**	**$0**	**$66,018,304**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(A) Executive Director's Office - Medicaid Funding							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$13,363,338	0.0	$6,681,669	$0	$0	$0	$6,681,669
SB 11-076 "PERA Contribution Rates"	($18,819)	0.0	($9,410)	$0	$0	$0	($9,409)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$13,344,519**	**0.0**	**$6,672,259**	**$0**	**$0**	**$0**	**$6,672,260**
Annualization of FY 2009-10 NP-BA#12: "DHS - 5% Operating Reduction"	$3,300	0.0	$1,650	$0	$0	$0	$1,650
SB 11-076 Annualization "PERA Contribution Rates"	$18,819	0.0	$9,410	$0	$0	$0	$9,409
FY 2012-13 Common Policy Adjustment	$1,831,314	0.0	$917,184	$0	$0	$0	$914,130
FY 2012-13 Base Request	**$15,197,952**	**0.0**	**$7,600,503**	**$0**	**$0**	**$0**	**$7,597,449**
FY 2012-13 February 15 Request	**$15,197,952**	**0.0**	**$7,600,503**	**$0**	**$0**	**$0**	**$7,597,449**
(B) Office of Information Technology Services - Medicaid Funding							
Colorado Benefits Management System							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$8,983,839	0.0	$4,461,609	$0	$14,428	$19,399	$4,488,403
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$8,983,839**	**0.0**	**$4,461,609**	**$0**	**$14,428**	**$19,399**	**$4,488,403**
Annualization of FY 2009-10 NP-BA#12: "DHS - 5% Operating Reduction"	$21,910	0.0	$10,865	$0	$45	$52	$10,948
Annualization of FY 2011-12 BRI#4: "CHP+ Program Reductions"	($15,184)	0.0	($7,530)	$0	($31)	($36)	($7,587)
Annualization of FY 2011-12 DI#5: "CBMS Compliance with Low Income Subsidy and Disability Determination Services Federal Requirements"	($214,920)	0.0	($107,460)	$0	$0	$0	($107,460)
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	($83,272)	0.0	($41,355)	$0	($314)	$0	($41,603)
SB 10-061 Annualization "Medicaid Hospice Room And Board Charges"	$151,453	0.0	$75,103	$0	$310	$362	$75,678
SB 11-008 "Aligning Children's Medicaid Eligibility"	$25,728	0.0	$12,777	$0	$41	$56	$12,854
SB 11-250 "Pregnant Women Medicaid Eligibility"	$25,728	0.0	$12,777	$0	$41	$56	$12,854
FY 2012-13 Base Request	**$8,895,282**	**0.0**	**$4,416,786**	**$0**	**$14,520**	**$19,889**	**$4,444,087**
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$14,040	0.0	$0	$0	$7,020	$0	$7,020
FY 2012-13 R#13: "CBMS Electronic Document Management System"	$464,126	0.0	$230,708	$0	$462	$1,392	$231,564
FY 2012-13 BA#5: "CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects"	($300,994)	0.0	($149,482)	$0	($483)	($650)	($150,379)
FY 2012-13 February 15 Request	**$9,072,454**	**0.0**	**$4,498,012**	**$0**	**$21,519**	**$20,631**	**$4,532,292**
Colorado Benefits Management System Projects - HCPF Only (new line item)							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2011-12 Total with Supplemental Requests	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2012-13 BA#5: "CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects"	$597,480	0.0	$0	$0	$298,740	$0	$298,740
FY 2012-13 February 15 Request	**$597,480**	**0.0**	**$0**	**$0**	**$298,740**	**$0**	**$298,740**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
CBMS SAS-70 Audit							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$55,204	0.0	$27,416	$0	$89	$119	$27,580
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$55,204**	**0.0**	**$27,416**	**$0**	**$89**	**$119**	**$27,580**
FY 2012-13 Base Request	**$55,204**	**0.0**	**$27,416**	**$0**	**$89**	**$119**	**$27,580**
FY 2012-13 February 15 Request	**$55,204**	**0.0**	**$27,416**	**$0**	**$89**	**$119**	**$27,580**
Other Office of Information Technology Services line items							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$556,271	0.0	$278,136	$0	$0	$0	$278,135
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$556,271**	**0.0**	**$278,136**	**$0**	**$0**	**$0**	**$278,135**
Annualization of FY 2009-10 NP-BA#12: "DHS - 5% Operating Reduction"	$684	0.0	$342	$0	$0	$0	$342
FY 2012-13 Common Policy Adjustment	($59,552)	0.0	($29,777)	$0	$0	$0	($29,775)
FY 2012-13 Base Request	**$497,403**	**0.0**	**$248,701**	**$0**	**$0**	**$0**	**$248,702**
FY 2012-13 February 15 Request	**$497,403**	**0.0**	**$248,701**	**$0**	**$0**	**$0**	**$248,702**
(C) Office of Operations - Medicaid Funding							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$5,159,398	0.0	$2,579,699	$0	$0	$0	$2,579,699
SB 11-076 "PERA Contribution Rates"	($66,044)	0.0	($33,022)	$0	$0	$0	($33,022)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$5,093,354**	**0.0**	**$2,546,677**	**$0**	**$0**	**$0**	**$2,546,677**
Annualization of FY 2009-10 NP-BA#12: "DHS - 5% Operating Reduction"	$21,246	0.0	$10,623	$0	$0	$0	$10,623
SB 11-076 Annualization "PERA Contribution Rates"	$66,044	0.0	$33,022	$0	$0	$0	$33,022
FY 2012-13 Common Policy Adjustment	$4,327	0.0	$2,164	$0	$0	$0	$2,163
FY 2012-13 Base Request	**$5,184,971**	**0.0**	**$2,592,486**	**$0**	**$0**	**$0**	**$2,592,485**
FY 2012-13 NP-R#2: "DHS - Statewide Vehicle Replacement"	$15,149	0.0	$7,574	$0	$0	$0	$7,575
FY 2012-13 NP-BA#1: "DHS - Utilities Funding Request"	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
FY 2012-13 February 15 Request	**$4,850,120**	**0.0**	**$2,425,060**	**$0**	**$0**	**$0**	**$2,425,060**
(D) Division of Child Welfare - Medicaid Funding							
Administration							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$133,659	0.0	$66,830	$0	$0	$0	$66,829
SB 11-076 "PERA Contribution Rates"	($2,721)	0.0	($1,361)	$0	$0	$0	($1,360)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$130,938**	**0.0**	**$65,469**	**$0**	**$0**	**$0**	**$65,469**
Annualization of FY 2009-10 NP-BA#12: "DHS - 5% Operating Reduction"	$646	0.0	$323	$0	$0	$0	$323
SB 11-076 Annualization "PERA Contribution Rates"	$2,721	0.0	$1,361	$0	$0	$0	$1,360
FY 2012-13 Base Request	**$134,305**	**0.0**	**$67,153**	**$0**	**$0**	**$0**	**$67,152**
FY 2012-13 February 15 Request	**$134,305**	**0.0**	**$67,153**	**$0**	**$0**	**$0**	**$67,152**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Child Welfare Services							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$14,328,538	0.0	$7,164,269	$0	$0	$0	$7,164,269
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$14,328,538**	**0.0**	**$7,164,269**	**$0**	**$0**	**$0**	**$7,164,269**
Annualization of Leap Year Adjustment	($35,266)	0.0	($17,633)	$0	$0	$0	($17,633)
FY 2012-13 Base Request	**$14,293,272**	**0.0**	**$7,146,636**	**$0**	**$0**	**$0**	**$7,146,636**
FY 2012-13 February 15 Request	**$14,293,272**	**0.0**	**$7,146,636**	**$0**	**$0**	**$0**	**$7,146,636**
(E) Office of Self Sufficiency - Medicaid Funding							
Systematic Alien Verification for Eligibility							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$33,951	0.0	$16,976	$0	$0	$0	$16,975
SB 11-076 "PERA Contribution Rates"	($740)	0.0	($370)	$0	$0	$0	($370)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$33,211**	**0.0**	**$16,606**	**$0**	**$0**	**$0**	**$16,605**
SB 11-076 Annualization "PERA Contribution Rates"	$740	0.0	$370	$0	$0	$0	$370
FY 2012-13 Base Request	**$33,951**	**0.0**	**$16,976**	**$0**	**$0**	**$0**	**$16,975**
FY 2012-13 February 15 Request	**$33,951**	**0.0**	**$16,976**	**$0**	**$0**	**$0**	**$16,975**
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding							
Administration							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$392,848	0.0	$196,424	$0	$0	$0	$196,424
SB 11-076 "PERA Contribution Rates"	($7,666)	0.0	($3,833)	$0	$0	$0	($3,833)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$385,182**	**0.0**	**$192,591**	**$0**	**$0**	**$0**	**$192,591**
Annualization of FY 2009-10 NP-BA#12: "DHS - 5% Operating Reduction"	$442	0.0	$221	$0	$0	$0	$221
SB 11-076 Annualization "PERA Contribution Rates"	$7,666	0.0	$3,833	$0	$0	$0	$3,833
FY 2012-13 Base Request	**$393,290**	**0.0**	**$196,645**	**$0**	**$0**	**$0**	**$196,645**
FY 2012-13 February 15 Request	**$393,290**	**0.0**	**$196,645**	**$0**	**$0**	**$0**	**$196,645**
Residential Treatment for Youth (H.B. 99-1116)							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$116,840	0.0	$58,420	$0	$0	$0	$58,420
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$116,840**	**0.0**	**$58,420**	**$0**	**$0**	**$0**	**$58,420**
FY 2012-13 Base Request	**$116,840**	**0.0**	**$58,420**	**$0**	**$0**	**$0**	**$58,420**
FY 2012-13 February 15 Request	**$116,840**	**0.0**	**$58,420**	**$0**	**$0**	**$0**	**$58,420**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Mental Health Institutes							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$4,176,550	0.0	$2,088,275	$0	$0	$0	$2,088,275
SB 11-076 "PERA Contribution Rates"	($46,631)	0.0	($23,316)	$0	$0	$0	($23,315)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$4,129,919**	**0.0**	**$2,064,959**	**$0**	**$0**	**$0**	**$2,064,960**
Annualization of FY 2009-10 NP-BA#12: "DHS - 5% Operating Reduction"	$20,362	0.0	$10,181	$0	$0	$0	$10,181
SB 11-076 Annualization "PERA Contribution Rates"	$46,631	0.0	$23,316	$0	$0	$0	$23,315
FY 2012-13 Base Request	**$4,196,912**	**0.0**	**$2,098,456**	**$0**	**$0**	**$0**	**$2,098,456**
FY 2012-13 NP-BA#2: "DHS - Colorado Mental Health Institutes Revenue Adjustment"	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
FY 2012-13 February 15 Request	**$5,322,778**	**0.0**	**$2,661,389**	**$0**	**$0**	**$0**	**$2,661,389**
Alcohol and Drug Abuse Division, High Risk Pregnant Women Program							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$1,999,146	0.0	$999,573	$0	$0	$0	$999,573
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$1,999,146**	**0.0**	**$999,573**	**$0**	**$0**	**$0**	**$999,573**
FY 2012-13 Base Request	**$1,999,146**	**0.0**	**$999,573**	**$0**	**$0**	**$0**	**$999,573**
FY 2012-13 February 15 Request	**$1,999,146**	**0.0**	**$999,573**	**$0**	**$0**	**$0**	**$999,573**
(G) Services for People with Disabilities - Medicaid Funding							
Community Services for People with Developmental Disabilities, Administration							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$2,923,329	0.0	$1,461,665	$0	$0	$0	$1,461,664
SB 11-076 "PERA Contribution Rates"	($50,650)	0.0	($25,325)	$0	$0	$0	($25,325)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$2,872,679**	**0.0**	**$1,436,340**	**$0**	**$0**	**$0**	**$1,436,339**
Annualization of FY 2009-10 NP-BA#12: "DHS - 5% Operating Reduction"	$12,632	0.0	$6,316	$0	$0	$0	$6,316
SB 11-076 Annualization "PERA Contribution Rates"	$50,650	0.0	$25,325	$0	$0	$0	$25,325
FY 2012-13 Base Request	**$2,935,961**	**0.0**	**$1,467,981**	**$0**	**$0**	**$0**	**$1,467,980**
FY 2012-13 February 15 Request	**$2,935,961**	**0.0**	**$1,467,981**	**$0**	**$0**	**$0**	**$1,467,980**
Community Services for People with Developmental Disabilities, Program Costs							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$328,231,550	0.0	$164,115,774	$0	$1	$0	$164,115,775
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$328,231,550**	**0.0**	**$164,115,774**	**$0**	**$1**	**$0**	**$164,115,775**
Annualization of FY 2011-12 NP#4: "DHS - Services for People with Disabilities-New Funding Developmental Disabilities Services"	$3,248,006	0.0	$1,624,004	$0	$0	$0	$1,624,002
Annualization of Leap Year Adjustment	($707,335)	0.0	($353,667)	$0	$0	$0	($353,668)
FY 2012-13 Base Request	**$330,772,221**	**0.0**	**$165,386,111**	**$0**	**$1**	**$0**	**$165,386,109**
FY 2012-13 NP-R#1: "DHS - New Funding – Developmental Disabilities Services"	$4,877,540	0.0	$2,438,770	$0	$0	$0	$2,438,770
FY 2012-13 February 15 Request	**$335,649,761**	**0.0**	**$167,824,881**	**$0**	**$1**	**$0**	**$167,824,879**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Regional Centers							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$47,676,045	0.0	$21,970,368	$0	$0	$1,867,655	$23,838,022
SB 11-076 "PERA Contribution Rates"	($846,245)	0.0	($423,123)	$0	$0	$0	($423,122)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$46,829,800**	**0.0**	**$21,547,245**	**$0**	**$0**	**$1,867,655**	**$23,414,900**
Annualization of FY 2009-10 NP-BA#12: "DHS - 5% Operating Reduction"	$125,770	0.0	$62,885	$0	$0	$0	$62,885
SB 11-076 Annualization "PERA Contribution Rates"	$846,245	0.0	$423,123	$0	$0	$0	$423,122
FY 2012-13 Base Request	**$47,801,815**	**0.0**	**$22,033,253**	**$0**	**$0**	**$1,867,655**	**$23,900,907**
FY 2012-13 February 15 Request	**$47,801,815**	**0.0**	**$22,033,253**	**$0**	**$0**	**$1,867,655**	**$23,900,907**
Regional Center Depreciation and Annual Adjustments							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$1,187,825	0.0	$593,913	$0	$0	$0	$593,912
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$1,187,825**	**0.0**	**$593,913**	**$0**	**$0**	**$0**	**$593,912**
FY 2012-13 Base Request	**$1,187,825**	**0.0**	**$593,913**	**$0**	**$0**	**$0**	**$593,912**
FY 2012-13 February 15 Request	**$1,187,825**	**0.0**	**$593,913**	**$0**	**$0**	**$0**	**$593,912**
(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$1,800	0.0	$900	$0	$0	$0	$900
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$1,800**	**0.0**	**$900**	**$0**	**$0**	**$0**	**$900**
FY 2012-13 Base Request	**$1,800**	**0.0**	**$900**	**$0**	**$0**	**$0**	**$900**
FY 2012-13 February 15 Request	**$1,800**	**0.0**	**$900**	**$0**	**$0**	**$0**	**$900**
(I) Division of Youth Corrections - Medicaid Funding							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$1,286,981	0.0	$643,491	$0	$0	$0	$643,490
SB 11-076 "PERA Contribution Rates"	($1,030)	0.0	($515)	$0	$0	$0	($515)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$1,285,951**	**0.0**	**$642,976**	**$0**	**$0**	**$0**	**$642,975**
SB 11-076 Annualization "PERA Contribution Rates"	$1,030	0.0	$515	$0	$0	$0	$515
Annualization of Leap Year Adjustment	($3,302)	0.0	($1,651)	$0	$0	$0	($1,651)
FY 2012-13 Base Request	**$1,283,679**	**0.0**	**$641,840**	**$0**	**$0**	**$0**	**$641,839**
FY 2012-13 NP-BA#3: "DHS - DYC Contract Placement Supplemental"	$349,104	0.0	$174,552	$0	$0	$0	$174,552
FY 2012-13 February 15 Request	**$1,632,783**	**0.0**	**$816,392**	**$0**	**$0**	**$0**	**$816,391**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(J) Other							
Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$500,000	0.0	$0	$0	$0	$0	$500,000
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$500,000**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$500,000**
FY 2012-13 Base Request	**$500,000**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$500,000**
FY 2012-13 February 15 Request	**$500,000**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$500,000**
(6) Department of Human Services Medicaid-Funded Programs							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$431,107,112	0.0	$213,405,407	$0	$14,518	$1,887,173	$215,800,014
SB 11-076 "PERA Contribution Rates"	($1,040,546)	0.0	($520,275)	$0	$0	$0	($520,271)
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$430,066,566**	**0.0**	**$212,885,132**	**$0**	**$14,518**	**$1,887,173**	**$215,279,743**
Annualization of FY 2009-10 NP-BA#12: "DHS - 5% Operating Reduction"	$206,992	0.0	$103,406	$0	$45	$52	$103,489
Annualization of FY 2011-12 BRI#4: "CHP+ Program Reductions"	($15,184)	0.0	($7,530)	$0	($31)	($36)	($7,587)
Annualization of FY 2011-12 DI#5: "CBMS Compliance with Low Income Subsidy and Disability Determination Services Federal Requirements"	($214,920)	0.0	($107,460)	$0	$0	$0	($107,460)
Annualization of FY 2011-12 NP#4: "DHS - Services for People with Disabilities-New Funding Developmental Disabilities Services"	$3,248,006	0.0	$1,624,004	$0	$0	$0	$1,624,002
SB 10-061 Annualization "Medicaid Hospice Room And Board Charges"	$151,453	0.0	$75,103	$0	$310	$362	$75,678
SB 11-076 Annualization "PERA Contribution Rates"	$1,040,546	0.0	$520,275	$0	$0	$0	$520,271
SB 11-008 "Aligning Children's Medicaid Eligibility"	$25,728	0.0	$12,777	$0	$41	$56	$12,854
SB 11-250 "Pregnant Women Medicaid Eligibility"	$25,728	0.0	$12,777	$0	$41	$56	$12,854
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	($83,272)	0.0	($41,355)	$0	($314)	$0	($41,603)
Annualization of Leap Year Adjustment	($745,903)	0.0	($372,951)	$0	$0	$0	($372,952)
FY 2012-13 Common Policy Adjustment	$1,776,089	0.0	$889,571	$0	$0	$0	$886,518
FY 2012-13 Base Request	**$435,481,829**	**0.0**	**$215,593,749**	**$0**	**$14,610**	**$1,887,663**	**$217,985,807**
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$14,040	0.0	$0	$0	$7,020	$0	$7,020
FY 2012-13 R#13: "CBMS Electronic Document Management System"	$464,126	0.0	$230,708	$0	$462	$1,392	$231,564
FY 2012-13 NP-R#1: "DHS - New Funding – Developmental Disabilities Services"	$4,877,540	0.0	$2,438,770	$0	$0	$0	$2,438,770
FY 2012-13 NP-R#2: "DHS - Statewide Vehicle Replacement"	$15,149	0.0	$7,574	$0	$0	$0	$7,575
FY 2012-13 BA#5: "CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects"	$296,486	0.0	($149,482)	$0	$298,257	($650)	$148,361
FY 2012-13 NP-BA#1: "DHS - Utilities Funding Request"	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
FY 2012-13 NP-BA#2: "DHS - Colorado Mental Health Institutes Revenue Adjustment"	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
FY 2012-13 NP-BA#3: "DHS - DYC Contract Placement Supplemental"	$349,104	0.0	$174,552	$0	$0	$0	$174,552
FY 2012-13 February 15 Request	**$442,274,140**	**0.0**	**$218,683,804**	**$0**	**$320,349**	**$1,888,405**	**$221,381,582**

Note that the Department is continuing to work with the Department of Human Services to reconcile minor differences between the two departments' FY 2012-13 Base Requests.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

Department Summary

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Department Summary							
FY 2011-12 Long Bill Appropriation (SB 11-209)	$5,086,626,060	312.2	$1,494,116,123	$284,621,517	$780,942,590	$7,535,223	$2,519,410,607
HB 11-1242 "Medicaid Provider Integration Of Service"	$113,500	0.0	$0	$0	$56,750	$0	$56,750
SB 11-076 "PERA Contribution Rates"	($1,630,244)	0.0	($714,347)	$0	($56,118)	$0	($859,779)
SB 11-125 "Nursing Home Fees & Order of Payments"	$31,054,411	0.0	$30,000	$0	$15,497,206	$0	$15,527,205
SB 11-177 "Repeal Sunset Teen Pregnancy & Dropout Program"	$386,665	1.0	$0	$0	$38,666	$0	$347,999
SB 11-210 "Phase Out Supplemental OAP Health Fund"	($2,230,500)	0.0	($2,230,500)	$0	$0	$0	$0
SB 11-211 "Tobacco Revenues Offset Medical Services"	$0	0.0	($33,000,000)	$0	$29,713,649	$3,286,351	$0
SB 11-212 "Use Provider Fee Offset GF Medicaid"	$0	0.0	($50,000,000)	$0	$50,000,000	$0	$0
SB 11-215 "2011 Nursing Facility Rate Reduction"	($8,865,830)	0.0	($4,432,915)	$0	$0	$0	($4,432,915)
SB 11-216 "Children's Basic Health Plan General Fund Appropriation"	($4,663,402)	(0.2)	($3,449,967)	$0	($24,363)	($446,100)	($742,972)
SB 11-219 "2011 Transfers For Health Care Services"	($2,607,170)	0.0	($15,775,670)	$0	$1,413,500	$0	$11,755,000
FY 2011-12 Total Appropriation (Long Bill plus Special Bills)	**$5,098,183,490**	**313.0**	**$1,384,542,724**	**$284,621,517**	**$877,581,880**	**$10,375,474**	**$2,541,061,895**
Annualization of FY 2009-10 NP-BA#12: "DHS - 5% Operating Reduction"	$206,992	0.0	$103,406	$0	$45	$52	$103,489
Annualization of FY 2010-11 BA#13: "Coordinated Payment and Payment Reform"	$112,500	0.0	$56,250	$0	$0	$0	$56,250
Annualization of FY 2010-11 BA#15: "MMIS Adjustments"	($1,064,400)	0.0	($106,440)	$0	$0	$0	($957,960)
Annualization of FY 2010-11 BA#17: "General Operating Expenses Reduction"	$69,140	0.0	$34,570	$0	$0	$0	$34,570
Annualization of FY 2011-12 BRI#1: "Client Overutilization Program Expansion"	($1,306,100)	0.0	($601,075)	$0	$0	$0	($705,025)
Annualization of FY 2011-12 BRI#4: "CHP+ Program Reductions"	($4,018,261)	0.0	($1,207,734)	$0	($200,904)	($36)	($2,609,587)
Annualization of FY 2011-12 BRI#5: "Medicaid Reductions"	($4,076,075)	0.0	($1,811,552)	$0	($179,235)	$0	($2,085,288)
Annualization of FY 2011-12 DI#5: "CBMS Compliance with Low Income Subsidy and Disability Determination Services Federal Requirements"	($214,920)	0.0	($107,460)	$0	$0	$0	($107,460)
Annualization of FY 2011-12 DI#8: "Prenatal Plus Administration Transfer"	$1,557	0.0	$779	$0	$0	$0	$778
Annualization of FY 2011-12 NP#4: "DHS - Services for People with Disabilities-New Funding Developmental Disabilities Services"	$3,248,006	0.0	$1,624,004	$0	$0	$0	$1,624,002
Annualization of FY 2011-12 BA#5: "School Based Health Program Refinancing"	$4,561,017	0.0	$0	$0	$2,103,154	$0	$2,457,863
Annualization of FY 2011-12 BA#9: "Medicaid Budget Balancing Reductions"	($4,990,094)	0.0	($2,081,416)	$0	($407,078)	$0	($2,501,600)
Annualization of FY 2011-12 BA#11: "Cash Fund Insolvency True-Up"	$0	0.0	($6,018,686)	$0	$0	$0	$6,018,686
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$3,162,525	0.0	($41,355)	$0	$1,558,267	$0	$1,645,613
HB 10-1027 Annualization "Medicaid Hospice Life Expectancy"	($25,000)	0.0	$0	$0	($12,500)	$0	($12,500)
HB 10-1380 Annualization "Use Supplemental OAP Health Fund for Medicaid"	$0	0.0	$3,000,000	$0	($3,000,000)	$0	$0
HB 11-1242 Annualization "Medicaid Provider Integration Of Service"	($113,500)	0.0	$0	$0	($56,750)	$0	($56,750)
SB 10-061 Annualization "Medicaid Hospice Room And Board Charges"	$494,804	0.5	$171,957	$0	($4,690)	$362	$327,175
SB 11-076 Annualization "PERA Contribution Rates"	$1,630,244	0.0	$714,347	$0	$56,118	$0	$859,779
SB 11-125 Annualization "Nursing Home Fees & Order of Payments"	$466,905	0.0	$0	$0	$233,452	$0	$233,453
SB 11-177 Annualization "Repeal Sunset Teen Pregnancy & Dropout Program"	$541,810	0.0	($2,204)	$0	$54,622	$0	$489,392
SB 11-211 Annualization "Tobacco Revenues Offset Medical Services"	$0	0.0	$33,000,000	$0	($29,713,649)	($3,286,351)	$0
SB 11-212 Annualization "Use Provider Fee Offset GF Medicaid"	$0	0.0	$25,000,000	$0	($25,000,000)	$0	$0
SB 11-215 Annualization "2011 Nursing Facility Rate Reduction"	$8,865,830	0.0	$4,432,915	$0	$0	$0	$4,432,915
SB 11-219 Annualization "2011 Transfers For Health Care Services"	$2,607,170	0.0	$15,775,670	$0	($1,413,500)	$0	($11,755,000)
SB 11-008 "Aligning Children's Medicaid Eligibility"	($2,305,786)	0.0	$3,364,780	$0	($4,126,528)	$56	($1,544,094)
SB 11-250 "Pregnant Women Medicaid Eligibility"	($1,826,854)	0.0	($636,720)	$0	$464	$56	($1,190,654)

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 RECONCILIATION OF DEPARTMENT REQUEST

Department Summary

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Annualization of the First Conference Committee Report on SB 09-259, Council for Affordable Health Insurance (CAHI)[1]	($150,000)	0.0	$0	$0	($150,000)	$0	$0
Align Fund Splits for Federal Allocation	$190,518	0.0	($3,567)	$0	$0	$0	$194,085
Annualization of Leap Year Adjustment	($745,903)	0.0	($372,951)	$0	$0	$0	($372,952)
Statewide Indirect Cost Allocation	$0	0.0	$88,624	$0	$27,698	($67,879)	($48,443)
FY 2012-13 Common Policy Adjustment	$1,786,341	0.0	$1,033,769	$0	($91,440)	$71,450	$772,562
FY 2012-13 Base Request	**$5,105,291,956**	**313.5**	**$1,459,952,635**	**$284,621,517**	**$817,259,426**	**$7,093,184**	**$2,536,365,194**
FY 2012-13 R#1: "Request for Medical Services Premiums"	$330,806,255	0.0	$129,303,556	$0	$36,238,486	$303,982	$164,960,231
FY 2012-13 R#2: "Medicaid Mental Health Community Programs"	$36,614,308	0.0	$21,388,240	$0	($3,087,673)	($13,544)	$18,327,285
FY 2012-13 R#3: "Children's Basic Health Plan Medical Premium and Dental Benefit Costs"	($3,434,456)	0.0	$0	$0	($862,887)	$0	($2,571,569)
FY 2012-13 R#4: "Medicare Modernization Act State Contribution Payment"	$5,518,142	0.0	$5,518,142	$0	$0	$0	$0
FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($1,845,030)	1.8	($865,469)	$0	($57,047)	$0	($922,514)
FY 2012-13 R#6: "Medicaid Budget Reductions"	($29,699,322)	0.0	($30,471,105)	$0	$15,496,446	$0	($14,724,663)
FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	($3,407,194)	0.0	($1,438,020)	$0	$91,841	$0	($2,061,015)
FY 2012-13 R#8: "Federally Mandated CHIPRA Quality Measures"	$236,671	0.0	$82,835	$0	$0	$0	$153,836
FY 2012-13 R#9: "CHP+ Eligibility for Children of State Employees"	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 R#10: "Utilize Supplemental Payments for General Fund Relief"	($1,006,752)	0.0	($1,006,752)	$0	$0	$0	$0
FY 2012-13 R#11: "CHIPRA Bonus Payment True-up"	$0	0.0	($15,036,785)	$0	$0	$0	$15,036,785
FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	($52,769)	0.0	$0	$0	$28,596	$0	($81,365)
FY 2012-13 R#13: "CBMS Electronic Document Management System"	$464,126	0.0	$230,708	$0	$462	$1,392	$231,564
FY 2012-13 NP-R#1: "DHS - New Funding – Developmental Disabilities Services"	$4,877,540	0.0	$2,438,770	$0	$0	$0	$2,438,770
FY 2012-13 NP-R#2: "DHS - Statewide Vehicle Replacement"	$15,149	0.0	$7,574	$0	$0	$0	$7,575
FY 2012-13 BA#1: "Medical Services Premiums Request"	$110,910,674	0.0	($4,016,472)	$0	$61,179,404	($190,350)	$53,938,092
FY 2012-13 BA#2: "Medicaid Mental Health Community Programs"	$2,726,901	0.0	($4,693,763)	$0	$6,226,382	$0	$1,194,282
FY 2012-13 BA#3: "Smoking Cessation Quitline for Medicaid Clients"	$1,373,470	0.0	$0	$0	$686,735	$0	$686,735
FY 2012-13 BA#4: "Utilize Supplemental Payments for General Fund Relief"	($10,527,400)	0.0	$400,246	$0	($5,946,273)	$0	($4,981,373)
FY 2012-13 BA#5: "CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects"	$296,486	0.0	($149,482)	$0	$298,257	($650)	$148,361
FY 2012-13 BA#6: "MMIS Technical Adjustments"	$1,065,358	0.0	$0	$0	$225,140	$0	$840,218
FY 2012-13 NP-BA#1: "DHS - Utilities Funding Request"	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
FY 2012-13 NP-BA#2: "DHS - Colorado Mental Health Institutes Revenue Adjustment"	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
FY 2012-13 NP-BA#3: "DHS - DYC Contract Placement Supplemental"	$349,104	0.0	$174,552	$0	$0	$0	$174,552
FY 2012-13 February 15 Request	**$5,551,349,083**	**315.3**	**$1,562,207,343**	**$284,621,517**	**$927,777,295**	**$7,194,014**	**$2,769,548,914**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2012-13 — Schedule 2

	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2009-10 Actual Expenditures							
(1) Executive Director's Office	$102,241,653	276.5	$33,466,646	$0	$8,921,543	$1,400,656	$58,452,808
(2) Medical Services Premiums	$2,877,822,564	0.0	$762,936,068	$0	$343,695,933	$3,917,255	$1,767,273,308
(3) Medicaid Mental Health Programs	$225,955,715	0.0	$80,353,236	$0	$6,393,602	$10,833	$139,198,044
(4) Indigent Care Programs	$518,967,785	0.0	$19,738,587	$450,000	$192,194,722	$10,735,690	$295,848,786
(5) Other Medical Services	$98,623,663	0.0	$59,225,631	$0	$21,629,028	$383,128	$17,385,876
(6) DHS Medicaid-Funded Programs	$415,140,344	0.0	$158,585,174	$0	$592,619	$2,065,986	$253,896,565
FY 2009-10 Total Actual Expenditures	**$4,238,751,724**	**276.5**	**$1,114,305,342**	**$450,000**	**$573,427,447**	**$18,513,548**	**$2,532,055,387**
FY 2010-11 Actual Expenditures							
(1) Executive Director's Office	$104,917,911	270.6	$33,633,591	$0	$9,480,297	$1,105,012	$60,699,011
(2) Medical Services Premiums	$3,395,627,672	0.0	$601,033,287	$279,344,485	$518,533,477	$7,414,327	$1,989,302,096
(3) Medicaid Mental Health Programs	$253,223,259	0.0	$96,589,817	$0	$9,559,892	$13,000	$147,060,550
(4) Indigent Care Programs	$540,375,861	0.0	$21,683,804	$436,728	$204,235,506	$7,293,608	$306,726,215
(5) Other Medical Services	$110,290,101	0.0	$60,423,086	$0	$19,509,080	$0	$30,357,935
(6) DHS Medicaid-Funded Programs	$438,883,396	0.0	$175,667,660	$0	$467,856	$1,870,759	$260,877,121
FY 2010-11 Total Actual Expenditures	**$4,843,318,200**	**270.6**	**$989,031,245**	**$279,781,213**	**$761,786,108**	**$17,696,706**	**$2,795,022,928**
FY 2011-12 Appropriation							
(1) Executive Director's Office	$138,437,180	313.0	$38,182,019	$0	$15,949,627	$2,086,698	$82,218,836
(2) Medical Services Premiums	$3,543,863,749	0.0	$898,839,033	$284,175,417	$608,317,175	$6,388,059	$1,746,144,065
(3) Medicaid Mental Health Programs	$276,400,984	0.0	$127,777,722	$0	$10,510,223	$13,544	$138,099,495
(4) Indigent Care Programs	$571,817,293	0.0	$38,784,151	$446,100	$215,780,182	$0	$316,806,860
(5) Other Medical Services	$137,597,718	0.0	$68,074,667	$0	$27,010,155	$0	$42,512,896
(6) DHS Medicaid-Funded Programs	$430,066,566	0.0	$212,885,132	$0	$14,518	$1,887,173	$215,279,743
FY 2011-12 Total Appropriation	**$5,098,183,490**	**313.0**	**$1,384,542,724**	**$284,621,517**	**$877,581,880**	**$10,375,474**	**$2,541,061,895**
FY 2012-13 Request							
(1) Executive Director's Office	$143,306,618	315.3	$38,806,294	$0	$17,570,719	$2,090,269	$84,839,336
(2) Medical Services Premiums	$3,972,941,557	0.0	$1,073,433,270	$284,175,417	$650,050,274	$3,215,340	$1,962,067,256
(3) Medicaid Mental Health Programs	$316,932,107	0.0	$144,888,669	$0	$13,648,932	$0	$158,394,506
(4) Indigent Care Programs	$528,225,710	0.0	$33,857,968	$446,100	$217,073,712	$0	$276,847,930
(5) Other Medical Services	$147,668,951	0.0	$52,537,338	$0	$29,113,309	$0	$66,018,304
(6) DHS Medicaid-Funded Programs	$442,274,140	0.0	$218,683,804	$0	$320,349	$1,888,405	$221,381,582
FY 2012-13 Total Request	**$5,551,349,083**	**315.3**	**$1,562,207,343**	**$284,621,517**	**$927,777,295**	**$7,194,014**	**$2,769,548,914**

Schedule 10
Summary of FY 2012-13 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: February 15, 2012
Number of Funding Requests: 19
Number of Non Prioritized Items: 5

Total Impact						**$446,057,127**	**1.8**	**$102,254,708**	**$0**	**$110,517,869**	**$100,830**	**$233,183,720**
Schedule 10 Priority	**Nov. 1, 2011 Priority**	**Jan. 3, 2012 Priority**	**Feb. 15, 2012 Priority**	**Title**	**IT Request**	**Total Request (FY 2012-13)**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2012-13 Funding Requests												
1	R-1	N/A	N/A	Request for Medical Services Premiums	No	$330,806,255	0.0	$129,303,556	$0	$36,238,486	$303,982	$164,960,231
2	R-2	N/A	N/A	Medicaid Mental Health Community Programs	No	$36,614,308	0.0	$21,388,240	$0	($3,087,673)	($13,544)	$18,327,285
3	R-3	N/A	N/A	Children's Basic Health Plan Medical and Dental Costs	No	($3,434,456)	0.0	$0	$0	($862,887)	$0	($2,571,569)
4	R-4	N/A	N/A	Medicare Modernization Act State Contribution Payment	No	$5,518,142	0.0	$5,518,142	$0	$0	$0	$0
5	R-5	N/A	N/A	Medicaid Fee-for-Service Reform	No	($1,845,030)	1.8	($865,469)	$0	($57,047)	$0	($922,514)
6	R-6	N/A	N/A	Medicaid Budget Reductions	No	($29,699,322)	0.0	($30,471,105)	$0	$15,496,446	$0	($14,724,663)
7	R-7	N/A	N/A	Cost Sharing for Medicaid and CHP+	No	($3,407,194)	0.0	($1,438,020)	$0	$91,841	$0	($2,061,015)
8	R-8	N/A	N/A	Federally Mandated CHIPRA Quality Measures	No	$236,671	0.0	$82,835	$0	$0	$0	$153,836
9	R-9	N/A	N/A	CHP+ Eligibility for Children of State Employees	No	$0	0.0	$0	$0	$0	$0	$0
10	R-10	N/A	N/A	Utilize Supplemental Payments for General Fund Relief	No	($1,006,752)	0.0	($1,006,752)	$0	$0	$0	$0
11	R-11	N/A	N/A	CHIPRA Bonus Payment True-up	No	$0	0.0	($15,036,785)	$0	$0	$0	$15,036,785
12	R-12	N/A	N/A	Hospital Provider Fee Administrative True-up	No	($52,769)	0.0	$0	$0	$28,596	$0	($81,365)
13	R-13	N/A	N/A	CBMS Electronic Document Management System	No	$464,126	0.0	$230,708	$0	$462	$1,392	$231,564
14	N/A	N/A	BA-1	Medical Services Premiums Request	No	$110,910,674	0.0	($4,016,472)	$0	$61,179,404	($190,350)	$53,938,092
15	N/A	N/A	BA-2	Medicaid Mental Health Community Programs	No	$2,726,901	0.0	($4,693,763)	$0	$6,226,382	$0	$1,194,282
16	N/A	BA-3	N/A	Smoking Cessation Quitline for Medicaid Clients	No	$1,373,470	0.0	$0	$0	$686,735	$0	$686,735
17	N/A	BA-4	N/A	Utilize Supplemental Payments for General Fund Relief	No	($10,527,400)	0.0	$400,246	$0	($5,946,273)	$0	($4,981,373)
18	N/A	BA-5	N/A	CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects	No	$296,486	0.0	($149,482)	$0	$298,257	($650)	$148,361
19	N/A	BA-6	N/A	MMIS Technical Adjustments	No	$1,065,358	0.0	$0	$0	$225,140	$0	$840,218
FY 2012-13 Funding Requests						**$440,039,468**	**1.8**	**$99,245,879**	**$0**	**$110,517,869**	**$100,830**	**$230,174,890**
Funding Requests R-1 through R-4						**$369,504,249**	**0.0**	**$156,209,938**	**$0**	**$32,287,926**	**$290,438**	**$180,715,947**
All Other Funding Requests						**$70,535,219**	**1.8**	**($56,964,059)**	**$0**	**$78,229,943**	**($189,608)**	**$49,458,943**

Schedule 10
Summary of FY 2012-13 Change Requests

Department Name: Health Care Policy and Financing
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Schedule 10 Priority	**Nov. 1, 2011 Priority**	**Jan. 3, 2012 Priority**	**Feb. 15, 2012 Priority**	**Title**	**IT Request**	**Total Request (FY 2012-13)**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2012-13 Non-Prioritized Funding Requests												
1	NP-R1	N/A	N/A	DHS - New Funding – Developmental Disabilities Services	No	$4,877,540	0.0	$2,438,770	$0	$0	$0	$2,438,770
2	NP-R2	N/A		DHS - Statewide Vehicle Replacement	No	$15,149	0.0	$7,574	$0	$0	$0	$7,575
3	N/A	NP-BA1		DHS - Utilities Funding Request	No	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
4	N/A	NP-BA2		DHS - Colorado Mental Health Institutes Revenue Adjustment	No	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
5	N/A	NP-BA3		DHS - DYC Contract Placement Supplemental	No	$349,104	0.0	$174,552	$0	$0	$0	$174,552
FY 2012-13 Non-Prioritized Funding Requests						**$6,017,659**	**0.0**	**$3,008,829**	**$0**	**$0**	**$0**	**$3,008,830**

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1	R-1	N/A	N/A	Request for Medical Services Premiums	No	$330,806,255	0.0	$129,303,556	$0	$36,238,486	$303,982	$164,960,231
2	R-2	N/A	N/A	Medicaid Mental Health Community Programs	No	$36,614,308	0.0	$21,388,240	$0	($3,087,673)	($13,544)	$18,327,285
3	R-3	N/A	N/A	Children's Basic Health Plan Medical and Dental Costs	No	($3,434,456)	0.0	$0	$0	($862,887)	$0	($2,571,569)
4	R-4	N/A	N/A	Medicare Modernization Act State Contribution Payment	No	$5,518,142	0.0	$5,518,142	$0	$0	$0	$0
5	R-5	N/A	N/A	Medicaid Fee-for-Service Reform	No	($1,845,030)	1.8	($865,469)	$0	($57,047)	$0	($922,514)
6	R-6	N/A	N/A	Medicaid Budget Reductions	No	($29,699,322)	0.0	($30,471,105)	$0	$15,496,446	$0	($14,724,663)
7	R-7	N/A	N/A	Cost Sharing for Medicaid and CHP+	No	($3,407,194)	0.0	($1,438,020)	$0	$91,841	$0	($2,061,015)
8	R-8	N/A	N/A	Federally Mandated CHIPRA Quality Measures	No	$236,671	0.0	$82,835	$0	$0	$0	$153,836
9	R-9	N/A	N/A	CHP+ Eligibility for Children of State Employees	No	$0	0.0	$0	$0	$0	$0	$0
10	R-10	N/A	N/A	Utilize Supplemental Payments for General Fund Relief	No	($1,006,752)	0.0	($1,006,752)	$0	$0	$0	$0
11	R-11	N/A	N/A	CHIPRA Bonus Payment True-up	No	$0	0.0	($15,036,785)	$0	$0	$0	$15,036,785
12	R-12	N/A	N/A	Hospital Provider Fee Administrative True-up	No	($52,769)	0.0	$0	$0	$28,596	$0	($81,365)
13	R-13	N/A	N/A	CBMS Electronic Document Management System	No	$464,126	0.0	$230,708	$0	$462	$1,392	$231,564
14	N/A	N/A	BA-1	Medical Services Premiums Request	No	$110,910,674	0.0	($4,016,472)	$0	$61,179,404	($190,350)	$53,938,092
15	N/A	N/A	BA-2	Medicaid Mental Health Community Programs	No	$2,726,901	0.0	($4,693,763)	$0	$6,226,382	$0	$1,194,282
16	N/A	BA-3	N/A	Smoking Cessation Quitline for Medicaid Clients	No	$1,373,470	0.0	$0	$0	$686,735	$0	$686,735
17	N/A	BA-4	N/A	Utilize Supplemental Payments for General Fund Relief	No	($10,527,400)	0.0	$400,246	$0	($5,946,273)	$0	($4,981,373)
18	N/A	BA-5	N/A	CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects	No	$296,486	0.0	($149,482)	$0	$298,257	($650)	$148,361
19	N/A	BA-6	N/A	MMIS Technical Adjustments	No	$1,065,358	0.0	$0	$0	$225,140	$0	$840,218
FY 2012-13 Funding Requests						**$440,039,468**	**1.8**	**$99,245,879**	**$0**	**$110,517,869**	**$100,830**	**$230,174,890**
Funding Requests R-1 through R-4						**$369,504,249**	**0.0**	**$156,209,938**	**$0**	**$32,287,926**	**$290,438**	**$180,715,947**
All Other Funding Requests						**$70,535,219**	**1.8**	**($56,964,059)**	**$0**	**$78,229,943**	**($189,608)**	**$49,458,943**

Schedule 10
Summary of FY 2012-13 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: February 15, 2012
Number of Funding Requests: 19
Number of Non Prioritized Items: 5

Total Impact						**$446,057,127**	**1.8**	**$102,254,708**	**$0**	**$110,517,869**	**$100,830**	**$233,183,720**
Schedule 10 Priority	**Nov. 1, 2011 Priority**	**Jan. 3, 2012 Priority**	**Feb. 15, 2012 Priority**	**Title**	**IT Request**	**Total Request (FY 2012-13)**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2012-13 Non-Prioritized Funding Requests												
1	NP-R1	N/A	N/A	DHS - New Funding – Developmental Disabilities Services	No	$4,877,540	0.0	$2,438,770	$0	$0	$0	$2,438,770
2	NP-R2	N/A		DHS - Statewide Vehicle Replacement	No	$15,149	0.0	$7,574	$0	$0	$0	$7,575
3	N/A	NP-BA1		DHS - Utilities Funding Request	No	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
4	N/A	NP-BA2		DHS - Colorado Mental Health Institutes Revenue Adjustment	No	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
5	N/A	NP-BA3		DHS - DYC Contract Placement Supplemental	No	$349,104	0.0	$174,552	$0	$0	$0	$174,552
FY 2012-13 Non-Prioritized Funding Requests						**$6,017,659**	**0.0**	**$3,008,829**	**$0**	**$0**	**$0**	**$3,008,830**

Schedule 12
Summary of FY 2012-13 Budget Amendments

Department Name: Health Care Policy and Financing
Submission Date: February 15, 2012
Number of Prioritized Budget Amendments: 6

Priority #	Page #	Title	IT Request	Total Request FY 2012-13	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Health Care Policy and Financing FY 2012-13 Late Budget Amendments										
BA-1	S-1A, BA-1.1	Medical Services Premiums Request	No	$110,910,674	0.0	($4,016,472)	$0	$61,179,404	($190,350)	$53,938,092
BA-2	S-2A, BA-2.1	Medicaid Mental Health Community Programs	No	$2,726,901	0.0	($4,693,763)	$0	$6,226,382	$0	$1,194,282
BA-3	S-9, BA-3.1	Smoking Cessation Quitline for Medicaid Clients	No	$1,373,470	0.0	$0	$0	$686,735	$0	$686,735
BA-4	S-10, BA-4.1	Utilize Supplemental Payments for General Fund Relief	No	($10,527,400)	0.0	$400,246	$0	($5,946,273)	$0	($4,981,373)
BA-5	S-12, BA-5.1	CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects	No	$296,486	0.0	($149,482)	$0	$298,257	($650)	$148,361
BA-6	BA-6.1	MMIS Technical Adjustments	No	$1,065,358	0.0	$0	$0	$225,140	$0	$840,218
FY 2012-13 Prioritized Subtotals				**$105,845,489**	**0.0**	**($8,459,471)**	**$0**	**$62,669,645**	**($191,000)**	**$51,826,315**
Health Care Policy and Financing FY 2012-13 Non-Prioritized Late Budget Amendments										
NP-BA1	NP-S2, NP-BA1.1	DHS - Utilities Funding Request	No	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
NP-BA2	NP-S3, NP-BA2.1	DHS - Colorado Mental Health Institutes Revenue Adjustment	No	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
NP-BA3	NP-S8, NP-BA3.1	DHS - DYC Contract Placement Supplemental	No	$349,104	0.0	$174,552	$0	$0	$0	$174,552
FY 2012-13 Non-Prioritized Subtotals				**$1,124,970**	**0.0**	**$562,485**	**$0**	**$0**	**$0**	**$562,485**
GRAND TOTAL FY 2012-13 Late Budget Amendments				**$106,970,459**	**0.0**	**($7,896,986)**	**$0**	**$62,669,645**	**($191,000)**	**$52,388,800**

MEDICAID CASELOAD

INTRODUCTION

Biannually, the Department of Health Care Policy and Financing ("the Department") submits its estimated funding need for the Medical Services Premiums line item. The first step in generating the November and February submissions is to project the Medicaid caseload. Medicaid caseload does not represent the number of uninsured individuals in Colorado, nor does it represent the number of Colorado residents living in poverty. Caseload figures only represent individuals that the Department expects will enroll in Medicaid because they meet specific eligibility requirements in one of three groups: 1) Families, Pregnant Women, and Children; 2) Aged and Disabled; or 3) Other.

Federal Medicaid statute defines over 50 groups of individuals that may qualify for Medicaid. Some groups are mandatory, while others are optional and each state decides which of the optional groups it will cover. From the inception of Medicaid in 1965 (Public Law 89-97) to the 1980s, the program was targeted at low-income families, the elderly, and the disabled. During the 1980s, Medicaid expanded to include pregnant women and children with greater income levels, as well as some optional elderly and disabled groups. In 2000, Medicaid coverage was extended to women with breast and cervical cancer. From the 1990s to the present, other Medicaid categories have been added through State-initiated waivers. All eligibility categories have specific income limits, and some have additional criteria such as age, resources or disability status. For budgetary purposes, the Department groups together clients with similar characteristics and costs. For example, clients grouped in the Eligible Children category have similar characteristics and costs but might have gained Medicaid eligibility through different criteria. Since each category of eligibility is affected by unique factors, the Department projects each category separately. Projecting an aggregate caseload would be easier but could be less precise.

Historic caseload data are used in conjunction with economic data to project caseload in each category. To make a projection, the Department uses several different statistical techniques (as described in the Methodology section below) and chooses the projection that best fits the data. After projections are chosen for each category, the Department presents its recommendations to the Office of State Planning and Budgeting (OSPB). The Department then meets with OSPB, and the two agencies agree on an Executive caseload proposal. It is important to note that the methodology the Department used to generate its projections is not wholly reflected by the Executive caseload proposal presented in this document, since those figures are often the result of compromises with OSPB.

In 2003, the process of projecting the Medicaid caseload was drastically affected by SB 03-196, which mandated that the Department transition from accrual to cash-based accounting. From that point forward, caseload numbers no longer incorporated retroactivity. Retroactivity caused historical adjustments to caseload to account for clients who were found to be eligible for Medicaid for past months, thus increasing the count of persons eligible for Medicaid. Since most clients are eligible back to the date of their application, retroactivity adjustments assured that all months were accounted for. However, this caused variability in the caseload reports, as monthly caseload was adjusted for months, even years, after the month had ended. It also required special manually run reports to make these adjustments. Under the cash accounting system, a monthly caseload report is created from the Medicaid Management Information System (MMIS) and that caseload is considered final.

If the Department had only applied the accounting conversion to the FY 2003-04 caseload projection, this would have produced an artificial drop in caseload relative to the prior year when retroactivity was still applicable. To control for this manufactured decrease in caseload, and to develop a more accurate portrayal of history, the Department recreated 10 years of Medicaid caseload history without retroactivity. By rebuilding the caseload without retroactivity, the Department was able to put the FY

2003-04 projection in perspective and test the historical data for accuracy. Medicaid eligibility, retroactive back to the date of application, is still in effect; however, it is no longer reported in caseload. For a complete explanation of how the historical data was rebuilt and tested, refer to the November 3, 2003 Budget Request, pages K-98 and K-99.

Through June 2008, the Department utilized the REX01/COLD (MARS) R-464600 report for caseload levels, which is a standard report from the MMIS. Eligibility information included in MMIS is fluid and is updated from the Colorado Benefits Management System on a daily basis. This report is run on the Friday before the last Tuesday of every month and does not incorporate eligibility changes that occurred between the run date and the last day of the given month. In addition, the report is a one-time snapshot and cannot be replicated in the future because of the dynamic nature of eligibility. The limitations of this report prevent the Department from analyzing caseload by characteristics other than eligibility types such as gender, county of residence, or age.

The Department has developed a new caseload report that it believes measures caseload more accurately: the REX01/COLD (MARS) R-474701. This report captures eligibility movements for the entire month in question and also stores the data table that underlies the report. As a result, the Department is able to analyze caseload by many other demographic and geographic characteristics while still balancing to the official Medicaid caseload. The Department began to use this new caseload report with the July 2008 caseload report to the Joint Budget Committee. 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. All caseload history and forecasts included in the following narrative, as well as the Medical Services Premiums and Medicaid Mental Health projections, are the official restated caseload.

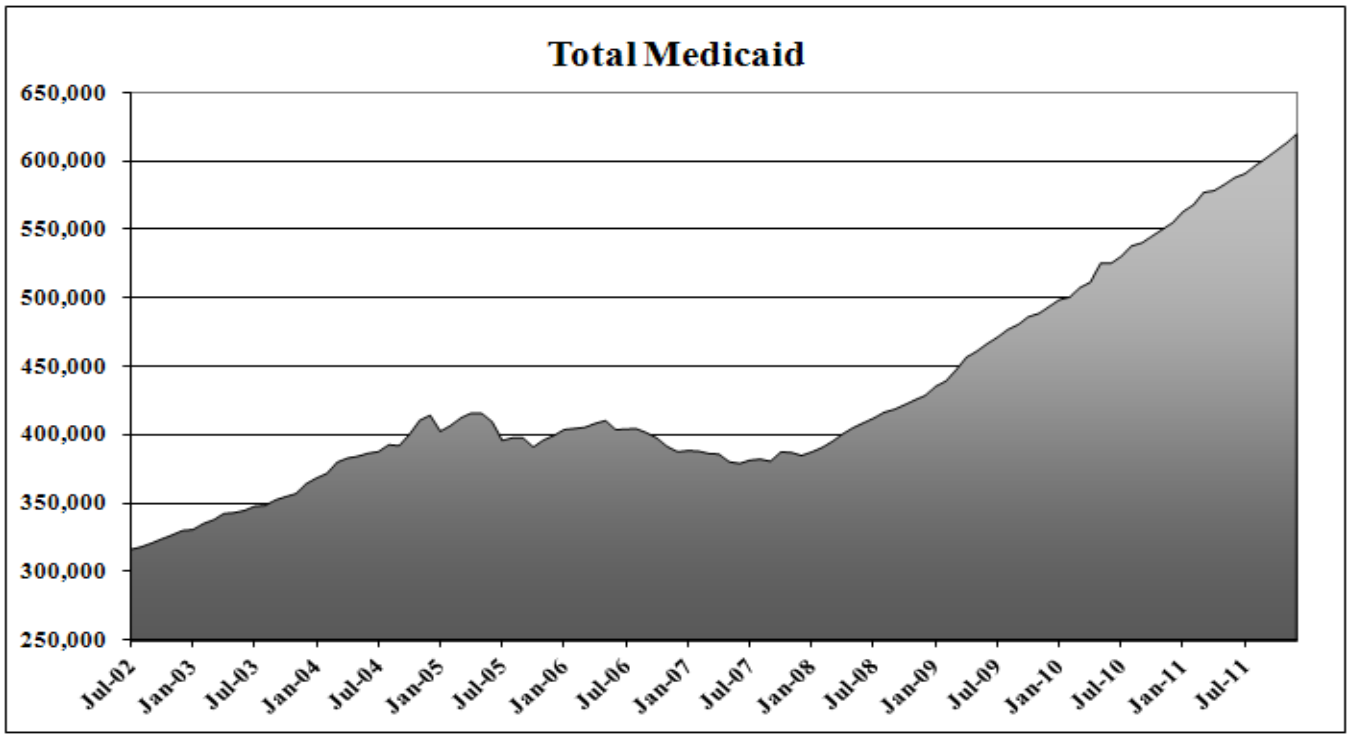
In addition to estimating the funding need for the Medical Services Premiums line item, Medicaid caseload is used to determine the funding need for the Medicaid Mental Health Community Programs. Comprehensive mental health services are available to eligible Medicaid clients. Thus, the Medicaid Mental Health caseload is the Medicaid caseload less Partial Dual Eligibles and Non-Citizens, which are not eligible for full Medicaid benefits. The following table displays a comparison of historical caseloads in Medicaid Medical Services Premiums and Mental Health.

Fiscal Year	Medical Services Premiums Caseload	Less: Mental Health Ineligible Categories	Mental Health Caseload
FY 2002-03	331,800	(13,072)	318,728
FY 2003-04	367,559	(14,635)	352,924
FY 2004-05	406,024	(14,755)	391,269
FY 2005-06	402,218	(17,304)	384,914
FY 2006-07	392,228	(18,109)	374,119
FY 2007-08	391,962	(18,405)	373,557
FY 2008-09	436,812	(19,062)	417,750
FY 2009-10	498,797	(19,612)	479,185
FY 2010-11	560,759	(20,303)	540,456

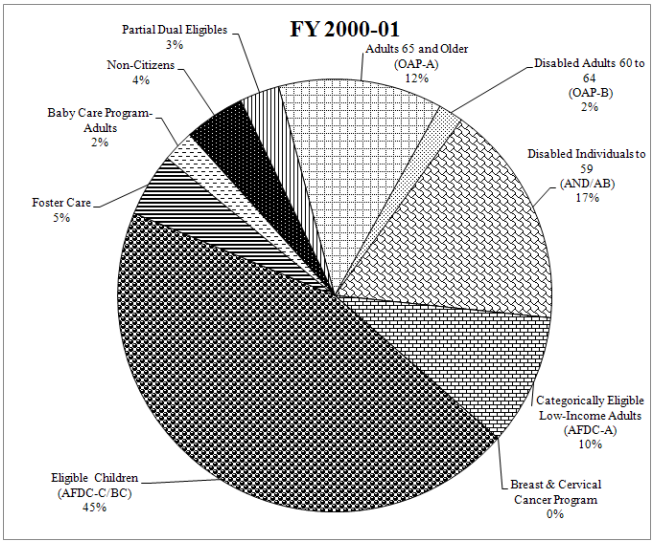
Recent Caseload History

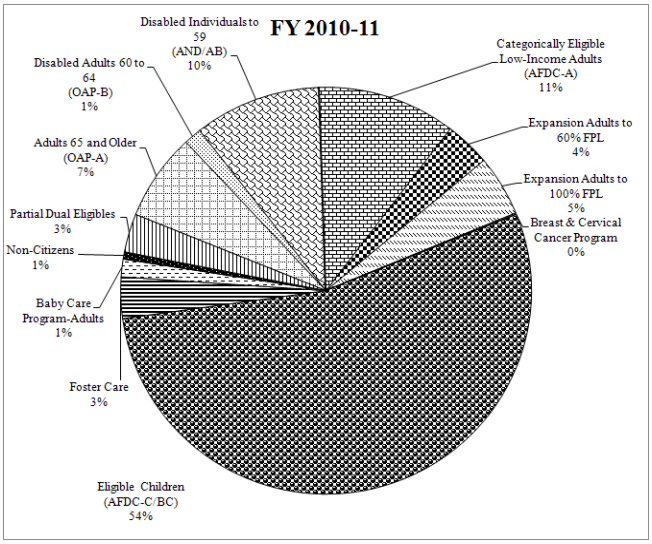
Exhibit B tabulates actual caseload figures and growth rates by eligibility category from FY 1995-96 to FY 2010-11. Projections for FY 2011-12 to FY 2013-14 are also presented in the table and will be discussed in the Categorical Projections section of this document. A graphical representation of aggregate Medicaid caseload history from FY 2002-03 is shown below. Medicaid in Colorado had double-digit growth rates in FY 2003-04 and FY 2004-05 of 10.78% and 10.48%, respectively. These

high rates of growth ceased in FY 2005-06, and caseload declined by 0.95% in FY 2005-06 and by a further 2.48% in FY 2006-07. Monthly declines continued in the first half of FY 2007-08 but reversed in the second half, resulting in a nearly flat decline of 0.07% for the fiscal year. With the weak economy, caseload has continued to grow at double digit rates, with in annual growth of 11.44% in FY 2008-09, 14.19% in FY 2009-10, and 12.41% in FY 2010-11. Reasons for these recent growth rates will be discussed below.



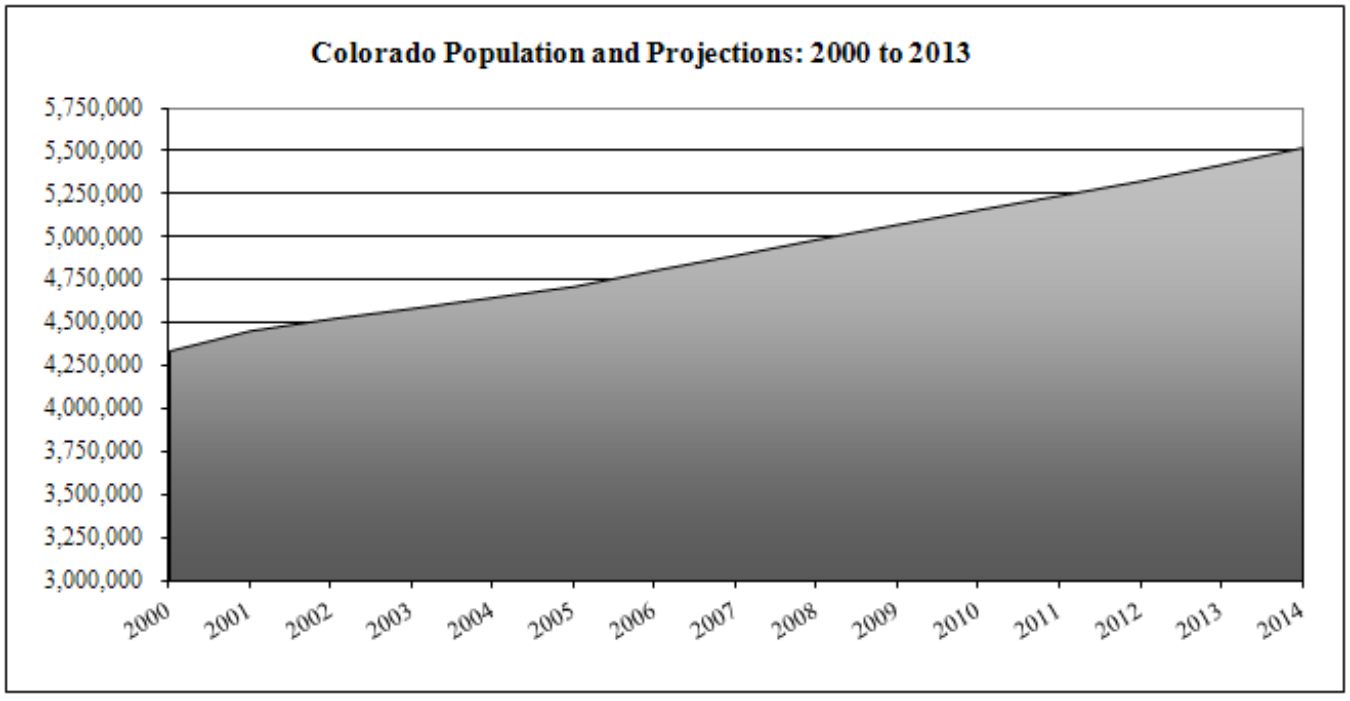
The charts below show a side-by-side comparison of the Medicaid caseload by category as a percentage of the overall caseload for FY 2000-01 and FY 2010-11. As a percentage of the entire Medicaid caseload, Eligible Children has increased by nine percentage points, the largest gain when compared with all other categories. Despite strong growth in recent years, the percentage of overall caseload in the Disabled Individuals to 59 (AND/AB) category has declined by approximately seven percentage points, and Adults 65 and Older (OAP-A) has decreased by five percentage points. This change in case mix implies that increases in a less expensive category (Eligible Children) has been coupled with decreases in more expensive categories (Disabled Individuals to 59 (AND/AB) Adults 65 and Older (OAP-A)) over the last 10 years.





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. Therefore, projections represent the *net effect* of what the Department expects will happen. Each factor and its expected impact on the Medicaid caseload are discussed below.

Population - Colorado's total population has increased by approximately 17.65% from July of 2001 to July of 2011, an annualized rate of 1.77% per year. The Department of Local Affairs forecasts that Colorado's population will increase a further 5.30% from July of 2011 to July of 2011, with annualized growth rates in line with historical trends. As the overall population has grown, so too has Medicaid caseload. This positive correlation implies that if population is projected to grow in the future, Medicaid caseload may also increase.

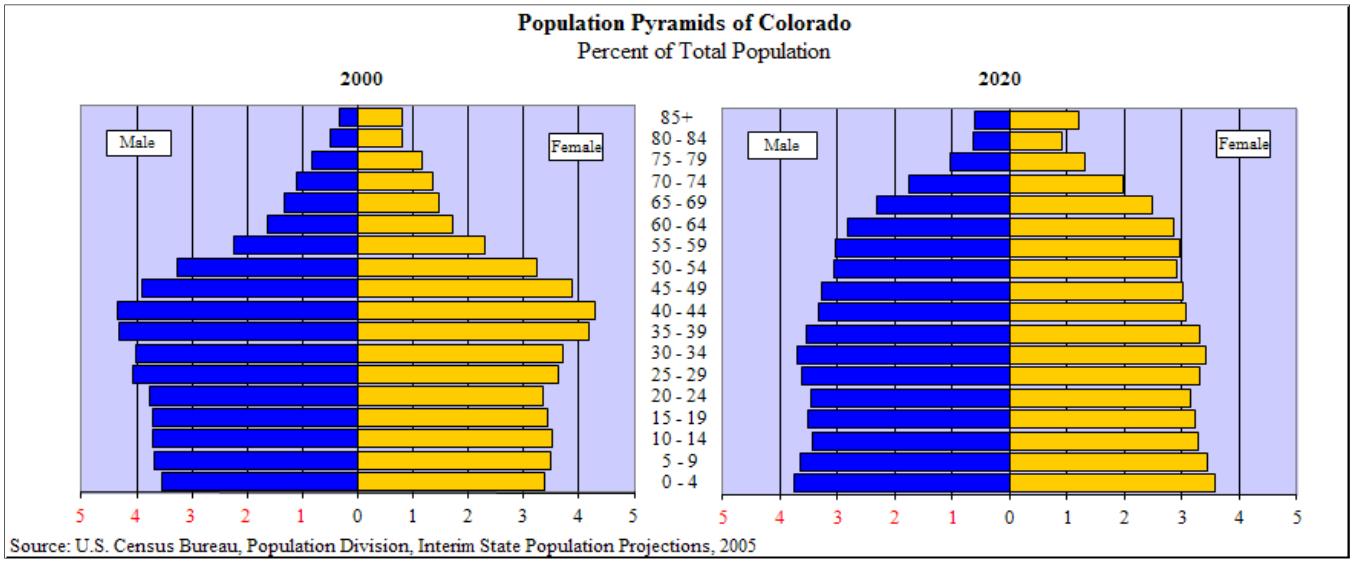


When using population data to project caseload, the Department marries population subgroups to their appropriate Medicaid category. For example, when projecting caseload for Eligible Children, the Department uses population statistics for Colorado residents aged 0 to 18. By using subgroups instead of total population figures, the Department is able to capture subgroup specific trends.

In-State Migration - Like population, in-State migration is positively correlated with Medicaid caseload. As more individuals move to Colorado from other states, Medicaid caseloads will increase. During economic downturns, people usually move from states with worse economic conditions to states with better conditions in search of jobs. Although Colorado experienced economic conditions in line with the overall conditions in the United States during the recent recession, net migration remained positive in 2010 at approximately 70,000[1]. An increase of 70,000 persons in a population of over 5.1 million may not be significant, but a positive migration rate means more people who could conceivably be eligible for Medicaid. According to 2010 estimates from the Census Bureau, Colorado experienced the sixth highest migration rate in the United States.[2] Conversely, as the economy recovers, in-state migration is expected to increase. Net migration grew to an estimated 52,346 in 2006, overtaking natural increase (births minus deaths) as the major component of population growth. Though in-state migration is projected decrease over the forecast period, the number of individuals moving into the state is expected to remain positive, buoyed by rates of unemployment and housing value deflation that are lower than the national average.

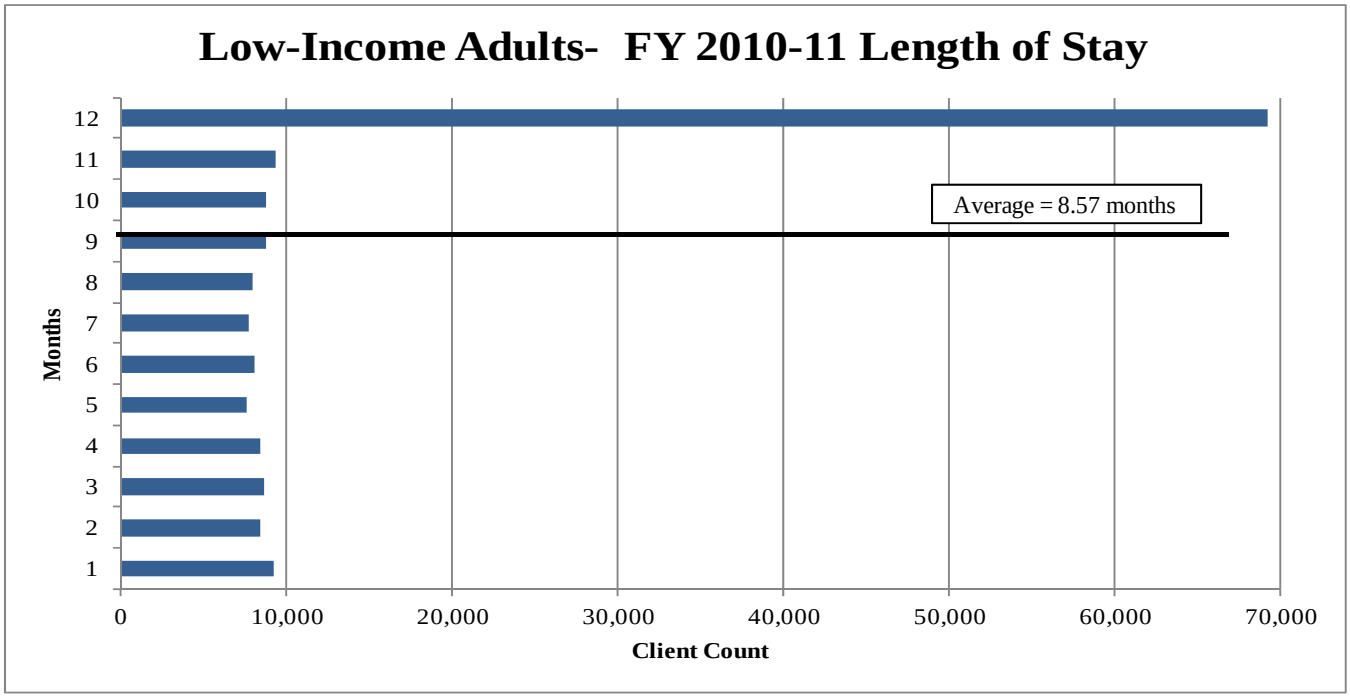
Age - The age of the population can provide some insight as to why Medicaid caseloads have been increasing. As the population ages, so too does the demand for medical care. Generally, as individuals age, their health becomes more fragile and the more likely they are to seek health care. From 2001 to 2011, Colorado's median age increased by 1.9 years, a 5.6% increase[3]. This may be the result of retirees moving to the State, increased longevity, or fewer births. Regardless of the reason, an aging population has a direct effect on the demand for medical services, though not necessarily Medicaid. According to data from the United States Census Bureau, Colorado had the 10th lowest median age in 2010 and the 4th lowest old-age dependency ratio in 2009 (defined as the population 65 and older as a percent of population 18 to 64) in the nation.[4] The population over 60 in Colorado is projected to increase by 45.3% between 2000 and 2010, which is expected to cause an increase in the State's median age. Additionally, Colorado's old-age dependency ratio is projected to increase from 15.6 in 2000 to 24.6 in 2020, a 57.2% increase.[5] This growth is significantly higher than the nation average, which is projected to increase by 34.8% over the same timeframe. This suggests that Colorado will be aging faster than the average state over the forecast period. Since 2009, Colorado has experienced increases in the eligibility categories that include older individuals, though the growth was not as high as population growth in the general population aged 60 and over. This may be the result of a healthier aging population and demographic factors, such as the elderly population working longer and some of the baby-boom generation not yet reaching retirement age.

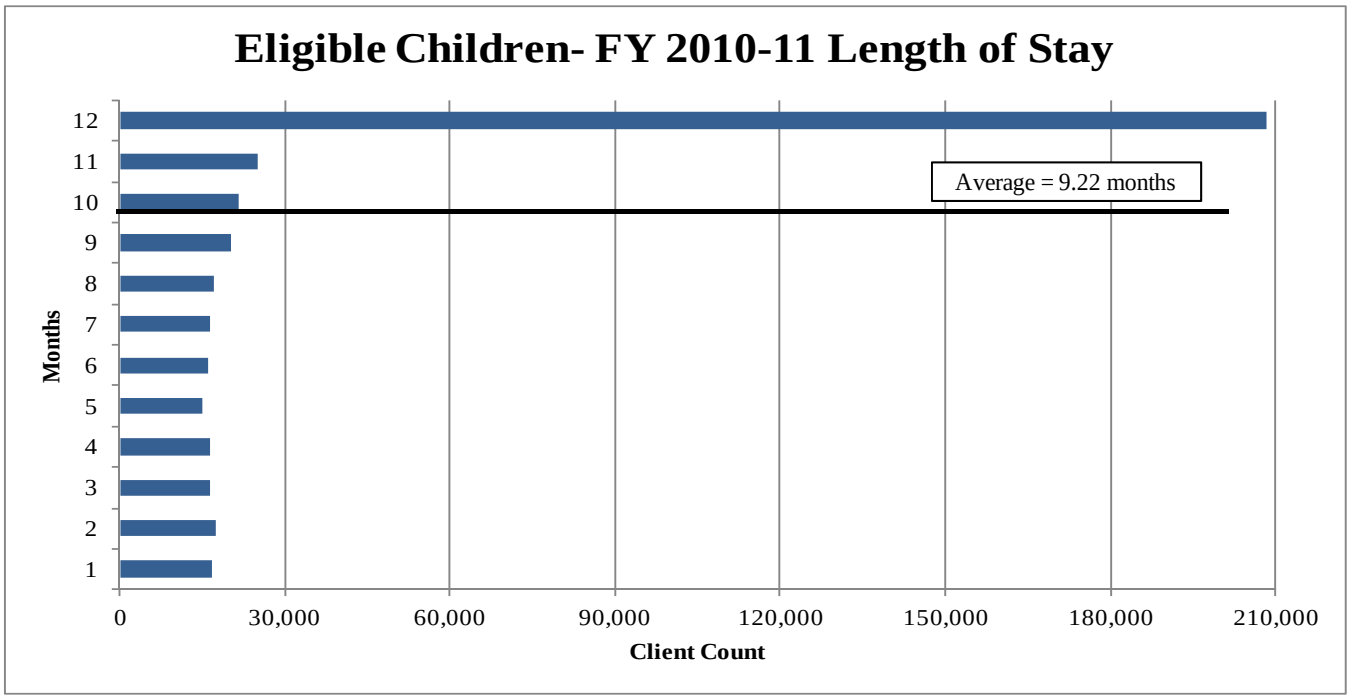
[1] Source: Department of Local Affairs, Demography Division
[2] Source: 20010 American Community Survey http://www.census.gov/acs/www/
[3] Source: Department of Local Affairs, Demography Division
[4] Source: 20010 American Community Survey http://www.census.gov/acs/www/
[5] Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005 http://www.census.gov/population/www/projections/index.html



Length of Stay- Medicaid caseload is not only affected by the number of individuals served but also the length of time they remain in the program. The severity and length of the recent economic downturn has prolonged the average amount of time clients remain on the Medicaid caseload. The table below shows that the average number of months on Medicaid dropped by 10.6% for adults and 8.5% for children between FY 2003-04 FY 2004-05 and in FY 2005-06 increased to levels near those for FY 2003-04. As caseload declined in FY 2006-07 and FY 2007-08, the average length of stay also declined. While the average length of stay for low-income adults declined in FY 2009-10, this was solely due to the implementation of the expansion to 100% of the federal poverty level in May 2009, which artificially reduced the average number of months of enrollment as these clients were eligible for only two months. Excluding these clients, the Department estimates that the average length of stay for low-income adults was approximately 7.91 months. In FY 2010-11, the average length of stay increased for both low-income adults and children, which is expected during periods of economic weakness. As can be seen in the table and charts that follow, enrollment in Medicaid averaged 8.57 months for low-income adults and 9.22 months for Eligible Children in FY 2010-11. The distribution of length of enrollment, however, is heavily weighted toward enrollment for the full year. This calculation, however, only considers enrollment in a given year in isolation, and does not account for clients that have eligibility that overlaps multiple fiscal years due to the timing of their eligibility determination. The Department will continue to refine this analysis to account for these factors and to provide a more accurate picture of the amount of time that individuals are enrolled in Medicaid over multiple years rather than considering fiscal years in isolation and independently of each other.

Average Number of Months on Medicaid		
Fiscal Year	**Low-Income Adults**	**Eligible Children**
FY 1999-00	6.78	8.29
FY 2000-01	6.87	8.29
FY 2001-02	7.20	8.51
FY 2002-03	7.66	8.71
FY 2003-04	7.84	8.99
FY 2004-05	7.01	8.23
FY 2005-06	7.85	8.72
FY 2006-07	7.73	8.57
FY 2007-08	7.62	8.42
FY 2008-09	7.77	8.61
FY 2009-10	7.63	9.01
FY 2010-11	8.57	9.22





Economic Conditions - Economic indicators help partially explain why some Medicaid caseload trends occur. Since Medicaid is a needs-based program where clients must meet income limits, it follows that caseload for families and children should be countercyclical to economic conditions. For example, as the state experiences recessionary conditions, the Medicaid caseload will increase. After the recession that ended in the early 1990s, Colorado enjoyed almost ten years of economic expansion. The terror attacks on the United States in 2001 combined with the bursting of the stock market bubble in late 2000 brought that expansion to a halt. For the first time in more than a decade, Colorado experienced significant job losses coupled with falling wages. In mid-2003, the Colorado economy hit bottom after the decline that started in early 2001. Due to seasonal fluctuations and wide confidence intervals for over the month changes, employment data is best analyzed by comparing the same month for different years. The first post-recession over-the-year gain in non-agricultural employment occurred in March of

2004. The State officially entered an expansionary period in early 2006, as employment surpassed the late 2000 peak. The recovery period lasted 30 months, one of the longest on record. Employment began to soften in October 2008, when 4,600 jobs were shed over the year. The State experienced over-the-year job losses for two years and the annual contractions appear to have peaked in August 2009, when job losses numbered 130,800 (5.6%) over the year. The State has seen very moderate over-the-year employment increases as of October 2010. As of December 2011, the over-the-year jobs gain was estimated to be 23,600, or 1.06%. Current economic forecasts project very moderate increases in employment throughout the forecast period.

The table that follows shows historical and projected unemployment rates, non-agricultural employment, and job growth statistics.[6]

Year	Wage and Salary Income (billions)	Non-Agricultural Employment	Employment Growth	Unemployment Rate
2004	$92.1	2,179,600	1.2%	5.6%
2005	$98.9	2,226,000	2.1%	5.1%
2006	$105.8	2,279,100	2.4%	4.4%
2007	$113.0	2,331,300	2.3%	3.7%
2008	$117.2	2,350,300	0.8%	4.8%
2009	$112.8	2,245,600	-4.5%	8.3%
2010	$114.3	2,220,100	-1.1%	8.9%
2011	$118.8	2,248,700	1.3%	8.5%
2012	$122.1	2,265,600	0.8%	8.6%
2013	$126.7	2,288,800	1.0%	8.2%

The timing of an economic cycle is important in estimating the impact on the Medicaid caseload. As the economy recovers from a downturn, workers need to find jobs in order to withdraw from the Medicaid rolls. Jobs that primarily affect family and children Medicaid populations[7] are hourly and concentrated in the service industry. These employment types are often the last to benefit from improving economic conditions. Therefore, any economic impact on the Medicaid caseload will have a lagged effect. Second, as workers find jobs they do not instantaneously lose their Medicaid eligibility. Since 1990, states have been federally required to provide Transitional Medical Assistance (known as Transitional Medicaid) benefits for up to one year to families who lost eligibility because of increased income due to employment. This policy was directed at clients who potentially might turn down employment for fear of losing their Medicaid benefits. To be eligible for Transitional Medicaid, a client must have been eligible in at least three of the preceding six months, though states may elect to reduce this requirement to fewer than three months. Clients may receive Transitional Medicaid as long as their income is below 185% of the federal poverty level, provided that the proper income reporting requirements are followed. Another small group of clients are eligible for Transitional Medicaid services that would otherwise lose their Medicaid benefits due to child or spousal support payments. Families in this group receive a four-month extension. Although this program has been set to expire many times, it has been renewed regularly, most recently through February 29, 2012. For the purposes of projecting caseload, the Department assumed that the federal Transitional Medicaid program would continue throughout FY 2012-13. As illustrated in the following table, the average number of adults and children on Transitional Medicaid increased dramatically in FY 2004-05. The Department suspects that the high growth in FY 2004-05 and FY 2005-06 may be partially related to large monthly increases that occurred around the implementation of the Colorado Benefits Management System. Monthly caseload declined between December 2005 and June 2008, but caseload increased throughout FY 2008-09 and FY 2009-10.

[6] Source: Office of State Planning and Budgeting, September 2011 Revenue Forecast

[7] Projecting elderly and disabled client populations does not prioritize economic variables

The Department implemented two changes that affected Transitional Medicaid in FY 2009-10. First, section 5004 of the American Recovery and Reinvestment Act of 2009 (ARRA) included options for states to modify eligibility for Transitional Medicaid, including waiving the requirement that the family was eligible for Medicaid in at least three of the preceding six months and extending families' eligibility to 12 months, rather than six months followed by a second six-month period that is dependent upon reporting, income, and technical eligibility requirements. Colorado elected the option to provide 12 months of Transitional Medicaid coverage, which was effective October 1, 2010. Finding #58a of the State of Colorado Statewide Single Audit for the Fiscal Year ending June 30, 2009 stated that the Department should address an issue in the Colorado Benefits Management System that prevented the prompt termination of Transitional Medicaid benefits if the proper reporting, income, and technical eligibility requirements were not met. The Department's response indicated that it was researching whether it would be more efficient for both county eligibility staff and clients, as well as from a fiscal standpoint, to grant 12 months of Transitional Medicaid eligibility with no reporting requirements. The Department determined that this was indeed more efficient and decided in May 2010 to go forward with this option. Second, when the Department implemented the eligibility expansion for Medicaid Parents to 100% of the federal poverty level, the Department made modifications to the Colorado Benefits Management System to increase eligibility for all Family Medicaid clients to 100% of the federal poverty level. Previously, the Expansion Adults to 60% of the federal poverty level (FPL) group had its own eligibility requirements within Family Medicaid, which the Centers for Medicare and Medicaid Services indicated to the Department was incorrect. This change leads to income eligibility for Transitional Medicaid spanning 101% to 185% FPL, rather than the Aid to Families with Dependent Children (AFDC) level, which is currently approximately 24% FPL, through 185% FPL. This change will result in a lower Transitional Medicaid caseload beginning in May 2010.

Fiscal Year	Average Number of Eligible Children on Transitional Medicaid	Average Number of Adults on Transitional Medicaid
FY 2002-03	7,645	4,689
FY 2003-04	7,349	4,709
FY 2004-05	10,776	6,586
FY 2005-06	16,749	10,745
FY 2006-07	16,065	9,968
FY 2007-08	13,000	7,778
FY 2008-09	13,489	7,905
FY 2009-10	13,582	8,099
FY 2010-11	11,042	6,173

Policy Changes - State and federal policy decisions can alter the Medicaid caseload. The following list briefly describes major State and federal policy changes that have affected Medicaid eligibility and, therefore, caseload. This list is not meant to be comprehensive in nature but a summary of major changes affecting eligibility since 2000.

- Breast and Cervical Cancer Prevention and Treatment Act of 2000, Public Law 106-354: Established a new group of eligibility for women under 65 who have been screened under the Centers for Disease Control and Prevention Board and need treatment for either diagnosis. Colorado implemented this optional eligibility group in July 2002 pursuant to SB 01S2-012.
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003: This act causes more potential beneficiaries to be screened for Medicaid when they apply for this Medicare benefit.
- Presumptive eligibility for Medicaid pregnant women was discontinued on September 1, 2004. It was re-established by HB 05-1262 on July 1, 2005.

- HB 05-1262, the Tobacco Tax bill: This bill provided funding for the removal of the Medicaid asset test, the expansion of the income guideline used to establish eligibility for parents of children eligible for either Medicaid or the Children's Basic Health Plan to 60% of the federal poverty level (known as Expansion Adults to 60% FPL), and to expand the number of children enrolled in the Home- and Community-Based Services and the Children's Extensive Support Waiver.
- Deficit Reduction Act of 2005: This Act contained provisions related to premiums and cost sharing, benefits, and asset transfers that will have implications for Medicaid beneficiaries. In addition, the Deficit Reduction Act contained a provision requiring States to obtain satisfactory documentary evidence of citizenship and identity for all Medicaid applicants who have declared that they are citizens or nationals of the United States, with exemptions for individuals that are eligible for Medicaid and entitled to or enrolled in Medicare and those eligible for Medicaid by virtue of receiving Supplemental Security Income benefits.
- SB 07-211: Established presumptive eligibility for Medicaid children.
- HB 09-1353: Expanded Medicaid eligibility to pregnant women who are legal permanent residents that have been in the country for less than 5 years.

Oftentimes, a forecast cannot instantaneously incorporate policy changes even with the use of dummy or indicator variables. When this occurs, adjustments are made to the forecast off-line. Off-line adjustments are made to account for the implementation of HB 09-1293, Colorado Health Care Affordability Act. This legislation establishes the Medicaid Buy-In Program for Working Adults with Disabilities and an Adults without Dependent Children (AwDC) program, which are scheduled to be implemented in March 2012 and May 2012, respectively. Under the current implementation plan, the AwDC program will be limited to 10% of the federal poverty level (FPL) with an enrollment cap of 10,000. In addition, the legislation establishes a Medicaid Disabled Buy-In Program for Children, which is scheduled to be implemented approximately four to six months after the Medicaid Buy-In Program for Working Adults with Disabilities and AwDC programs. Off-line adjustments are also made due to SB 11-008, which increases eligibility for children age 6 to 19 in Medicaid from 100% to 133% FPL, and SB 11-250, which increases eligibility for pregnant women in Medicaid from 133% to 185% FPL. The implementation date for both of these expansions is anticipated to be January 1, 2013. Detailed accountings of off-line adjustments are in Exhibit B, page EB-2.

The combination of the aforementioned factors led to significant growth in the Medicaid caseload between FY 2002-03 and FY 2004-05. During this time, Medicaid caseload increased by 74,224 clients, growth of 22.37%. Caseload decreased in the subsequent years, resulting in a decline of 14,062, or 3.46%, between FY 2004-05 and FY 2007-08. The Department believes that the improving economic conditions were the driving factor in this decrease, as consistent monthly declines occurred in Categorically Eligible Low-Income Adults and Eligible Children, which are expected to be most affected by the economy. This trend reversed as of the second half of FY 2007-08, when the Eligible Children caseload started to show significant monthly increases. Strong increases continued in Medicaid in FY 2008-09 and FY 2009-10, with average monthly growth increasing at an increasing rate throughout the year, resulting in annual growth of 11.44% and 14.19%, respectively. Strong monthly growth continued in FY 2010-11, with annual caseload increasing by 12.41% to a new historical high of 560,722. Given the recent trends and projected economic conditions, base caseload is anticipated to continue growing at a decreasing rate through the forecast period, but large caseload increases are anticipated due to expansions from the Colorado Health Care Affordability Act (HB 09-1293), SB 11-008, and SB 11-250. The Department is forecasting Medicaid caseload to increase by 11.21% in FY 2011-12 to 623,595. In FY 2012-13, the trend is projected to be 10.24%, and caseload is forecasted to reach 687,473. Expansions from HB 09-1293, SB 11-008, and SB 11-250 account for 14,510 of the projected 63,878 total Medicaid caseload increase in FY 2012-13. The following table shows actual and projected aggregate Medicaid caseload from FY 2003-04 through FY 2013-14.

Fiscal Year	Medicaid Caseload	Growth Rate	Level Growth
FY 2003-04	367,559	10.78%	35,759
FY 2004-05	406,024	10.46%	38,465
FY 2005-06	402,218	-0.94%	-3,806
FY 2006-07	392,228	-2.48%	-9,990
FY 2007-08	391,962	-0.07%	-266
FY 2008-09	436,812	11.44%	44,850
FY 2009-10	498,797	14.19%	61,985
FY 2010-11	560,759	11.21%	62,836
FY 2011-12 Projection	623,595	11.21%	62,836
FY 2012-13 Projection	687,473	10.24%	63,878
FY 2013-14 Projection	739,403	7.55%	51,929

METHODOLOGY

The Department's caseload projections utilize statistical forecasting methodologies to predict Medicaid caseload by eligibility category. Historical monthly caseload data from July 1993 to December 2011 and historical and forecasted economic and demographic data that were revised in December 2011 are used. Two forecasting methodologies are used: trend and regression. The software used by the Department for developing trend and regression forecasts is *Forecast Pro XE*.

Trend Models

Trend models have been very successful in forecasting select Medicaid caseloads. There are two types of trend models used to forecast caseload: Box Jenkins and Exponential Smoothing. Each model employs a different mathematical algorithm that uses only the trend history of the variable itself to predict future values. The choice of algorithm varies depending on the statistical properties of the time-series. For example, if a time-series exhibits seasonal patterns, the algorithm adjusts for those variations. *Forecast Pro XE* is programmed to recommend logarithmic and other exponential transformations to the data series when appropriate, and will recommend whether an Exponential Smoothing technique or the Box-Jenkins methodology is best for the particular series. Generally, both trend techniques are used to forecast caseload for each eligibility category. This allows for a greater choice of projections for the Department to consider.

Exponential Smoothing

For over 30 years, Exponential Smoothing models have been used to forecast data within a variety of applications. Considered simplistic, Exponential Smoothing models extract trend and seasonal patterns from a time-series to predict a future stream of values. One advantage of this model is that it produces robust results with limited data sets. This becomes invaluable for Medicaid eligibility categories that have not been in existence for very long, such as the Breast and Cervical Cancer Program category. There are two types of Exponential Smoothing models that address trend and seasonality in time-series data: Holt and Winters. The Holt Exponential Smoothing model adjusts for long-term linear trend in data, while the Winters Exponential Smoothing model adjusts for both trend and seasonal components of data. Both Holt and Winters use recursive equations to determine the estimated parameters of the model, giving more weight to recent observations and exponentially smaller weight to historically distant observations.

Box Jenkins

As compared to Exponential Smoothing models, Box-Jenkins models are more complex, but often produce results that are more accurate with a time-series that is longer and stable. Box-Jenkins models identify Autoregressive Integrated Moving Average processes that provide a good fit to a stationary

time-series. The optimal model can contain numerous autoregressive terms, moving average terms, or combinations thereof, causing the Box-Jenkins models to be much more complex than their Exponential Smoothing counterparts. A minimum of 50 observations is recommended to perform a Box-Jenkins forecast.

Regression Models

Regression analysis, unlike trend analysis, incorporates independent variables when making projections. For example, a regression equation may include the unemployment rate if the forecaster expects that it has an effect on the caseload for Categorically Eligible Low-Income Adults. Statistically, the forecaster can test whether or not there is a relationship between independent variables and the caseload by constructing a correlation matrix. Variables that are highly correlated with the caseload are more likely to be predictive. Regression equations are useful in that they provide some insight into why the trend projection is increasing, decreasing, or static. Although regression equations help explain why trends occur, their value depends on the quality of the independent variables used. In order to project caseload, historical and forecasted values of the independent variables must be used. Therefore, the accuracy of the caseload forecast depends on the accuracy of the forecasted independent variables.

In December 2011, the Office of State Planning and Budgeting and the Colorado Department of Local Affairs' Demography Division supplied actual and forecasted values of the following independent variables, which were used in the regression models:

- Employment - level of employment, this variable is measured in thousands;
- Unemployment Rate - the number of unemployed divided by the number in the labor force, this variable is measured as a percent;
- Total Wages - level of total wages, this variable is measured in billions;
- Population by Age Group - level of population broken into specific age groupings;
- Births - number of births per thousand women; and,
- Migration - net increases or decreases in the State population adjusted for births and deaths.

The Department uses the December forecasts for variables because caseload estimates must be completed before January in order to calculate the February 15th request.

Trend vs. Regression Models

After several different forecasts are produced, the Department normally chooses one for each category. In most eligibility categories, trend and regression projections are considered. In the case of the Expansion Adults categories, statistical models cannot be applied and the estimate is based on the growth experienced since the implementation of the populations.

To determine which model is the best, the Department evaluates each model's forecast on two criteria: goodness of fit and expected growth patterns. *Forecast Pro XE* performs several statistical tests that evaluate the goodness of fit. These tests include: serial correlation of first and multiple orders, heteroskedacticity, robustness of error terms, and collinearity. Each model is judged on its statistical soundness, and models that perform poorly are eliminated. Elimination is subjective and directly related to the model's statistical performance. Finally, the Department is left with a reduced menu of forecasts to consider. Historical patterns, along with economic and policy expectations are considered, and one model is chosen to be the best. In some cases, the forecasts that are produced by the models are adjusted upward or downward based on information that is not internal to the model.

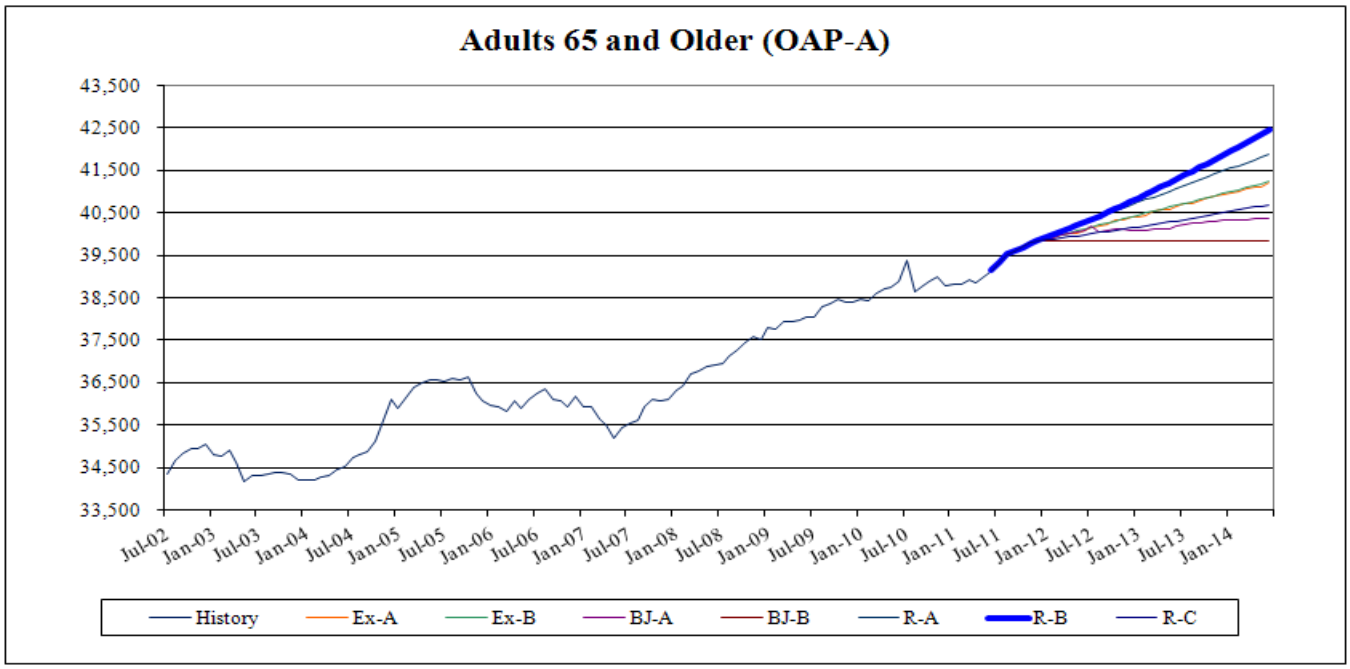
CATEGORICAL PROJECTIONS

This section details the caseload projections by eligibility category. For each category, the following are presented: a discussion of the category, model results, rationale for the forecast, statutory authority, and historical caseload and forecasts. FY 2013-14 projections are included for informational purposes. Graphical representations of caseload history to FY 2002-03 are included in each categorical section.

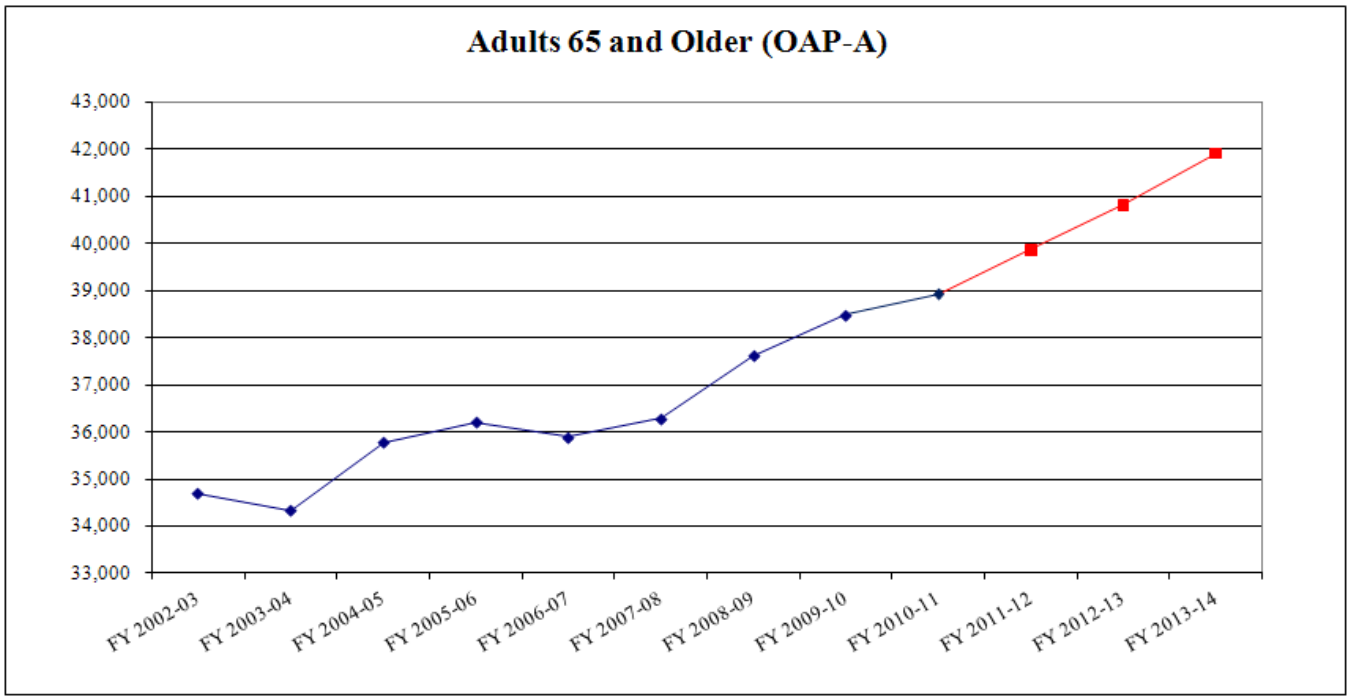
Adults 65 and Older

Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources. The Supplemental Security Income adults aged 65 and older are included in this category. Also included are individuals aged 65 and older who meet the Medicaid resource and income requirements, but are not receiving Supplemental Security Income. In addition, states may extend coverage to individuals with incomes above the Supplemental Security Income limit and who meet the nursing home level of care. Referred to as Three-hundred Percenters, these clients have incomes no more than three times the Supplemental Security Income maximum limit, and they meet the level of care to be in a nursing home.

Adults 65 and Older: Model Results



Adults 65 and Older: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9970	
Exponential Smoothing B*	0.9900	
Box-Jenkins A	0.9972	
Box-Jenkins B	0.9895	
Regression A	0.9969	OAP-A [-1], OAP-A [-7], CBMS Dummy [-2], Systems Dummy
Regression B	0.9969	OAP-A [-1], Population 65+, CBMS Dummy, CBMS Dummy [-1], Auto [-9]
Regression C	0.9971	OAP-A [-1], Total Population, CBMS Dummy, Trend



Adults 65 and Older: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	38,487	38,921	2.27%	39,805	884	79
Exponential Smoothing B*	38,487	38,921	2.31%	39,820	899	81
Box Jenkins A	38,487	38,921	2.29%	39,812	891	78
Box Jenkins B	38,487	38,921	2.11%	39,742	821	58
Regression A	38,487	38,921	2.44%	39,871	950	94
Regression B	**38,487**	**38,921**	**2.43%**	**39,867**	**946**	**94**
Regression C	38,487	38,921	2.21%	39,781	860	69

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2012-13	**Projected FY 2010-11 Caseload**	**Projected FY 2011-12 Caseload**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	38,921	39,867	1.49%	40,461	594	46
Exponential Smoothing B*	38,921	39,867	1.52%	40,473	606	47
Box Jenkins A	38,921	39,867	0.77%	40,174	307	7
Box Jenkins B	38,921	39,867	0.27%	39,975	108	0
Regression A	38,921	39,867	2.11%	40,708	841	67
Regression B	**38,921**	**39,867**	**2.39%**	**40,820**	**953**	**85**
Regression C	38,921	39,867	0.95%	40,246	379	28

FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	39,867	40,820	1.37%	41,379	559	46
Exponential Smoothing B*	39,867	40,820	1.38%	41,383	563	47
Box Jenkins A	39,867	40,820	0.48%	41,016	196	16
Box Jenkins B	39,867	40,820	0.00%	40,820	0	0
Regression A	39,867	40,820	1.98%	41,628	808	68
Regression B	**39,867**	**40,820**	**2.68%**	**41,914**	**1,094**	**96**
Regression C	39,867	40,820	0.90%	41,187	367	32

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Adults 65 and Older: Trend Selections

FY 2011-12: 2.43%
FY 2012-13: 2.39%
FY 2013-14: 2.68%

Adults 65 and Older: Justifications

- This population will be effected by the "baby boomers", defined by the U.S. Census Bureau as the generation born between 1946 and 1964, beginning in approximately calendar year 2011.
- Regression analysis indicates that the caseload for this population is not significantly correlated with the size of the over-65 population or economic conditions. Data for FY 2010-11 indicate that approximately 31.9% of this eligibility type were automatically eligible for Medicaid due to their receipt of Supplemental Security Income (SSI). Additionally, 87.7% of this population were dual eligibles (Medicaid and Medicare) in FY 2010-11 and 31.9% were enrolled in Home- and Community-based Services waivers (HCBS). Enrollment in waivers has increased by an average of 5.1% per year for the last three years. (Source: MARS 474701 report)
- This population may be effected by provisions in the Deficit Reduction Act of 2005, notably sections 6011 (lengthening of look-back period), 6012 (treatment of annuities), 6014 (disqualification of individuals with substantial home equity), 6015 (reform of asset test rules). These provisions may decrease the long-term growth rates as fewer people may now be eligible due to these provisions.
- The graph above shows that historically, this population has had relatively flat growth, though monthly growth has been strong since FY 2007-08. Between FY 2002-03 and FY 2006-07, the caseload increased by an average of 19 clients per month, compared with 77 between FY 2007-08 and FY 2010-11. Historical growth rates are stable and tend to fluctuate between 1% and 2%. The Department suspects that the high growth rate in FY 2004-05 is due to the court order regarding the Colorado Benefits Management System. The Department speculates that the decline in FY 2006-07 may be indicative that the effects of the asset and annuities provisions in the Deficit Reduction Act may be stronger than expected. The Department has seen strong growth in the Home- and Community-Based Services for the Elderly, Blind, and Disabled waiver over the last three years. There has also been a large increase in the number of clients in this eligibility type who are not eligible for SSI or on a waiver. The Department believes this is related to caseload declines in the State-only Old Age Pension Health and Medical Care program, which were caused by the implementation of new requirements around Systematic Alien Verification for Entitlements (SAVE) to comply with HB 06S-1023 and Department regulations.
- Growth in the first half of FY 2011-12 was higher than the Department's November 2011 forecast, in which the annual caseload was projected to be 39,579 and average monthly growth was projected to be 65. The selected trend for FY 2011-12 is higher than that from the Department's November 2011 forecast, and would result in average growth of 72 per month for the remainder of FY 2011-12.
- Out-year trends are positive to reflect the aging population, but are slightly lowered to reflect the Deficit Reduction provisions, which may negatively affect caseload. Population growth in this age group is projected to overtake that of the 60-64 group in 2012 to become the fastest growing age group, with projected increases of an average of 5.8% per year over the forecast period.

25.5-5-101 (1), C.R.S.

(f) Individuals receiving supplemental security income;

(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions;

(h) Institutionalized individuals who were eligible for medical assistance in December 1973;

(i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under P.L. 92-336;

(j) Individuals who become ineligible for cash assistance as a result of old-age, survivors, and disability insurance cost-of-living increases after April 1977;

25.5-5-201 (1), C.R.S.
(b) Individuals who would be eligible for cash assistance except for their institutionalized status;
(c) Individuals receiving home-and community-based services as specified in part 6 of this article;
(f) Individuals receiving only optional state supplement;
(g) Individuals in institutions who are eligible under a special income level. Colorado's program for citizens sixty-five years of age or older or physically disabled or blind, whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, qualifies for federal funding under this provision;
(j) Individuals who are qualified aliens and were or would have been eligible for supplemental security income as a result of a disability but are not eligible for such supplemental security income as a result of the passage of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193;

Adults 65 and Older: Historical Caseload and Forecasts

Adults 65 and Older: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Dec-09	38,410	-	-
Jan-10	38,452	42	0.11%
Feb-10	38,432	(20)	-0.05%
Mar-10	38,597	165	0.43%
Apr-10	38,727	130	0.34%
May-10	38,754	27	0.07%
Jun-10	38,900	146	0.38%
Jul-10	39,382	482	1.24%
Aug-10	38,648	(734)	-1.86%
Sep-10	38,774	126	0.33%
Oct-10	38,901	127	0.33%
Nov-10	39,009	108	0.28%
Dec-10	38,769	(240)	-0.62%
Jan-11	38,808	39	0.10%
Feb-11	38,823	15	0.04%
Mar-11	38,939	116	0.30%
Apr-11	38,861	(78)	-0.20%
May-11	38,981	120	0.31%
Jun-11	39,154	173	0.44%
Jul-11	39,341	187	0.48%
Aug-11	39,537	196	0.50%
Sep-11	39,600	63	0.16%
Oct-11	39,697	97	0.24%
Nov-11	39,789	92	0.23%
Dec-11	39,843	54	0.14%

	Caseload*	% Change	Level Change
FY 1995-96	31,321	-	-
FY 1996-97	32,080	2.42%	759
FY 1997-98	32,664	1.82%	584
FY 1998-99	33,007	1.05%	343
FY 1999-00	33,135	0.39%	128
FY 2000-01	33,649	1.55%	514
FY 2001-02	33,916	0.79%	267
FY 2002-03	34,704	2.32%	788
FY 2003-04	34,329	-1.08%	(375)
FY 2004-05	35,780	4.23%	1,451
FY 2005-06	36,207	1.19%	427
FY 2006-07	35,888	-0.88%	(319)
FY 2007-08	36,284	1.10%	396
FY 2008-09	37,619	3.68%	1,335
FY 2009-10	38,487	2.31%	868
FY 2010-11	38,921	1.13%	434
FY 2011-12	39,867	2.43%	946
FY 2012-13	40,820	2.39%	953
FY 2013-14	41,914	2.68%	1,094

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

November 2011 Forecast	
Forecasted December 2011 Level	39,553

November 2011 Trends			
FY 2011-12	39,579	1.69%	658
FY 2012-13	40,347	1.94%	768
FY 2013-14	41,118	1.91%	771

Actuals	Monthly Change	% Change
6-month average	115	0.29%
12-month average	90	0.23%
18-month average	52	0.13%
24-month average	60	0.15%
24-month average*	62	0.16%

*Without outliers

Base trend from December 2011 level			
FY 2011-12	39,843	2.37%	922

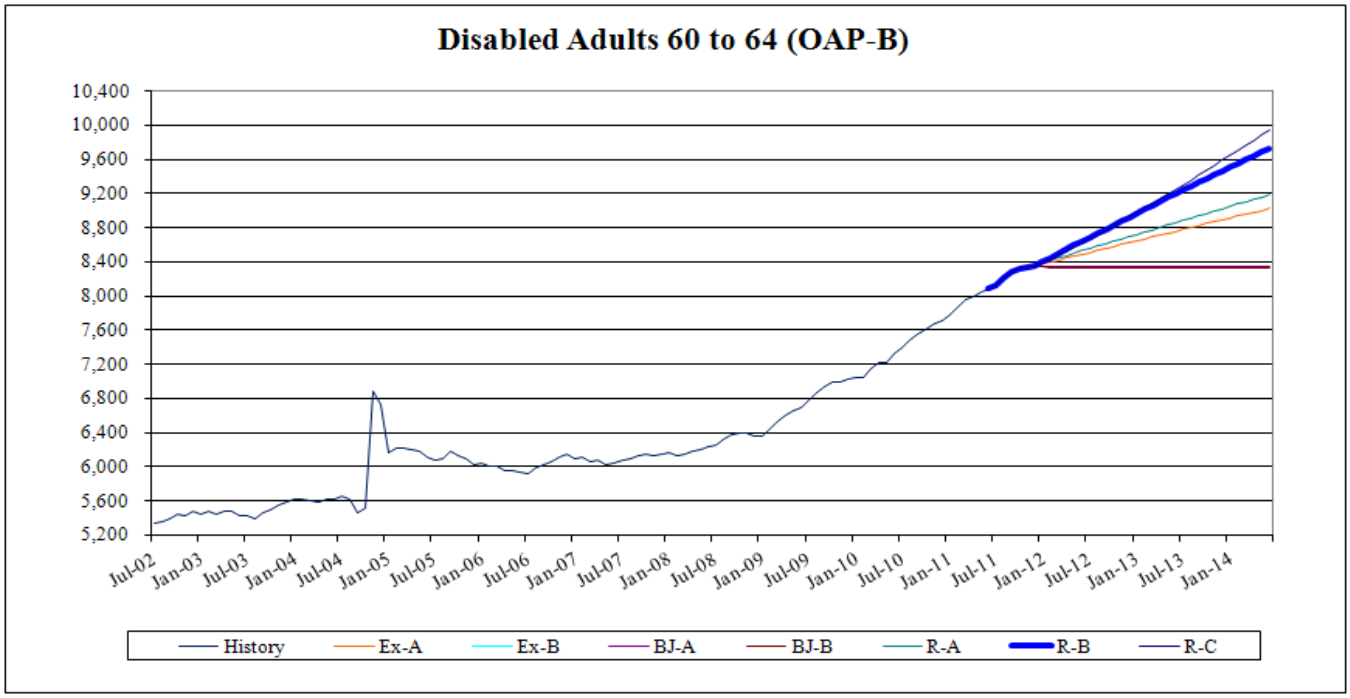
Monthly Average Growth Comparisons		
FY 2010-11 Actuals	21	0.06%
FY 2010-11 1st Half	(22)	-0.05%
FY 2010-11 2nd Half	64	0.17%
FY 2011-12 1st Half Actuals	115	0.29%
FY 2011-12 2nd Half Forecast	72	0.24%
FY 2011-12 Forecast	94	0.24%
November 2011 Forecast	65	0.17%
FY 2012-13 Forecast	85	0.21%
November 2011 Forecast	64	0.16%

Disabled Adults 60 to 64

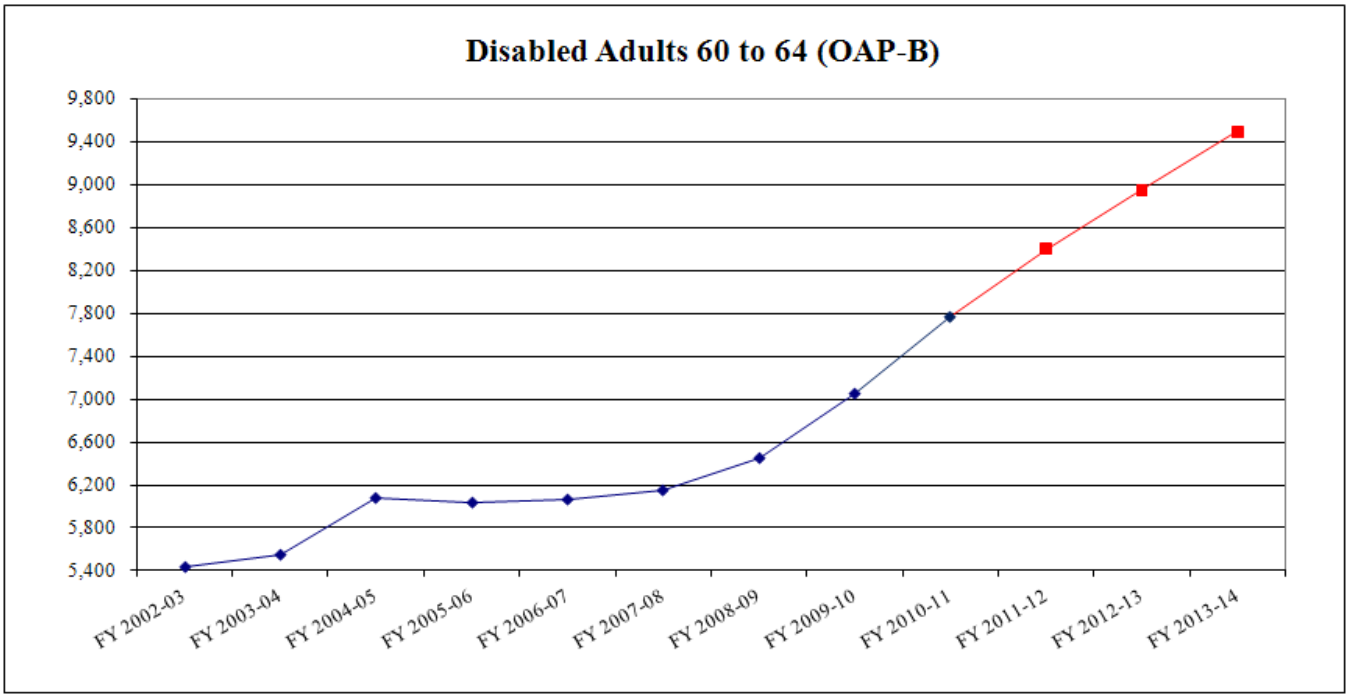
Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources. Disabled adults aged 60 to 64 who are eligible for Supplemental Security Income are included in this category. In addition, states may extend coverage to individuals with incomes above the Supplemental Security Income limit, and who meet the nursing home level of care. Referred to as Three-hundred Percenters, these clients have incomes no more than three times the Supplemental Security Income maximum limit, and they meet the level of care to be in a nursing home.

Quality control checks are completed from time to time to look for eligibility coding errors that commonly result in clients being misclassified between this Medicaid category and the State-only Old Age Pension Health and Medical Care program (non-Medicaid). Historical miscoding can make it difficult to forecast this Medicaid category as groups of individuals identified through this process may be abruptly moved in and out of this category.

Disabled Adults 60 to 64: Model Results



Disabled Adults 60 to 64: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9905	
Exponential Smoothing B*	0.9724	
Box-Jenkins A	0.9919	
Box-Jenkins B	0.9733	
Regression A	0.9979	OAP-B [-1], OAP-B [-3], CBMS Dummy, Auto [-4]
Regression B	0.9989	OAP-B [-1], OAP-B [-2], Population 60-64, CBMS Dummy, CBMS Dummy [-2], Trend, Constant, Auto [-1]
Regression C	0.9988	OAP-B [-1], OAP-B [-2], Total Population, CBMS Dummy, CBMS Dummy [-2], Auto [-1]



Disabled Adults 60 to 64: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	7,049	7,767	7.57%	8,355	588	33
Exponential Smoothing B*	7,049	7,767	7.07%	8,316	549	22
Box Jenkins A	7,049	7,767	7.02%	8,312	545	21
Box Jenkins B	7,049	7,767	6.93%	8,305	538	20
Regression A	7,049	7,767	7.80%	8,373	606	38
Regression B	**7,049**	**7,767**	**8.14%**	**8,399**	**632**	**46**
Regression C	7,049	7,767	8.05%	8,392	625	45

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2012-13	**Projected FY 2010-11 Caseload**	**Projected FY 2011-12 Caseload**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	7,767	8,399	3.35%	8,680	281	22
Exponential Smoothing B*	7,767	8,399	0.47%	8,438	39	0
Box Jenkins A	7,767	8,399	0.41%	8,433	34	0
Box Jenkins B	7,767	8,399	0.33%	8,427	28	0
Regression A	7,767	8,399	4.02%	8,737	338	27
Regression B	**7,767**	**8,399**	**6.54%**	**8,948**	**549**	**46**
Regression C	7,767	8,399	6.70%	8,962	563	52

FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	8,399	8,948	3.12%	9,227	279	22
Exponential Smoothing B*	8,399	8,948	0.00%	8,948	0	0
Box Jenkins A	8,399	8,948	0.00%	8,948	0	0
Box Jenkins B	8,399	8,948	0.00%	8,948	0	0
Regression A	8,399	8,948	3.73%	9,282	334	28
Regression B	**8,399**	**8,948**	**6.07%**	**9,491**	**543**	**44**
Regression C	8,399	8,948	7.45%	9,615	667	59

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Disabled Adults 60 to 64: Trend Selections
FY 2011-12: 8.14%
FY 2012-13: 6.54%
FY 2013-14: 6.07%

Disabled Adults 60 to 64: Justifications
- The 1,615 client caseload spike in November 2004 is directly related to the court order regarding the Colorado Benefits Management System. Of this group, 1,166 clients came from the Disabled Adults to 59 (AND/AB) population, while the remaining 449 clients came from the Adults 65 and Older (OAP-A) population. This has been corrected for in regressions.
- Historically, this category has displayed consistently slow growth, with caseload increasing by an average of 12 clients per month between FY 2002-03 and FY 2007-08, excluding the level shift that occurred from the court order regarding the Colorado Benefits Management System. Growth from FY 2008-09 through FY 2010-11 averaged 52 per month. This population, like the Adults 65 and Older category, may be effected by the asset and annuities provisions in the Deficit Reduction Act of 2005, which would promote low growth. This category began to be effected by the baby-boom generation, defined by the U.S. Census Bureau as the generation born between 1946 and 1964, in calendar year 2006, which may have resulted in higher growth. The Department has seen strong growth in the Home- and Community-Based Services (HCBS) for the Elderly, Blind, and Disabled waiver over the last three years. There has also been a large increase in the number of clients in this eligibility type who are not eligible for Supplemental Security Income (SSI) or on a waiver. The Department believes this is related to caseload declines in the State-only Old Age Pension Health and Medical Care program, which were caused by the implementation of new requirements around Systematic Alien Verification for Entitlements (SAVE) to comply with HB 06S-1023 and Department regulations.
- However, because this population is disabled, the effects of both the baby boom generation and the Deficit Reduction Act are likely to be mitigated. Data for FY 2010-11 indicate that approximately 53.7% of this eligibility type were automatically eligible for Medicaid due to their receipt of SSI. Additionally, 44.4% of this population were dual eligibles (Medicaid and Medicare) in FY 2010-11 and 32.0% were enrolled in HCBS waivers. Enrollment in waivers has increased by an average of 10.9% per year for the last three years. (Source: MARS 474701 report)
- Growth in the first half of FY 2011-12 was lower than the Department's November 2011 forecast, in which the annual caseload was projected to be 8,451 and average monthly growth was projected to be 55. The selected trend for FY 2011-12 is lower than that from the Department's November 2011 forecast, and would yield average growth of 48 per month for the remainder of FY 2011-12.
- Out-year trends are moderate, as this population may become effected by a larger portion of the baby-boom generation over the next 5 years. Population growth in this age group is forecasted to slow, with projected increases of an average of approximately 4.0% per year over the forecast period.

25.5-5-101 (1), C.R.S.
(f) Individuals receiving supplemental security income;
(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions;
(h) Institutionalized individuals who were eligible for medical assistance in December 1973;
(i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under P.L. 92-336;
(j) Individuals who become ineligible for cash assistance as a result of old-age, survivors, and disability insurance cost-of-living increases after April 1977;

25.5-5-201 (1), C.R.S.
(b) Individuals who would be eligible for cash assistance except for their institutionalized status;
(c) Individuals receiving home-and community-based services as specified in part 6 of this article;
(f) Individuals receiving only optional state supplement;
(g) Individuals in institutions who are eligible under a special income level. Colorado's program for citizens sixty-five years of age or older or physically disabled or blind, whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, qualifies for federal funding under this provision;
(j) Individuals who are qualified aliens and were or would have been eligible for supplemental security income as a result of a disability but are not eligible for such supplemental security income as a result of the passage of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193;

Disabled Adults 60 to 64: Historical Caseload and Forecasts

Disabled Adults 60 to 64: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Dec-09	7,025	-	-
Jan-10	7,047	22	0.31%
Feb-10	7,049	2	0.03%
Mar-10	7,152	103	1.46%
Apr-10	7,212	60	0.84%
May-10	7,228	16	0.22%
Jun-10	7,326	98	1.36%
Jul-10	7,395	69	0.94%
Aug-10	7,492	97	1.31%
Sep-10	7,562	70	0.93%
Oct-10	7,602	40	0.53%
Nov-10	7,682	80	1.05%
Dec-10	7,721	39	0.51%
Jan-11	7,781	60	0.78%
Feb-11	7,870	89	1.14%
Mar-11	7,966	96	1.22%
Apr-11	7,987	21	0.26%
May-11	8,051	64	0.80%
Jun-11	8,089	38	0.47%
Jul-11	8,133	44	0.54%
Aug-11	8,222	89	1.09%
Sep-11	8,280	58	0.71%
Oct-11	8,328	48	0.58%
Nov-11	8,343	15	0.18%
Dec-11	8,355	12	0.14%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	4,261	-	-
FY 1996-97	4,429	3.94%	168
FY 1997-98	4,496	1.51%	67
FY 1998-99	4,909	9.19%	413
FY 1999-00	5,092	3.73%	183
FY 2000-01	5,157	1.28%	65
FY 2001-02	5,184	0.52%	27
FY 2002-03	5,431	4.76%	247
FY 2003-04	5,548	2.15%	117
FY 2004-05	6,082	9.63%	534
FY 2005-06	6,042	-0.66%	(40)
FY 2006-07	6,059	0.28%	17
FY 2007-08	6,146	1.44%	87
FY 2008-09	6,447	4.90%	301
FY 2009-10	7,049	9.34%	602
FY 2010-11	7,767	10.19%	718
FY 2011-12	8,399	8.14%	632
FY 2012-13	8,948	6.54%	549
FY 2013-14	9,491	6.07%	543

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

November 2011 Forecast	
Forecasted December 2011 Level	8,425

Actuals		
	Monthly Change	**% Change**
6-month average	44	0.54%
12-month average	53	0.66%
18-month average	57	0.73%
24-month average	55	0.73%

Base trend from December 2011 level			
FY 2011-12	8,355	7.57%	588

November 2011 Trends			
FY 2011-12	8,451	8.81%	684
FY 2012-13	9,101	7.69%	650
FY 2013-14	9,735	6.97%	634

Monthly Average Growth Comparisons		
FY 2010-11 Actuals	64	0.83%
FY 2010-11 1st Half	66	0.88%
FY 2010-11 2nd Half	61	0.78%
FY 2011-12 1st Half Actuals	44	0.54%
FY 2011-12 2nd Half Forecast	48	0.55%
FY 2011-12 Forecast	46	0.57%
November 2011 Forecast	55	0.68%
FY 2012-13 Forecast	46	0.53%
November 2011 Forecast	53	0.61%

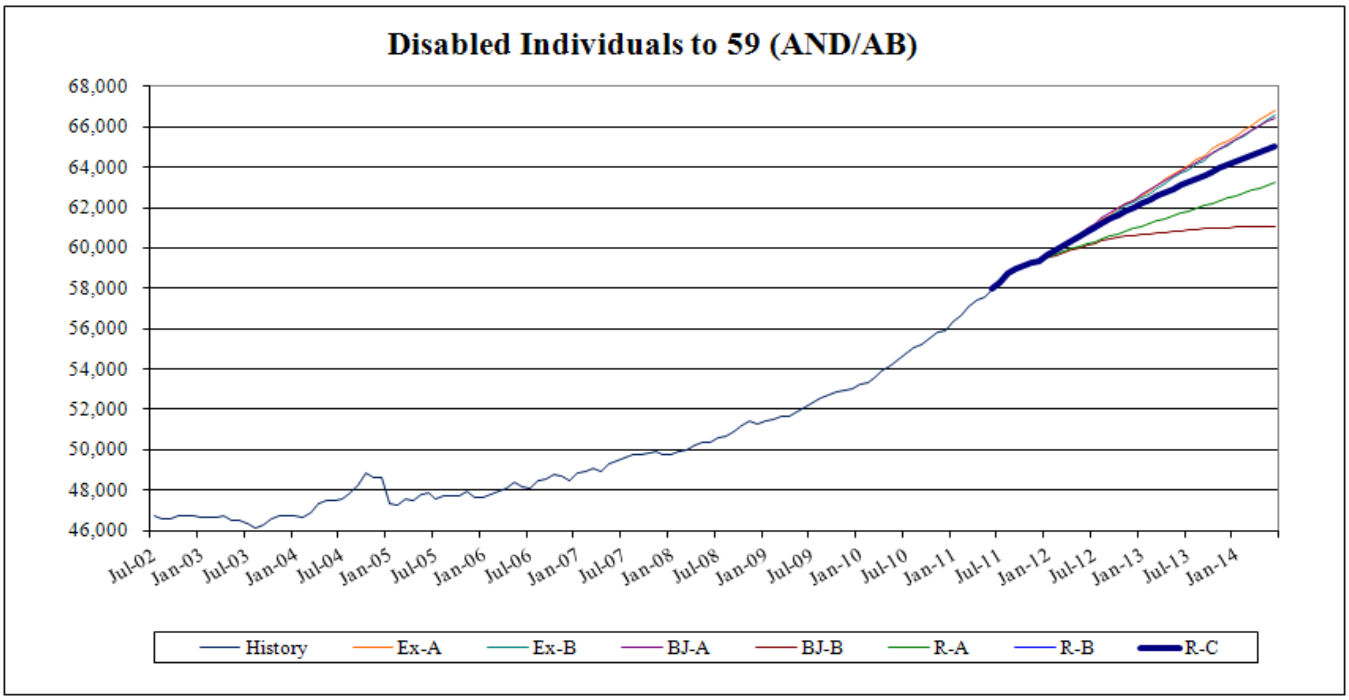
Disabled Individuals to 59

Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources. This category includes the disabled portion of this group through age 59. These individuals: are blind, have a physical or mental impairment that keeps them from performing substantial work expected to last 12 months or result in death, or are children who have a marked and severe functional limitation expected to last 12 months or until death. Children were added to the Title XVI Act in 1972. In addition, states may extend coverage to individuals with incomes too high for Supplemental Security Income, and who meet the nursing facility level of care. Referred to as Three-hundred Percenters, these clients have incomes no more than three times the Supplemental Security Income maximum limit, and they meet the level of care to be in a nursing home. Often, Three-hundred Percenters are enrolled in a Home- and Community-Based waiver program.

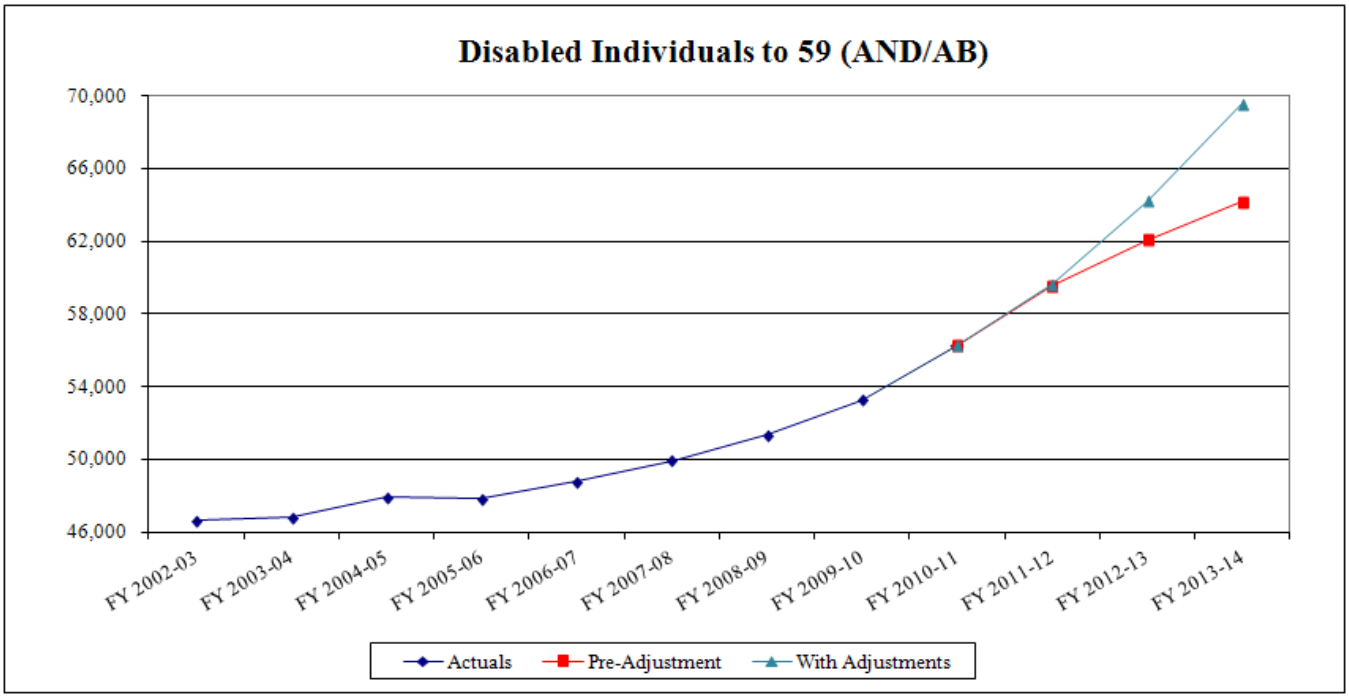
The 1990 outcome of the *Zebley v. Sullivan* lawsuit found that children could not be held to higher standard of disability than adults. Zebley required that children's disability be measured using child-appropriate activities. As a result, the number of children determined to be disabled significantly increased until 1996. Welfare reform in 1996 tightened the disability criteria for children. An Individual Evaluation Plan from the public school system was no longer sufficient to verify disability, and children were required to have a physician document their level of functional impairment. However, any child receiving Supplemental Security Income before 1996 who lost his/her Supplemental Security Income benefits due to the new rules is still eligible for Medicaid. This category also includes disabled adult children age 18 and older who lost their Supplemental Security Income eligibility due to their parents receiving Social Security Administration benefits and disabled widows and widowers aged 50 to 64 who lost Supplemental Security Income due to the receipt of Social Security Administration benefits.

In July 2001, the Med-9 disability determination application process was disbanded due to federal requirements. This process let individuals under 65 who were seeking Medicaid coverage because of a disability experience an expeditious application process as compared to other applicants. By discontinuing the Med-9, clients underwent a more rigorous eligibility determination and caseload fell slightly.

Disabled Individuals to 59: Model Results



Disabled Individuals to 59: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9979	
Exponential Smoothing B*	0.9970	
Box-Jenkins A	0.9979	
Box-Jenkins B	0.9962	
Regression A	0.9962	AND/AB [-1], AND/AB [-3], Auto [-5]
Regression B	0.9973	AND/AB [-1], Unemployment Rate, CBMS Dummy, Auto [-12]
Regression C	0.9971	AND/AB [-1], AND/AB [-24], Auto [-12]



Disabled Individuals to 59: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	53,264	56,285	5.93%	59,623	3,338	243
Exponential Smoothing B*	53,264	56,285	5.89%	59,600	3,315	238
Box Jenkins A	53,264	56,285	5.98%	59,651	3,366	249
Box Jenkins B	53,264	56,285	5.53%	59,398	3,113	177
Regression A	53,264	56,285	5.58%	59,426	3,141	185
Regression B	53,264	56,285	5.83%	59,566	3,281	228
Regression C	**53,264**	**56,285**	**5.87%**	**59,589**	**3,304**	**233**

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2012-13	**Projected FY 2010-11 Caseload**	**Projected FY 2011-12 Caseload**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	56,285	59,589	4.83%	62,467	2,878	247
Exponential Smoothing B*	56,285	59,589	4.67%	62,372	2,783	238
Box Jenkins A	56,285	59,589	4.83%	62,467	2,878	235
Box Jenkins B	56,285	59,589	2.02%	60,793	1,204	61
Regression A	56,285	59,589	2.68%	61,186	1,597	125
Regression B	56,285	59,589	4.13%	62,050	2,461	195
Regression C	**56,285**	**59,589**	**4.21%**	**62,098**	**2,509**	**195**

FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	59,589	62,098	4.75%	65,048	2,950	247
Exponential Smoothing B*	59,589	62,098	4.58%	64,942	2,844	238
Box Jenkins A	59,589	62,098	4.37%	64,812	2,714	222
Box Jenkins B	59,589	62,098	0.67%	62,514	416	21
Regression A	59,589	62,098	2.48%	63,638	1,540	127
Regression B	59,589	62,098	3.42%	64,222	2,124	161
Regression C	**59,589**	**62,098**	**3.36%**	**64,184**	**2,086**	**161**

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Disabled Individuals to 59: Trend Selections

FY 2011-12: 5.87%
FY 2012-13: 4.21%
FY 2013-14: 3.36%

Disabled Individuals to 59: Justifications

- As the graph above shows, caseload growth through FY 2003-04 remained relatively constant, with average monthly growth of 32 clients in FY 2002-03 and FY 2003-04. The elimination of the Med-9 disability determination has also contributed to slower growth.
- HB 05-1262 expanded the number of children that can be enrolled in the Children's Home- and Community-Based Service (HCBS) Waiver Program and the Children's Extensive Support (CES) Waiver Program. The original expansion was 527 slots, which began to be filled in FY 2005-06. During the March 13, 2006 Figure Setting, the number of expansion slots funded under the Tobacco Tax bill was increased by 200 in the Children's HCBS Waiver Program and 30 in the CES Waiver Program. The Department received approval for the additional expansions from the Centers for Medicare and Medicaid Services in December 2006. All new expansion slots were filled by FY 2007-08.
- This population has historically been stable, having increased by approximately 5,000 clients between FY 1998-99 and FY 2007-08, or an average of 0.8% per year. However, growth rates in this population have increased significantly in the last three fiscal years, with caseload in HCBS waivers showing strong growth. In addition, over the last three years, the number of individuals eligible for

Medicaid due to receipt of SSI has represented most of the growth in this eligibility group. The Department believes that this may be related to economic condition in that individuals with work-limiting disabilities who were employed prior to the recession and have exhausted their federally-extended unemployment benefits may now be applying for Supplemental Security Income (SSI) if they cannot find work. Data for FY 2010-11 indicate that approximately 68.3% of this eligibility type were automatically eligible for Medicaid due to their receipt of SSI. Additionally, 33.1% of this population were dual eligibles (Medicaid and Medicare) in FY 2010-11 and 28.9% were enrolled in HCBS waivers. Enrollment in waivers has increased by an average of 5.1% per year for the last three years. (Source: MARS 474701 report)

- Growth in the first half of FY 2011-12 was slightly lower than the Department's November 2011 forecast, in which the annual base caseload was projected to be 59,596 and average monthly growth was projected to be 245. The selected trend for FY 2011-12 is in line with the Department's November 2011 forecast, and would yield average growth of 233 per month for the remainder of FY 2011-12.
- Out-year growth is projected to moderate and maintain a long-term trend.
- There is a bottom-line adjustment to this eligibility type from HB 09-1293, which establishes the Buy-In Program for Working Adults with Disabilities beginning in March 2012 and for Disabled Children four to six months later. This program will allow individuals to pay a premium to purchase Medicaid coverage if they are over income or are otherwise ineligible for Medicaid.

25.5-5-101 (1), C.R.S.
(f) Individuals receiving supplemental security income;
(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions;
(h) Institutionalized individuals who were eligible for medical assistance in December 1973;
(i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under P.L. 92-336;
(j) Individuals who become ineligible for cash assistance as a result of old-age, survivors, and disability insurance cost-of-living increases after April 1977;
(k) Disabled widows or widowers fifty through sixty years of age who have become ineligible for federal supplemental security income or state supplementation as a result of becoming eligible for federal social security survivor's benefits, in accordance with the social security act, 42 U.S.C. sec. 1383c;

25.5-5-201 (1), C.R.S.
(b) Individuals who would be eligible for cash assistance except for their institutionalized status;
(c) Individuals receiving home-and community-based services as specified in part 6 of this article;
(f) Individuals receiving only optional state supplement;
(g) Individuals in institutions who are eligible under a special income level. Colorado's program for citizens sixty-five years of age or older or physically disabled or blind, whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, qualifies for federal funding under this provision;
(j) Individuals who are qualified aliens and were or would have been eligible for supplemental security income as a result of a disability but are not eligible for such supplemental security income as a result of the passage of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193;

Disabled Individuals to 59: Historical Caseload and Forecasts

Disabled Individuals to 59: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Dec-09	53,000	-	-
Jan-10	53,255	255	0.48%
Feb-10	53,298	43	0.08%
Mar-10	53,629	331	0.62%
Apr-10	53,904	275	0.51%
May-10	54,164	260	0.48%
Jun-10	54,493	329	0.61%
Jul-10	54,740	247	0.45%
Aug-10	55,032	292	0.53%
Sep-10	55,223	191	0.35%
Oct-10	55,508	285	0.52%
Nov-10	55,804	296	0.53%
Dec-10	55,937	133	0.24%
Jan-11	56,417	480	0.86%
Feb-11	56,671	254	0.45%
Mar-11	57,103	432	0.76%
Apr-11	57,385	282	0.49%
May-11	57,608	223	0.39%
Jun-11	57,986	378	0.66%
Jul-11	58,294	308	0.53%
Aug-11	58,712	418	0.72%
Sep-11	58,937	225	0.38%
Oct-11	59,159	222	0.38%
Nov-11	59,298	139	0.23%
Dec-11	59,384	86	0.15%

	Caseload*	% Change	Level Change
FY 1995-96	44,736	-	-
FY 1996-97	46,090	3.03%	1,354
FY 1997-98	46,003	-0.19%	(87)
FY 1998-99	46,310	0.67%	307
FY 1999-00	46,386	0.16%	76
FY 2000-01	46,046	-0.73%	(340)
FY 2001-02	46,349	0.66%	303
FY 2002-03	46,647	0.64%	298
FY 2003-04	46,789	0.30%	142
FY 2004-05	47,929	2.44%	1,140
FY 2005-06	47,855	-0.15%	(74)
FY 2006-07	48,799	1.97%	944
FY 2007-08	49,933	2.32%	1,134
FY 2008-09	51,355	2.85%	1,422
FY 2009-10	53,264	3.72%	1,909
FY 2010-11	56,285	5.67%	3,021
FY 2011-12	59,589	5.87%	3,304
FY 2012-13	62,098	4.21%	2,509
FY 2013-14	64,184	3.36%	2,086

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

Adjustments	
FY 2011-12	58
FY 2012-13	2,208
FY 2013-14	5,671

November 2011 Forecast	
Forecasted December 2011 Level	59,457

Base trend from December 2011 level			
FY 2011-12	59,384	5.51%	3,099

Monthly Average Growth Comparisons		
FY 2010-11 Actuals	291	0.52%
FY 2010-11 1st Half	241	0.44%
FY 2010-11 2nd Half	342	0.60%
FY 2011-12 1st Half Actuals	233	0.40%
FY 2011-12 2nd Half Forecast	233	0.39%
FY 2011-12 Forecast	233	0.40%
November 2011 Forecast	245	0.42%
FY 2012-13 Forecast	195	0.32%
November 2011 Forecast	196	0.32%

February 2012 Projections After Adjustments			
FY 2011-12	59,647	5.97%	3,362
FY 2012-13	64,306	7.81%	4,659
FY 2013-14	69,855	8.63%	5,549

November 2011 Trends (BEFORE ADJUSTMENTS)			
FY 2011-12	59,596	5.89%	3,315
FY 2012-13	62,224	4.41%	2,628
FY 2013-14	64,396	3.49%	2,172

Actuals		
	Monthly Change	% Change
6-month average	233	0.40%
12-month average	287	0.50%
18-month average	272	0.48%
24-month average	266	0.48%

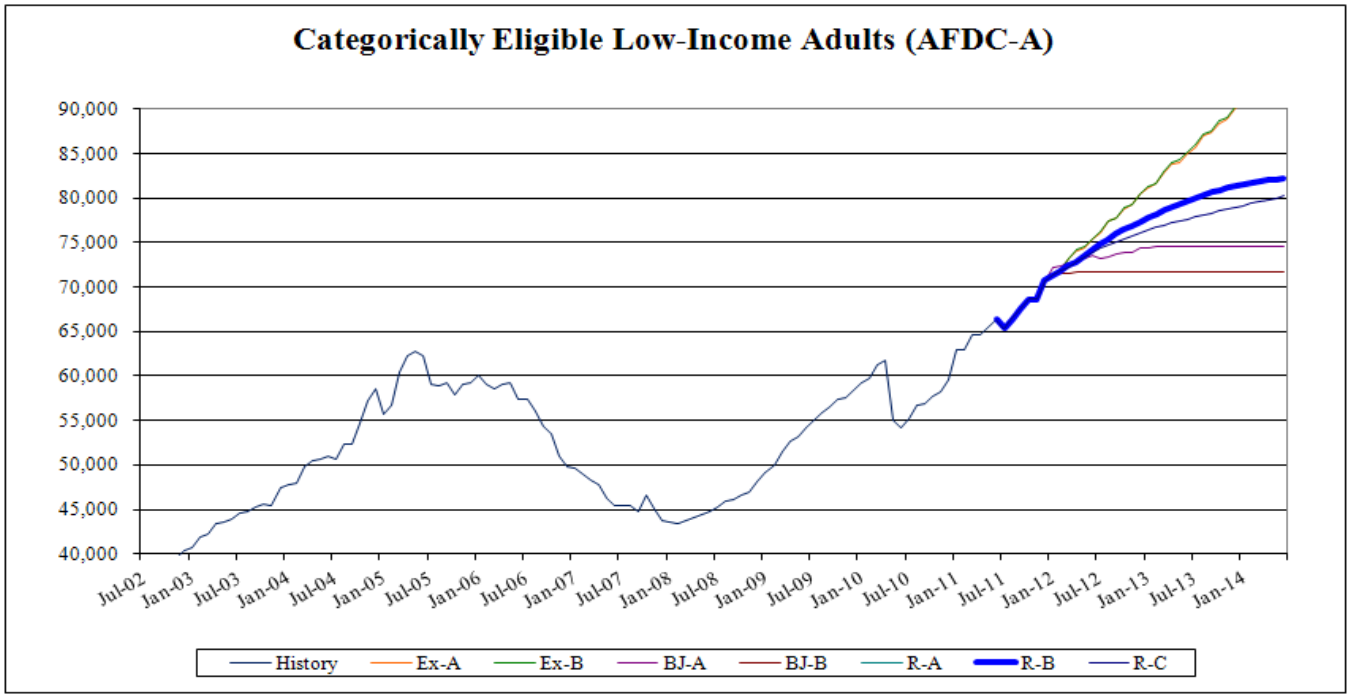
Categorically Eligible Low-Income Adults

One of the primary ways that adults qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to Families with Dependent Children program was discontinued. Aid to Families with Dependent Children was replaced by the Temporary Assistance for Needy Families program (referred to as Colorado Works) on July 16, 1996. Clients enrolled in the Temporary Assistance for Needy Families program are no

longer automatically eligible for Medicaid. Therefore, the Categorically Eligible Low-Income Adults category includes adults who receive Medicaid under Section 1931 and those families who receive Temporary Aid to Needy Families financial assistance coupled with Medicaid. Also included in this category are adults receiving Transitional Medicaid. Transitional Medicaid is available to adults in families who have received 1931 Medicaid in three of the past six months and become ineligible due to an increase in earned income. Adults may receive Transitional Medicaid benefits for one year. In FY 2010-11, there were an average of 6,173 adults in this program. Transitional Medicaid benefits have been extended through February 29, 2012, and the Department's forecast assumes that the program will continue through FY 2012-13.

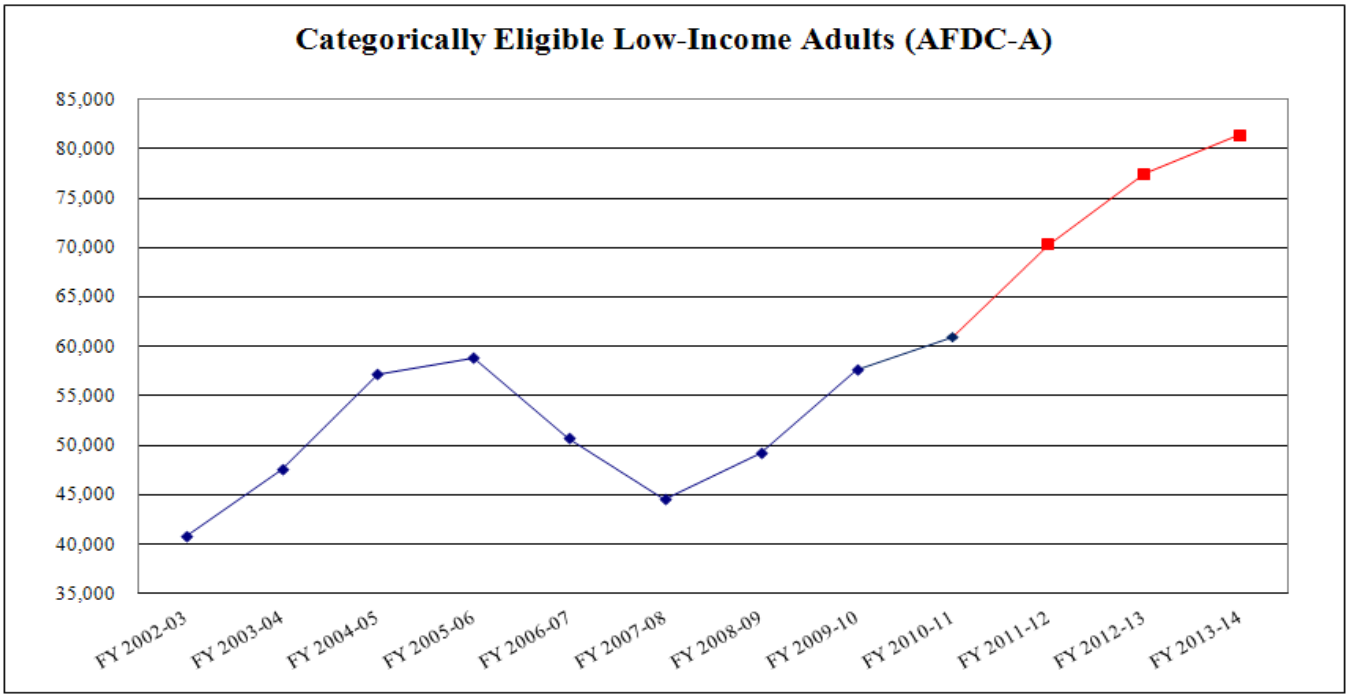
Before 1999, caseload in this category was falling. Decreases in caseload can be attributed to economic expansion and effects of the Personal Responsibility Work and Opportunity Reconciliation Act, known as welfare reform. When welfare reform was instituted in Colorado in 1997, the link between cash assistance for welfare and Medicaid was broken. When the Department implemented this change into the Client Oriented Information Network eligibility data system, it was estimated that 46,006[8] clients had their cases closed in error. In reaction, the Tatum lawsuit was brought against the State. Starting in May 2001, the Department began to reinstate clients who inadvertently lost their Medicaid eligibility. This may help to explain why from 1997 to 1999 caseload fell, and may have contributed to a spike in caseload in FY 2001-02. For a complete explanation of the Tatum lawsuit, see the November 1, 2001 Budget Request, pages A-37 to A-38.

Categorically Eligible Low-Income Adults: Model Results



[8] Source: November 1, 2001 Budget Request, page A-37

Categorically Eligible Low-Income Adults: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9940	
Exponential Smoothing B*	0.9839	
Box-Jenkins A	0.9960	
Box-Jenkins B	0.9834	
Regression A	0.9958	AFDC-A [-1], AFDC-A [-9], Unemployment Rate, CBMS Dummy, Systems Dummy, Auto [-6]
Regression B	0.9961	AFDC-A [-1], AFDC-A [-9], Unemployment Rate, Total Wages, CBMS Dummy, CBMS Dummy [-2], Systems Dummy, Auto [-9]
Regression C	0.9956	AFDC-A [-1], AFDC-A [-9], Total Wages, CBMS Dummy, Systems Dummy



Categorically Eligible Low-Income Adults: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	57,661	60,960	15.98%	70,701	9,741	759
Exponential Smoothing B*	57,661	60,960	15.98%	70,701	9,741	754
Box Jenkins A	57,661	60,960	15.42%	70,360	9,400	602
Box Jenkins B	57,661	60,960	14.41%	69,744	8,784	439
Regression A	57,661	60,960	15.33%	70,305	9,345	662
Regression B	**57,661**	**60,960**	**15.32%**	**70,299**	**9,339**	**650**
Regression C	57,661	60,960	15.24%	70,250	9,290	627

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2012-13	**Projected FY 2010-11 Caseload**	**Projected FY 2011-12 Caseload**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	60,960	70,299	14.15%	80,246	9,947	801
Exponential Smoothing B*	60,960	70,299	14.29%	80,345	10,046	811
Box Jenkins A	60,960	70,299	5.38%	74,081	3,782	77
Box Jenkins B	60,960	70,299	2.71%	72,204	1,905	0
Regression A	60,960	70,299	10.28%	77,526	7,227	460
Regression B	**60,960**	**70,299**	**10.18%**	**77,455**	**7,156**	**464**
Regression C	60,960	70,299	8.44%	76,232	5,933	316

FY 2013-14	Projected FY 2011-12 Caseload	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	70,299	77,455	11.92%	86,688	9,233	801
Exponential Smoothing B*	70,299	77,455	12.06%	86,796	9,341	811
Box Jenkins A	70,299	77,455	0.50%	77,842	387	0
Box Jenkins B	70,299	77,455	0.00%	77,455	0	0
Regression A	70,299	77,455	4.98%	81,312	3,857	191
Regression B	**70,299**	**77,455**	**5.03%**	**81,351**	**3,896**	**207**
Regression C	70,299	77,455	3.82%	80,414	2,959	215

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Categorically Eligible Low-Income Adults: Trend Selections

FY 2011-12: 15.32%
FY 2012-13: 10.18%
FY 2013-14: 5.03%

Categorically Eligible Low-Income Adults: Justifications

- Caseload trends in this category are highly affected by economic conditions, and tend to be positively correlated with the population of adults aged 19 to 59. Growth in the 19 to 59 population dropped from approximately 2.7% per year from FY 1995-96 to FY 2001-02 to 1.2% per year from FY 2002-03 to FY 2010-11. The growth in this population is projected to remain at an average of 0.8% over the forecast period[9]. The economy is projected remain relatively weak over the forecast period, with the unemployment rate to average 8.4% between 2011 and 2013. Wage and salary income is projected to increase by 3.9% in 2011, with moderate growth of 2.8% in 2012, increasing to 3.8% in 2013.[10]
- There were large and consistent declines between July 2006 and December 2007, which seems to indicate that the improved economy was having the expected effect on caseload. There is evidence that a number of clients that left this eligibility category went to the Expansion Adults to 60% FPL, from both 1931 and Transitional Medicaid, due to increased income. Similarly, large and consistent increases since July 2008 indicate that the weakening economic conditions are impacting caseload in this eligibility type.
- The Department believes that economic conditions are largely responsible for the growth over the last four years, as the seasonally adjusted unemployment rate increased from a low of 3.5% in March 2007 to a high of 9.3% in February 2011 (source: Bureau of Labor Statistics). The unemployment rate is at the highest level in recent history, and has also remained at a high level for an unprecedented period of time. The unemployment rate has exceeded 8.0% since April 2009. During the 2001-2002 recession, the AFDC-Adults caseload was increasing by approximately 1.7% per month for 36 months. Caseload has increased by an average of 1.5% since January 2008, excluding outliers.
- Growth in the first half of FY 2011-12 was lower than the Department's November 2011 forecast, in which the annual caseload was projected to be 72,180 and average monthly growth was projected to be 821. The selected trend for FY 2011-12 is lower than that from the Department's November 2011 forecast, and would yield average increases of 568 per month for the remainder of FY 2011-12. This forecast is reflective of the consistent increases since the second half of FY 2007-08, which moderated in FY 2009-10 but increased in FY 2010-11. Because the economy is believed to be largely responsible this change, projected economic conditions give no indication that the trend will not continue to be positive throughout FY 2011-12. The selected trends for FY 2011-12 and FY

[9] Source: Department of Local Affairs, Demography Division
[10] Source: Office of State Planning and Budgeting, December 2011 Revenue Forecast

2012-13 are conservative due to recent volatility in the monthly data, and the Department will continue to monitor this category and economic conditions closely over the next six months. The low trend for FY 2010-11 is due to the level shift experienced at the end of FY 2009-10 with the expansion to 100% FPL.

- Current forecasts indicate that the economic conditions should begin to improve at the end of 2012. The selected out-year trend reflects this, and the monthly increases are forecasted to moderate over the forecast period.

25.5-5-101 (1), C.R.S.
(a) Individuals who meet the eligibility criteria for the aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;
(b) Families who meet the eligibility criteria for the aid to families with dependent children program established in rules that were in effect on July 16, 1996, and who subsequently would have become ineligible under such eligibility criteria because of increased earnings or increased hours of employment whose eligibility is specified for a period of time by the federal government;
(c) Qualified pregnant women . . . who meet the income resource requirements of the state's aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;

25.5-5-201 (1), C.R.S.
(a) Individuals who would be eligible for but are not receiving cash assistance;
(d) Individuals who would be eligible for aid to families with dependent children if child care were paid from earnings;
(h) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706;

Categorically Eligible Low-Income Adults: Historical Caseload and Forecasts

Categorically Eligible Low-Income Adults: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Dec-09	58,381	-	-
Jan-10	59,210	829	1.42%
Feb-10	59,700	490	0.83%
Mar-10	61,190	1,490	2.50%
Apr-10	61,702	512	0.84%
May-10	55,110	(6,592)	-10.68%
Jun-10	54,173	(937)	-1.70%
Jul-10	55,213	1,040	1.92%
Aug-10	56,687	1,474	2.67%
Sep-10	56,852	165	0.29%
Oct-10	57,801	949	1.67%
Nov-10	58,276	475	0.82%
Dec-10	59,591	1,315	2.26%
Jan-11	62,929	3,338	5.60%
Feb-11	63,025	96	0.15%
Mar-11	64,697	1,672	2.65%
Apr-11	64,673	(24)	-0.04%
May-11	65,402	729	1.13%
Jun-11	66,369	967	1.48%
Jul-11	65,372	(997)	-1.50%
Aug-11	66,406	1,034	1.58%
Sep-11	67,613	1,207	1.82%
Oct-11	68,677	1,064	1.57%
Nov-11	68,638	(39)	-0.06%
Dec-11	70,766	2,128	3.10%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	36,690	-	-
FY 1996-97	33,250	-9.38%	(3,440)
FY 1997-98	27,179	-18.26%	(6,071)
FY 1998-99	22,852	-15.92%	(4,327)
FY 1999-00	23,515	2.90%	663
FY 2000-01	27,081	15.16%	3,566
FY 2001-02	33,347	23.14%	6,266
FY 2002-03	40,798	22.34%	7,451
FY 2003-04	47,562	16.58%	6,764
FY 2004-05	57,140	20.14%	9,578
FY 2005-06	58,885	3.05%	1,745
FY 2006-07	50,687	-13.92%	(8,198)
FY 2007-08	44,555	-12.10%	(6,132)
FY 2008-09	49,147	10.31%	4,592
FY 2009-10	57,661	17.32%	8,514
FY 2010-11	60,960	5.72%	3,299
FY 2011-12	70,299	15.32%	9,339
FY 2012-13	77,455	10.18%	7,156
FY 2013-14	81,351	5.03%	3,896

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

November 2011 Forecast	
Forecasted December 2011 Level	72,122

November 2011 Trends			
FY 2011-12	72,180	18.41%	11,222
FY 2012-13	79,578	10.25%	7,398
FY 2013-14	83,692	5.17%	4,114

Actuals		
	Monthly Change	**% Change**
6-month average	733	1.09%
12-month average	931	1.46%
18-month average	922	1.51%
24-month average	516	0.85%
24-month average*	552	0.89%

*Without outliers

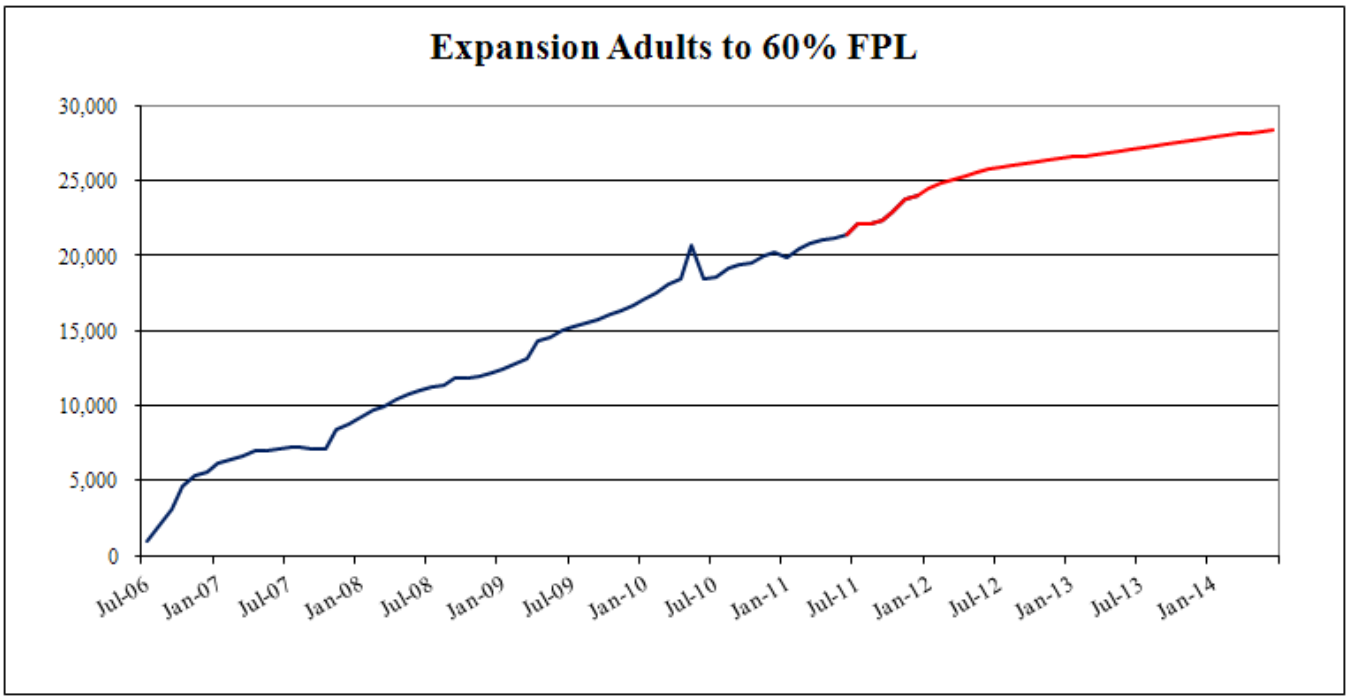
Base trend from December 2011 level			
FY 2011-12	70,766	16.09%	9,806

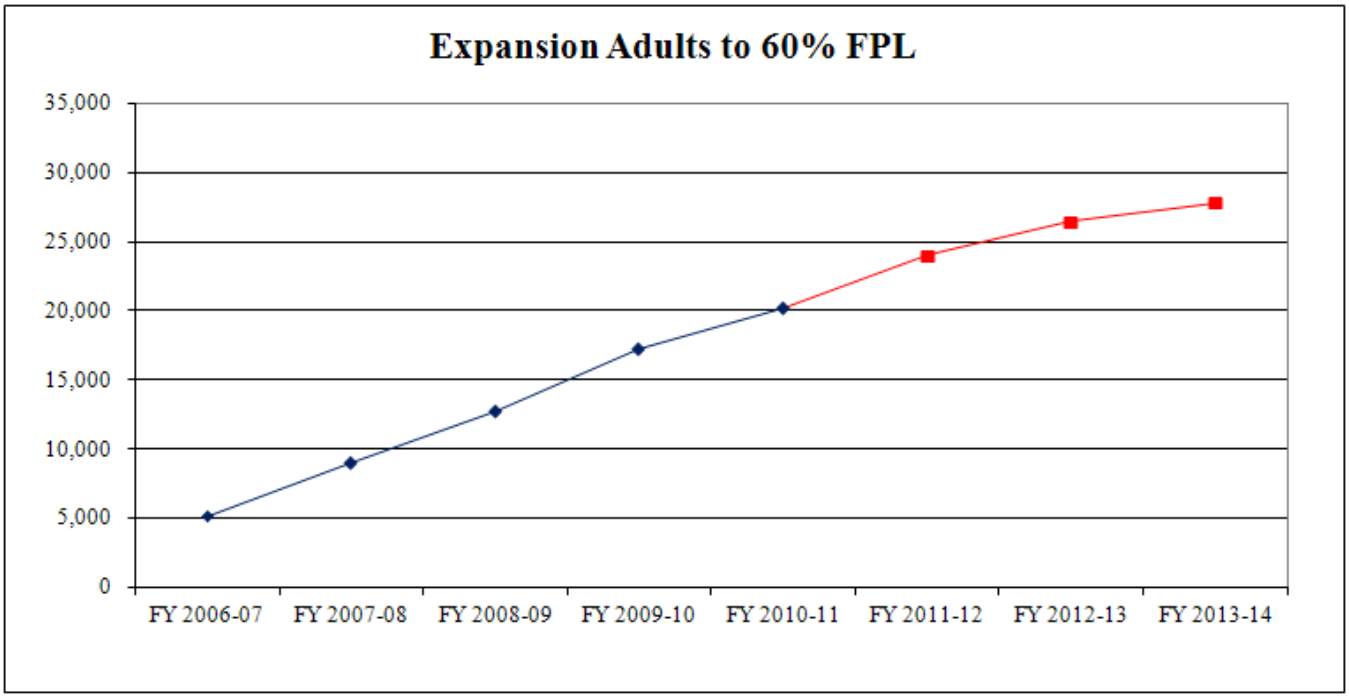
Monthly Average Growth Comparisons		
FY 2010-11 Actuals	1,016	1.72%
FY 2010-11 1st Half	903	1.60%
FY 2010-11 2nd Half	1,130	1.83%
FY 2011-12 1st Half Actuals	733	1.09%
FY 2011-12 2nd Half Forecast	568	0.94%
FY 2011-12 Forecast	650	0.98%
November 2011 Forecast	821	1.24%
FY 2012-13 Forecast	464	0.63%
November 2011 Forecast	475	0.62%

Expansion Adults to 60% FPL

HB 05-1262 (Tobacco Tax bill) allows for expanding Medicaid eligibility to parents of children enrolled in either Medicaid or the Children's Basic Health Plan up to 60% of the federal poverty level (FPL). The increase in the percentage of allowable federal poverty level was implemented on July 1, 2006. The Department has created a new category to track these clients, known as the Expansion Adults to 60% FPL.

Expansion Adults: Model Results





Expansion Adults to 60% FPL: Justification and Monthly Projections

- This population would be expected to have a high penetration rate, as these are parents of children in either the Children's Basic Health Plan or Medicaid, which have high enrollment rates.
- This population would be expected to be effected by the economy in similar ways as the AFDC-adult and children populations, although the effects are likely increased given that these clients are up to 60% of the federal poverty level, which would support higher growth rates.
- Growth in the first half of FY 2011-12 was much higher than the Department's November 2011 forecast, in which the annual caseload was projected to be 24,050 and average monthly growth was projected to be 67. The selected trend for FY 2011-12 is much higher than that from the

Department's November 2011 forecast, and would yield average growth of 290 per month for the remainder of FY 2011-12. This forecast is based on the average monthly change experienced in 2011. The forecast assumes that monthly growth will decrease over time as the population continues to mature, and will average 1.54% per month in FY 2011-12.

- The monthly growth rates for this eligibility group have converged with those experienced in the AFDC-Adults category over the last 18 months. As such, the Department has chosen to mirror the FY 2012-13 and FY 2013-14 growth rates from AFDC-Adults for this population. The forecasted growth rates are 10.18% for FY 2012-13 and 5.03% for FY 2013-14.

25.5-5-201 (1), C.R.S.
(m) (I)(A) Parents of children who are eligible for the medical assistance program or the children's basic health plan, article 8 of this title, whose family income does not exceed a specified percent of the federal poverty level, adjusted for family size, as set by the state board by rule, which percentage shall be not less than one hundred percent;

Expansion Adults to 60% FPL: Historical Caseload and Forecasts

Expansion Adults to 60% FPL: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Dec-09	16,739	-	-
Jan-10	17,193	454	2.71%
Feb-10	17,514	321	1.87%
Mar-10	18,096	582	3.32%
Apr-10	18,490	394	2.18%
May-10	20,694	2,204	11.92%
Jun-10	18,435	(2,259)	-10.92%
Jul-10	18,556	121	0.66%
Aug-10	19,176	620	3.34%
Sep-10	19,403	227	1.18%
Oct-10	19,490	87	0.45%
Nov-10	20,002	512	2.63%
Dec-10	20,182	180	0.90%
Jan-11	19,893	(289)	-1.43%
Feb-11	20,522	629	3.16%
Mar-11	20,877	355	1.73%
Apr-11	21,090	213	1.02%
May-11	21,194	104	0.49%
Jun-11	21,458	264	1.25%
Jul-11	22,184	726	3.38%
Aug-11	22,112	(72)	-0.32%
Sep-11	22,388	276	1.25%
Oct-11	22,985	597	2.67%
Nov-11	23,803	818	3.56%
Dec-11	24,012	209	0.88%

	Caseload	**% Change**	**Level Change**
FY 2006-07	5,162	-	-
FY 2007-08	8,918	72.76%	3,756
FY 2008-09	12,727	42.71%	3,809
FY 2009-10	17,178	34.97%	4,451
FY 2010-11	20,154	17.32%	2,976
FY 2011-12	24,050	19.33%	3,896
FY 2012-13	26,498	10.18%	2,448
FY 2013-14	27,831	5.03%	1,333

November 2011 Trends			
	Caseload	**% Change**	**Level Change**
FY 2011-12	21,986	9.09%	1,832
FY 2012-13	22,413	1.94%	427
FY 2013-14	22,692	1.24%	279

Monthly Average Growth Comparisons		
	Monthly Change	**% Change**
FY 2011-12	358	1.54%
FY 2012-13	110	0.42%
FY 2013-14	106	0.38%

November 2011 Forecast	
Forecasted December 2011 Level	22,006

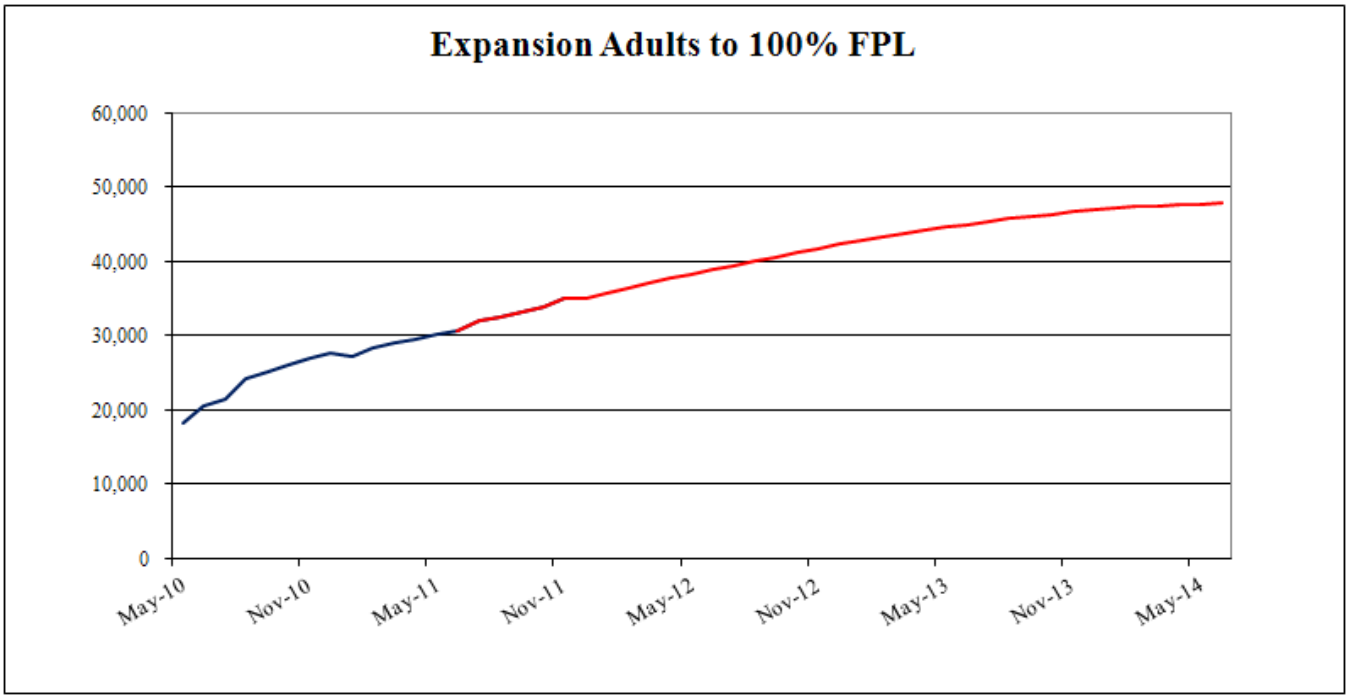
Actuals		
	Monthly Change	**% Change**
6-month average	426	1.90%
12-month average	319	1.47%
18-month average	310	1.49%
24-month average	303	1.58%

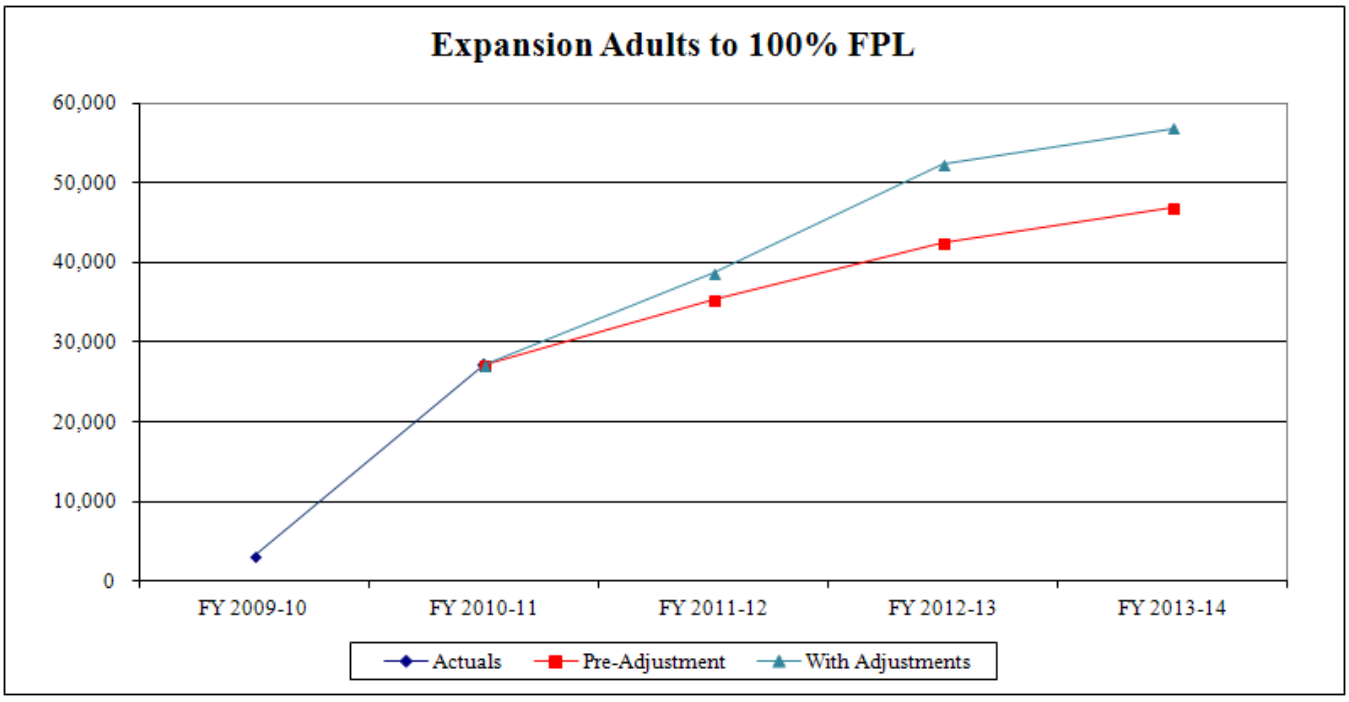
Monthly Average Growth Comparisons		
FY 2010-11 Actuals	252	1.28%
FY 2010-11 1st Half	291	1.53%
FY 2010-11 2nd Half	213	1.04%
FY 2011-12 1st Half Actuals	426	1.90%
FY 2011-12 2nd Half Forecast	290	1.17%
FY 2011-12 Forecast	358	1.54%
November 2011 Forecast	67	0.31%
FY 2012-13 Forecast	110	0.42%
November 2011 Forecast	24	0.10%

Base trend from December 2011 level			
FY 2011-12	24,012	19.14%	3,858

Expansion Adults to 100% FPL

HB 09-1293 (Colorado Health Care Affordability Act) allows for expanding Medicaid eligibility to parents of children enrolled in either Medicaid or the Children's Basic Health Plan up to 100% of the federal poverty level (FPL). The increase in the percentage of allowable federal poverty level was implemented on May 1, 2010. The Department has created a new category to track these clients, known as the Expansion Adults to 100% FPL.





- This eligibility type was created from HB 09-1293, which expands eligibility for parents of children in Medicaid from 60% to 100% of the federal poverty level. This increase was effective May 1, 2010.

- The planned implementation for this group did not include redeterminations for current Family Medical cases. This population would have included only newly eligible individuals that had their applications processed on or after May 1, 2010. However, when the expansion was implemented, the Colorado Benefits Management System redetermined all existing Family Medical cases, as well as any cases that were denied in the previous three months. This resulted in a large number of individuals being immediately eligible for this population, and a May 2010 caseload of 18,253.
- Growth in the first half of FY 2011-12 was much higher than the Department's November 2011 forecast, in which the annual caseload was projected to be 35,406 and average monthly growth was projected to be 414. The selected trend for FY 2011-12 is much higher than that from the Department's November 2011 forecast, and would yield average growth of 665 per month for the remainder of FY 2011-12. This forecast is based on the average monthly change experienced from September 2010 through December 2011. The forecast assumes that monthly growth will decrease over time as the population continues to mature, and will average 1.98% per month in FY 2011-12.
- The Department assumes that growth will continue to decrease throughout the forecast period, to an average of 1.22% per month in FY 2012-13 and 0.52% per month FY 2013-14. Though economic conditions may be partially responsible for the increased caseload in this group, monthly growth is expected to moderate as the eligibility category becomes established.
- The Department has changed the forecasting methodology for this population effective with this forecast. At the time of the Department's November 2011 forecast, there were only two months of actuals for this group and there was no data to support deviating from the February 2011 forecast. That forecast was based on uninsured data for 2009 trended forward, phased in on an annual basis. After further research, the Department determined that this methodology was resulting in dramatic changes in forecasted monthly growth rates needed to reach the projected annual averages. For example, caseload would have had to increase by an average of 414 in FY 2011-12 but only by an average of 60 per month in FY 2012-13 to reach the forecasted annual average caseload levels.
- The Department now has 20 months of actuals to use to forecast caseload in this eligibility group using a similar methodology to that formerly used in the Expansion Adults to 60% FPL category. As such, the growth rates are based on actual growth experienced from September 2010 through December 2011, with decay factors to incorporate the assumption that the growth rates will decline as the population matures and caseload reaches a potential ceiling of eligibles. This change in forecasting methodology has resulted in a dramatic increase in the projected monthly growth needed to reach the FY 2012-13 caseload level; in the Department's November 2011 forecast, the monthly growth was estimated to be 60, but the revised forecast is for average growth of 507 per month in FY 2012-13. However, as can be seen in the table below, the Department's revised forecast yields a projection that is consistent with experience from previous Medicaid expansions, and is in fact conservative.

Comparison of Growth Rates for Medicaid Expansions			
	Year 1*	Year 2	Year 3
Breast & Cervical Cancer Program	1850.00%	57.50%	27.92%
Expansion Adults to 60% FPL	604.76%	51.18%	33.46%
Expansion Adults to 100% FPL**	61.51%	25.04%	15.39%

* Growth for the Breast & Cervical Cancer Program and the Expansion Adults to 60% is calculated as that experienced from July to the following June.

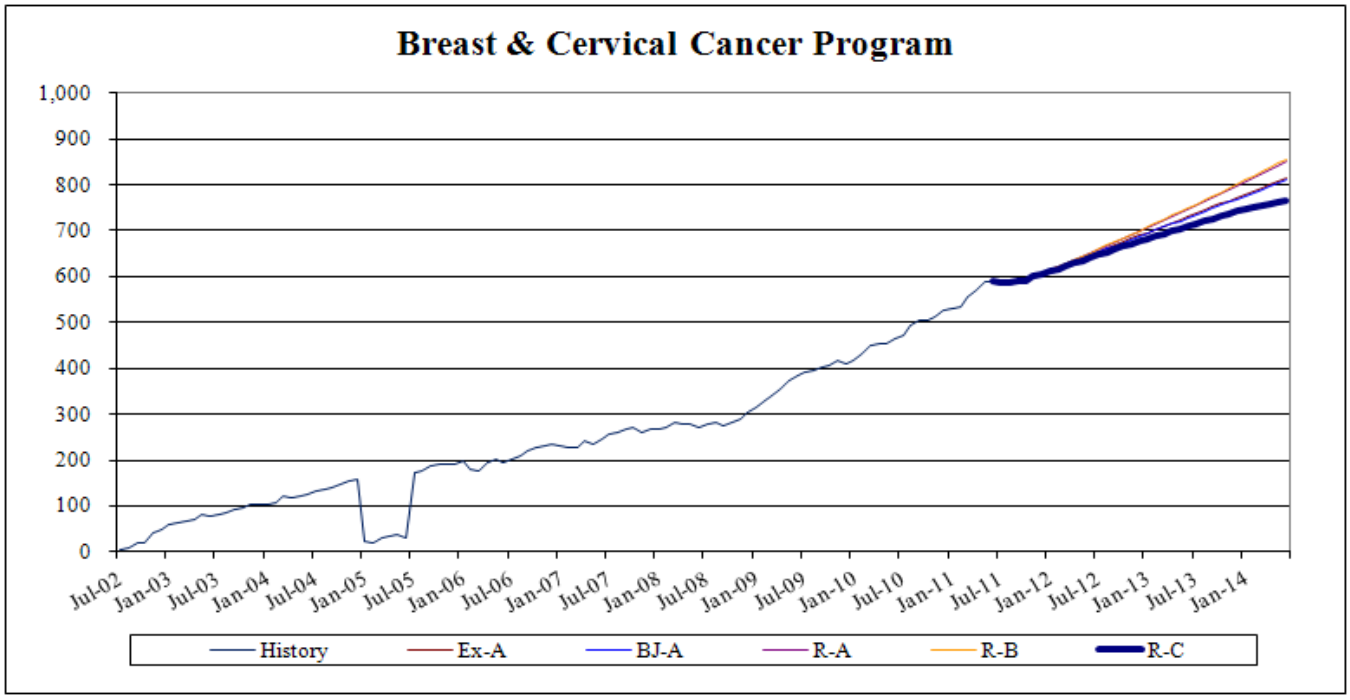
** Growth for the Expansion Adults to 100% FPL are calculated as the change from May to the following April due to the implementation date of the population.

- There is a bottom-line adjustment to this eligibility type from HB 09-1293, which establishes the Adults without Dependent Children (AwDC). Enrollment in this program will initially be opened to individuals with income 0-10% of federal poverty line (FPL) and enrollment will be limited to 10,000, with enrollment anticipated to start in May 2012.

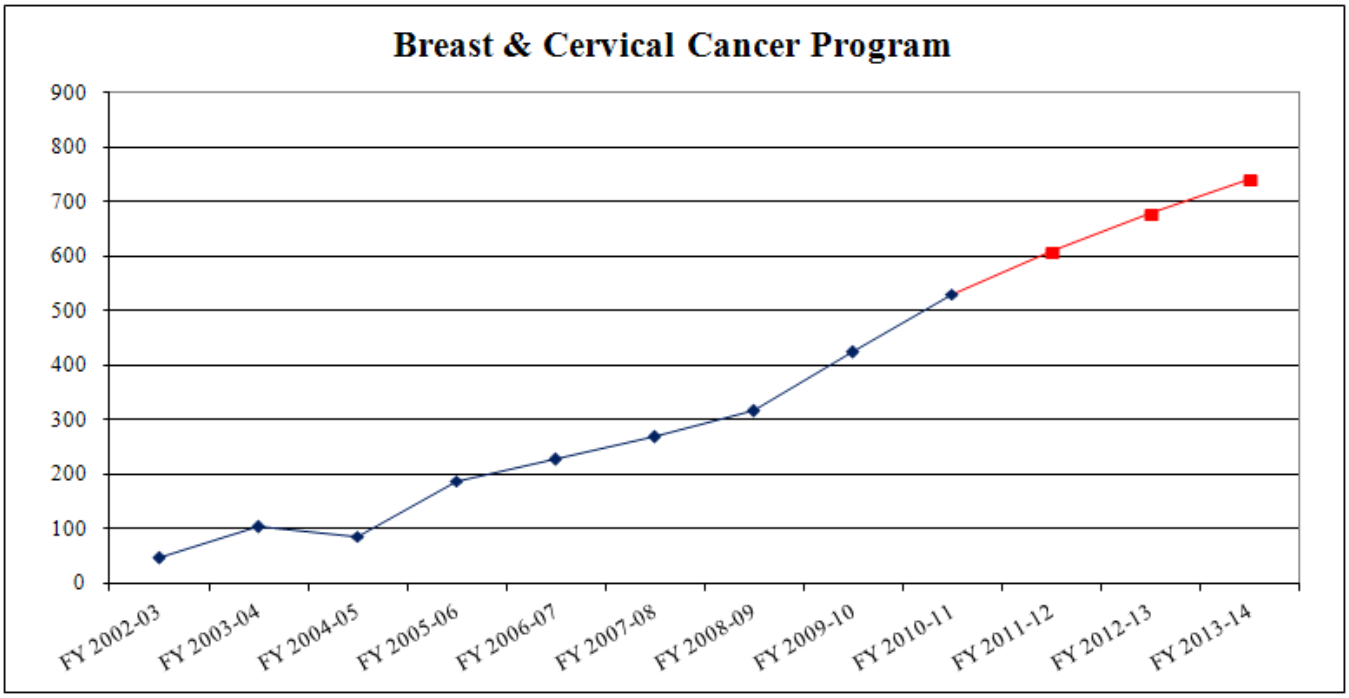
Breast and Cervical Cancer Program

The Breast and Cervical Cancer Treatment Program was authorized under SB 01S2-012 and began enrolling eligible women in July 2002. Women under this optional coverage group were screened using the Centers for Disease Control's national breast and cervical cancer early detection and prevention guidelines, and found to have breast or cervical cancer. These women are between the ages of 40 and 64, uninsured, and otherwise not eligible for Medicaid. The Colorado Department of Public Health and Environment administers the screening program as a grantee of the Centers of Disease Control. Regulations for the nationwide screening program indicate that the program is for low-income women, which the Department of Public Health and Environment has interpreted to be less than 250% of the federal poverty level. To date, all 50 states have approved the option of covering these women under Medicaid.

Breast and Cervical Cancer Program: Model Results



Breast and Cervical Cancer Program: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A	0.9982	
Box-Jenkins A*	0.9982	
Regression A	0.9982	BCCP [-1], Female Population 19-59
Regression B	0.9982	BCCP [-1], Trend
Regression C	0.9984	BCCP [-1], Unemployment Rate, Total Wages, Female Population 19-59



Breast and Cervical Cancer Program: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing	425	531	15.25%	612	81	5
Box Jenkins *	425	531	15.25%	612	81	5
Regression A	425	531	15.44%	613	82	5
Regression B	425	531	15.44%	613	82	5
Regression C	**425**	**531**	**14.88%**	**610**	**79**	**4**

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2012-13	**Projected FY 2010-11 Caseload**	**Projected FY 2011-12 Caseload**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing	531	610	13.24%	691	81	7
Box Jenkins *	531	610	12.91%	689	79	7
Regression A	531	610	14.68%	700	90	8
Regression B	531	610	14.85%	701	91	8
Regression C	**531**	**610**	**11.31%**	**679**	**69**	**6**

FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing	610	679	11.98%	760	81	7
Box Jenkins *	610	679	11.72%	759	80	7
Regression A	610	679	14.08%	775	96	9
Regression B	610	679	14.49%	777	98	9
Regression C	**610**	**679**	**9.43%**	**743**	**64**	**5**

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Breast and Cervical Cancer Program: Trend Selections

FY 2011-12: 14.88%
FY 2012-13: 11.31%
FY 2013-14: 9.43%

Breast and Cervical Cancer Program: Justifications

- Clients in this eligibility type exceed Medicaid income guidelines, so it is reasonable to expect that the caseload will continue to grow, as they are not affected by the economy as much as low-income adults and children, and they do not have alternative insurance to utilize. These clients may be affected by economic conditions, though it may be mitigated by the specificity of the diagnoses required for eligibility.
- This program receives ongoing Tobacco Tax funding to subcontract with clinics that provide screenings. The Department knows of no new clinics coming into the program during the forecast period.
- The graph above shows caseload steadily increasing from July of 2002 to December of 2004. At that time, the reported caseload decreased dramatically because of an issue within the Medicaid Management Information System that was used to report the data. Because of this issue within the Medicaid Management Information System, a more reliable source was utilized to create caseload figures. Until the problem was resolved, the Department obtained a caseload report directly from raw data in the Colorado Benefits Management System. This report was used from July 2005 through March 2006, when the reports from the Medicaid Management Information System and the Colorado Benefits Management System were synchronized. All subsequent monthly caseload data are obtained from the Medicaid Management Information System report that is used to report all other categories of Medicaid caseload. The caseload counts for the six months from January through June 2005 were left as originally reported. This explains the six months of unusually low figures that are shown in the graph.
- Growth in the first half of FY 2011-12 was lower than the Department's November 2011 forecast, in which the annual caseload was projected to be 640 and average monthly growth was projected to be 7. The selected trend for FY 2011-12 is lower than that from the Department's November 2011 forecast, and would yield average growth of 6 per month for the remainder of FY 2011-12.
- Out-year growth is projected to continue at historic levels. As a program matures, growth is expected to slow and stabilize. The Department believes that the Breast and Cervical Cancer program is approaching a level of maturity where, barring unforeseen circumstances, average growth of more than 2% per month should no longer expected.

25.5-5-201 (1), C.R.S.
(i) Persons who are eligible for the breast and cervical cancer prevention and treatment program pursuant to section 25.5-5-308;

Breast and Cervical Cancer Program: Historical Caseload and Forecasts

Breast and Cervical Cancer Program: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Dec-09	411	-	-
Jan-10	416	5	1.22%
Feb-10	431	15	3.61%
Mar-10	449	18	4.18%
Apr-10	452	3	0.67%
May-10	455	3	0.66%
Jun-10	466	11	2.42%
Jul-10	471	5	1.07%
Aug-10	493	22	4.67%
Sep-10	503	10	2.03%
Oct-10	505	2	0.40%
Nov-10	511	6	1.19%
Dec-10	526	15	2.94%
Jan-11	532	6	1.14%
Feb-11	535	3	0.56%
Mar-11	556	21	3.93%
Apr-11	569	13	2.34%
May-11	587	18	3.16%
Jun-11	589	2	0.34%
Jul-11	587	(2)	-0.34%
Aug-11	586	(1)	-0.17%
Sep-11	590	4	0.68%
Oct-11	592	2	0.34%
Nov-11	602	10	1.69%
Dec-11	606	4	0.66%

	Caseload	**% Change**	**Level Change**
FY 2002-03	47	-	-
FY 2003-04	105	123.40%	58
FY 2004-05	87	-17.14%	(18)
FY 2005-06	188	116.09%	101
FY 2006-07	228	21.28%	40
FY 2007-08	270	18.42%	42
FY 2008-09	317	17.41%	47
FY 2009-10	425	34.07%	108
FY 2010-11	531	24.94%	106
FY 2011-12	610	14.88%	79
FY 2012-13	679	11.31%	69
FY 2013-14	743	9.43%	64

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

November 2011 Trends			
FY 2011-12	640	20.53%	109
FY 2012-13	717	12.03%	77
FY 2013-14	777	8.37%	60

November 2011 Forecast	
Forecasted December 2011 Level	638

Actuals		
	Monthly Change	**% Change**
6-month average	3	0.48%
12-month average	7	1.19%
18-month average	8	1.48%
24-month average	8	1.64%

Monthly Average Growth Comparisons		
FY 2010-11 Actuals	10	1.98%
FY 2010-11 1st Half	10	2.05%
FY 2010-11 2nd Half	11	1.91%
FY 2011-12 1st Half Actuals	3	0.48%
FY 2011-12 2nd Half Forecast	6	1.43%
FY 2011-12 Forecast	4	0.68%
November 2011 Forecast	7	1.19%
FY 2012-13 Forecast	6	0.92%
November 2011 Forecast	6	0.85%

Base trend from December 2011 level			
FY 2011-12	606	14.12%	75

Eligible Children

One of the primary ways that children qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to Families with Dependent Children program was discontinued. Aid to Families with Dependent Children was replaced by the Temporary Assistance for Needy Families welfare program (referred to as Colorado Works) on July 16, 1996, and clients under the Temporary Assistance for Needy Families program were no longer automatically eligible for Medicaid.

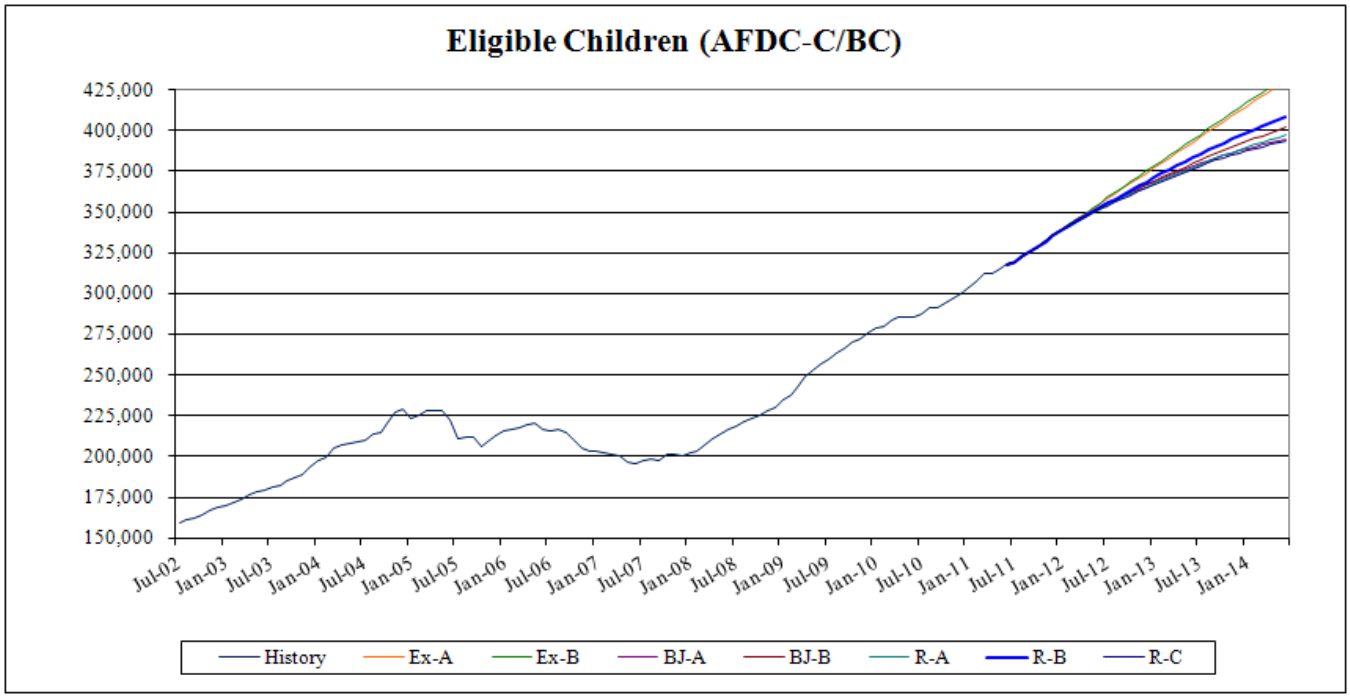
This category also includes children on Transitional Medicaid. Transitional Medicaid is available to children in families who have received 1931 Medicaid three of the past six months and become ineligible due to an increase in earned income. Children receive Transitional Medicaid benefits for one year. In FY 2010-11, there were an average of 11,042 children on Transitional Medicaid. Authorization

for Transitional Medicaid benefits was extended through February 29, 2012, and the Department's forecast assumes that the program will continue through FY 2012-13.

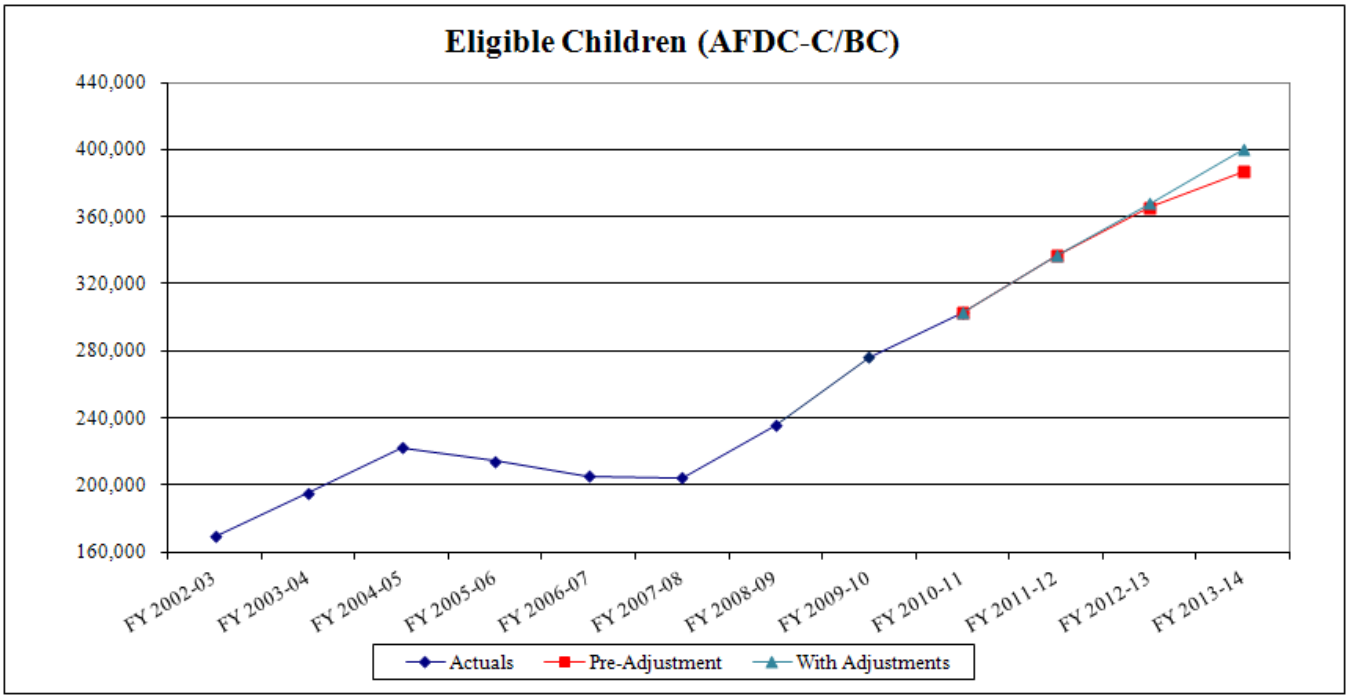
Children who are born to women enrolled in the Baby and Kid Care program are also included in this category. Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby and Kid Care in Colorado, this program was authorized through the Medicare Catastrophic Coverage Act of 1988. The program enrolls Baby Care women (see the Baby Care-Adults section of this document for information on women) and Kid Care children. Kid Care children are born to women with incomes up to 133% of the federal poverty level, and are covered up to age six. The Baby and Kid Care Program serves a much higher income level than the 1931 Families program, and pregnant mothers are not subject to resource or asset limitations to qualify for the program. Moreover, the Baby and Kid Care Program has never had a cash-assistance component and was unaffected by welfare reform in 1996.

In previous years, this caseload was adjusted to include Ribicoff children. Ribicoff children were children aged six to 19, with incomes up to 100% of the federal poverty level with resources limited to $1,000 who were born after September 30, 1983. Beginning with age six, a new age cohort was phased-in each year. Caseload was adjusted upwards to include these children. However, the final cohort of children was phased-in during FY 2002-03, so no further caseload adjustments are needed. Therefore, the Eligible Children category includes: children in families who receive Medicaid under Section 1931, children in families who receive Temporary Aid to Needy Families financial assistance coupled with Medicaid, children who are eligible for Kid Care, Ribicoff children, and children who receive Transitional Medicaid.

Eligible Children: Model Results



Eligible Children: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9920	
Exponential Smoothing B*	0.9979	
Box-Jenkins A	0.9992	
Box-Jenkins B	0.9980	
Regression A	0.9993	KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, CBMS Dummy, Systems Dummy
Regression B	0.9993	KIDS [-1], KIDS [-7], Unemployment Rate, CBMS Dummy, CBMS Dummy [-1], Systems Dummy, Auto [-18]
Regression C	0.9894	KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, Trend, CBMS Dummy [-2], Systems Dummy



Eligible Children: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	275,672	302,410	11.52%	337,248	34,838	3,120
Exponential Smoothing B*	275,672	302,410	11.57%	337,399	34,989	3,162
Box Jenkins A	275,672	302,410	11.36%	336,764	34,354	2,923
Box Jenkins B	275,672	302,410	11.30%	336,582	34,172	2,898
Regression A	275,672	302,410	11.22%	336,340	33,930	2,849
Regression B	275,672	302,410	11.32%	336,643	34,233	2,943
Regression C	**275,672**	**302,410**	**11.30%**	**336,582**	**34,172**	**2,873**

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2012-13	**Projected FY 2010-11 Caseload**	**Projected FY 2011-12 Caseload**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	302,410	336,582	11.34%	374,750	38,168	3,156
Exponential Smoothing B*	302,410	336,582	11.61%	375,659	39,077	3,241
Box Jenkins A	302,410	336,582	9.03%	366,975	30,393	2,122
Box Jenkins B	302,410	336,582	9.23%	367,649	31,067	2,284
Regression A	302,410	336,582	8.84%	366,336	29,754	2,129
Regression B	302,410	336,582	9.81%	369,601	33,019	2,530
Regression C	**302,410**	**336,582**	**8.60%**	**365,528**	**28,946**	**2,032**

FY 2013-14	Projected FY 2011-12 Caseload	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	336,582	365,528	10.08%	402,373	36,845	3,156
Exponential Smoothing B*	336,582	365,528	10.33%	403,287	37,759	3,241
Box Jenkins A	336,582	365,528	5.59%	385,961	20,433	1,391
Box Jenkins B	336,582	365,528	6.65%	389,836	24,308	1,844
Regression A	336,582	365,528	6.16%	388,045	22,517	1,664
Regression B	336,582	365,528	7.52%	393,016	27,488	2,094
Regression C	**336,582**	**365,528**	**5.72%**	**386,436**	**20,908**	**1,397**

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Eligible Children: Trend Selections

FY 2011-12: 11.30%
FY 2012-13: 8.60%
FY 2013-14: 5.72%

Eligible Children: Justifications

- This population is effected by economic conditions in similar ways as the Categorically Eligible Low-Income Adults and Baby Care-Adults, as children on Medicaid have eligibility granted as a function of a parent or guardian in most cases. Caseload trends in this category are highly affected by economic conditions, and tend to be positively correlated with the population of children aged 0 to 18. Growth in the 0 to 18 population dropped from around 2.3% per year from FY 1995-96 to FY 2001-02 to about 1.2% per year from FY 2002-03 to FY 2010-11. The expansion in this age group is projected to average 1.7% throughout the forecast period.[11] The economy is projected remain relatively weak over the forecast period, with the unemployment rate to average 8.4% between 2011 and 2013. Wage and salary income is projected to increase by 3.9% in 2011, with moderate growth of 2.8% in 2012, increasing to 3.8% in 2013.[12]
- Caseload declines occurred from 1993 to 1999 due to economic expansion and effects from the Tatum lawsuit (see Categorically Eligible Low-Income Adults section for more information on the lawsuit). When the Children's Basic Health Plan program was enacted in 1998, it required that children be screened for Medicaid before conferring Children's Basic Health Plan eligibility. As more children applied, many were found to be Medicaid eligible and were enrolled in Medicaid. Between FY 2002-03 and FY 2004-05, caseload in this category grew by 31.4%, which the Department believes is largely due to the state of the economy. The rate of growth fell drastically in FY 2005-06, and the caseload actually contracted by 3.74%. There were large and consistent declines between July 2006 and December 2007, which seems to indicate that the improved economy was having the expected effect on caseload. Similarly, large and consistent increases since January 2008 indicate that the weakening economic conditions are impacting caseload in this eligibility type.
- Recent changes to the rules regarding the citizenship requirements of the Deficit Reduction Act of 2005 may effect this population and result in higher growth. Children who cannot provide proper proof of citizenship will no longer automatically remain eligible for the Children's Basic Health Plan. This may increase growth in Medicaid as families find documents to ensure coverage of children.
- Growth in the first half of FY 2011-12 was higher than the Department's November 2011 forecast, in which the annual base caseload was projected to be 332,377 and average monthly growth was projected to be 2,229. The selected trend for FY 2011-12 is higher than that from the Department's November 2011 forecast, and would yield average increases of 2,663 per month for the remainder of FY 2011-12. This forecast is reflective of the consistent increases since the second half of FY 2007-08, which moderated in FY 2009-10 but increased in FY 2010-11. Because the economy is believed

[11] Department of Local Affairs, Demography Division
[12] Source: Office of State Planning and Budgeting, June 2010 Revenue Forecast

to be largely responsible this change, projected economic conditions give no indication that the trend will not continue to be positive throughout FY 2011-12. The selected trends for FY 2011-12 and FY 2012-13 are conservative due to volatility in the monthly data, and the Department will continue to monitor this category and economic conditions closely.

- Similar to the pattern seen in AFDC-Adults, the out-year trend is expected to slow with declining monthly growth, reflective of projected moderating economic conditions beginning at the end of 2012. Growth in children is expected to be higher than that in the adult populations due to current outreach activities funded by the Department and a number of community initiatives to enroll eligibles, most of which target children.
- As part of the Department's efforts to increase administrative efficiencies, it is implementing Express Lane Eligibility in FY 2011-12. This will allow the program to take utilize information in the Colorado Benefits Management System (CBMS) gathered for the free/reduced price lunch program to expedite eligibility processing for children potentially eligible for Medicaid. Currently, school aged children are specifically targeted in many ways for application assistance. Many school districts hand out Medical Assistance Applications at schools, and community partners throughout the State provide application assistance to families at Back-to-School nights and other school-related events. Thus, the coordination with the free/reduced price lunch program will serve to decrease the administrative burden on school districts, community partners, and families by utilizing existing data within CBMS. The Department estimates that any caseload increases resulting from this initiative are negligible and has included them in its caseload forecast.
- There is a bottom-line adjustment to this eligibility type from SB 11-008, which increases eligibility for children age 6 to 19 in Medicaid from 100% of federal poverty line (FPL) to 133% FPL effective January 1, 2013.

25.5-5-101 (1), C.R.S.
(a) Individuals who meet the eligibility criteria for the aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;
(b) Families who meet the eligibility criteria for the aid to families with dependent children program established in rules that were in effect on July 16, 1996, and who subsequently would have become ineligible under such eligibility criteria because of increased earnings or increased hours of employment whose eligibility is specified for a period of time by the federal government;
(c) Qualified pregnant women, and children under the age of seven, who meet the income resource requirements of the state's aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;
(d) A newborn child born of a woman who is categorically needy. Such child is deemed Medicaid-eligible on the date of birth and remains eligible for one year so long as the woman remains categorically needy and the child is a member of her household;
(m) Low-income pregnant women, and children through the age of six, whose income is at or below a certain percentage of the federal poverty level as determined by the federal government;

25.5-5-201 (1), C.R.S.
(a) Individuals who would be eligible for but are not receiving cash assistance;
(d) Individuals who would be eligible for aid to families with dependent children if child care were paid from earnings;
(e) Individuals under the age of twenty-one who would be eligible for aid to families with dependent children but do not qualify as dependent children;
(h) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706, C.R.S.;

25.5-5-205 (3), C.R.S.
(a) On and after April 1, 1990, children under the age of six years and pregnant women shall be eligible for benefits under the baby and kid care program… (b) The percentage level of the federal poverty line,

as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this subsection (3) shall be one hundred thirty-three percent…;
(c) (I) On and after July 1, 1991, children born after September 30, 1983, who have attained age six but have not attained age nineteen shall be eligible for benefits under the baby and kid care program… (II) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this paragraph (c) shall be one hundred percent;

Eligible Children: Historical Caseload and Forecasts

Eligible Children: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Dec-09	275,867	-	-
Jan-10	279,000	3,133	1.14%
Feb-10	279,898	898	0.32%
Mar-10	283,625	3,727	1.33%
Apr-10	285,746	2,121	0.75%
May-10	285,779	33	0.01%
Jun-10	285,778	(1)	0.00%
Jul-10	287,674	1,896	0.66%
Aug-10	290,871	3,197	1.11%
Sep-10	291,592	721	0.25%
Oct-10	294,155	2,563	0.88%
Nov-10	296,482	2,327	0.79%
Dec-10	299,499	3,017	1.02%
Jan-11	304,042	4,543	1.52%
Feb-11	307,032	2,990	0.98%
Mar-11	312,300	5,268	1.72%
Apr-11	312,603	303	0.10%
May-11	315,116	2,513	0.80%
Jun-11	317,551	2,435	0.77%
Jul-11	319,065	1,514	0.48%
Aug-11	322,779	3,714	1.16%
Sep-11	325,673	2,894	0.90%
Oct-11	328,632	2,959	0.91%
Nov-11	332,183	3,551	1.08%
Dec-11	336,053	3,870	1.17%

	Caseload*	% Change	Level Change
FY 1995-96	113,439	-	-
FY 1996-97	110,586	-2.52%	(2,853)
FY 1997-98	103,912	-6.04%	(6,674)
FY 1998-99	102,074	-1.77%	(1,838)
FY 1999-00	109,816	7.58%	7,742
FY 2000-01	123,221	12.21%	13,405
FY 2001-02	143,909	16.79%	20,688
FY 2002-03	169,311	17.65%	25,402
FY 2003-04	195,279	15.34%	25,968
FY 2004-05	222,472	13.93%	27,193
FY 2005-06	214,158	-3.74%	(8,314)
FY 2006-07	205,390	-4.09%	(8,768)
FY 2007-08	204,022	-0.67%	(1,368)
FY 2008-09	235,129	15.25%	31,107
FY 2009-10	275,672	17.24%	40,543
FY 2010-11	302,410	9.70%	26,738
FY 2011-12	336,582	11.30%	34,172
FY 2012-13	365,528	8.60%	28,946
FY 2013-14	386,436	5.72%	20,908

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

Adjustments	
FY 2011-12	0
FY 2012-13	2,121
FY 2013-14	13,431

November 2011 Forecast	
Forecasted December 2011 Level	331,592

February 2012 Projections After Adjustments			
FY 2011-12	336,582	11.30%	34,172
FY 2012-13	367,649	9.23%	31,067
FY 2013-14	399,867	8.76%	32,218

Base trend from December 2011 level			
FY 2011-12	336,053	11.12%	33,643

November 2011 Trends (BEFORE ADJUSTMENTS)			
FY 2011-12	332,377	9.92%	29,996
FY 2012-13	356,408	7.23%	24,031
FY 2013-14	374,977	5.21%	18,569

Monthly Average Growth Comparisons		
FY 2010-11 Actuals	2,648	0.88%
FY 2010-11 1st Half	2,287	0.79%
FY 2010-11 2nd Half	3,009	0.98%
FY 2011-12 1st Half Actuals	3,084	0.95%
FY 2011-12 2nd Half Forecast	2,663	0.86%
FY 2011-12 Forecast	2,873	0.90%
November 2011 Forecast	2,229	0.70%
FY 2012-13 Forecast	2,032	0.58%
November 2011 Forecast	1,795	0.52%

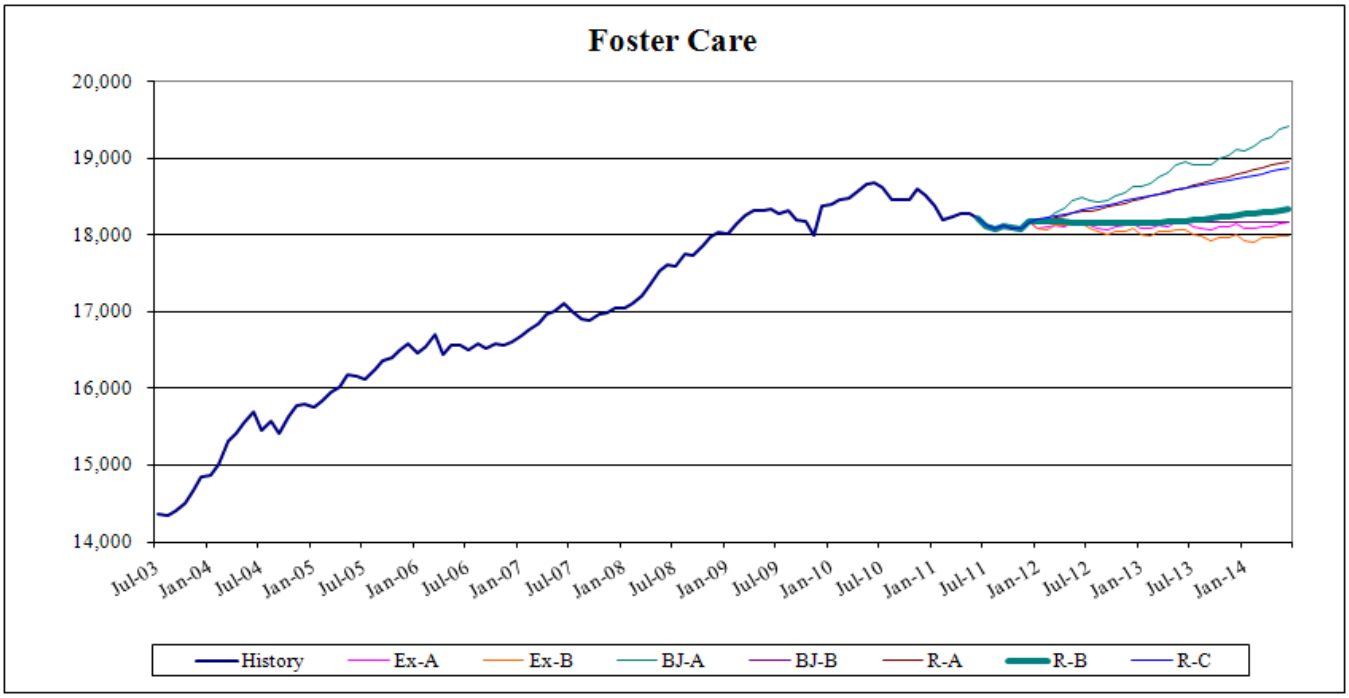
Actuals		
	Monthly Change	% Change
6-month average	3,084	0.95%
12-month average	3,046	0.97%
18-month average	2,793	0.91%
24-month average	2,508	0.83%
24-month average*	2,493	0.82%

*Without outliers

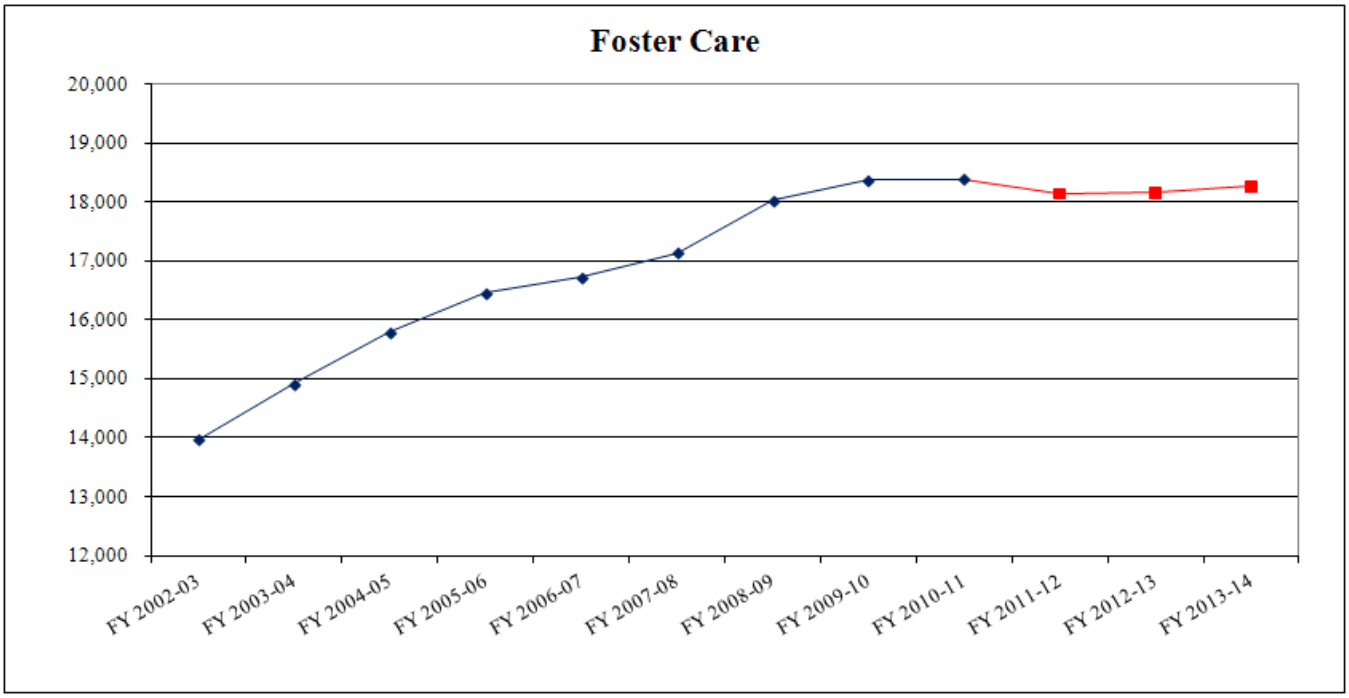
Foster Care

Federal law mandates that states provide Medicaid to individuals under Title IV-E of the Social Security Act (42 U.S.C. 470-479A) for adoption assistance and foster care. Title IV-E is a subpart of Title IV, Child Welfare, of the federal Social Security Act. Title IV-E provides federal reimbursement to states for the room and board costs of children placed in foster homes and other out-of-home placements. This is an entitlement program for children who are eligible and for whom the state can seek reimbursement. Eligibility is determined on family circumstances at the time when the child was removed from the home. Once eligible, the state determines if it can claim reimbursement for maintenance costs for the child. Adoption assistance is available for children with special health care needs who meet the same requirements. States have the option to extend Medicaid to former foster care children aged 18 through 20 years who were eligible for Title IV-E prior to their 18th birthday. During the 2007 legislative session, SB 07-002 was passed extending Medicaid eligibility through age 20 for children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act, which was implemented in July 2008. Eligibility for children receiving state subsidized adoption or foster care payments (non Title IV-E) was extended through age 20 in the 2008 Legislative Session through SB 08-099, which was implemented in July 2009.

Foster Care: Model Results



Foster Care: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A	0.9990	
Exponential Smoothing B	0.9951	
Box-Jenkins A*	0.9990	
Box-Jenkins B*	0.9942	
Regression A	0.9987	FOSTER [-1], Population Under 19, Auto [-12]
Regression B	0.9983	FOSTER [-1], FOSTER [-24]
Regression C	0.9989	FOSTER [-1], Trend



Foster Care: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	18,381	18,393	-1.48%	18,121	(272)	(3)
Exponential Smoothing B	18,381	18,393	-1.53%	18,112	(281)	(7)
Box Jenkins A*	18,381	18,393	-0.96%	18,216	(177)	22
Box Jenkins B*	18,381	18,393	-1.38%	18,139	(254)	(4)
Regression A	18,381	18,393	-1.19%	18,174	(219)	6
Regression B	**18,381**	**18,393**	**-1.37%**	**18,141**	**(252)**	**(5)**
Regression C	18,381	18,393	-1.13%	18,185	(208)	8

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2012-13	**Projected FY 2010-11 Caseload**	**Projected FY 2011-12 Caseload**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	18,393	18,141	-0.02%	18,137	(4)	(1)
Exponential Smoothing B	18,393	18,141	-0.38%	18,072	(69)	(6)
Box Jenkins A*	18,393	18,141	2.37%	18,571	430	39
Box Jenkins B*	18,393	18,141	0.15%	18,168	27	0
Regression A	18,393	18,141	1.58%	18,428	287	27
Regression B	**18,393**	**18,141**	**0.10%**	**18,159**	**18**	**2**
Regression C	18,393	18,141	1.59%	18,429	288	24

FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	18,141	18,159	-0.04%	18,152	(7)	(1)
Exponential Smoothing B	18,141	18,159	-0.42%	18,083	(76)	(6)
Box Jenkins A*	18,141	18,159	2.53%	18,618	459	39
Box Jenkins B*	18,141	18,159	0.00%	18,159	0	0
Regression A	18,141	18,159	1.85%	18,495	336	29
Regression B	**18,141**	**18,159**	**0.58%**	**18,264**	**105**	**13**
Regression C	18,141	18,159	1.47%	18,426	267	22

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Foster Care: Trend Selections
FY 2011-12: -1.37%
FY 2012-13: 0.10%
FY 2013-14: 0.58%

Foster Care: Justifications
- Caseload in this category is affected by programmatic changes initiated by the Department of Human Services who oversee the Child Welfare system. In January 2001, the Department of Human Services converted to a new data reporting system for children in foster care called Trails. The conversion may be partially responsible for unusually slow growth experienced in this category in FY 2001-02. Legislation in 2003 (HB 03-1004) made the manufacturing of controlled substances in the presence of children a felony, and deemed such actions child abuse. This may positively affect caseload in subsequent years, as more children are placed into state custody.
- Caseload in this category is only weakly correlated with population of children aged 0 to 18 and economic indicators. The graph above shows that growth in this category since FY 2002-03 has been positive and stable, but has leveled out in the last two years. Growth at the end of FY 2007-08 began to increase, which is partially due to the implementation of SB 07-002 and SB 08-099, which expanded eligibility for Foster Care through age 20.
- Growth in the first half of FY 2011-12 was much lower than the Department's November 2011 forecast, in which the annual caseload was projected to be 18,363 and average monthly growth was projected to be 22. The selected trend for FY 2011-12 is lower than that from the Department's November 2011 forecast, and would yield average decreases of 2 per month for the remainder of FY 2011-12.
- Out-year growth reflects a continuation of the very low positive monthly growth experienced over the last two years.

25.5-5-101 (1), C.R.S.
(e) Children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the "Social Security Act", as amended;

25.5-5-201 (1), C.R.S.
(l) Children for whom subsidized adoption assistance payments are made by the state pursuant to article 7 of title 26, C.R.S, but who do not meet the requirements of Title IV-E of the "Social Security Act", as amended;
(n) Individuals under the age of twenty-one years eligible for medical assistance pursuant to paragraph (l) of this subsection (1) or section 25.5-5-101 (1) (e) immediately prior to attaining the age of eighteen years or otherwise becoming emancipated;

Foster Care: Historical Caseload and Forecasts

Foster Care: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Dec-09	18,371	-	-
Jan-10	18,400	29	0.16%
Feb-10	18,467	67	0.36%
Mar-10	18,486	19	0.10%
Apr-10	18,552	66	0.36%
May-10	18,651	99	0.53%
Jun-10	18,678	27	0.14%
Jul-10	18,628	(50)	-0.27%
Aug-10	18,455	(173)	-0.93%
Sep-10	18,451	(4)	-0.02%
Oct-10	18,464	13	0.07%
Nov-10	18,597	133	0.72%
Dec-10	18,510	(87)	-0.47%
Jan-11	18,386	(124)	-0.67%
Feb-11	18,200	(186)	-1.01%
Mar-11	18,244	44	0.24%
Apr-11	18,280	36	0.20%
May-11	18,279	(1)	-0.01%
Jun-11	18,221	(58)	-0.32%
Jul-11	18,125	(96)	-0.53%
Aug-11	18,084	(41)	-0.23%
Sep-11	18,119	35	0.19%
Oct-11	18,096	(23)	-0.13%
Nov-11	18,077	(19)	-0.10%
Dec-11	18,172	95	0.53%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	8,376	-	-
FY 1996-97	9,261	10.57%	885
FY 1997-98	10,453	12.87%	1,192
FY 1998-99	11,526	10.26%	1,073
FY 1999-00	12,474	8.22%	948
FY 2000-01	13,076	4.83%	602
FY 2001-02	13,121	0.34%	45
FY 2002-03	13,967	6.45%	846
FY 2003-04	14,914	6.78%	947
FY 2004-05	15,795	5.91%	881
FY 2005-06	16,460	4.21%	665
FY 2006-07	16,724	1.60%	264
FY 2007-08	17,141	2.49%	417
FY 2008-09	18,033	5.20%	892
FY 2009-10	18,381	1.93%	348
FY 2010-11	18,393	0.07%	12
FY 2011-12	18,141	-1.37%	(252)
FY 2012-13	18,159	0.10%	18
FY 2013-14	18,264	0.58%	105

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

November 2011 Forecast	
Forecasted December 2011 Level	18,361

November 2011 Trends			
FY 2011-12	18,363	-0.16%	(29)
FY 2012-13	18,668	1.66%	305
FY 2013-14	19,008	1.82%	340

Actuals		
	Monthly Change	**% Change**
6-month average	(8)	-0.04%
12-month average	(28)	-0.15%
18-month average	(28)	-0.15%
24-month average	(8)	-0.04%

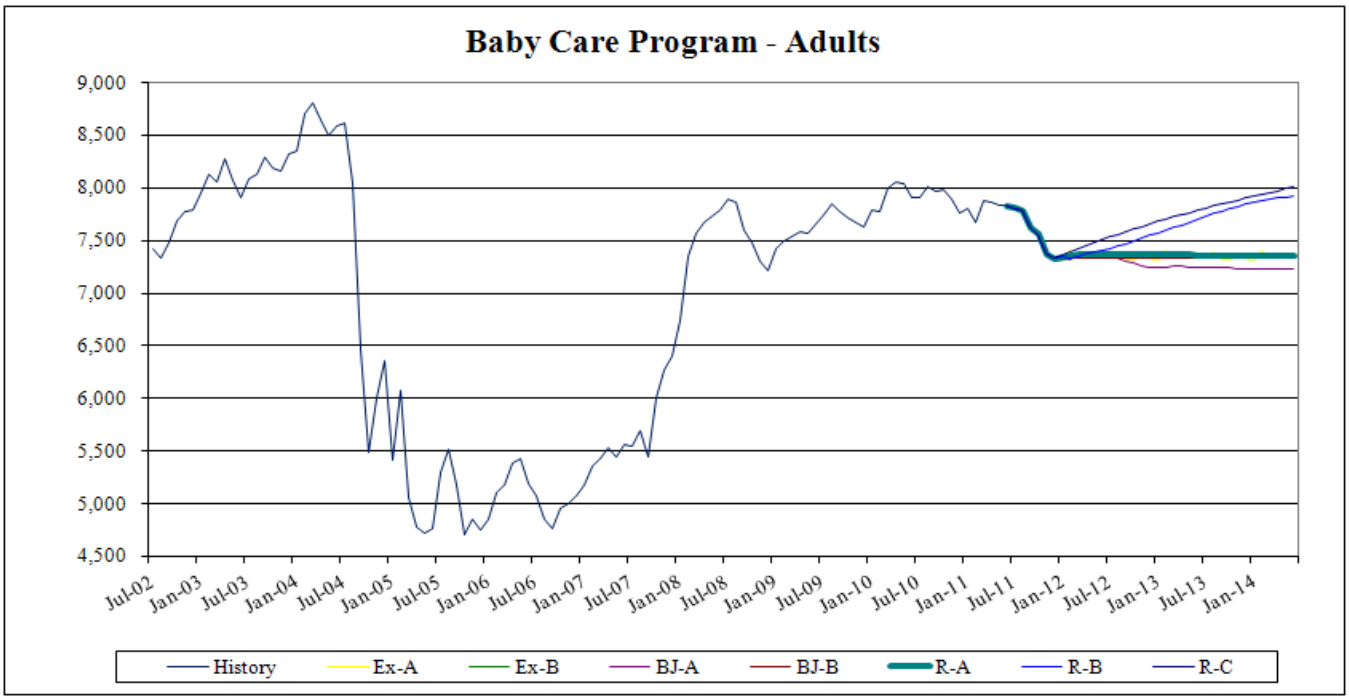
Monthly Average Growth Comparisons		
FY 2010-11 Actuals	(38)	-0.21%
FY 2010-11 1st Half	(28)	-0.15%
FY 2010-11 2nd Half	(48)	-0.26%
FY 2011-12 1st Half Actuals	(8)	-0.04%
FY 2011-12 2nd Half Forecast	(2)	-0.03%
FY 2011-12 Forecast	(5)	-0.03%
November 2011 Forecast	22	0.12%
FY 2012-13 Forecast	2	0.01%
November 2011 Forecast	28	0.15%

Base trend from December 2011 level			
FY 2011-12	18,172	-1.20%	(221)

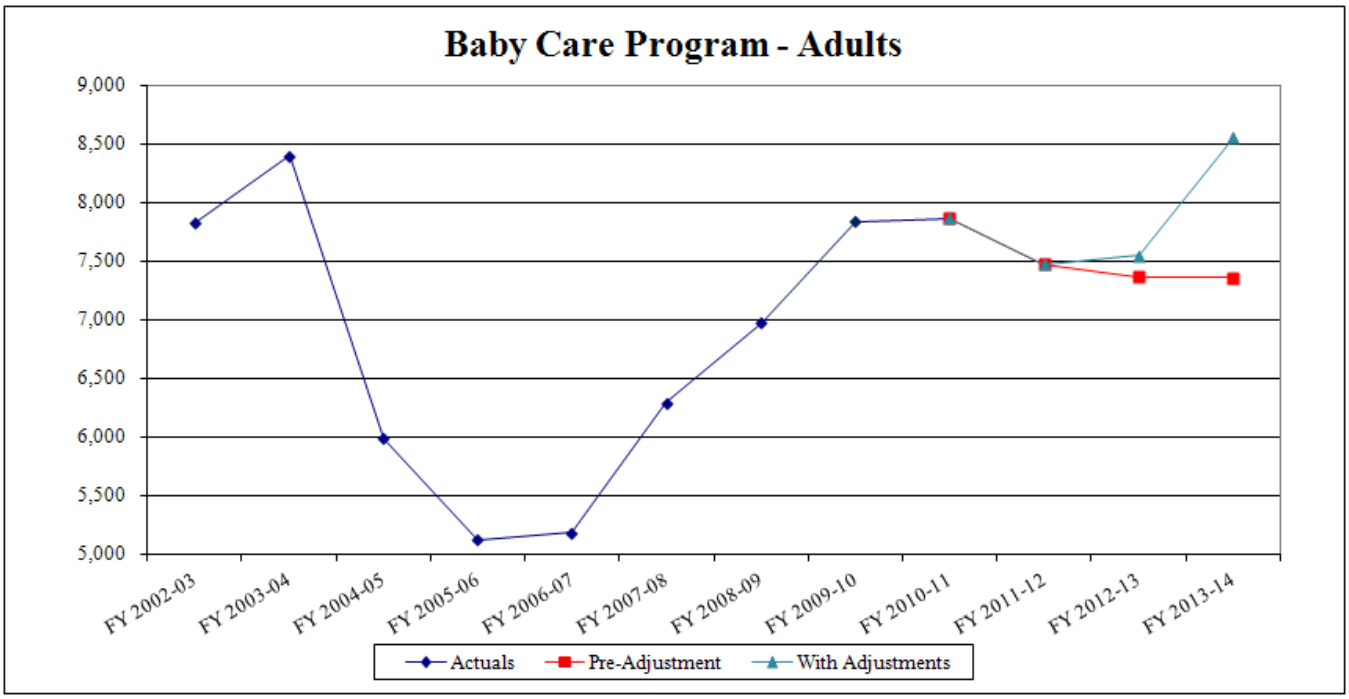
Baby Care-Adults

Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby and Kid Care in Colorado, the program was authorized through the Medicare Catastrophic Coverage Act of 1988. The program enrolls Baby Care women and Kid Care children (see the Eligible Children section of this document for information on children). Baby Care-Adults are women with incomes up to 133% of the federal poverty level. Coverage includes prenatal care and delivery services, plus 60 days of postpartum care. The Baby and Kid Care Program serves a much higher income level than the 1931 families program, and pregnant mothers were never subject to resource/asset limitations to qualify for the program. Moreover, the Baby and Kid Care Program has never had a cash-assistance component and was unaffected by welfare reform.

Baby Care Program- Adults: Model Results



Baby Care Program-Adults: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A	0.9492	
Exponential Smoothing B*	0.9350	
Box-Jenkins A*	0.9503	
Box-Jenkins	0.9355	
Regression A	0.9527	BCA [-1], BCA Dummy, Auto [-4]
Regression B	0.9476	BCA [-1], Migration, Unemployment Rate, Auto [-3]
Regression C	0.9546	BCA [-1], Unemployment Rate, Female Population 19-59, BCA Dummy



Baby Care Program-Adults: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	7,830	7,868	-5.07%	7,469	(399)	(40)
Exponential Smoothing B	7,830	7,868	-5.22%	7,457	(411)	(41)
Box Jenkins A*	7,830	7,868	-5.16%	7,462	(406)	(40)
Box Jenkins B*	7,830	7,868	-5.22%	7,457	(411)	(41)
Regression A	**7,830**	**7,868**	**-5.03%**	**7,472**	**(396)**	**(38)**
Regression B	7,830	7,868	-5.01%	7,474	(394)	(35)
Regression C	7,830	7,868	-4.56%	7,509	(359)	(27)

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2012-13	**Projected FY 2010-11 Caseload**	**Projected FY 2011-12 Caseload**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	7,868	7,472	-1.61%	7,352	(120)	0
Exponential Smoothing B	7,868	7,472	-1.66%	7,348	(124)	0
Box Jenkins A*	7,868	7,472	-2.52%	7,284	(188)	(8)
Box Jenkins B*	7,868	7,472	-1.66%	7,348	(124)	0
Regression A	**7,868**	**7,472**	**-1.43%**	**7,365**	**(107)**	**(1)**
Regression B	7,868	7,472	1.18%	7,560	88	25
Regression C	7,868	7,472	2.09%	7,628	156	23

FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	7,472	7,365	0.00%	7,365	0	0
Exponential Smoothing B	7,472	7,365	0.00%	7,365	0	0
Box Jenkins A*	7,472	7,365	-0.51%	7,327	(38)	(2)
Box Jenkins B*	7,472	7,365	0.00%	7,365	0	0
Regression A	**7,472**	**7,365**	**-0.07%**	**7,360**	**(5)**	**0**
Regression B	7,472	7,365	3.72%	7,639	274	18
Regression C	7,472	7,365	3.20%	7,601	236	18

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Baby Care Program- Adults: Trend Selections

FY 2011-12: -5.03%
FY 2012-13: -1.43%
FY 2013-14: -0.07%

Baby Care Program- Adults: Justifications

- This population is effected by the economy in similar ways as the Low-Income Adults and Children populations, although the effects may be increased given that these clients have incomes up to 133% of the federal poverty level.
- Presumptive eligibility allows pregnant women who had applied for Medicaid to receive services based on self-declaration until the status of their application has been determined. The State paid for all Medicaid costs during this time regardless of whether or not the woman was eventually found to be Medicaid eligible or not. On September 1, 2004, the Department discontinued this procedure, which explains the drop of nearly 2,500 clients in September and October 2004, as well as the corresponding decline in fiscal year average caseload. Presumptive eligibility was reinstated by HB 05-1262 (Tobacco Tax bill) effective July 1, 2005. Discounting these policy changes, caseload for this category is erratic and tends to be mired with spikes, as displayed in the graph above.
- Models in this aid category are heavily influenced by the caseload decline due to the end of the presumptive eligibility program in 2004. The exponential smoothing and Box-Jenkins models do not reflect the reimplementation of presumptive eligibility. The volatility in this population forces many forecasts to be flat, even after accounting for presumptive eligibility.

- In FY 2009-10, the Department received approval from the Centers for Medicare and Medicaid Services to grant full Medicaid eligibility to pregnant women who are legal permanent residents that have been in the country for less than 5 years, as authorized by the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA). As a result, the Department has restated the FY 2009-10 monthly caseload for this eligibility type to include clients who had previously been in the State-only Prenatal population. These clients are now included in the base caseload.
- Growth in the first half of FY 2011-12 was much lower than the Department's November 2011 forecast, in which the annual caseload was projected to be 7,839 and average monthly declines were projected to be 2. The selected trend for FY 2011-12 is lower than that from the Department's November 2011 forecast, and would yield average growth of 6 per month for the remainder of FY 2011-12. Caseload in this eligibility type has been volatile for 3 years, as can be seen in the tables on the next page. While the cause of the volatility is unknown at this time, the Department does not anticipate that either large decreases or increases will continue, and projects small monthly average decreases throughout the forecast period.
- The Colorado Department of Public Health & Environment Family Planning Initiative was awarded a grant for approximately $3.5 million to address the issue of unintended pregnancy in Colorado for Title X clients, the vast majority of which are under 200% of the federal poverty level. Out-year trends are moderate due to this Family Planning initiative.
- There is a bottom-line adjustment to this eligibility type from SB 11-250, which increases eligibility for pregnant women in Medicaid from 133% of federal poverty line (FPL) to 185% FPL effective January 1, 2013.

25.5-5-101 (1), C.R.S.
(m) Low-income pregnant women, and children through the age of six, whose income is at or below a certain percentage of the federal poverty level as determined by the federal government;

25.5-5-201 (2), C.R.S.
(b) Notwithstanding the five-year waiting period established in paragraph (a) of this subsection (2), but subject to the availability of sufficient appropriations and the receipt of federal financial participation, the state department may provide benefits under this article and articles 4 and 6 of this title to a pregnant woman who is a qualified alien and a child under nineteen years of age who is a qualified alien so long as such woman or child meets eligibility criteria other than citizenship.

25.5-5-205 (3), C.R.S.
(a) On and after April 1, 1990, children under the age of six years and pregnant women shall be eligible for benefits under the baby and kid care program… (b) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this subsection (3) shall be one hundred thirty-three percent…;

Baby Care Program- Adults: Historical Caseload and Forecasts

Baby Care Program-Adults: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Dec-09	7,627	-	-
Jan-10	7,796	169	2.22%
Feb-10	7,779	(17)	-0.22%
Mar-10	7,996	217	2.79%
Apr-10	8,054	58	0.73%
May-10	8,039	(15)	-0.19%
Jun-10	7,903	(136)	-1.69%
Jul-10	7,909	6	0.08%
Aug-10	8,014	105	1.33%
Sep-10	7,971	(43)	-0.54%
Oct-10	7,985	14	0.18%
Nov-10	7,891	(94)	-1.18%
Dec-10	7,764	(127)	-1.61%
Jan-11	7,804	40	0.52%
Feb-11	7,677	(127)	-1.63%
Mar-11	7,881	204	2.66%
Apr-11	7,864	(17)	-0.22%
May-11	7,830	(34)	-0.43%
Jun-11	7,828	(2)	-0.03%
Jul-11	7,810	(18)	-0.23%
Aug-11	7,786	(24)	-0.31%
Sep-11	7,628	(158)	-2.03%
Oct-11	7,558	(70)	-0.92%
Nov-11	7,371	(187)	-2.47%
Dec-11	7,333	(38)	-0.52%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	7,223	-	-
FY 1996-97	5,476	-24.19%	(1,747)
FY 1997-98	4,295	-21.57%	(1,181)
FY 1998-99	5,017	16.81%	722
FY 1999-00	6,174	23.06%	1,157
FY 2000-01	6,561	6.27%	387
FY 2001-02	7,131	8.69%	570
FY 2002-03	7,823	9.70%	692
FY 2003-04	8,398	7.35%	575
FY 2004-05	5,984	-28.74%	(2,414)
FY 2005-06	5,119	-14.46%	(865)
FY 2006-07	5,182	1.23%	63
FY 2007-08	6,288	21.34%	1,106
FY 2008-09	6,976	10.94%	688
FY 2009-10	7,830	12.24%	854
FY 2010-11	7,868	0.49%	38
FY 2011-12	7,472	-5.03%	(396)
FY 2012-13	7,365	-1.43%	(107)
FY 2013-14	7,360	-0.07%	(5)

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

Adjustments	
FY 2011-12	0
FY 2012-13	181
FY 2013-14	1,194

November 2011 Forecast	
Forecasted December 2011 Level	7,838

Base trend from December 2011 level			
FY 2011-12	7,333	-6.80%	(535)

February 2012 Projections After Adjustments			
FY 2011-12	7,472	-5.03%	(396)
FY 2012-13	7,546	0.99%	74
FY 2013-14	8,554	13.36%	1,008

Monthly Average Growth Comparisons		
FY 2010-11 Actuals	(6)	-0.07%
FY 2010-11 1st Half	(23)	-0.29%
FY 2010-11 2nd Half	11	0.15%
FY 2011-12 1st Half Actuals	(83)	-1.08%
FY 2011-12 2nd Half Forecast	6	-0.50%
FY 2011-12 Forecast	(38)	-0.49%
November 2011 Forecast	2	0.03%
FY 2012-13 Forecast	(1)	-0.01%
November 2011 Forecast	3	0.04%

November 2011 Trends (BEFORE ADJUSTMENTS)			
FY 2011-12	7,839	-0.37%	(29)
FY 2012-13	7,877	0.48%	38
FY 2013-14	7,914	0.47%	37

Actuals		
	Monthly Change	**% Change**
6-month average	(83)	-1.08%
12-month average	(36)	-0.47%
18-month average	(32)	-0.41%
24-month average	(12)	-0.15%

Non-Citizens

Section 403 of the Personal Responsibility Work Opportunity Reconciliation Act provides that certain immigrants arriving in the United States after August 22, 1996 are ineligible for full Medicaid benefits for their first five years of residence. The five-year ban only applies to immigrants who arrived in the United States after August 22, 1996. Full Medicaid coverage of individuals for the first five years is optional. Per federal regulations, states must provide mandatory full coverage for:

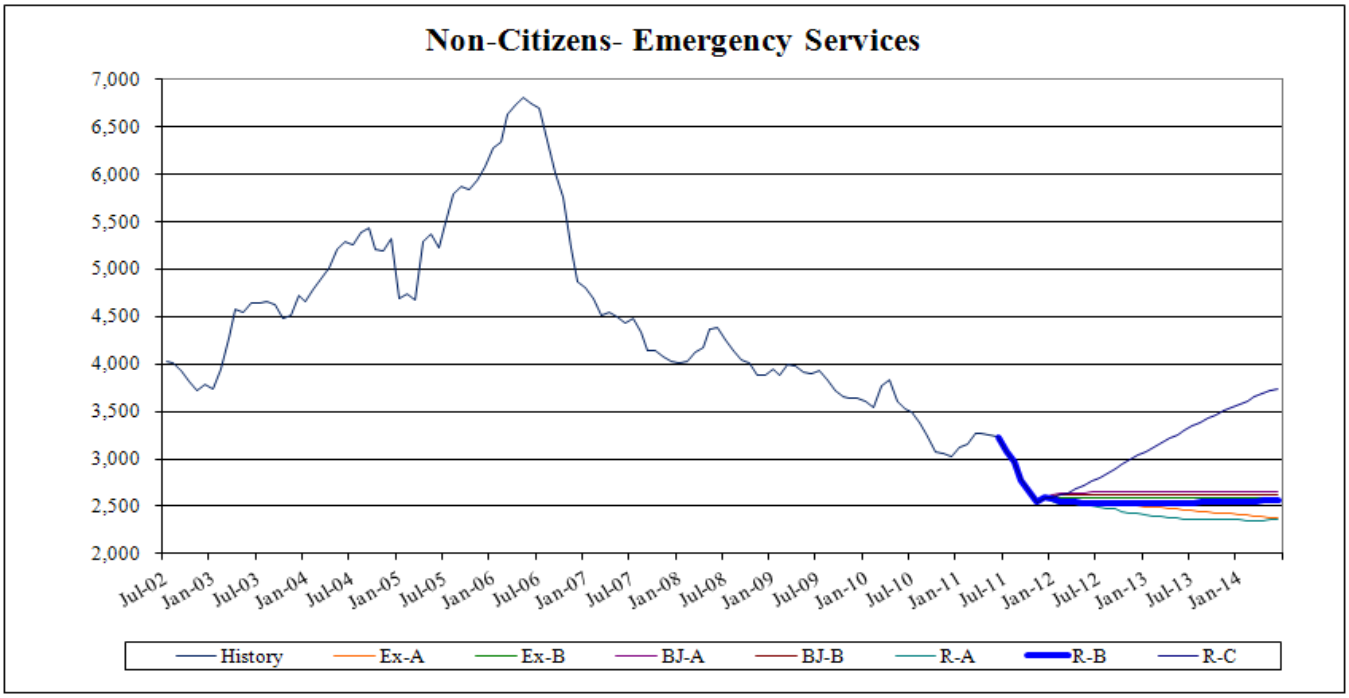
- Refugees for the first seven years after entry into the United States;

- Asylees for the first seven years after asylum is granted;
- Individuals whose deportation is being withheld for the first seven years after the initial withhold;
- Victims of trafficking;
- Lawful permanent residents who have 40 qualifying quarters of Social Security coverage;
- Cuban or Haitian entrants; and,
- Immigrants who are honorably discharged veterans of the United States military.

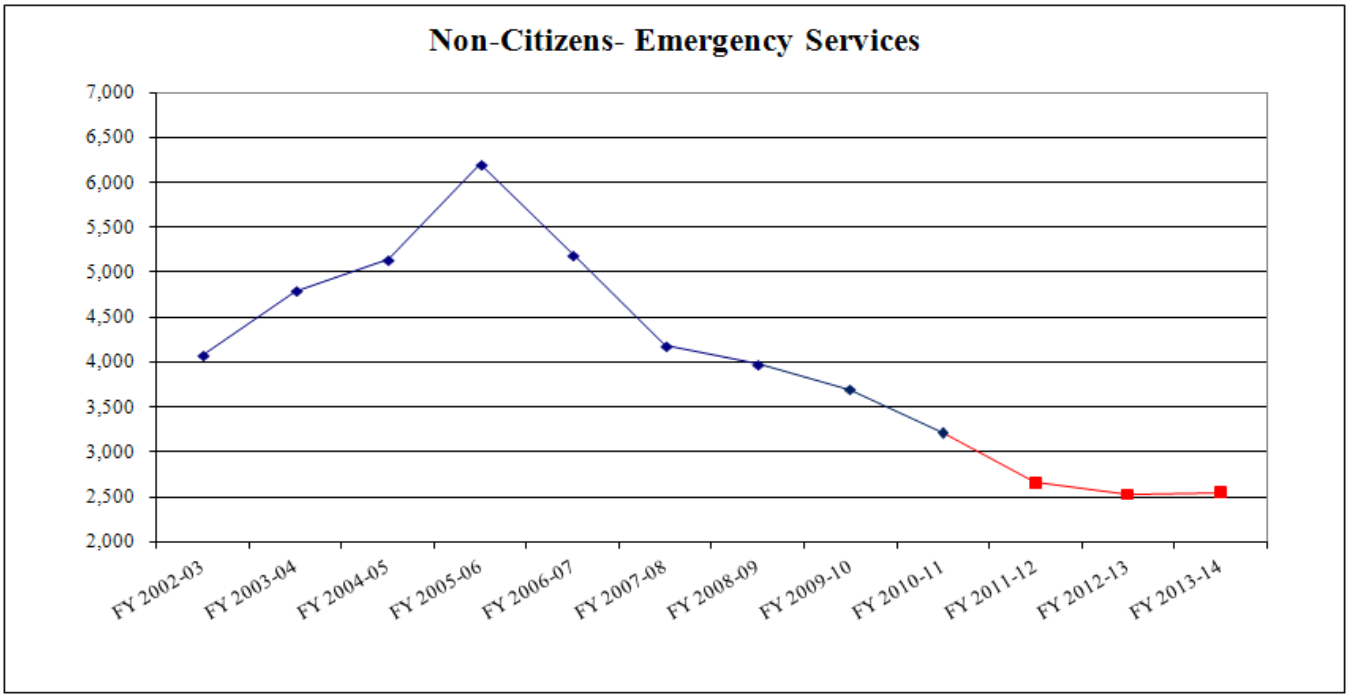
Regardless of whether the individual is an optional or mandatory immigrant, federal law requires all states to provide emergency medical services for individuals who otherwise meet Medicaid eligibility criteria, except for proof of U.S. citizenship.

In April 2001, an eligibility policy change was implemented such that clients are now only counted as eligible in the months they receive emergency medical care. Prior to this policy change, eligibility for this group continued as it would for any other category, although only for emergency medical services. For example, a Non-Citizen with an emergency visit on April 2000 could be eligible in that month, and continue to be eligible for as many months as he/she met other eligibility criteria. The same client would only be eligible for one month, had the emergency service occurred in April 2001. Thus, caseloads presented from April 2001 and forward are much lower than in previous years.

Non-Citizens: Model Results



Non-Citizens: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A	0.9680	
Exponential Smoothing B*	0.9671	
Box-Jenkins A*	0.9805	
Box-Jenkins B	0.9716	
Regression A	0.9866	ALIEN [-1], Female Population 19-59, Migration, Alien Dummy, Auto [-3], Auto [-7]
Regression B	0.9894	ALIEN [-1], ALIEN [-2], Alien Dummy, Auto [-3], Auto [-6]
Regression C	0.9891	ALIEN [-1], Unemployment Rate, Alien Dummy, Auto [-1], Auto [-2]



Non-Citizens- Emergency Services: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	3,693	3,213	-16.93%	2,669	(544)	(57)
Exponential Smoothing B	3,693	3,213	-16.56%	2,681	(532)	(53)
Box Jenkins A*	3,693	3,213	-15.84%	2,704	(509)	(49)
Box Jenkins B*	3,693	3,213	-16.22%	2,692	(521)	(51)
Regression A	3,693	3,213	-17.55%	2,649	(564)	(60)
Regression B	**3,693**	**3,213**	**-17.24%**	**2,659**	**(554)**	**(58)**
Regression C	3,693	3,213	-15.38%	2,719	(494)	(39)

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2012-13	**Projected FY 2010-11 Caseload**	**Projected FY 2011-12 Caseload**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	3,213	2,659	-6.29%	2,492	(167)	(7)
Exponential Smoothing B	3,213	2,659	-3.36%	2,570	(89)	0
Box Jenkins A*	3,213	2,659	-2.14%	2,602	(57)	0
Box Jenkins B*	3,213	2,659	-2.86%	2,583	(76)	0
Regression A	3,213	2,659	-8.61%	2,430	(229)	(12)
Regression B	**3,213**	**2,659**	**-4.89%**	**2,529**	**(130)**	**0**
Regression C	3,213	2,659	12.36%	2,988	329	45

FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	2,659	2,529	-3.40%	2,443	(86)	(7)
Exponential Smoothing B	2,659	2,529	0.00%	2,529	0	0
Box Jenkins A*	2,659	2,529	0.04%	2,530	1	0
Box Jenkins B*	2,659	2,529	0.00%	2,529	0	0
Regression A	2,659	2,529	-2.68%	2,461	(68)	(1)
Regression B	**2,659**	**2,529**	**0.79%**	**2,549**	**20**	**2**
Regression C	2,659	2,529	16.37%	2,943	414	37

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Non-Citizens: Trend Selections
FY 2011-12: -17.24%
FY 2012-13: -4.89%
FY 2013-14: 0.79%

Non-Citizens: Justifications
- The graph above illustrates that the caseload in this category had a positive trend between FY 2002-03 and FY 2005-06. Caseload trends should be correlated with economic conditions and migration trends. As the economy recovers, more immigrants are expected to migrate to the State. Research shows that Mexican immigrants tend to have longer life expectancies than natives of the United States or of other Hispanic origins, and that the mortality advantage is higher for lower income immigrants.[13]
- Expenditures in this category did not decrease along with caseload in FY 2006-07 and FY 2007-08, indicating that the caseload decline was not occurring in clients that were utilizing services. Until October 2006, the eligibility spans for pregnant clients who delivered in Non-Citizens were left open for 60 days post-partum in case of an emergency. These clients, however, rarely utilized any services. The caseload declines in FY 2006-07 and FY 2007-08 may indicate that eligibility spans for the Non-Citizens clients are now being ended sooner, caused by eligibility technicians actively working more cases because they are required to collect citizenship information. In addition, it is possible that some undocumented citizens are not applying for Medicaid emergency services out of fear due to the Deficit Reduction Act and HB 06S-1023 identification requirements, even though the Medicaid application clearly states that emergency services are exempt. Although the effects of these state and federal legislations, as well as the 60-day post-partum policy change, are unquantifiable, the Department believes that these large declines are unlikely to continue.
- The Department believes that the caseload volatility in this eligibility type beginning in FY 2008-09 are somewhat related to those experienced in the Baby Care-Adults caseload, as a large portion of the Non-Citizens caseload are pregnant women. Though the cause of this volatility is unknown at this time, the Department does not anticipate that large decreases will continue.
- Growth in the first half of FY 2011-12 was much lower than the Department's November 2011 forecast, in which the annual caseload was projected to be 3,233 and average monthly growth was projected to be 2. The selected trend for FY 2011-12 is much higher than that from the Department's November 2011 forecast, and would yield average decreases of 10 per month for the remainder of FY 2011-12.
- The out-year trends assume small monthly decreases throughout the forecast period. As discussed in the Baby Care-Adults section, a number of Family Planning initiatives will be implemented during the forecast period, which may be expected to decrease the number of pregnancies.

25.5-5-103 (3), C.R.S.
(a) Emergency medical assistance shall be provided to any person who is not a citizen of the United States, including undocumented aliens, aliens who are not qualified aliens, and qualified aliens who entered the United States on or after August 22, 1996, who has an emergency medical condition and meets one of the categorical requirements set forth in section 25.5-5-101; except that such persons shall not be required to meet any residency requirement other than that required by federal law.

[13] Source: Turra, CM and Goldman, N. *Socioeconomic differences in mortality among U.S. adults: insights into the Hispanic paradox.* The Journals of Gerontology, Series B, Psychological sciences and social sciences, Volume 62 Issue 3, pages 184-192.

Non-Citizens: Historical Caseload and Forecasts

Non-Citizens- Emergency Services: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Dec-09	3,632	-	-
Jan-10	3,610	(22)	-0.61%
Feb-10	3,550	(60)	-1.66%
Mar-10	3,768	218	6.14%
Apr-10	3,831	63	1.67%
May-10	3,615	(216)	-5.64%
Jun-10	3,522	(93)	-2.57%
Jul-10	3,492	(30)	-0.85%
Aug-10	3,378	(114)	-3.26%
Sep-10	3,231	(147)	-4.35%
Oct-10	3,080	(151)	-4.67%
Nov-10	3,049	(31)	-1.01%
Dec-10	3,023	(26)	-0.85%
Jan-11	3,116	93	3.08%
Feb-11	3,161	45	1.44%
Mar-11	3,271	110	3.48%
Apr-11	3,274	3	0.09%
May-11	3,255	(19)	-0.58%
Jun-11	3,229	(26)	-0.80%
Jul-11	3,089	(140)	-4.34%
Aug-11	2,973	(116)	-3.76%
Sep-11	2,774	(199)	-6.69%
Oct-11	2,657	(117)	-4.22%
Nov-11	2,543	(114)	-4.29%
Dec-11	2,591	48	1.89%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	4,100	-	-
FY 1996-97	4,610	12.44%	510
FY 1997-98	5,032	9.15%	422
FY 1998-99	5,799	15.24%	767
FY 1999-00	9,065	56.32%	3,266
FY 2000-01	12,451	37.35%	3,386
FY 2001-02	4,028	-67.65%	(8,423)
FY 2002-03	4,084	1.39%	56
FY 2003-04	4,793	17.36%	709
FY 2004-05	5,150	7.45%	357
FY 2005-06	6,212	20.62%	1,062
FY 2006-07	5,201	-16.27%	(1,011)
FY 2007-08	4,191	-19.42%	(1,010)
FY 2008-09	3,987	-4.87%	(204)
FY 2009-10	3,693	-7.37%	(294)
FY 2010-11	3,213	-13.00%	(480)
FY 2011-12	2,659	-17.24%	(554)
FY 2012-13	2,529	-4.89%	(130)
FY 2013-14	2,549	0.79%	20

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

November 2011 Forecast	
Forecasted December 2011 Level	3,229

Actuals		
	Monthly Change	**% Change**
6-month average	(106)	-3.57%
12-month average	(36)	-1.22%
18-month average	(52)	-1.65%
24-month average	(43)	-1.35%

Base trend from December 2011 level			
FY 2011-12	2,591	-19.36%	(622)

November 2011 Trends			
FY 2011-12	3,233	0.62%	20
FY 2012-13	3,276	1.33%	43
FY 2013-14	3,339	1.92%	63

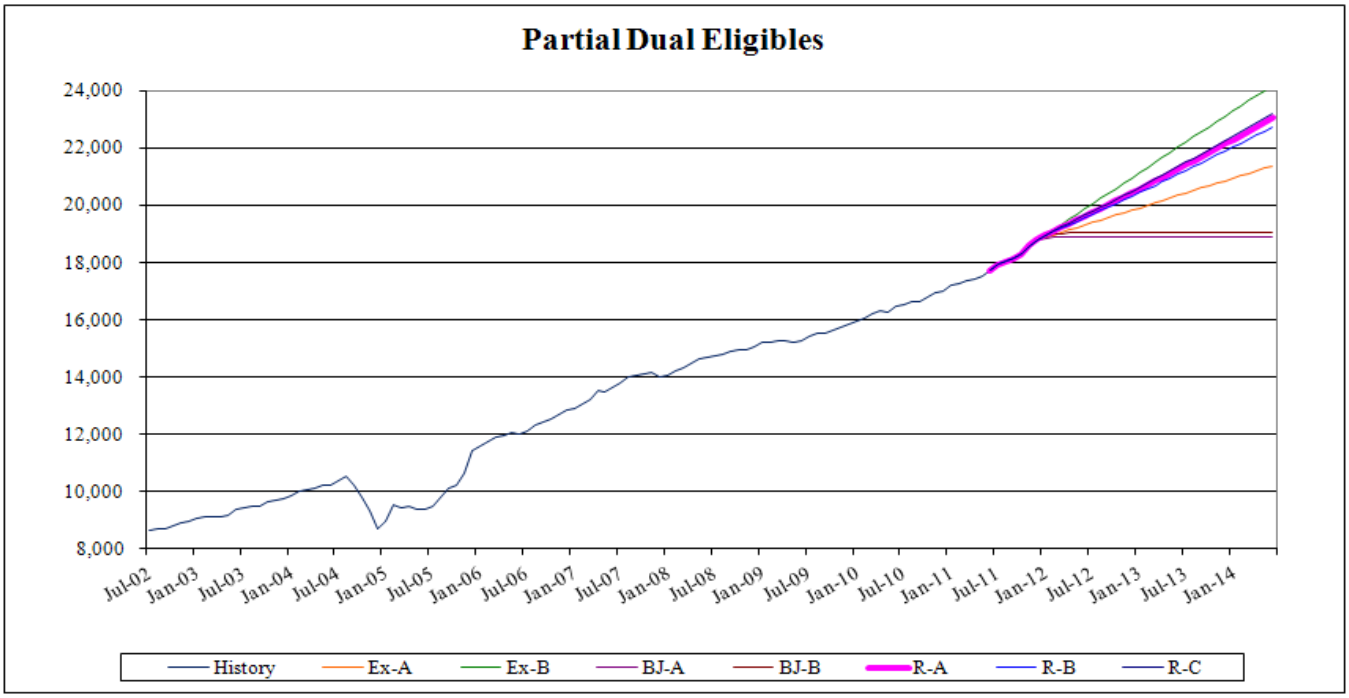
Monthly Average Growth Comparisons		
FY 2010-11 Actuals	(24)	-0.69%
FY 2010-11 1st Half	(83)	-2.50%
FY 2010-11 2nd Half	34	1.12%
FY 2011-12 1st Half Actuals	(106)	-3.57%
FY 2011-12 2nd Half Forecast	(10)	-1.98%
FY 2011-12 Forecast	(58)	-1.80%
November 2011 Forecast	2	0.06%
FY 2012-13 Forecast	0	0.00%
November 2011 Forecast	4	0.12%

Partial Dual Eligibles

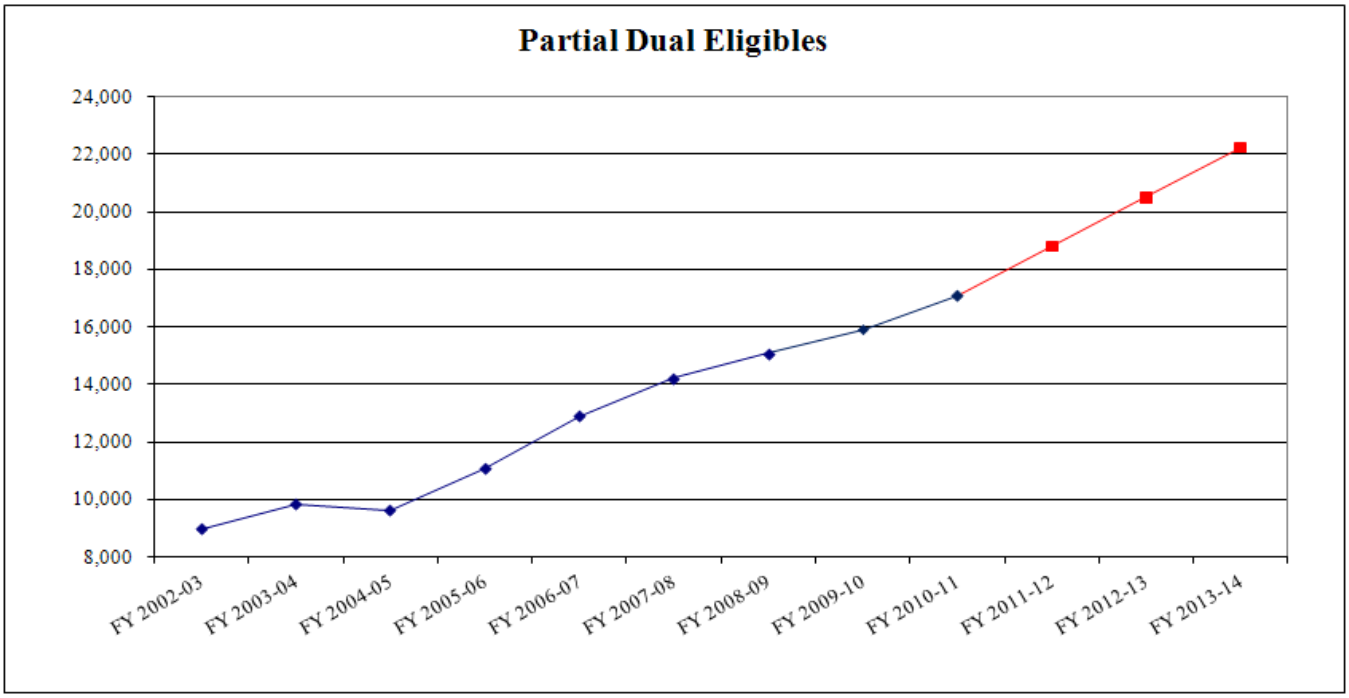
Medicare-eligible beneficiaries who have incomes at a certain federal poverty level and limited resources may qualify to have Medicaid cover some of their out-of-pocket expenses, such as their Medicare Part B premiums and other coinsurance and deductibles. The two groups of clients that qualify for this cost-sharing program are Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries. This group, formerly known as Qualified Medicare Beneficiaries/Special Low Income Medicare Beneficiaries, is now collectively known as Partial Dual Eligibles. Qualified Medicare Beneficiaries have incomes at or below 100% of the federal poverty level, and resources twice the standard allowed under the federal Supplemental Security Income program. These clients receive hospital insurance and supplementary medical insurance premium coverage along with Medicare coinsurance and deductibles. Special Low Income Medicare Beneficiaries have incomes greater than

100% of the federal poverty level, but less than 120%. For Special Low Income Medicare Beneficiaries, Medicaid only pays the supplementary medical insurance premiums.

Partial Dual Eligibles: Model Results



Partial Dual Eligibles: Model Statistics	Adjusted R^2	Notes
Exponential Smoothing A*	0.9985	
Exponential Smoothing B	0.9977	
Box-Jenkins A	0.9984	
Box-Jenkins B*	0.9979	
Regression A	0.9994	PDE [-1], PDE Dummy, CBMS Dummy, Auto [-1]
Regression B	0.9994	PDE [-1], Population 65+, PDE Dummy, CBMS Dummy, Auto [-1]
Regression C	0.9994	PDE [-1], PDE [-2], PDE Dummy, CBMS Dummy, Auto [-3]



Partial Dual Eligibles: Model Results						
FY 2011-12	**FY 2009-10**	**FY 2010-11**	**Projected Growth Rate**	**Projected FY 2011-12 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	15,919	17,090	9.43%	18,702	1,612	132
Exponential Smoothing B*	15,919	17,090	10.39%	18,866	1,776	179
Box Jenkins A	15,919	17,090	8.81%	18,596	1,506	97
Box Jenkins B	15,919	17,090	9.14%	18,652	1,562	109
Regression A	**15,919**	**17,090**	**9.98%**	**18,796**	**1,706**	**158**
Regression B	15,919	17,090	9.89%	18,780	1,690	153
Regression C	15,919	17,090	10.05%	18,808	1,718	161

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2012-13	**Projected FY 2010-11 Caseload**	**Projected FY 2011-12 Caseload**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	17,090	18,796	6.25%	19,971	1,175	86
Exponential Smoothing B*	17,090	18,796	11.55%	20,967	2,171	180
Box Jenkins A	17,090	18,796	1.69%	19,114	318	1
Box Jenkins B	17,090	18,796	2.11%	19,193	397	0
Regression A	**17,090**	**18,796**	**9.08%**	**20,503**	**1,707**	**138**
Regression B	17,090	18,796	8.52%	20,397	1,601	127
Regression C	17,090	18,796	9.35%	20,553	1,757	141

FY 2013-14	**Projected FY 2011-12 Caseload**	**Projected FY 2012-13 Caseload**	**Projected Growth Rate**	**Projected FY 2013-14 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	18,796	20,503	5.17%	21,563	1,060	86
Exponential Smoothing B*	18,796	20,503	10.25%	22,605	2,102	180
Box Jenkins A	18,796	20,503	0.02%	20,507	4	0
Box Jenkins B	18,796	20,503	0.01%	20,505	2	0
Regression A	**18,796**	**20,503**	**8.43%**	**22,231**	**1,728**	**149**
Regression B	18,796	20,503	7.78%	22,098	1,595	136
Regression C	18,796	20,503	8.59%	22,264	1,761	153

[1] Average monthly change is calculated as that between June of the respective fiscal year and June of the prior fiscal year. This is not directly comparable to the annual level change, which is calculated as the difference between the annual average caseload.

Partial Dual Eligibles: Trend Selections
FY 2011-12: 9.98%
FY 2012-13: 9.08%
FY 2013-14: 8.43%

Partial Dual Eligibles: Justification
- These clients have higher income than Adults 65 and Older or Disabled Adults 60 to 64, and are relatively healthy. Given the increased life expectancy, more people are living healthier longer, which would support strong growth rates in this population. In addition, this population may start to be effected by the "baby boomers", defined by the U.S. Census Bureau as the generation born between 1946 and 1964, beginning in calendar year 2006.
- Caseload trends are somewhat correlated with age and economic indicators. The assets and annuities provisions in the Deficit Reduction Act of 2005 may also contribute to growth in this category, as some clients who might have qualified for the Adults 65 and Older category now have too much income or assets.
- Caseload growth in this category was positive and steady between FY 1999-00 and FY 2003-04. Caseload experienced an unprecedented contraction on FY 2004-05, due to large monthly declines that occurred as a result of the court order regarding the Colorado Benefits Management System. The relatively strong growth since the beginning of FY 2005-06 may be due to a wood work effect from Medicare Modernization Act, under which Medicare Part D clients are screened for Medicaid as they apply for the low-income subsidy.
- Growth in the first half of FY 2011-12 was higher with the Department's November 2011 forecast, in which the annual caseload was projected to be 18,375 and average monthly growth was projected to be 100. The selected trend for FY 2011-12 is slightly higher than the Department's November 2011 forecast, and would yield average growth of 137 per month for the remainder of FY 2011-12.
- Out-year trend selections are slightly higher than historic rates, reflecting the complete incorporation of baby boomers and any clients affected by the Medicare Modernization Act.

25.5-5-101 (1), C.R.S.
(l) Individuals with income and resources at a level which qualifies them as Medicare-eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act".

25.5-5-104, C.R.S.
Qualified medicare beneficiaries are medicare-eligible individuals with income and resources at a level which qualifies them as eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act of 1988", as amended, or subsequent amending federal legislation.

25.5-5-105, C.R.S.
Qualified disabled and working individuals are persons with income and resources and disability status, as determined by the social security administration, which qualify them as "qualified disabled and working individuals" under sections 6012 and 6408 of the federal "Omnibus Budget Reconciliation Act of 1989", or subsequent amending federal legislation. The state department is hereby designated as the single state agency to administer benefits available to qualified disabled and working individuals. Such benefits are limited to medicare cost-sharing expenses as determined by the federal government.

Partial Dual Eligibles: Historical Caseload and Forecasts

Partial Dual Eligibles: Historical Caseload and Projections			
	Actuals	**Monthly Change**	**% Change**
Dec-09	15,846	-	-
Jan-10	15,954	108	0.68%
Feb-10	16,076	122	0.76%
Mar-10	16,212	136	0.85%
Apr-10	16,308	96	0.59%
May-10	16,285	(23)	-0.14%
Jun-10	16,495	210	1.29%
Jul-10	16,539	44	0.27%
Aug-10	16,634	95	0.57%
Sep-10	16,652	18	0.11%
Oct-10	16,794	142	0.85%
Nov-10	16,941	147	0.88%
Dec-10	17,002	61	0.36%
Jan-11	17,210	208	1.22%
Feb-11	17,249	39	0.23%
Mar-11	17,390	141	0.82%
Apr-11	17,399	9	0.05%
May-11	17,546	147	0.84%
Jun-11	17,727	181	1.03%
Jul-11	17,923	196	1.11%
Aug-11	18,046	123	0.69%
Sep-11	18,156	110	0.61%
Oct-11	18,314	158	0.87%
Nov-11	18,584	270	1.47%
Dec-11	18,798	214	1.15%

	Caseload*	**% Change**	**Level Change**
FY 1995-96	3,937	-	-
FY 1996-97	4,316	9.63%	379
FY 1997-98	4,560	5.65%	244
FY 1998-99	6,104	33.86%	1,544
FY 1999-00	7,597	24.46%	1,493
FY 2000-01	8,157	7.37%	560
FY 2001-02	8,428	3.32%	271
FY 2002-03	8,988	6.64%	560
FY 2003-04	9,842	9.50%	854
FY 2004-05	9,605	-2.41%	(237)
FY 2005-06	11,092	15.48%	1,487
FY 2006-07	12,908	16.37%	1,816
FY 2007-08	14,214	10.12%	1,306
FY 2008-09	15,075	6.06%	861
FY 2009-10	15,919	5.60%	844
FY 2010-11	17,090	7.36%	1,171
FY 2011-12	18,796	9.98%	1,706
FY 2012-13	20,503	9.08%	1,707
FY 2013-14	22,231	8.43%	1,728

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

November 2011 Forecast	
Forecasted December 2011 Level	18,324

Actuals		
	Monthly Change	**% Change**
6-month average	179	0.98%
12-month average	150	0.84%
18-month average	128	0.73%
24-month average	123	0.72%

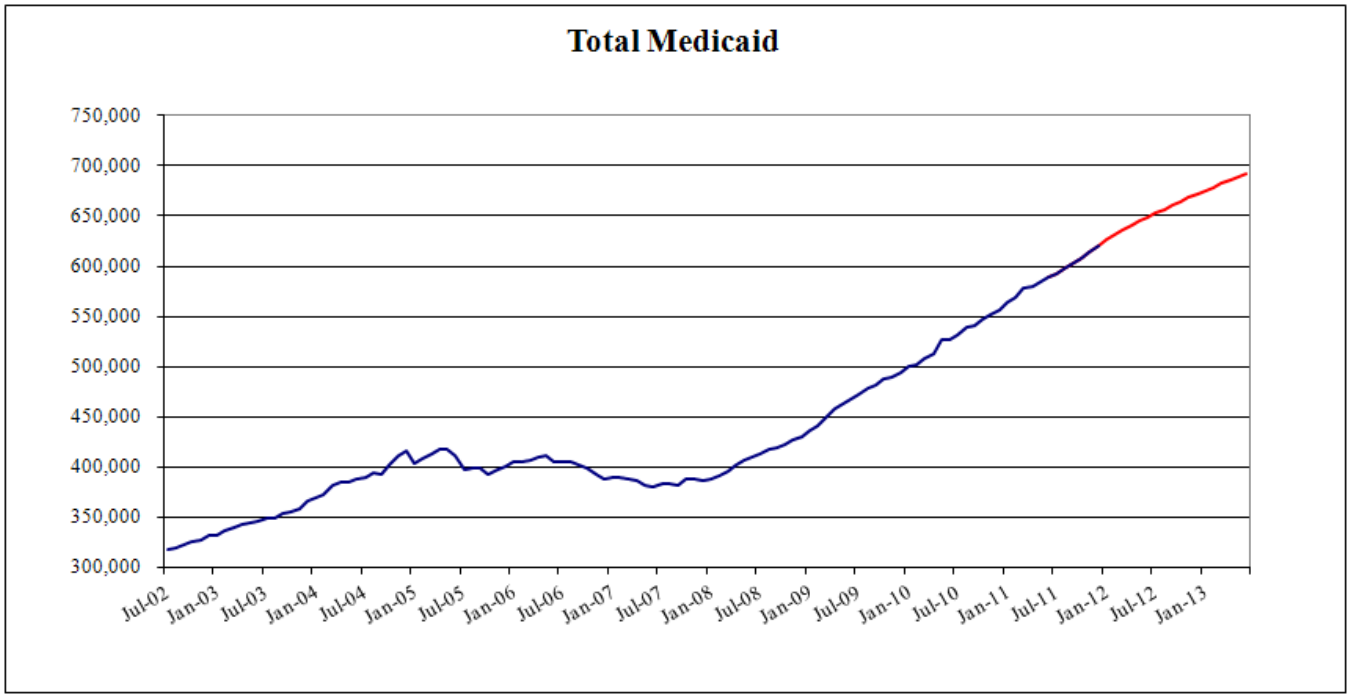
Base trend from December 2011 level			
FY 2011-12	18,798	9.99%	1,708

November 2011 Trends			
FY 2011-12	18,375	7.52%	1,285
FY 2012-13	19,602	6.68%	1,227
FY 2013-14	20,874	6.49%	1,272

Monthly Average Growth Comparisons		
FY 2010-11 Actuals	103	0.60%
FY 2010-11 1st Half	85	0.51%
FY 2010-11 2nd Half	121	0.70%
FY 2011-12 1st Half Actuals	179	0.98%
FY 2011-12 2nd Half Forecast	137	0.85%
FY 2011-12 Forecast	158	0.89%
November 2011 Forecast	100	0.56%
FY 2012-13 Forecast	138	0.71%
November 2011 Forecast	104	0.55%

Summary

The Department is forecasting a FY 2011-12 total Medicaid caseload of 623,595, an 11.21% increase from FY 2010-11. The trend is projected to moderate slightly in FY 2012-13 with caseload expected to increase by 10.24% to 687,473, with a large portion of the growth to come from the implementation of the Medicaid Buy-In Program for Working Adults with Disabilities in March 2012, Adults without Dependent Children (AwDC) program in May 2012, and SB 11-008, and SB 11-250, both of which are scheduled for implementation in January 2013. In addition, a Medicaid Disabled Buy-In Program for Children is scheduled to be implemented approximately four to six months after the Medicaid Buy-In Program for Working Adults with Disabilities program.


Total Medicaid
750,000
700,000
650,000
600,000
550,000
500,000
450,000
400,000
350,000
300,000
Jul-02
Jan-03
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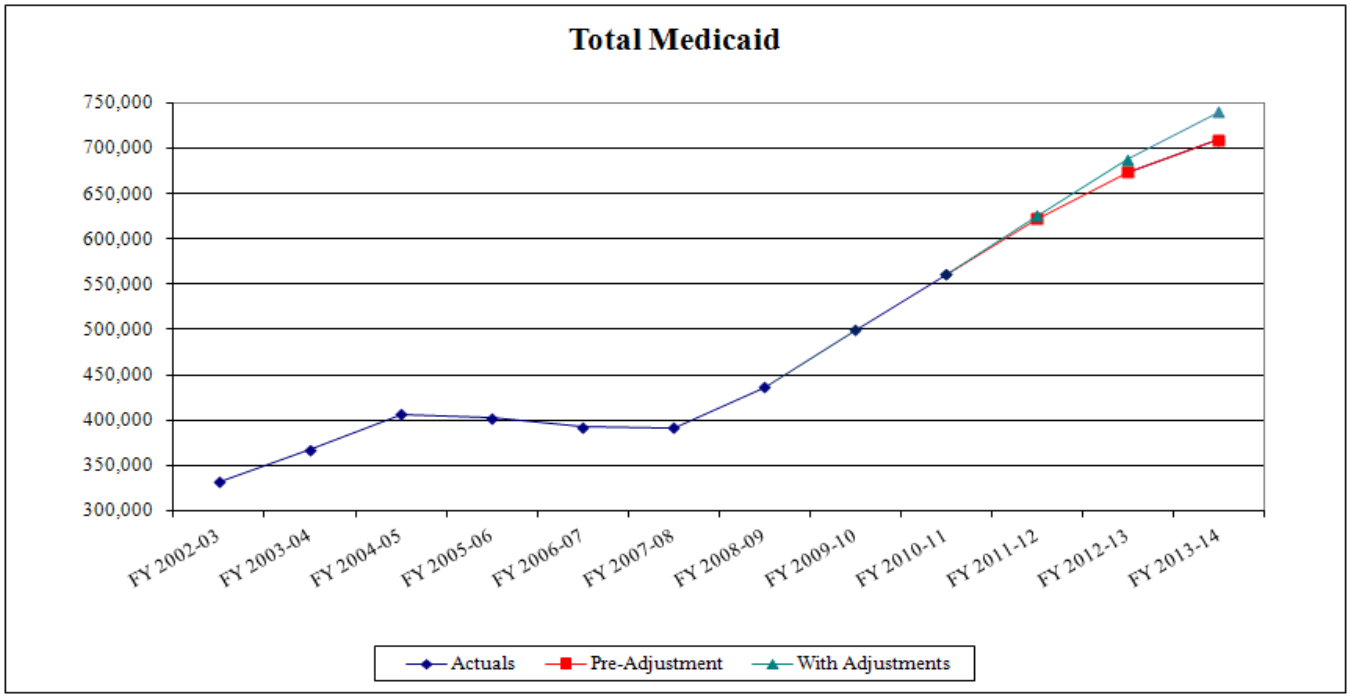
Total Medicaid
750,000
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650,000
600,000
550,000
500,000
450,000
400,000
350,000
300,000
FY 2002-03
FY 2003-04
FY 2004-05
FY 2005-06
FY 2006-07
FY 2007-08
FY 2008-09
FY 2009-10
FY 2010-11
FY 2011-12
FY 2012-13
FY 2013-14
Actuals
Pre-Adjustment
With Adjustments

Total Medicaid: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Dec-09	494,699	-	-
Jan-10	499,735	5,036	1.02%
Feb-10	501,596	1,861	0.37%
Mar-10	508,592	6,996	1.39%
Apr-10	512,398	3,806	0.75%
May-10	526,431	14,033	2.74%
Jun-10	526,221	(210)	-0.04%
Jul-10	531,445	5,224	0.99%
Aug-10	539,073	7,628	1.44%
Sep-10	541,285	2,212	0.41%
Oct-10	546,301	5,016	0.93%
Nov-10	551,168	4,867	0.89%
Dec-10	556,120	4,952	0.90%
Jan-11	564,115	7,995	1.44%
Feb-11	569,088	4,973	0.88%
Mar-11	578,192	9,104	1.60%
Apr-11	579,436	1,244	0.22%
May-11	583,951	4,515	0.78%
Jun-11	588,925	4,974	0.85%
Jul-11	591,843	2,918	0.50%
Aug-11	597,705	5,862	0.99%
Sep-11	602,910	5,205	0.87%
Oct-11	608,533	5,623	0.93%
Nov-11	614,146	5,613	0.92%
Dec-11	620,799	6,653	1.08%
Jan-12	**626,317**	**5,518**	**0.89%**
Feb-12	**631,063**	**4,747**	**0.76%**
Mar-12	**635,654**	**4,590**	**0.73%**
Apr-12	**640,031**	**4,377**	**0.69%**
May-12	**644,807**	**4,776**	**0.75%**
Jun-12	**648,848**	**4,041**	**0.63%**
Jul-12	**652,458**	**3,609**	**0.56%**
Aug-12	**656,493**	**4,035**	**0.62%**
Sep-12	**660,423**	**3,931**	**0.60%**
Oct-12	**664,299**	**3,875**	**0.59%**
Nov-12	**668,079**	**3,780**	**0.57%**
Dec-12	**671,810**	**3,731**	**0.56%**

**Bold denotes projection

	Caseload*	% Change	Level Change
FY 1995-96	254,083	-	-
FY 1996-97	250,098	-1.57%	(3,985)
FY 1997-98	238,594	-4.60%	(11,504)
FY 1998-99	237,598	-0.42%	(996)
FY 1999-00	253,254	6.59%	15,656
FY 2000-01	275,399	8.74%	22,145
FY 2001-02	295,413	7.27%	20,014
FY 2002-03	331,800	12.32%	36,387
FY 2003-04	367,559	10.78%	35,759
FY 2004-05	406,024	10.46%	38,465
FY 2005-06	402,218	-0.94%	(3,806)
FY 2006-07	392,228	-2.48%	(9,990)
FY 2007-08	391,962	-0.07%	(266)
FY 2008-09	436,812	11.44%	44,850
FY 2009-10	498,797	14.19%	61,985
FY 2010-11	560,759	12.42%	61,962
FY 2011-12	621,870	10.90%	61,111
FY 2012-13	672,963	8.22%	51,093
FY 2013-14	709,189	5.38%	36,226

* Medicaid caseload was restated back to FY 2002-03 effective July 1, 2008. Caseload prior to FY 2002-03 has not been restated and is not directly comparable to the restated caseload.

Adjustments	
FY 2011-12	1,725
FY 2012-13	14,510
FY 2013-14	30,214

Projections After Adjustments			
FY 2011-12	623,595	11.21%	62,836
FY 2012-13	687,473	10.24%	63,878
FY 2013-14	739,403	7.55%	51,929

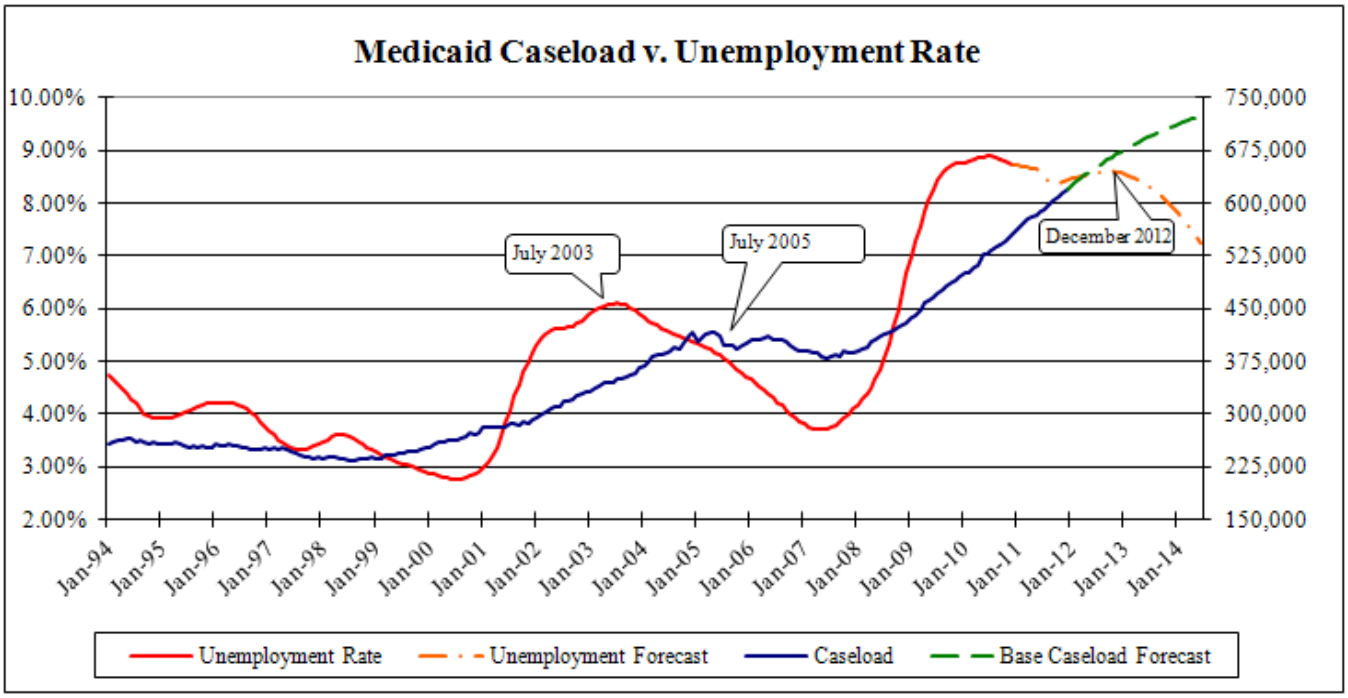
November 2011 Trends (BEFORE ADJUSTMENTS)			
FY 2011-12	616,595	9.96%	55,873
FY 2012-13	656,294	6.44%	39,699
FY 2013-14	685,061	4.38%	28,767

November 2011 Forecast	
Forecasted December 2011 Level	615,597

Actuals		
	Monthly Change	% Change
6-month average	5,312	0.88%
12-month average	5,390	0.92%
18-month average	5,254	0.92%
24-month average	5,254	0.95%

Monthly Average Growth Comparisons		
FY 2010-11 Actuals	5,225	0.94%
FY 2010-11 1st Half	4,983	0.93%
FY 2010-11 2nd Half	5,468	0.96%
FY 2011-12 1st Half Actuals	5,312	0.88%
FY 2011-12 2nd Half Forecast	4,675	0.74%
FY 2011-12 Forecast	4,994	0.81%
November 2011 Forecast	4,031	0.66%
FY 2012-13 Forecast	1,672	0.25%
November 2011 Forecast	2,811	0.43%

Base trend from December 2011 level			
FY 2011-12	620,799	10.71%	60,040


Medicaid Caseload v. Unemployment Rate
10.00%
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
750,000
675,000
600,000
525,000
450,000
375,000
300,000
225,000
150,000
July 2003
July 2005
December 2012
Jan-94
Jan-95
Jan-96
Jan-97
Jan-98
Jan-99
Jan-00
Jan-01
Jan-02
Jan-03
Jan-04
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Jan-06
Jan-07
Jan-08
Jan-09
Jan-10
Jan-11
Jan-12
Jan-13
Jan-14
Unemployment Rate
Unemployment Forecast
Caseload
Base Caseload Forecast

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medical Services Premiums Request

Priority Number: S-1A, BA-1

Dept. Approval by: John Bartholomew 2/15/12 Date

OSPB Approval by: 2/15/12 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$3,543,863,749	$38,583,139	$3,559,795,929	$110,910,674	$138,701,369
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	($9,238,775)	$981,320,305	($4,016,472)	$5,663,472
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$27,520,070	$534,529,617	$61,179,404	$41,266,136
	RF	$6,388,059	($22,954)	$3,101,708	($190,350)	($420,660)
	FF	$1,746,144,065	$20,324,798	$1,756,668,882	$53,938,092	$92,192,421
(2) Medical Services Premiums	**Total**	$3,543,863,749	$38,583,139	$3,559,795,929	$110,910,674	$138,701,369
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	($9,238,775)	$981,320,305	($4,016,472)	$5,663,472
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$27,520,070	$534,529,617	$61,179,404	$41,266,136
	RF	$6,388,059	($22,954)	$3,101,708	($190,350)	($420,660)
	FF	$1,746,144,065	$20,324,798	$1,756,668,882	$53,938,092	$92,192,421

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:** See Exhibit D

Cash or Federal Fund Name and COFRS Fund Number: See Exhibit D

Reappropriated Funds Source, by Department and Line Item Name: See Exhibit D

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: None.

Other Information:

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Exhibits for the Medical Services Premiums Budget Request

Exhibit A - Summary of Request

Calculation of Request						
FY 2011-12						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2011-12 Appropriation						
FY 2011-12 Long Bill Appropriation (SB 11-209)	$3,521,401,973	$1,004,304,853	$284,175,417	$495,061,484	$3,101,708	$1,734,758,511
SB 11-008 Medicaid Eligibility for Children	$0	$0	$0	$0	$0	$0
SB 11-177 Pregnancy and Dropout Prevention	$333,195	($26,735)	$0	$38,666	$0	$321,264
SB 11-125 Nursing Home Fees and Order of Payments	$30,994,411	$0	$0	$15,497,206	$0	$15,497,205
SB 11-210 Phase Out Supplemental OAP Health Fund	$0	($2,230,500)	$0	$2,230,500	$0	$0
SB 11-211 Tobacco Revenues Offset Medical Services	$0	($33,000,000)	$0	$29,713,649	$3,286,351	$0
SB 11-212 Use Provider Fee Offset Medicaid	$0	($50,000,000)	$0	$50,000,000	$0	$0
SB 11-215 2011 Nursing Facility Rate Reduction	($8,865,830)	($4,432,915)	$0	$0	$0	($4,432,915)
SB 11-219 2011 Transfers for Health Care Services	$0	($15,775,670)	$0	$15,775,670	$0	$0
SB 11-250 Eligibility for Pregnant Women	$0	$0	$0	$0	$0	$0
FY 2011-12 Total Spending Authority	**$3,543,863,749**	**$898,839,033**	**$284,175,417**	**$608,317,175**	**$6,388,059**	**$1,746,144,065**
Total Projected FY 2011-12 Expenditures	$3,644,816,560	$940,912,711	$284,175,417	$613,729,717	$6,445,828	$1,799,552,887
FY 2011-12 Requested Change from Appropriation	**$100,952,811**	**$42,073,678**	**$0**	**$5,412,542**	**$57,769**	**$53,408,822**
Percent Change	2.85%	4.68%	0.00%	0.89%	0.90%	3.06%
FY 2011-12 November Supplemental Request (S-1)	$62,369,672	$51,312,453	$0	($22,107,528)	$80,723	$33,084,024
FY 2011-12 Current Supplemental Request (S-1A)	**$38,583,139**	**($9,238,775)**	**$0**	**$27,520,070**	**($22,954)**	**$20,324,798**

Exhibit A - Summary of Request

Calculation of Request						
FY 2012-13						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2011-12 Appropriation Plus Special Bills	$3,543,863,749	$898,839,033	$284,175,417	$608,317,175	$6,388,059	$1,746,144,065
Bill Annualizations						
Annualization of FY 2011-12 Long Bill Appropriation (SB 11-209)	($9,588,011)	($4,201,139)	$0	($586,313)	$0	($4,800,559)
Annualization of HB 10-1380 Use Supplemental OAP Health Fund for Medicaid	$0	$3,000,000	$0	($3,000,000)	$0	$0
Annualization of SB 11-008 Medicaid Eligibility for Children	$8,298,832	$2,904,591	$0	$0	$0	$5,394,241
Annualization of SB 11-177 Pregnancy and Dropout Prevention	$542,168	($2,025)	$0	$54,622	$0	$489,571
Annualization of SB 11-125 Nursing Home Fees and Order of Payments	$466,905	$0	$0	$233,452	$0	$233,453
Annualization of SB 11-210 Phase Out Supplemental OAP Health Fund	$0	$0	$0	$0	$0	$0
Annualization of SB 11-211 Tobacco Revenues Offset Medical Services	$0	$33,000,000	$0	($29,713,649)	($3,286,351)	$0
Annualization of SB 11-212 Use Provider Fee Offset Medicaid	$0	$25,000,000	$0	($25,000,000)	$0	$0
Annualization of SB 11-215 2011 Nursing Facility Rate Reduction	$8,865,830	$4,432,915	$0	$0	$0	$4,432,915
Annualization of SB 11-219 2011 Transfers for Health Care Services	$0	$15,775,670	$0	($15,775,670)	$0	$0
Annualization of SB 11-250 Eligibility for Pregnant Women	$7,346,456	$2,571,260	$0	$0	$0	$4,775,196
Total Annualizations	$15,932,180	$82,481,272	$0	($73,787,558)	($3,286,351)	$10,524,817
FY 2012-13 Base Amount	**$3,559,795,929**	**$981,320,305**	**$284,175,417**	**$534,529,617**	**$3,101,708**	**$1,756,668,882**
Total Projected FY 2012-13 Expenditures	$4,001,512,858	$1,106,607,389	$284,175,417	$631,947,507	$3,215,340	$1,975,567,205
FY 2012-13 Request	**$441,716,929**	**$125,287,084**	**$0**	**$97,417,890**	**$113,632**	**$218,898,323**
Percent Change from FY 2011-12 Base	12.41%	12.77%	0.00%	18.22%	3.66%	12.46%
FY 2012-13 November Decision Item (R-1)	$330,806,255	$129,303,556	$0	$36,238,486	$303,982	$164,960,231
FY 2012-13 Current Budget Amendment (BA-1)	**$110,910,674**	**($4,016,472)**	**$0**	**$61,179,404**	**($190,350)**	**$53,938,092**

Exhibit A - Summary of Request

Calculation of Request						
FY 2013-14						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2012-13 Appropriation Plus Special Bills	$3,559,795,929	$981,320,305	$284,175,417	$534,529,617	$3,101,708	$1,756,668,882
Bill Annualizations						
Annualization of SB 08-118 Money Transfer for Medicaid Programs	$0	$2,000,000	$0	$0	($2,000,000)	$0
Annualization of SB 11-008 Medicaid Eligibility for Children	$26,454,555	$9,259,094	$0	$0	$0	$17,195,461
Annualization of SB 11-212 Use Proivder Fee Offset Medicaid	$0	$25,000,000	$0	($25,000,000)	$0	$0
Annualization of SB 11-250 Eligibility for Pregnant Women	$8,803,834	$3,081,341	$0	$0	$0	$5,722,493
Total Annualizations	$35,258,389	$39,340,435	$0	($25,000,000)	($2,000,000)	$22,917,954
FY 2013-14 Total Spending Authority	**$3,595,054,318**	**$1,020,660,740**	**$284,175,417**	**$509,529,617**	**$1,101,708**	**$1,779,586,836**
Total Projected FY 2013-14 Expenditures	$4,256,817,384	$1,223,408,131	$284,175,417	$585,369,479	$1,215,340	$2,162,649,017
FY 2013-14 Requested Change From Appropriation	**$661,763,066**	**$202,747,391**	**$0**	**$75,839,862**	**$113,632**	**$383,062,181**
Percent Change	18.41%	19.86%	0.00%	14.88%	10.31%	21.53%
FY 2012-13 November Decision Item (R-1)	$523,061,697	$197,083,919	$0	$34,573,726	$534,292	$290,869,760
FY 2012-13 Current Budget Amendment (BA-1)	**$138,701,369**	**$5,663,472**	**$0**	**$41,266,136**	**($420,660)**	**$92,192,421**

Calculation of Fund Splits
FY 2011-12

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
Acute Care Services							
Base Acute	$1,717,655,085	$858,827,542	$0	$0	$858,827,543	50.00%	
Breast and Cervical Cancer Program	$11,042,638	$0	$2,705,446	$1,159,477	$7,177,715	65.00%	State fund sources vary; see Exhibit F
Family Planning	$14,925,914	$1,472,828	$19,763	$0	$13,433,323	90.00%	CF: Local Funds
Home Health Telemedicine Services	$130,240	$0	$130,240	$0	$0	50.00%	CF: Home Health Telemedicine Cash Fund
Indian Health Service	$1,176,502	$0	$0	$0	$1,176,502	100.00%	
Affordable Care Act Drug Rebate Offset	($14,422,125)	$0	$0	$0	($14,422,125)	0.00%	
Expansion Adults to 100% Adjustment	$86,986,169	$0	$43,493,085	$0	$43,493,084	50.00%	CF: Hospital Provider Fee Cash Fund
Acute Care Services Sub-Total	$1,817,494,423	$860,300,370	$46,348,534	$1,159,477	$909,686,042		
Community Based Long Term Care Services							
Base Community Based Long Term Care	$336,432,229	$168,216,114	$0	$0	$168,216,115	50.00%	
Children with Autism Waiver Services	$1,757,250	$0	$878,625	$0	$878,625	50.00%	CF: Colorado Autism Treatment Fund
Expansion Adults to 100% Adjustment	$112,591	$0	$56,296	$0	$56,295	50.00%	CF: Hospital Provider Fee Cash Fund
Community Based Long Term Care Sub-Total	$338,302,070	$168,216,114	$934,921	$0	$169,151,035		
Long Term Care and Insurance							
Base Class I Nursing Facilities	$512,062,190	$256,031,095	$0	$0	$256,031,095	50.00%	
Base Class II Nursing Facilities	$3,878,892	$1,939,446	$0	$0	$1,939,446	50.00%	
PACE	$82,788,665	$41,394,332	$0	$0	$41,394,333	50.00%	
Supplemental Medicare Insurance Benefit (SMIB)	$113,621,017	$68,172,610	$0	$0	$45,448,407	50.00%*	Approximately 20% of Total is State-Only
Health Insurance Buy-In	$1,240,416	$620,208	$0	$0	$620,208	50.00%	
Long Term Care and Insurance Sub-Total	$713,591,180	$368,157,691	$0	$0	$345,433,489		
Service Management							
Base Service Management	$49,769,154	$24,884,577	$0	$0	$24,884,577	50.00%	
Tobacco Tax Funded Disease Management	$500,000	$0	$0	$250,000	$250,000	50.00%	RF: Transfer from DPHE
Coordinated Care for People with Disabilities Program	$273,600	$0	$136,800	$0	$136,800	50.00%	CF: Coordinated Care for People with Disabilities Fund
Expansion Adults to 100% Adjustment	$2,862,221	$0	$1,431,111	$0	$1,431,110	50.00%	CF: Hospital Provider Fee Cash Fund
Service Management Sub-Total	$53,404,975	$24,884,577	$1,567,911	$250,000	$26,702,487		
Expansion Populations							
Disabled Buy-In	$566,364	$0	$383,406	$0	$182,958	50.00%*	CF: Hospital Provider Fee Cash Fund and Medicaid Buy-In Fund *Federal Match Applies Only to State Share
Adults Without Dependent Children	$6,626,200	$0	$3,313,100	$0	$3,313,100	50.00%	CF: Hospital Provider Fee Cash Fund
Expansion Populations Sub-Total	$7,192,564	$0	$3,696,506.00	$0	$3,496,058		
FY 2011-12 Estimate of Total Expenditures for Medical Services to Clients	**$2,929,985,212**	**$1,421,558,752**	**$52,547,872.00**	**$1,409,477**	**$1,454,469,111**		
Financing							
Upper Payment Limit Financing	$4,748,099	($7,234,195)	$4,748,099	$0	$7,234,195	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($16,375,911)	$33,723,046	$0	($17,347,135)	51.44%	CF: Department Recoveries
Denver Health Outstationing	$5,485,699	$0	$2,742,849	$0	$2,742,850	50.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$614,029,587	$0	$307,014,793	$0	$307,014,794	50.00%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$85,145,251	$0	$42,572,625	$0	$42,572,626	50.00%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$5,422,712	$0	$2,556,266	$0	$2,866,446	52.86%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($67,104,348)	$67,104,348	$0	$0	N/A	CF: Health Care Expansion Fund
Cash Funds Financing[1]	$0	($105,756,170)	$100,719,819	$5,036,351	$0	N/A	CF: Various, see narrative
Financing Sub-Total	$714,831,348	($196,470,624)	$561,181,845	$5,036,351	$345,083,776		
Total Projected FY 2011-12 Expenditures[2]	**$3,644,816,560**	**$1,225,088,128**	**$613,729,717**	**$6,445,828**	**$1,799,552,887**		

Definitions: FMAP: Federal Medical Assistance Percentage DPHE: Department of Public Health and Environment

(1) This line adjusts for transfers from cash funds to the General Fund as provided by for the special bills listed on page EA-1.

(2) Of the General Fund total, $284,175,417 is General Fund Exempt.

Exhibit A - Summary of Request

Calculation of Fund Splits
FY 2012-13

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
Acute Care Services							
Base Acute	$1,813,151,790	$906,575,895	$0	$0	$906,575,895	50.00%	
Breast and Cervical Cancer Program	$12,110,906	$1,511,738	$1,511,739	$1,215,340	$7,872,089	65.00%	State fund sources vary; see Exhibit F
Family Planning	$16,019,337	$1,561,065	$40,869	$0	$14,417,403	90.00%	CF: Local Funds
Home Health Telemedicine Services	$312,576	$136,121	$40,335	$0	$136,120	50.00%	CF not available (see narrative)
Indian Health Service	$1,386,155	$0	$0	$0	$1,386,155	100.00%	
Affordable Care Act Drug Rebate Offset	($14,932,840)	$0	$0	$0	($14,932,840)	0.00%	
SB 11-008: "Aligning Medicaid Eligibility for Children" Adjustment	$3,294,614	$1,153,115	$0	$0	$2,141,499	65.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid" Adjustment	$1,506,373	$527,231	$0	$0	$979,142	65.00%	
Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act)	$4,950,838	$0	$0	$0	$4,950,838	100.00%	
Expansion Adults to 100% Adjustment	$108,772,108	$0	$54,386,054	$0	$54,386,054	50.00%	CF: Hospital Provider Fee Cash Fund
Acute Care Services Sub-Total	$1,946,571,857	$911,465,165	$55,978,997	$1,215,340	$977,912,355		
Community Based Long Term Care Services							
Base Community Based Long Term Care	$356,871,753	$178,435,876	$0	$0	$178,435,877	50.00%	
Children with Autism Waiver Services	$1,757,250	$0	$878,625	$0	$878,625	50.00%	CF: Colorado Autism Treatment Fund
Expansion Adults to 100% Adjustment	$139,857	$0	$69,928	$0	$69,929	50.00%	CF: Hospital Provider Fee Cash Fund
Community Based Long Term Care Sub-Total	$358,768,860	$178,435,876	$948,553	$0	$179,384,431		
Long Term Care and Insurance							
Base Class I Nursing Facilities	$538,803,358	$269,401,679	$0	$0	$269,401,679	50.00%	
Class II Nursing Facilities	$5,216,775	$2,608,387	$0	$0	$2,608,388	50.00%	
PACE	$89,649,719	$44,824,859	$0	$0	$44,824,860	50.00%	
Supplemental Medicare Insurance Benefit (SMIB)	$118,755,863	$71,253,518	$0	$0	$47,502,345	50.00%*	Approximately 20% of total is state-only
Health Insurance Buy-In	$3,723,549	$1,861,774	$0	$0	$1,861,775	50.00%	
Long Term Care and Insurance Sub-Total	$756,149,264	$389,950,217	$0	$0	$366,199,047		
Service Management							
Base Service Management	$58,424,396	$29,212,198	$0	$0	$29,212,198	50.00%	
Tobacco Tax Funded Disease Management	$500,000	$0	$0	$250,000	$250,000	50.00%	RF: Transfer from DPHE
Coordinated Care for People with Disabilities Program	$536,400	$0	$268,200	$0	$268,200	50.00%	CF: Coordinated Care for People with Disabilities Fund
Expansion Adults to 100% Adjustment	$4,124,943	$0	$2,062,471	$0	$2,062,472	50.00%	CF: Hospital Provider Fee Cash Fund
Service Management Sub-Total	$63,585,739	$29,212,198	$2,330,671	$250,000	$31,792,870		
Expansion Populations							
Disabled Buy-In	$23,492,951	$0	$14,837,340	$0	$8,655,611	50.00%*	CF: Hospital Provider Fee Cash Fund and Medicaid Buy-In Fund *Federal Match Applies Only to State Share
Adults Without Dependent Children	$98,333,000	$0	$49,166,500	$0	$49,166,500	50.00%	CF: Hospital Provider Fee Cash Fund
Expansion Populations Sub-Total	$121,825,951	$0	$64,003,840	$0	$57,822,111		
FY 2012-13 Estimate of Total Expenditures for Medical Services to Clients	**$3,246,901,671**	**$1,509,063,456**	**$123,262,061**	**$1,465,340**	**$1,613,110,814**		
Financing							
Upper Payment Limit Financing	$4,111,163	($4,809,179)	$4,111,163	$0	$4,809,179	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($17,602,800)	$35,205,601	$0	($17,602,801)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$5,485,699	$0	$2,742,849	$0	$2,742,850	50.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$651,089,802	$0	$325,544,901	$0	$325,544,901	50.00%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$86,763,011	$0	$43,381,505	$0	$43,381,506	50.00%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$7,161,512	$0	$3,580,756	$0	$3,580,756	50.00%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($66,888,171)	$66,888,171	$0	$0	N/A	CF: Health Care Expansion Fund
Cash Funds Financing[1]	$0	($28,980,500)	$27,230,500	$1,750,000	$0	N/A	CF: Various, see narrative
Financing Sub-Total	$754,611,187	($118,280,650)	$508,685,446	$1,750,000	$362,456,391		
Total Projected FY 2012-13 Expenditures[2]	**$4,001,512,858**	**$1,390,782,806**	**$631,947,507**	**$3,215,340**	**$1,975,567,205**		

Definitions: FMAP: Federal Medical Assistance Percentage DPHE: Department of Public Health and Environment

(1) This line adjusts for transfers from cash funds to the General Fund as provided by for the special bills listed on page EA-1.

(2) Of the General Fund total, $284,175,417 is General Fund Exempt.

Exhibit A - Summary of Request

Calculation of Fund Splits
FY 2013-14

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
Acute Care Services							
Base Acute	$1,904,964,712	$952,482,356	$0	$0	$952,482,356	50.00%	
Breast and Cervical Cancer Program	$13,108,008	$1,686,232	$1,686,231	$1,215,340	$8,520,205	65.00%	State fund sources vary; see Exhibit F
Family Planning	$17,244,054	$1,654,586	$69,819	$0	$15,519,649	90.00%	CF: Local Funds
Home Health Telemedicine Services	$312,576	$156,288	$0	$0	$156,288	50.00%	CF not available (see narrative)
Indian Health Service	$1,633,168	$0	$0	$0	$1,633,168	100.00%	
Affordable Care Act Drug Rebate Offset	($15,461,640)	$0	$0	$0	($15,461,640)	0.00%	
SB 11-008: "Aligning Medicaid Eligibility for Children" Adjustment	$20,766,966	$7,268,438	$0	$0	$13,498,528	65.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid" Adjustment	$9,440,092	$3,304,032	$0	$0	$6,136,060	65.00%	
Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act)	$12,872,971	$0	$0	$0	$12,872,971	100.00%	
Expansion Adults to 100% Adjustment	$121,639,862	$0	$30,409,966	$0	$91,229,896	75.00%	CF: Hospital Provider Fee Cash Fund
Acute Care Services Sub-Total	$2,086,520,769	$966,551,932	$32,166,016	$1,215,340	$1,086,587,481		
Community Based Long Term Care Services							
Base Community Based Long Term Care	$378,501,196	$189,250,598	$0	$0	$189,250,598	50.00%	
Children with Autism Waiver Services	$1,757,250	$0	$878,625	$0	$878,625	50.00%	CF: Colorado Autism Treatment Fund
Expansion Adults to 100% Adjustment	$161,112	$0	$40,278	$0	$120,834	75.00%	CF: Hospital Provider Fee Cash Fund
Community Based Long Term Care Sub-Total	$380,419,558	$189,250,598	$918,903	$0	$190,250,057		
Long Term Care and Insurance							
Base Class I Nursing Facilities	$559,764,979	$279,882,489	$0	$0	$279,882,490	50.00%	
Class II Nursing Facilities	$6,116,443	$3,058,221	$0	$0	$3,058,222	50.00%	
PACE	$96,694,590	$48,347,295	$0	$0	$48,347,295	50.00%	
Supplemental Medicare Insurance Benefit (SMIB)	$131,451,475	$78,870,885	$0	$0	$52,580,590	50.00%*	Approximately 20% of total is state-only
Health Insurance Buy-In	$5,870,326	$2,935,163	$0	$0	$2,935,163	50.00%	
Long Term Care and Insurance Sub-Total	$799,897,813	$413,094,053	$0	$0	$386,803,760		
Service Management							
Base Service Management	$60,106,002	$30,053,001	$0	$0	$30,053,001	50.00%	
Coordinated Care for People with Disabilities Program	$540,000	$0	$270,000	$0	$270,000	50.00%	CF: Coordinated Care for People with Disabilities Fund
Expansion Adults to 100% Adjustment	$4,124,758	$0	$1,031,190	$0	$3,093,568	75.00%	CF: Hospital Provider Fee Cash Fund
Service Management Sub-Total	$64,770,760	$30,053,001	$1,301,190	$0	$33,416,569		
Expansion Populations							
Disabled Buy-In	$62,777,782	$0	$38,815,381	$0	$23,962,401	50.00%*	CF: Hospital Provider Fee Cash Fund and Medicaid Buy-In Fund *Federal Match Applies Only to State Share
Adults Without Dependent Children	$105,367,200	$0	$26,341,800	$0	$79,025,400	75.00%	CF: Hospital Provider Fee Cash Fund 100% FMAP as of January 1, 2014
Expansion Populations Sub-Total	$168,144,982	$0	$65,157,181	$0	$102,987,801		
FY 2013-14 Estimate of Total Expenditures for Medical Services to Clients	**$3,499,753,882**	**$1,598,949,584**	**$99,543,290**	**$1,215,340**	**$1,800,045,668**		
Financing							
Upper Payment Limit Financing	$4,628,521	($4,628,521)	$4,628,521	$0	$4,628,521	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($18,242,662)	$36,485,325	$0	($18,242,663)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$5,485,699	$0	$2,742,849	$0	$2,742,850	50.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$651,089,802	$0	$325,544,901	$0	$325,544,901	50.00%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$88,411,508	$0	$44,205,754	$0	$44,205,754	50.00%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$7,447,972	$0	$3,723,986	$0	$3,723,986	50.00%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($66,264,353)	$66,264,353	$0	$0	N/A	CF: Health Care Expansion Fund
Cash Funds Financing[1]	$0	($2,230,500)	$2,230,500	$0	$0	N/A	CF: Various, see narrative
Financing Sub-Total	$757,063,502	($91,366,036)	$485,826,189	$0	$362,603,349		
Total Projected FY 2013-14 Expenditures[2]	**$4,256,817,384**	**$1,507,583,548**	**$585,369,479**	**$1,215,340**	**$2,162,649,017**		

Definitions: FMAP: Federal Medical Assistance Percentage DPHE: Department of Public Health and Environment

(1) This line adjusts for transfers from cash funds to the General Fund as provided by for the special bills listed on page EA-1.

(2) Of the General Fund total, $284,175,417 is General Fund Exempt.

Exhibit B - Medicaid Caseload

Final Request															
Official Medicaid Caseload Actuals and Projection without Retroactivity from REX01/COLD (MARS) 474701 Report															
Item	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60% FPL**	**Expansion Adults to 100% FPL**	**Adults Without Dependent Children (AwDC)**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
FY 1995-96 Actuals	31,321	4,261	44,736	-	36,690	-	-	-	-	113,439	8,376	7,223	4,100	3,937	254,083
FY 1996-97 Actuals	32,080	4,429	46,090	-	33,250	-	-	-	-	110,586	9,261	5,476	4,610	4,316	250,098
FY 1997-98 Actuals	32,664	4,496	46,003	-	27,179	-	-	-	-	103,912	10,453	4,295	5,032	4,560	238,594
Percent Change	4.29%	5.52%	2.83%	-	-25.92%	-	-	-	-	-8.40%	24.80%	-40.54%	22.73%	15.82%	-6.10%
FY 1998-99 Actuals	33,007	4,909	46,310	-	22,852	-	-	-	-	102,074	11,526	5,017	5,799	6,104	237,598
Percent Change	1.05%	9.19%	0.67%	-	-15.92%	-	-	-	-	-1.77%	10.26%	16.81%	15.24%	33.86%	-0.42%
FY 1999-00 Actuals	33,135	5,092	46,386	-	23,515	-	-	-	-	109,816	12,474	6,174	9,065	7,597	253,254
Percent Change	0.39%	3.73%	0.16%	-	2.90%	-	-	-	-	7.58%	8.22%	23.06%	56.32%	24.46%	6.59%
FY 2000-01 Actuals	33,649	5,157	46,046	-	27,081	-	-	-	-	123,221	13,076	6,561	12,451	8,157	275,399
Percent Change	1.55%	1.28%	-0.73%	-	15.16%	-	-	-	-	12.21%	4.83%	6.27%	37.35%	7.37%	8.74%
FY 2001-02 Actuals	33,916	5,184	46,349	-	33,347	-	-	-	-	143,909	13,121	7,131	4,028	8,428	295,413
Percent Change	0.79%	0.52%	0.66%	-	23.14%	-	-	-	-	16.79%	0.34%	8.69%	-67.65%	3.32%	7.27%
FY 2002-03 Actuals	34,704	5,431	46,647	-	40,798	-	-	-	47	169,311	13,967	7,823	4,084	8,988	331,800
Percent Change	2.32%	4.76%	0.64%	-	22.34%	-	-	-	-	17.65%	6.45%	9.70%	1.39%	6.64%	12.32%
FY 2003-04 Actuals	34,329	5,548	46,789	-	47,562	-	-	-	105	195,279	14,914	8,398	4,793	9,842	367,559
Percent Change	-1.08%	2.15%	0.30%	-	16.58%	-	-	-	123.40%	15.34%	6.78%	7.35%	17.36%	9.50%	10.78%
FY 2004-05 Actuals	35,780	6,082	47,929	-	57,140	-	-	-	87	222,472	15,795	5,984	5,150	9,605	406,024
Percent Change	4.23%	9.63%	2.44%	-	20.14%	-	-	-	-17.14%	13.93%	5.91%	-28.74%	7.45%	-2.41%	10.46%
FY 2005-06 Actuals	36,207	6,042	47,855	-	58,885	-	-	-	188	214,158	16,460	5,119	6,212	11,092	402,218
Percent Change	1.19%	-0.66%	-0.15%	-	3.05%	-	-	-	116.09%	-3.74%	4.21%	-14.46%	20.62%	15.48%	-0.94%
FY 2006-07 Actuals	35,888	6,059	48,799	-	50,687	5,162	-	-	228	205,390	16,724	5,182	5,201	12,908	392,228
Percent Change	-0.88%	0.28%	1.97%	-	-13.92%	-	-	-	21.28%	-4.09%	1.60%	1.23%	-16.27%	16.37%	-2.48%
FY 2007-08 Actuals	36,284	6,146	49,933	-	44,555	8,918	-	-	270	204,022	17,141	6,288	4,191	14,214	391,962
Percent Change	1.10%	1.44%	2.32%	-	-12.10%	72.76%	-	-	18.42%	-0.67%	2.49%	21.34%	-19.42%	10.12%	-0.07%
FY 2008-09 Actuals	37,619	6,447	51,355	-	49,147	12,727	-	-	317	235,129	18,033	6,976	3,987	15,075	436,812
% Change from FY 2007-08	3.68%	4.90%	2.85%	-	10.31%	42.71%	-	-	17.41%	15.25%	5.20%	10.94%	-4.87%	6.06%	11.44%
FY 2009-10 Actuals	38,487	7,049	53,264	-	57,661	17,178	3,238	-	425	275,672	18,381	7,830	3,693	15,919	498,797
% Change from FY 2008-09	2.31%	9.34%	3.72%	-	17.32%	34.97%	-	-	34.07%	17.24%	1.93%	12.24%	-7.37%	5.60%	14.19%
FY 2010-11 Actuals	38,921	7,767	56,285	-	60,960	20,154	27,167	-	531	302,410	18,393	7,868	3,213	17,090	560,759
% Change from FY 2009-10	1.13%	10.19%	5.67%	-	5.72%	17.32%	739.01%	-	24.94%	9.70%	0.07%	0.49%	-13.00%	7.36%	12.42%
FY 2011-12 Projection	39,867	8,399	59,589	58	70,299	24,050	35,406	1,667	610	336,582	18,141	7,472	2,659	18,796	623,595
% Change from FY 2010-11	2.43%	8.14%	5.87%	-	15.32%	19.33%	30.33%	-	14.88%	11.30%	-1.37%	-5.03%	-17.24%	9.98%	11.21%
FY 2012-13 Projection	40,820	8,948	62,098	2,208	77,455	26,498	42,381	10,000	679	367,649	18,159	7,546	2,529	20,503	687,473
% Change from FY 2011-12	2.39%	6.54%	4.21%	3706.90%	10.18%	10.18%	19.70%	499.88%	11.31%	9.23%	0.10%	0.99%	-4.89%	9.08%	10.24%
FY 2013-14 Projection	41,914	9,491	64,184	5,671	81,351	27,831	46,835	10,000	743	399,867	18,264	8,472	2,549	22,231	739,403
% Change from FY 2011-12	2.68%	6.07%	3.36%	156.84%	5.03%	5.03%	10.51%	0.00%	9.43%	8.76%	0.58%	12.27%	0.79%	8.43%	7.55%
FY 2011-12 Appropriation	39,556	8,098	57,841	4,329	64,432	23,628	34,050	16,400	595	316,392	18,878	7,657	3,082	18,210	613,148
Difference between the Total FY 2011-12 Projection and Appropriation	311	301	1,748	(4,271)	5,867	422	1,356	(14,733)	15	20,190	(737)	(185)	(423)	586	10,447

Exhibit B - Medicaid Caseload

Medicaid Caseload Adjustments															
Item	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60% FPL**	**Expansion Adults to 100% FPL**	**Adults Without Dependent Children (AwDC)**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
HB 09-1293 (Health Care Affordability Act)	-	-	-	58	-	-	-	1,667	-	-	-	-	-	-	1,725
Total FY 2011-12 Adjustments	-	-	-	58	-	-	-	1,667	-	-	-	-	-	-	1,725
HB 09-1293 (Health Care Affordability Act)	-	-	-	2,208	-	-	-	10,000	-	-	-	-	-	-	12,208
SB 11-008 Aligning Medicaid Eligibility for Children	-	-	-	-	-	-	-	-	-	2,121	-	-	-	-	2,121
SB 11-250 Eligibility for Pregnant Women in Medicaid	-	-	-	-	-	-	-	-	-	-	-	181	-	-	181
Total FY 2012-13 Adjustments	-	-	-	2,208	-	-	-	10,000	-	2,121	-	181	-	-	14,510
HB 09-1293 (Health Care Affordability Act)	-	-	-	5,671	-	-	-	10,000	-	-	-	-	-	-	15,671
SB 11-008 Aligning Medicaid Eligibility for Children	-	-	-	-	-	-	-	-	-	13,431	-	-	-	-	13,431
SB 11-250 Eligibility for Pregnant Women in Medicaid	-	-	-	-	-	-	-	-	-	-	-	1,112	-	-	1,112
Total FY 2013-14 Adjustments	-	-	-	5,671	-	-	-	10,000	-	13,431	-	1,112	-	-	30,214

Exhibit B - Medicaid Caseload

Prior to Adjustments - Not Official Department Request

Preliminary Medicaid Caseload without Retroactivity from REX01/COLD (MARS) 474701 Report

Prior to Adjustments

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 1995-96 Actuals	31,321	4,261	44,736	-	36,690	-	-	-	-	113,439	8,376	7,223	4,100	3,937	254,083
FY 1996-97 Actuals	32,080	4,429	46,090	-	33,250	-	-	-	-	110,586	9,261	5,476	4,610	4,316	250,098
FY 1997-98 Actuals	32,664	4,496	46,003	-	27,179	-	-	-	-	103,912	10,453	4,295	5,032	4,560	238,594
Percent Change	4.29%	5.52%	2.83%	-	-25.92%	-	-	-	-	-8.40%	24.80%	-40.54%	22.73%	15.82%	-6.10%
FY 1998-99 Actuals	33,007	4,909	46,310	-	22,852	-	-	-	-	102,074	11,526	5,017	5,799	6,104	237,598
Percent Change	1.05%	9.19%	0.67%	-	-15.92%	-	-	-	-	-1.77%	10.26%	16.81%	15.24%	33.86%	-0.42%
FY 1999-00 Actuals	33,135	5,092	46,386	-	23,515	-	-	-	-	109,816	12,474	6,174	9,065	7,597	253,254
Percent Change	0.39%	3.73%	0.16%	-	2.90%	-	-	-	-	7.58%	8.22%	23.06%	56.32%	24.46%	6.59%
FY 2000-01 Actuals	33,649	5,157	46,046	-	27,081	-	-	-	-	123,221	13,076	6,561	12,451	8,157	275,399
Percent Change	1.55%	1.28%	-0.73%	-	15.16%	-	-	-	-	12.21%	4.83%	6.27%	37.35%	7.37%	8.74%
FY 2001-02 Actuals	33,916	5,184	46,349	-	33,347	-	-	-	-	143,909	13,121	7,131	4,028	8,428	295,413
Percent Change	0.79%	0.52%	0.66%	-	23.14%	-	-	-	-	16.79%	0.34%	8.69%	-67.65%	3.32%	7.27%
FY 2002-03 Actuals	34,704	5,431	46,647	-	40,798	-	-	-	47	169,311	13,967	7,823	4,084	8,988	331,800
Percent Change	2.32%	4.76%	0.64%	-	22.34%	-	-	-	-	17.65%	6.45%	9.70%	1.39%	6.64%	12.32%
FY 2003-04 Actuals	34,329	5,548	46,789	-	47,562	-	-	-	105	195,279	14,914	8,398	4,793	9,842	367,559
% Change from FY 2002-03	-1.08%	2.15%	0.30%	-	16.58%	-	-	-	123.40%	15.34%	6.78%	7.35%	17.36%	9.50%	10.78%
FY 2004-05 Actuals	35,780	6,082	47,929	-	57,140	-	-	-	87	222,472	15,795	5,984	5,150	9,605	406,024
% Change from FY 2003-04	4.23%	9.63%	2.44%	-	20.14%	-	-	-	-17.14%	13.93%	5.91%	-28.74%	7.45%	-2.41%	10.46%
FY 2005-06 Actuals	36,207	6,042	47,855	-	58,885	-	-	-	188	214,158	16,460	5,119	6,212	11,092	402,218
% Change from FY 2004-05	1.19%	-0.66%	-0.15%	-	3.05%	-	-	-	116.09%	-3.74%	4.21%	-14.46%	20.62%	15.48%	-0.94%
FY 2006-07 Actuals	35,888	6,059	48,799	-	50,687	5,162	-	-	228	205,390	16,724	5,182	5,201	12,908	392,228
% Change from FY 2005-06	-0.88%	0.28%	1.97%	-	-13.92%	-	-	-	21.28%	-4.09%	1.60%	1.23%	-16.27%	16.37%	-2.48%
FY 2007-08 Actuals	36,284	6,146	49,933	-	44,555	8,918	-	-	270	204,022	17,141	6,288	4,191	14,214	391,962
% Change from FY 2006-07	1.10%	1.44%	2.32%	-	-12.10%	72.76%	-	-	18.42%	-0.67%	2.49%	21.34%	-19.42%	10.12%	-0.07%
FY 2008-09 Actuals	37,619	6,447	51,355	-	49,147	12,727	-	-	317	235,129	18,033	6,976	3,987	15,075	436,812
% Change from FY 2007-08	3.68%	4.90%	2.85%	-	10.31%	42.71%	-	-	17.41%	15.25%	5.20%	10.94%	-4.87%	6.06%	11.44%
FY 2009-10 Actuals	38,487	7,049	53,264	-	57,661	17,178	3,238	-	425	275,672	18,381	7,830	3,693	15,919	498,797
% Change from FY 2008-09	2.31%	9.34%	3.72%	-	17.32%	34.97%	-	-	34.07%	17.24%	1.93%	12.24%	-7.37%	5.60%	14.19%
FY 2010-11 Actuals	38,921	7,767	56,285	-	60,960	20,154	27,167	-	531	302,410	18,393	7,868	3,213	17,090	560,759
% Change from FY 2009-10	1.13%	10.19%	5.67%	-	5.72%	17.32%	739.01%	-	24.94%	9.70%	0.07%	0.49%	-13.00%	7.36%	12.42%
FY 2011-12 Projection [(1)]	39,867	8,399	59,589	-	70,299	24,050	35,406	-	610	336,582	18,141	7,472	2,659	18,796	621,870
% Change from FY 2010-11	2.43%	8.14%	5.87%	-	15.32%	19.33%	30.33%	-	14.88%	11.30%	-1.37%	-5.03%	-17.24%	9.98%	10.90%
FY 2012-13 Projection [(1)]	40,820	8,948	62,098	-	77,455	26,498	42,381	-	679	365,528	18,159	7,365	2,529	20,503	672,963
% Change from FY 2011-12	2.39%	6.54%	4.21%	-	10.18%	10.18%	19.70%	-	11.31%	8.60%	0.10%	-1.43%	-4.89%	9.08%	8.22%
FY 2013-14 Projection [(1)]	41,914	9,491	64,184	-	81,351	27,831	46,835	-	743	386,436	18,264	7,360	2,549	22,231	709,189
% Change from FY 2011-12	2.68%	6.07%	3.36%	-	5.03%	5.03%	10.51%	-	9.43%	5.72%	0.58%	-0.07%	0.79%	8.43%	5.38%
FY 2011-12 Appropriation	39,556	8,098	57,841	4,329	64,432	23,628	34,050	16,400	595	316,392	18,878	7,657	3,082	18,210	613,148
Difference between the Total FY 2011-12 Projection and Appropriation	311	301	1,748	(4,271)	5,867	422	1,356	(14,733)	15	20,190	(737)	(185)	(423)	586	10,447

[(1)] Medicaid Caseload forecast without adjustments.

Exhibit B - Medicaid Caseload Forecast

MEDICAID CASELOAD FY 2006-07 WITHOUT RETROACTIVITY															
FY 2006-07	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2006	36,264	5,927	48,080	57,372	1,008	-	202	215,937	16,499	5,074	6,703	12,145	405,211	-	-
August 2006	36,356	5,989	48,443	56,033	2,051	-	211	216,226	16,574	4,852	6,364	12,316	405,415	204	0.05%
September 2006	36,113	6,032	48,576	54,433	3,051	-	220	214,255	16,524	4,761	6,011	12,443	402,419	(2,996)	-0.74%
October 2006	36,088	6,067	48,747	53,443	4,620	-	226	209,565	16,576	4,950	5,761	12,536	398,579	(3,840)	-0.95%
November 2006	35,939	6,113	48,736	50,988	5,325	-	232	205,572	16,554	5,002	5,226	12,693	392,380	(6,199)	-1.56%
December 2006	36,195	6,141	48,498	49,733	5,592	-	236	202,812	16,595	5,070	4,864	12,879	388,615	(3,765)	-0.96%
January 2007	35,947	6,102	48,829	49,624	6,124	-	231	202,963	16,683	5,181	4,798	12,905	389,387	772	0.20%
February 2007	35,929	6,116	48,948	48,952	6,395	-	228	202,656	16,761	5,353	4,690	13,060	389,088	(299)	-0.08%
March 2007	35,664	6,064	49,044	48,235	6,607	-	228	201,549	16,849	5,422	4,514	13,213	387,389	(1,699)	-0.44%
April 2007	35,526	6,083	48,903	47,717	7,030	-	241	200,833	16,962	5,526	4,547	13,547	386,915	(474)	-0.12%
May 2007	35,186	6,028	49,337	46,245	7,042	-	236	196,757	17,007	5,437	4,501	13,493	381,269	(5,646)	-1.46%
June 2007	35,448	6,048	49,449	45,470	7,104	-	246	195,549	17,100	5,561	4,437	13,669	380,081	(1,188)	-0.31%
Year-to-Date Average	**35,888**	**6,059**	**48,799**	**50,687**	**5,162**	**-**	**228**	**205,390**	**16,724**	**5,182**	**5,201**	**12,908**	**392,229**		
MEDICAID CASELOAD FY 2007-08 WITHOUT RETROACTIVITY															
FY 2007-08	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2007	35,532	6,073	49,590	45,453	7,273	-	255	197,420	17,003	5,551	4,475	13,821	382,446	2,365	0.62%
August 2007	35,624	6,091	49,768	45,363	7,187	-	260	198,001	16,915	5,691	4,330	13,988	383,218	772	0.20%
September 2007	35,916	6,124	49,743	44,739	7,160	-	267	197,134	16,877	5,448	4,148	14,064	381,620	(1,598)	-0.42%
October 2007	36,104	6,141	49,853	46,590	7,110	-	273	201,710	16,968	5,479	4,136	14,105	388,469	6,849	1.79%
November 2007	36,059	6,127	49,889	45,100	8,364	-	261	201,378	16,995	5,759	4,069	14,144	388,145	(324)	-0.08%
December 2007	36,126	6,150	49,741	43,665	8,783	-	268	200,121	17,042	5,896	4,032	14,028	385,852	(2,293)	-0.59%
January 2008	36,329	6,158	49,785	43,491	9,268	-	268	201,816	17,050	6,233	4,007	14,066	388,471	2,619	0.68%
February 2008	36,418	6,128	49,891	43,344	9,755	-	272	203,657	17,117	6,827	4,026	14,212	391,647	3,176	0.82%
March 2008	36,702	6,145	49,989	43,723	9,949	-	282	206,695	17,208	7,035	4,130	14,333	396,191	4,544	1.16%
April 2008	36,771	6,188	50,237	44,037	10,395	-	280	210,620	17,358	7,142	4,178	14,479	401,685	5,494	1.39%
May 2008	36,897	6,203	50,358	44,349	10,775	-	280	213,554	17,537	7,191	4,371	14,628	406,143	4,458	1.11%
June 2008	36,932	6,227	50,351	44,802	10,995	-	270	216,154	17,620	7,200	4,389	14,700	409,640	3,497	0.86%
Year-to-Date Average	**36,284**	**6,146**	**49,933**	**44,555**	**8,918**	**-**	**270**	**204,022**	**17,141**	**6,288**	**4,191**	**14,214**	**391,961**		
MEDICAID CASELOAD FY 2008-09 WITHOUT RETROACTIVITY															
FY 2008-09	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2008	36,961	6,249	50,565	45,318	11,236	-	277	218,619	17,588	7,286	4,258	14,768	413,125	3,485	0.85%
August 2008	37,127	6,317	50,671	45,954	11,335	-	283	221,736	17,761	7,270	4,136	14,821	417,411	4,286	1.04%
September 2008	37,273	6,369	50,864	46,099	11,794	-	275	223,167	17,736	7,027	4,052	14,898	419,554	2,143	0.51%
October 2008	37,441	6,386	51,201	46,589	11,836	-	282	225,486	17,864	6,932	4,005	14,933	422,955	3,401	0.81%
November 2008	37,591	6,399	51,406	47,013	12,008	-	290	228,186	17,977	6,773	3,889	14,980	426,512	3,557	0.84%
December 2008	37,530	6,361	51,298	48,042	12,142	-	304	230,447	18,033	6,689	3,884	15,053	429,783	3,271	0.77%
January 2009	37,814	6,367	51,452	49,155	12,486	-	314	234,744	18,022	6,847	3,954	15,194	436,349	6,566	1.53%
February 2009	37,769	6,438	51,494	50,023	12,730	-	331	237,345	18,144	6,910	3,885	15,205	440,274	3,925	0.90%
March 2009	37,942	6,539	51,640	51,530	13,190	-	339	242,805	18,265	6,959	3,988	15,293	448,490	8,216	1.87%
April 2009	37,947	6,597	51,695	52,740	14,346	-	355	249,444	18,328	6,995	3,984	15,268	457,699	9,209	2.05%
May 2009	37,989	6,654	51,862	53,134	14,619	-	373	252,943	18,327	6,973	3,919	15,240	462,033	4,334	0.95%
June 2009	38,044	6,691	52,107	54,171	14,996	-	383	256,630	18,348	7,045	3,892	15,249	467,556	5,523	1.20%
Year-to-Date Average	**37,619**	**6,447**	**51,355**	**49,147**	**12,727**	**-**	**317**	**235,129**	**18,033**	**6,976**	**3,987**	**15,075**	**436,812**		

Exhibit B - Medicaid Caseload Forecast

MEDICAID CASELOAD FY 2009-10 WITHOUT RETROACTIVITY

FY 2009-10	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2009	38,058	6,774	52,315	55,087	15,269	-	393	259,609	18,285	7,745	3,930	15,434	472,899	5,343	1.14%
August 2009	38,306	6,863	52,573	55,937	15,530	-	395	263,415	18,325	7,849	3,835	15,522	478,550	5,651	1.19%
September 2009	38,346	6,945	52,710	56,489	15,703	-	402	266,381	18,200	7,775	3,724	15,513	482,188	3,638	0.76%
October 2009	38,480	6,985	52,847	57,359	16,115	-	406	270,514	18,169	7,713	3,650	15,638	487,876	5,688	1.18%
November 2009	38,387	6,986	52,982	57,595	16,362	-	418	272,453	17,992	7,674	3,644	15,743	490,236	2,360	0.48%
December 2009	38,410	7,025	53,000	58,381	16,739	-	411	275,867	18,371	7,627	3,632	15,846	495,309	5,073	1.03%
January 2010	38,452	7,047	53,255	59,210	17,193	-	416	279,000	18,400	7,796	3,610	15,954	500,333	5,024	1.01%
February 2010	38,432	7,049	53,298	59,700	17,514	-	431	279,898	18,467	7,779	3,550	16,076	502,194	1,861	0.37%
March 2010	38,597	7,152	53,629	61,190	18,096	-	449	283,625	18,486	7,996	3,768	16,212	509,200	7,006	1.40%
April 2010	38,727	7,212	53,904	61,702	18,490	-	452	285,746	18,552	8,054	3,831	16,308	512,978	3,778	0.74%
May 2010	38,754	7,228	54,164	55,110	20,694	18,253	455	285,779	18,651	8,039	3,615	16,285	527,027	14,049	2.74%
June 2010	38,900	7,326	54,493	54,173	18,435	20,607	466	285,778	18,678	7,903	3,522	16,495	526,776	(251)	-0.05%
Year-to-Date Average	**38,487**	**7,049**	**53,264**	**57,661**	**17,178**	**3,238**	**425**	**275,672**	**18,381**	**7,829**	**3,693**	**15,919**	**498,797**		

MEDICAID CASELOAD FY 2010-11 WITHOUT RETROACTIVITY

FY 2010-11	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2010	39,382	7,395	54,740	55,213	18,556	21,446	471	287,674	18,628	7,909	3,492	16,539	531,445	4,669	0.89%
August 2010	38,648	7,492	55,032	56,687	19,176	24,193	493	290,871	18,455	8,014	3,378	16,634	539,073	7,628	1.44%
September 2010	38,774	7,562	55,223	56,852	19,403	25,071	503	291,592	18,451	7,971	3,231	16,652	541,285	2,212	0.41%
October 2010	38,901	7,602	55,508	57,801	19,490	26,016	505	294,155	18,464	7,985	3,080	16,794	546,301	5,016	0.93%
November 2010	39,009	7,682	55,804	58,276	20,002	26,924	511	296,482	18,597	7,891	3,049	16,941	551,168	4,867	0.89%
December 2010	38,769	7,721	55,937	59,591	20,182	27,596	526	299,499	18,510	7,764	3,023	17,002	556,120	4,952	0.90%
January 2011	38,813	7,781	56,417	62,929	19,895	27,188	532	304,042	18,386	7,806	3,116	17,210	564,115	7,995	1.44%
February 2011	38,823	7,870	56,671	63,025	20,522	28,323	535	307,032	18,200	7,677	3,161	17,249	569,088	4,973	0.88%
March 2011	38,939	7,966	57,103	64,697	20,877	28,968	556	312,300	18,244	7,881	3,271	17,390	578,192	9,104	1.60%
April 2011	38,861	7,987	57,385	64,673	21,090	29,451	569	312,603	18,280	7,864	3,274	17,399	579,436	1,244	0.22%
May 2011	38,981	8,051	57,608	65,402	21,194	30,102	587	315,116	18,279	7,830	3,255	17,546	583,951	4,515	0.78%
June 2011	39,154	8,089	57,986	66,369	21,458	30,724	589	317,551	18,221	7,828	3,229	17,727	588,925	4,974	0.85%
Year-to-Date Average	**38,921**	**7,767**	**56,285**	**60,960**	**20,154**	**27,167**	**531**	**302,410**	**18,393**	**7,868**	**3,213**	**17,090**	**560,759**	**5,179**	**0.94%**

MEDICAID CASELOAD FY 2011-12 WITHOUT RETROACTIVITY

FY 2011-12	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2011	39,341	8,133	58,294	65,372	22,184	31,920	587	319,065	18,125	7,810	3,089	17,923	591,843	2,918	0.50%
August 2011	39,537	8,222	58,712	66,406	22,112	32,462	586	322,779	18,084	7,786	2,973	18,046	597,705	5,862	0.99%
September 2011	39,600	8,280	58,937	67,613	22,388	33,152	590	325,673	18,119	7,628	2,774	18,156	602,910	5,205	0.87%
October 2011	39,697	8,328	59,159	68,677	22,985	33,838	592	328,632	18,096	7,558	2,657	18,314	608,533	5,623	0.93%
November 2011	39,789	8,343	59,298	68,638	23,803	34,915	602	332,183	18,077	7,371	2,543	18,584	614,146	5,613	0.92%
December 2011	39,843	8,355	59,384	70,628	24,150	34,886	606	336,053	18,172	7,333	2,591	18,798	620,799	6,653	1.08%
January 2012															
February 2012															
March 2012															
April 2012															
May 2012															
June 2012															
Year-to-Date Average	**39,635**	**8,277**	**58,964**	**67,889**	**22,937**	**33,529**	**594**	**327,398**	**18,112**	**7,581**	**2,771**	**18,304**	**605,989**	**5,312**	**0.88%**

Effective November 3, 2008, the Department has restated caseload for fiscal years FY 2002-03 through FY 2007-08. For complete information on the restatement, please see the Department's caseload narrative accompanying this Request. The number of days captured in the monthly figure is equal to the number of days in the report month.

Exhibit C - History and Projections of Per Capita Costs

Per Capita Costs - Cash Based															
Fiscal Year	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-in**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Adults without Dependent Children**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
FY 1995-96	$11,438.90	$8,020.74	$6,216.02	-	$2,612.84	-	-	-	-	$1,253.09	$2,391.78	$5,922.44	$3,364.90	$1,544.32	$3,901.23
FY 1996-97	$13,535.28	$8,388.91	$7,164.80	-	$3,174.99	-	-	-	-	$1,233.89	$2,413.14	$6,856.06	$3,872.40	$1,520.98	$4,509.91
FY 1997-98	$13,297.59	$8,457.61	$7,186.27	-	$3,036.03	-	-	-	-	$1,375.75	$2,177.83	$6,743.66	$3,687.26	$1,369.92	$4,631.18
Percent Change	-1.76%	0.82%	0.30%	-	-4.38%	-	-	-	-	11.50%	-9.75%	-1.64%	-4.78%	-9.93%	2.69%
FY 1998-99	$14,049.96	$9,886.63	$7,796.82	-	$3,129.24	-	-	-	-	$1,466.08	$2,023.98	$6,272.97	$3,576.18	$1,013.41	$4,950.52
Percent Change	5.66%	16.90%	8.50%	-	3.07%	-	-	-	-	6.57%	-7.06%	-6.98%	-3.01%	-26.02%	6.90%
FY 1999-00	$15,040.64	$10,793.96	$8,772.23	-	$3,440.54	-	-	-	-	$1,544.54	$2,203.23	$5,430.89	$3,273.65	$917.32	$5,166.43
Percent Change	7.05%	9.18%	12.51%	-	9.95%	-	-	-	-	5.35%	8.86%	-13.42%	-8.46%	-9.48%	4.36%
FY 2000-01	$15,311.41	$11,851.80	$9,792.12	-	$3,277.51	-	-	-	-	$1,570.78	$2,351.36	$4,801.64	$2,966.03	$959.04	$5,143.57
Percent Change	1.80%	9.80%	11.63%	-	-4.74%	-	-	-	-	1.70%	6.72%	-11.59%	-9.40%	4.55%	-0.44%
FY 2001-02	$16,837.64	$11,821.86	$10,033.18	-	$3,125.56	-	-	-	-	$1,532.60	$2,530.78	$4,760.42	$9,774.69	$963.28	$5,202.22
Percent Change	9.97%	-0.25%	2.46%	-	-4.64%	-	-	-	-	-2.43%	7.63%	-0.86%	229.55%	0.44%	1.14%
FY 2002-03	$16,269.83	$11,909.35	$11,071.22	-	$3,425.30	-	-	-	$30,399.56	$1,346.59	$2,689.77	$5,435.44	$11,932.93	$882.68	$4,977.91
Percent Change	-3.37%	0.74%	10.35%	-	9.59%	-	-	-	-	-12.14%	6.28%	14.18%	22.08%	-8.37%	-4.31%
FY 2003-04	$17,917.49	$13,642.60	$11,967.29	-	$3,853.40	-	-	-	$25,417.70	$1,188.86	$3,019.91	$7,534.30	$11,504.23	$961.96	$5,010.73
Percent Change	10.13%	14.55%	8.09%	-	12.50%	-	-	-	-16.39%	-11.71%	12.27%	38.61%	-3.59%	8.98%	0.66%
FY 2004-05	$18,024.54	$13,297.64	$11,432.79	-	$3,224.86	-	-	-	$28,627.25	$1,314.92	$2,908.66	$6,405.47	$8,682.52	$1,137.99	$4,662.42
Percent Change	0.60%	-2.53%	-4.47%	-	-16.31%	-	-	-	12.63%	10.60%	-3.68%	-14.98%	-24.53%	18.30%	-6.95%
FY 2005-06	$18,452.47	$14,387.34	$11,705.52	-	$3,315.44	-	-	-	$36,225.53	$1,439.11	$2,969.74	$7,695.99	$8,904.59	$1,204.54	$4,928.66
Percent Change	2.37%	8.19%	2.39%	-	2.81%	-	-	-	26.54%	9.44%	2.10%	20.15%	2.56%	5.85%	5.71%
FY 2006-07	$18,730.43	$14,802.45	$11,695.80	-	$3,925.23	-	$1,467.77	-	$24,376.09	$1,610.83	$3,211.25	$9,215.49	$10,470.57	$1,313.15	$5,222.57
Percent Change	1.51%	2.89%	-0.08%	-	18.39%	-	-	-	-32.71%	11.93%	8.13%	19.74%	17.59%	9.02%	5.96%
FY 2007-08	$19,415.43	$16,324.25	$13,065.11	-	$4,260.90	-	$2,132.72	-	$26,305.08	$1,781.99	$3,738.66	$8,532.40	$12,797.32	$1,333.66	$5,681.77
Percent Change	3.66%	10.28%	11.71%	-	8.55%	-	45.30%	-	7.91%	10.63%	16.42%	-7.41%	22.22%	1.56%	8.79%
FY 2008-09	$20,680.18	$17,708.89	$14,233.44	-	$4,244.04	-	$2,489.04	-	$22,261.37	$1,837.39	$3,747.29	$8,654.00	$14,858.01	$1,254.95	$5,742.83
Percent Change	6.51%	8.48%	8.94%	-	-0.40%	-	16.71%	-	-15.37%	3.11%	0.23%	1.43%	16.10%	-5.90%	1.07%
FY 2009-10	$19,457.33	$15,804.34	$13,286.60	-	$3,636.11	-	$2,337.91	$689.29	$20,511.28	$1,657.09	$3,517.62	$8,300.18	$12,655.02	$1,213.77	$4,975.87
Percent Change	-5.91%	-10.75%	-6.65%	-	-14.32%	-	-6.07%	-	-7.86%	-9.81%	-6.13%	-4.09%	-14.83%	-3.28%	-13.36%
FY 2010-11	$20,336.39	$17,105.76	$14,635.16	-	$3,741.31	-	$2,848.31	$2,316.20	$19,033.37	$1,711.49	$4,014.76	$8,894.53	$14,661.32	$1,428.00	$5,063.72
Percent Change	4.52%	8.23%	10.15%	-	2.89%	-	21.83%	236.03%	-7.21%	3.28%	14.13%	7.16%	15.85%	17.65%	1.77%
FY 2011-12 Projection	$19,823.40	$16,415.33	$14,125.93	$9,764.90	$3,492.04	$3,974.93	$2,835.12	$2,540.84	$18,106.54	$1,602.07	$3,929.31	$8,400.44	$15,276.73	$1,292.63	$4,698.54
Percent Change	-2.52%	-4.04%	-3.48%	-	-6.66%	-	-0.46%	9.70%	-4.87%	-6.39%	-2.13%	-5.56%	4.20%	-9.48%	-7.21%
FY 2012-13 Projection	$20,203.33	$16,627.71	$14,433.56	$10,639.92	$3,466.16	$9,833.30	$2,873.79	$2,667.16	$17,839.85	$1,578.74	$4,008.35	$8,413.24	$16,264.06	$1,350.95	$4,722.95
Percent Change	1.92%	1.29%	2.18%	8.96%	-0.74%	147.38%	1.36%	4.97%	-1.47%	-1.46%	2.01%	0.15%	6.46%	4.51%	0.52%
FY 2013-14 Projection	$20,593.96	$16,890.09	$14,852.63	$11,069.97	$3,467.14	$10,536.72	$2,936.44	$2,688.71	$17,642.00	$1,569.66	$4,120.20	$8,569.43	$17,535.53	$1,430.86	$4,733.22
Percent Change	1.93%	1.58%	2.90%	4.04%	0.03%	7.15%	2.18%	0.81%	-1.11%	-0.57%	2.79%	1.86%	7.82%	5.92%	0.22%

This exhibit does not include supplemental payments, outstationing payments, or upper payment limit financing. Effective with the Department's February 2012 request, Nursing Facility Supplemental Payments have been removed from per capita figures.

See narrative for a description of events that alter trends.

Exhibit C - History and Projections of Per Capita Costs

Per Capita Costs - Adjusted for Payment Delays

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Adults without Dependent Children	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 1995-96	$11,438.90	$8,020.74	$6,216.02	-	$2,612.84	-	-	-	-	$1,253.09	$2,391.78	$5,922.44	$3,364.90	$1,544.32	$3,901.23
FY 1996-97	$13,535.28	$8,388.91	$7,164.80	-	$3,174.99	-	-	-	-	$1,233.89	$2,413.14	$6,856.06	$3,872.40	$1,520.98	$4,509.91
FY 1997-98	$13,297.59	$8,457.61	$7,186.27	-	$3,036.03	-	-	-	-	$1,375.75	$2,177.83	$6,743.66	$3,687.26	$1,369.92	$4,631.18
Percent Change	-1.76%	0.82%	0.30%	-	-4.38%	-	-	-	-	11.50%	-9.75%	-1.64%	-4.78%	-9.93%	2.69%
FY 1998-99	$14,049.96	$9,886.63	$7,796.82	-	$3,129.24	-	-	-	-	$1,466.08	$2,023.98	$6,272.97	$3,576.18	$1,013.41	$4,950.52
Percent Change	5.66%	16.90%	8.50%	-	3.07%	-	-	-	-	6.57%	-7.06%	-6.98%	-3.01%	-26.02%	6.90%
FY 1999-00	$15,040.64	$10,793.96	$8,772.23	-	$3,440.54	-	-	-	-	$1,544.54	$2,203.23	$5,430.89	$3,273.65	$917.32	$5,166.43
Percent Change	7.05%	9.18%	12.51%	-	9.95%	-	-	-	-	5.35%	8.86%	-13.42%	-8.46%	-9.48%	4.36%
FY 2000-01	$15,311.41	$11,851.80	$9,792.12	-	$3,277.51	-	-	-	-	$1,570.78	$2,351.36	$4,801.64	$2,966.03	$959.04	$5,143.57
Percent Change	1.80%	9.80%	11.63%	-	-4.74%	-	-	-	-	1.70%	6.72%	-11.59%	-9.40%	4.55%	-0.44%
FY 2001-02	$16,837.64	$11,821.86	$10,033.18	-	$3,125.56	-	-	-	-	$1,532.60	$2,530.78	$4,760.42	$9,774.69	$963.28	$5,202.22
Percent Change	9.97%	-0.25%	2.46%	-	-4.64%	-	-	-	-	-2.43%	7.63%	-0.86%	229.55%	0.44%	1.14%
FY 2002-03	$16,269.83	$11,909.35	$11,071.22	-	$3,425.30	-	-	-	$30,399.56	$1,346.59	$2,689.77	$5,435.44	$11,932.93	$882.68	$4,977.91
Percent Change	-3.37%	0.74%	10.35%	-	9.59%	-	-	-	-	-12.14%	6.28%	14.18%	22.08%	-8.37%	-4.31%
FY 2003-04	$17,917.49	$13,642.60	$11,967.29	-	$3,853.40	-	-	-	$25,417.70	$1,188.86	$3,019.91	$7,534.30	$11,504.23	$961.96	$5,010.73
Percent Change	10.13%	14.55%	8.09%	-	12.50%	-	-	-	-16.39%	-11.71%	12.27%	38.61%	-3.59%	8.98%	0.66%
FY 2004-05	$18,024.54	$13,297.64	$11,432.79	-	$3,224.86	-	-	-	$28,627.25	$1,314.92	$2,908.66	$6,405.47	$8,682.52	$1,137.99	$4,662.42
Percent Change	0.60%	-2.53%	-4.47%	-	-16.31%	-	-	-	12.63%	10.60%	-3.68%	-14.98%	-24.53%	18.30%	-6.95%
FY 2005-06	$18,452.47	$14,387.34	$11,705.52	-	$3,315.44	-	-	-	$36,225.53	$1,439.11	$2,969.74	$7,695.99	$8,904.59	$1,204.54	$4,928.66
Percent Change	2.37%	8.19%	2.39%	-	2.81%	-	-	-	26.54%	9.44%	2.10%	20.15%	2.56%	5.85%	5.71%
FY 2006-07	$18,730.43	$14,802.45	$11,695.80	-	$3,925.23	-	$1,467.77	-	$24,376.09	$1,610.83	$3,211.25	$9,215.49	$10,470.57	$1,313.15	$5,222.57
Percent Change	1.51%	2.89%	-0.08%	-	18.39%	-	-	-	-32.71%	11.93%	8.13%	19.74%	17.59%	9.02%	5.96%
FY 2007-08	$19,415.43	$16,324.25	$13,065.11	-	$4,260.90	-	$2,132.72	-	$26,305.08	$1,781.99	$3,738.66	$8,532.40	$12,797.32	$1,333.66	$5,681.77
Percent Change	3.66%	10.28%	11.71%	-	8.55%	-	45.30%	-	7.91%	10.63%	16.42%	-7.41%	22.22%	1.56%	8.79%
FY 2008-09	$20,680.18	$17,708.89	$14,233.44	-	$4,244.04	-	$2,489.04	-	$22,261.37	$1,837.39	$3,747.29	$8,654.00	$14,858.01	$1,254.95	$5,742.83
Percent Change	6.51%	8.48%	8.94%	-	-0.40%	-	16.71%	-	-15.37%	3.11%	0.23%	1.43%	16.10%	-5.90%	1.07%
FY 2009-10	$19,769.35	$16,244.99	$13,686.55	-	$3,788.33	-	$2,392.59	$952.90	$21,192.52	$1,715.89	$3,651.33	$8,602.92	$13,125.32	$1,225.15	$5,116.67
Percent Change	-4.40%	-8.27%	-3.84%	-	-10.74%	-	-3.88%	-	-4.80%	-6.61%	-2.56%	-0.59%	-11.66%	-2.37%	-10.90%
FY 2010-11	$20,027.85	$16,705.85	$14,256.68	-	$3,597.33	-	$2,801.70	$2,284.78	$18,488.13	$1,657.89	$3,881.13	$8,593.25	$14,120.76	$1,417.39	$4,938.48
Percent Change	1.31%	2.84%	4.17%	-	-5.04%	-	17.10%	139.77%	-12.76%	-3.38%	6.29%	-0.11%	7.58%	15.69%	-3.48%
FY 2011-12 Projection	$19,823.40	$16,415.33	$14,125.93	$9,764.90	$3,492.04	$3,974.93	$2,835.12	$2,540.84	$18,106.54	$1,602.07	$3,929.31	$8,400.44	$15,276.73	$1,292.63	$4,698.54
Percent Change	-1.02%	-1.74%	-0.92%	-	-2.93%	-	1.19%	11.21%	-2.06%	-3.37%	1.24%	-2.24%	8.19%	-8.80%	-4.86%
FY 2012-13 Projection	$20,203.33	$16,627.71	$14,433.56	$10,639.92	$3,466.16	$9,833.30	$2,873.79	$2,667.16	$17,839.85	$1,578.74	$4,008.35	$8,413.24	$16,264.06	$1,350.95	$4,722.95
Percent Change	1.92%	1.29%	2.18%	8.96%	-0.74%	147.38%	1.36%	4.97%	-1.47%	-1.46%	2.01%	0.15%	6.46%	4.51%	0.52%
FY 2013-14 Projection	$20,593.96	$16,890.09	$14,852.63	$11,069.97	$3,467.14	$10,536.72	$2,936.44	$2,688.71	$17,642.00	$1,569.66	$4,120.20	$8,569.43	$17,535.53	$1,430.86	$4,733.22
Percent Change	1.93%	1.58%	2.90%	4.04%	0.03%	7.15%	2.18%	0.81%	-1.11%	-0.57%	2.79%	1.86%	7.82%	5.92%	0.22%

This exhibit does not include supplemental payments, outstationing payments, or upper payment limit financing. Effective with the Department's February 2012 request, Nursing Facility Supplemental Payments have been removed from per capita figures.

See narrative for a description of events that alter trends.

The per capita costs reported here are adjusted for the two-week FY 2009-10 payment delay; that is, the claims which were delayed at the end of FY 2009-10 (and paid in FY 2010-11) are included in the FY 2009-10 totals and excluded from the FY 2010-11 totals.

Exhibit D - Cash Funds Report

Cash Funds Report

Cash Fund	FY 2011-12			FY 2012-13			FY 2013-14		
	Spending Authority	Request	Change	Base Spending Authority	Request	Change	Base Spending Authority	Request	Change
Cash Funds									
Certified Funds	$7,667,816	$10,047,214	$2,379,398	$7,722,438	$10,434,768	$2,712,330	$7,722,438	$11,095,356	$3,372,918
Local Funds	$0	$19,763	$19,763	$0	$40,869	$40,869	$0	$69,819	$69,819
Hospital Provider Fee Cash Fund	$404,642,186	$405,543,816	$901,630	$379,420,151	$466,535,239	$87,115,088	$354,420,151	$411,443,016	$57,022,865
Medicaid Buy-In Fund	$6,638,222	$147,975	($6,490,247)	$6,638,222	$4,531,955	($2,106,267)	$6,638,222	$10,740,500	$4,102,278
Tobacco Tax Cash Fund	$2,230,500	$2,230,500	$0	$2,230,500	$2,230,500	$0	$2,230,500	$2,230,500	$0
Health Care Expansion Fund	$68,329,996	$67,104,348	($1,225,648)	$67,978,040	$66,888,171	($1,089,869)	$67,978,040	$66,264,353	($1,713,687)
Breast and Cervical Cancer Prevention and Treatment Fund	$2,743,722	$2,705,446	($38,276)	$2,731,400	$1,511,739	($1,219,661)	$2,731,400	$1,686,231	($1,045,169)
Colorado Autism Treatment Fund	$878,625	$878,625	$0	$878,625	$878,625	$0	$878,625	$878,625	$0
Coordinated Care for People with Disabilities Fund	$200,335	$136,800	($63,535)	$200,335	$268,200	$67,865	$200,335	$270,000	$69,665
Nursing Facility Cash Fund	$42,924,415	$42,572,625	($351,790)	$43,157,867	$43,381,505	$223,638	$43,157,867	$44,205,754	$1,047,887
Home Health Telemedicine Fund	$170,575	$130,240	($40,335)	$170,575	$40,335	($130,240)	$170,575	$0	($170,575)
Tobacco Education Program Fund	$17,758,594	$17,758,594	$0	$0	$0	$0	$0	$0	$0
Supplemental Old Age Pension Health and Medical Care Fund	$3,000,000	$3,000,000	$0	$0	$0	$0	$0	$0	$0
Prevention, Early Detection, and Treatment Fund	$11,955,055	$11,955,055	$0	$0	$0	$0	$0	$0	$0
Primary Care Fund	$15,775,670	$15,775,670	$0	$0	$0	$0	$0	$0	$0
Department Recoveries	$23,401,464	$33,723,046	$10,321,582	$23,401,464	$35,205,601	$11,804,137	$23,401,464	$36,485,325	$13,083,861
Total Cash Funds	**$608,317,175**	**$613,729,717**	**$5,412,542**	**$534,529,617**	**$631,947,507**	**$97,417,890**	**$509,529,617**	**$585,369,479**	**$75,839,862**
Reappropriated Funds - Transfers from the Department of Public Health and Environment									
(1) Administration and Support; (B) Special Health Programs, (1) Health Disparities Program	$3,286,351	$3,286,351	$0	$0	$0	$0	$0	$0	$0
(9) Prevention Services Division; (A) Prevention Programs, (1) Programs and Administration	$2,000,000	$2,000,000	$0	$2,000,000	$2,000,000	$0	$0	$0	$0
(9) Prevention Services Division; (B) Women's Health - Family Planning	$248,569	$0	($248,569)	$248,569	$0	($248,569)	$248,569	$0	($248,569)
(9) Prevention Services Division; (A) Prevention Programs, (3) Chronic Disease and Cancer Prevention Grants Program	$853,139	$1,159,477	$306,338	$853,139	$1,215,340	$362,201	$853,139	$1,215,340	$362,201
Total Reappropriated Funds	**$6,388,059**	**$6,445,828**	**$57,769**	**$3,101,708**	**$3,215,340**	**$113,632**	**$1,101,708**	**$1,215,340**	**$113,632**

Note: Calculation of letternote changes for FY 2011-12 can be found on page ED-2. Request amounts shown above for FY 2012-13 and FY 2013-14 represent the total letternote amount that would appear in the Long Bill.

Exhibit D - Cash Funds Report

Cash Funds Spending Authority by Source of Authority
FY 2011-12

Spending Authority	FY 2011-12 Long Bill Appropriation (SB 11-209)	SB 11-177 Pregnancy and Dropout Prevention	SB 11-125 Nursing Home Fees and Order of Payments	SB 11-210 Phase Out Supplemental OAP Health Fund	SB 11-211 Tobacco Revenues Offset Medical Services	SB 11-212 Use Provider Fee Offset Medicaid	SB 11-219 2011 Transfers for Health Care Services	Total
Certified Funds	$7,629,150	$38,666	$0	$0	$0	$0	$0	$7,667,816
Local Funds	$0	$0	$0	$0	$0	$0	$0	$0
Hospital Provider Fee Cash Fund	$354,642,186	$0	$0	$0	$0	$50,000,000	$0	$404,642,186
Medicaid Buy-In Fund	$6,638,222	$0	$0	$0	$0	$0	$0	$6,638,222
Tobacco Tax Cash Fund	$0	$0	$0	$2,230,500	$0	$0	$0	$2,230,500
Health Care Expansion Fund	$68,329,996	$0	$0	$0	$0	$0	$0	$68,329,996
Breast and Cervical Cancer Prevention and Treatment Fund	$2,743,722	$0	$0	$0	$0	$0	$0	$2,743,722
Colorado Autism Treatment Fund	$878,625	$0	$0	$0	$0	$0	$0	$878,625
Coordinated Care for People with Disabilities Fund	$200,335	$0	$0	$0	$0	$0	$0	$200,335
Nursing Facility Cash Fund	$27,427,209	$0	$15,497,206	$0	$0	$0	$0	$42,924,415
Home Health Telemedicine Fund	$170,575	$0	$0	$0	$0	$0	$0	$170,575
Comprehensive Primary and Preventive Care Fund	$0	$0	$0	$0	$0	$0	$0	$0
Pediatric Specialty Hospital Fund	$0	$0	$0	$0	$0	$0	$0	$0
Tobacco Education Program Fund	$0	$0	$0	$0	$17,758,594	$0	$0	$17,758,594
Health Disparities Grant Program Fund	$0	$0	$0	$0	$0	$0	$0	$0
Supplemental Old Age Pension Health and Medical Care Fund	$3,000,000	$0	$0	$0	$0	$0	$0	$3,000,000
Prevention, Early Detection, and Treatment Fund	$0	$0	$0	$0	$11,955,055	$0	$0	$11,955,055
Primary Care Fund	$0	$0	$0	$0	$0	$0	$15,775,670	$15,775,670
Department Recoveries	$23,401,464	$0	$0	$0	$0	$0	$0	$23,401,464
Total Cash Funds	**$495,061,484**	**$38,666**	**$15,497,206**	**$2,230,500**	**$29,713,649**	**$50,000,000**	**$15,775,670**	**$608,317,175**

Revised Totals for Letternotes and Appropriation Clauses
FY 2011-12

FY 2011-12 Request	FY 2011-12 Long Bill Appropriation (SB 11-209)	SB 11-177 Pregnancy and Dropout Prevention	SB 11-125 Nursing Home Fees and Order of Payments	SB 11-210 Phase Out Supplemental OAP Health Fund	SB 11-211 Tobacco Revenues Offset Medical Services	SB 11-212 Use Provider Fee Offset Medicaid	SB 11-219 2011 Transfers for Health Care Services	Total
Certified Funds	**$10,047,214**	**$0**	$0	$0	$0	$0	$0	$10,047,214
Local Funds	$0	**$19,763**	$0	$0	$0	$0	$0	$19,763
Hospital Provider Fee Cash Fund	**$355,543,816**	$0	$0	$0	$0	$50,000,000	$0	$405,543,816
Medicaid Buy-In Fund	**$147,975**	$0	$0	$0	$0	$0	$0	$147,975
Tobacco Tax Cash Fund	$0	$0	$0	$2,230,500	$0	$0	$0	$2,230,500
Health Care Expansion Fund	**$67,104,348**	$0	$0	$0	$0	$0	$0	$67,104,348
Breast and Cervical Cancer Prevention and Treatment Fund	**$2,705,446**	$0	$0	$0	$0	$0	$0	$2,705,446
Colorado Autism Treatment Fund	$878,625	$0	$0	$0	$0	$0	$0	$878,625
Coordinated Care for People with Disabilities Fund	**$136,800**	$0	$0	$0	$0	$0	$0	$136,800
Nursing Facility Cash Fund	**$27,075,419**	$0	$15,497,206	$0	$0	$0	$0	$42,572,625
Home Health Telemedicine Fund	**$130,240**	$0	$0	$0	$0	$0	$0	$130,240
Comprehensive Primary and Preventive Care Fund	$0	$0	$0	$0	$0	$0	$0	$0
Pediatric Specialty Hospital Fund	$0	$0	$0	$0	$0	$0	$0	$0
Tobacco Education Program Fund	$0	$0	$0	$0	$17,758,594	$0	$0	$17,758,594
Health Disparities Grant Program Fund	$0	$0	$0	$0	$0	$0	$0	$0
Supplemental Old Age Pension Health and Medical Care Fund	$3,000,000	$0	$0	$0	$0	$0	$0	$3,000,000
Prevention, Early Detection, and Treatment Fund	$0	$0	$0	$0	$11,955,055	$0	$0	$11,955,055
Primary Care Fund	$0	$0	$0	$0	$0	$0	$15,775,670	$15,775,670
Department Recoveries	**$33,723,046**	$0	$0	$0	$0	$0	$0	$33,723,046
Total Cash Funds	$500,492,929	$19,763	$15,497,206	$2,230,500	$29,713,649	$50,000,000	$15,775,670	$613,729,717

Cells in **bold and underline** font indicate a requested change from the appropriation. The font in the "Total" columns are intentionally left unchanged. Please note, this table shows the total change required to the letternotes and appropriation clauses and include the incremental amounts from prior budget requests (in particular, the Department's January 2012 S-1 request).

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2011-12	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Adults without Dependent Children	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Acute Care	**$95,282,838**	**$64,887,710**	**$555,306,053**	**$0**	**$239,069,757**	**$0**	**$64,470,579**	**$86,986,136**	**$11,042,638**	**$529,762,351**	**$61,715,027**	**$62,282,652**	**$40,558,194**	**$6,130,488**	**$1,817,494,423**
Community Based Long Term Care	**$147,569,232**	**$25,084,978**	**$155,477,265**	**$0**	**$87,787**	**$0**	**$51,724**	**$112,638**	**$0**	**$640,471**	**$8,978,060**	**$0**	**$0**	**$299,915**	**$338,302,070**
Long Term Care															
Class I Nursing Facilities	$400,580,930	$32,432,578	$78,462,165	$0	$7,809	$0	$0	$0	$0	$0	$0	$0	$0	$578,708	$512,062,190
Class II Nursing Facilities	$0	$980,278	$2,898,614	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,878,892
PACE	$70,871,391	$8,311,727	$3,605,547	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$82,788,665
Subtotal Long Term Care	**$471,452,321**	**$41,724,583**	**$84,966,326**	**$0**	**$7,809**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$578,708**	**$598,729,747**
Insurance															
Supplemental Medicare Insurance Benefit	$62,490,976	$3,412,827	$30,235,091	$0	$202,090	$0	$0	$0	$0	$0	$0	$0	$0	$17,280,033	$113,621,017
Heath Insurance Buy-In	$2,367	$748	$1,227,548	$0	$6,101	$0	$0	$0	$0	$2,419	$1,233	$0	$0	$0	$1,240,416
Subtotal Insurance	**$62,493,343**	**$3,413,575**	**$31,462,639**	**$0**	**$208,191**	**$0**	**$0**	**$0**	**$0**	**$2,419**	**$1,233**	**$0**	**$0**	**$17,280,033**	**$114,861,433**
Service Management															
Single Entry Points	$12,336,806	$2,195,204	$10,783,329	$0	$4,271	$0	$0	$0	$0	$1,424	$8,541	$0	$62,626	$7,118	$25,399,319
Disease Management	$34,947	$19,544	$172,808	$0	$82,772	$0	$0	$0	$2,354	$144,905	$22,865	$19,805	$0	$0	$500,000
Prepaid Inpatient Health Plan	$1,129,934	$546,761	$3,581,622	$0	$6,026,000	$0	$3,662,374	$2,862,214	$0	$8,675,343	$555,802	$465,606	$0	$0	$27,505,656
Subtotal Service Management	**$13,501,687**	**$2,761,509**	**$14,537,759**	**$0**	**$6,113,043**	**$0**	**$3,662,374**	**$2,862,214**	**$2,354**	**$8,821,672**	**$587,208**	**$485,411**	**$62,626**	**$7,118**	**$53,404,975**
Expansion Populations															
Disabled Buy-In	$0	$0	$0	$566,364	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$566,364
Adults Without Dependent Children	$0	$0	$0	$0	$0	$6,626,200	$0	$0	$0	$0	$0	$0	$0	$0	$6,626,200
Subtotal Expansion Populations	**$0**	**$0**	**$0**	**$566,364**	**$0**	**$6,626,200**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$7,192,564**
Medical Services Total	**$790,299,421**	**$137,872,355**	**$841,750,042**	**$566,364**	**$245,486,587**	**$6,626,200**	**$68,184,677**	**$89,960,988**	**$11,044,992**	**$539,226,913**	**$71,281,528**	**$62,768,063**	**$40,620,820**	**$24,296,262**	**$2,929,985,212**
Caseload	39,867	8,399	59,589	58	70,299	1,667	24,050	35,406	610	336,582	18,141	7,472	2,659	18,796	623,595
Medical Services Per Capita	$19,823.40	$16,415.33	$14,125.93	$9,764.90	$3,492.04	$3,974.93	$2,835.12	$2,540.84	$18,106.54	$1,602.07	$3,929.31	$8,400.44	$15,276.73	$1,292.63	$4,698.54
Financing	$192,810,120	$33,636,853	$205,362,578	$138,176	$59,891,602	$1,616,600	$16,635,082	$21,947,870	$2,694,657	$131,555,716	$17,390,624	$15,313,586	$9,910,301	$5,927,583	$714,831,348
Grand Total Medical Services Premiums	**$983,109,541**	**$171,509,208**	**$1,047,112,620**	**$704,540**	**$305,378,189**	**$8,242,800**	**$84,819,759**	**$111,908,858**	**$13,739,649**	**$670,782,629**	**$88,672,152**	**$78,081,649**	**$50,531,121**	**$30,223,845**	**$3,644,816,560**
Total Per Capita	$24,659.73	$20,420.19	$17,572.25	$12,147.24	$4,343.99	$4,944.69	$3,526.81	$3,160.73	$22,524.01	$1,992.92	$4,887.94	$10,449.90	$19,003.81	$1,607.99	$5,844.85

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2012-13	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Adults without Dependent Children	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Acute Care	**$97,140,941**	**$69,330,549**	**$585,446,274**	**$0**	**$258,647,322**	**$0**	**$70,583,329**	**$108,772,292**	**$12,110,906**	**$570,962,062**	**$62,681,711**	**$62,801,573**	**$41,065,615**	**$7,029,283**	**$1,946,571,857**
Community Based Long Term Care	**$153,976,923**	**$27,436,796**	**$166,700,311**	**$0**	**$95,712**	**$0**	**$59,151**	**$139,798**	**$0**	**$707,108**	**$9,408,501**	**$0**	**$0**	**$244,560**	**$358,768,860**
Long Term Care															
Class I Nursing Facilities	$421,500,268	$34,126,288	$82,559,655	$0	$8,217	$0	$0	$0	$0	$0	$0	$0	$0	$608,930	$538,803,358
Class II Nursing Facilities	$0	$1,318,389	$3,898,386	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,216,775
PACE	$75,943,739	$9,471,930	$4,234,050	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$89,649,719
Subtotal Long Term Care	**$497,444,007**	**$44,916,607**	**$90,692,091**	**$0**	**$8,217**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$608,930**	**$633,669,852**
Insurance															
Supplemental Medicare Insurance Benefit	$61,689,343	$3,808,862	$33,219,016	$0	$230,400	$0	$0	$0	$0	$0	$0	$0	$0	$19,808,242	$118,755,863
Heath Insurance Buy-In	$7,105	$2,245	$3,684,962	$0	$18,315	$0	$0	$0	$0	$7,261	$3,661	$0	$0	$0	$3,723,549
Subtotal Insurance	**$61,696,448**	**$3,811,107**	**$36,903,978**	**$0**	**$248,715**	**$0**	**$0**	**$0**	**$0**	**$7,261**	**$3,661**	**$0**	**$0**	**$19,808,242**	**$122,479,412**
Service Management															
Single Entry Points	$12,863,588	$2,497,923	$11,526,300	$0	$4,514	$0	$0	$0	$0	$1,505	$9,026	$0	$66,183	$7,522	$26,976,561
Disease Management	$34,947	$19,544	$172,808	$0	$82,772	$0	$0	$0	$2,354	$144,905	$22,865	$19,805	$0	$0	$500,000
Prepaid Inpatient Health Plan	$1,542,927	$772,251	$4,853,564	$0	$9,383,797	$0	$5,507,233	$4,124,743	$0	$8,597,886	$661,838	$664,939	$0	$0	$36,109,178
Subtotal Service Management	**$14,441,462**	**$3,289,718**	**$16,552,672**	**$0**	**$9,471,083**	**$0**	**$5,507,233**	**$4,124,743**	**$2,354**	**$8,744,296**	**$693,729**	**$684,744**	**$66,183**	**$7,522**	**$63,585,739**
Expansion Populations															
Disabled Buy-In	$0	$0	$0	$23,492,951	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$23,492,951
Adults Without Dependent Children	$0	$0	$0	$0	$0	$98,333,000	$0	$0	$0	$0	$0	$0	$0	$0	$98,333,000
Subtotal Expansion Populations	**$0**	**$0**	**$0**	**$23,492,951**	**$0**	**$98,333,000**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$121,825,951**
Medical Services Total	**$824,699,781**	**$148,784,777**	**$896,295,326**	**$23,492,951**	**$268,471,049**	**$98,333,000**	**$76,149,713**	**$113,036,833**	**$12,113,260**	**$580,420,727**	**$72,787,602**	**$63,486,317**	**$41,131,798**	**$27,698,537**	**$3,246,901,671**
Caseload	40,820	8,948	62,098	2,208	77,455	10,000	26,498	42,381	679	367,649	18,159	7,546	2,529	20,503	687,473
Medical Services Per Capita	$20,203.33	$16,627.71	$14,433.56	$10,639.92	$3,466.16	$9,833.30	$2,873.79	$2,667.16	$17,839.85	$1,578.74	$4,008.35	$8,413.24	$16,264.06	$1,350.95	$4,722.95
Financing	$191,668,163	$34,579,014	$208,307,657	$5,459,988	$62,395,255	$22,853,535	$17,697,926	$26,270,848	$2,815,238	$134,895,361	$16,916,539	$14,754,831	$9,559,426	$6,437,406	$754,611,187
Grand Total Medical Services Premiums	**$1,016,367,944**	**$183,363,791**	**$1,104,602,983**	**$28,952,939**	**$330,866,304**	**$121,186,535**	**$93,847,639**	**$139,307,681**	**$14,928,498**	**$715,316,088**	**$89,704,141**	**$78,241,148**	**$50,691,224**	**$34,135,943**	**$4,001,512,858**
Total Per Capita	$24,898.77	$20,492.15	$17,788.06	$13,112.74	$4,271.72	$12,118.65	$3,541.69	$3,287.03	$21,986.01	$1,945.65	$4,939.93	$10,368.56	$20,043.98	$1,664.92	$5,820.61

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2013-14	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Adults without Dependent Children	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Acute Care	**$100,072,525**	**$74,805,802**	**$620,977,140**	**$0**	**$272,271,341**	**$0**	**$76,152,391**	**$121,639,961**	**$13,108,008**	**$618,265,933**	**$64,633,079**	**$71,935,296**	**$44,628,118**	**$8,031,175**	**$2,086,520,769.00**
Community Based Long Term Care	**$161,630,612**	**$29,914,054**	**$177,562,915**	**$0**	**$100,062**	**$0**	**$64,568**	**$161,112**	**$0**	**$779,741**	**$9,941,278**	**$0**	**$0**	**$265,216**	**$380,419,558.00**
Long Term Care															
Class I Nursing Facilities	$437,898,325	$35,453,939	$85,771,558	$0	$8,537	$0	$0	$0	$0	$0	$0	$0	$0	$632,620	$559,764,979.00
Class II Nursing Facilities	$0	$1,545,754	$4,570,689	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,116,443.00
PACE	$81,149,891	$10,664,446	$4,880,253	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$96,694,590.00
Subtotal Long Term Care	**$519,048,216**	**$47,664,139**	**$95,222,500**	**$0**	**$8,537**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$632,620**	**$662,576,012.00**
Insurance															
Supplemental Medicare Insurance Benefit	$67,454,803	$4,302,339	$36,564,205	$0	$257,700	$0	$0	$0	$0	$0	$0	$0	$0	$22,872,428	$131,451,475.00
Heath Insurance Buy-In	$11,202	$3,539	$5,809,611	$0	$28,875	$0	$0	$0	$0	$11,447	$5,652	$0	$0	$0	$5,870,326.00
Subtotal Insurance	**$67,466,005**	**$4,305,878**	**$42,373,816**	**$0**	**$286,575**	**$0**	**$0**	**$0**	**$0**	**$11,447**	**$5,652**	**$0**	**$0**	**$22,872,428**	**$137,321,801.00**
Service Management															
Single Entry Points	$13,412,863	$2,842,387	$12,320,462	$0	$4,770	$0	$0	$0	$0	$1,590	$9,539	$0	$69,942	$7,949	$28,669,502.00
Disease Management	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0.00
Prepaid Inpatient Health Plan	$1,545,021	$771,548	$4,844,253	$0	$9,383,797	$0	$5,507,233	$4,124,743	$0	$8,597,886	$661,838	$664,939	$0	$0	$36,101,258.00
Subtotal Service Management	**$14,957,884**	**$3,613,935**	**$17,164,715**	**$0**	**$9,388,567**	**$0**	**$5,507,233**	**$4,124,743**	**$0**	**$8,599,476**	**$671,377**	**$664,939**	**$69,942**	**$7,949**	**$64,770,760.00**
Expansion Populations															
Disabled Buy-In	$0	$0	$0	$62,777,782	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$62,777,782.00
Adults Without Dependent Children	$0	$0	$0	$0	$0	$105,367,200	$0	$0	$0	$0	$0	$0	$0	$0	$105,367,200.00
Subtotal Expansion Populations	**$0**	**$0**	**$0**	**$62,777,782**	**$0**	**$105,367,200**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$168,144,982.00**
Medical Services Total	**$863,175,242**	**$160,303,808**	**$953,301,086**	**$62,777,782**	**$282,055,082**	**$105,367,200**	**$81,724,192**	**$125,925,816**	**$13,108,008**	**$627,656,597**	**$75,251,386**	**$72,600,235**	**$44,698,060**	**$31,809,388**	**$3,499,753,882.00**
Caseload	41,914	9,491	64,184	5,671	81,351	10,000	27,831	46,835	743	399,867	18,264	8,472	2,549	22,231	739,403
Medical Services Per Capita	$20,593.96	$16,890.09	$14,852.63	$11,069.97	$3,467.14	$10,536.72	$2,936.44	$2,688.71	$17,642.00	$1,569.66	$4,120.20	$8,569.43	$17,535.53	$1,430.86	$4,733.22
Financing	$186,721,264	$34,676,771	$206,217,204	$13,580,031	$61,013,893	$22,792,935	$17,678,501	$27,240,155	$2,835,512	$135,774,091	$16,278,310	$15,704,815	$9,669,043	$6,880,977	$757,063,502
Grand Total Medical Services Premiums	**$1,049,896,506**	**$194,980,579**	**$1,159,518,290**	**$76,357,813**	**$343,068,975**	**$128,160,135**	**$99,402,693**	**$153,165,971**	**$15,943,520**	**$763,430,688**	**$91,529,696**	**$88,305,050**	**$54,367,103**	**$38,690,365**	**$4,256,817,384**
Total Per Capita	$25,048.83	$20,543.73	$18,065.53	$13,464.61	$4,217.15	$12,816.01	$3,571.65	$3,270.33	$21,458.30	$1,909.21	$5,011.48	$10,423.16	$21,328.80	$1,740.38	$5,757.10

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills
FY 2011-12

Item	Long Bill and Special Bills	R-1 Request (November 2011)	S-1A Request (February 2012)	Difference from Appropriation	Difference from R-1 Request	Description of Difference from R-1 Request	Department Source
Acute Care							
Base Acute Cost	$1,806,053,054	$1,885,579,476	$1,885,433,963	$79,380,909	($145,513)	Different caseload and per capita cost assumptions	Exhibit F
Bottom Line Impacts							
FY 2011-12 BRI-1: Client Overutilization Program Expansion	($136,600)	($136,600)	($136,600)	$0	$0		Exhibit F
FY 2011-12 BRI-5: State Allowable Cost Expansion	($1,833,333)	($1,833,334)	($1,833,334)	($1)	$0		Exhibit F
FY 2011-12 BRI-5: Reduce Rates for Diabetes Supplies	($919,340)	($842,728)	($842,728)	$76,612	$0		Exhibit F
FY 2011-12 BRI-5: Reduce Payment for Uncomplicated C-Section	($6,846,550)	($6,276,004)	($6,276,004)	$570,546	$0		Exhibit F
FY 2011-12 BRI-5: Reduce Payments for Renal Dialysis	($2,366,947)	($1,418,733)	($1,418,733)	$948,214	$0		Exhibit F
FY 2011-12 BRI-5: Deny Payment of Hospital Readmissions 48 hrs	($2,700,456)	($2,475,418)	($2,475,418)	$225,038	$0		Exhibit F
FY 2011-12 BRI-5: Prior Authorize Certain Radiology	($672,136)	($672,136)	($672,136)	$0	$0		Exhibit F
FY 2011-12 BRI-5: Limit Acute Home Health Services	($1,234,424)	($1,131,555)	($1,131,555)	$102,869	$0		Exhibit F
FY 2011-12 BRI-5: HMO Impact to Rates	($2,707,680)	($1,906,233)	($1,906,233)	$801,447	$0		Exhibit F
FY 2011-12 BA-9: 0.75% Provider Rate Reduction	($11,711,574)	($12,092,847)	($12,092,847)	($381,273)	$0		Exhibit F
FY 2011-12 BA-9: Estimated ACC Savings	($13,067,458)	($10,250,663)	($6,189,762)	$6,877,696	$4,060,901	Delayed implementation and enrollment case mix	Exhibit F
FY 2011-12 BA-9: Limit Fluoride Application Benefit	($33,798)	($30,982)	($30,982)	$2,816	$0		Exhibit F
FY 2011-12 BA-9: Limit Dental Prophylaxis Benefit	($176,658)	($161,936)	($161,936)	$14,722	$0		Exhibit F
FY 2011-12 BA-9: Limit Oral Hygiene Instruction	($4,626,574)	($4,241,026)	($4,241,026)	$385,548	$0		Exhibit F
FY 2011-12 BA-9: Limit Physical and Occupational Therapy	($504,744)	($347,012)	($154,227)	$350,517	$192,785	Delayed implementation	Exhibit F
FY 2011-12 BA-9: Home Health Billing Changes	($2,739,756)	($2,511,443)	($2,511,443)	$228,313	$0		Exhibit F
Estimated Impact of Increasing PACE Enrollment	$0	($1,245,550)	($1,318,382)	($1,318,382)	($72,832)	Revised case mix estimate	Exhibit F
Eliminate Circumcision Benefit	($373,000)	($373,000)	($373,000)	$0	$0		Exhibit F
Wound Therapy DME Reduction	($100,000)	($100,000)	($100,000)	$0	$0		Exhibit F
Repeal of BA-9 0.75% Pharmacy Reduction (June 2011 1331 Supplemental Request)	$0	$1,250,589	$0	$0	($1,250,589)	Included in the supplemental bill	Exhibit F
SB 11-177: "Sunset of Pregnancy Prevention Program"	$333,195	$333,195	$140,982	($192,213)	($192,213)	Delayed implementation	Exhibit F
Managed Care Organization Reconciliations	$0	$0	($5,386,882)	($5,386,882)	($5,386,882)	Recoupments for overpayments	Exhibit F
Annualization of FY 2010-11 BRI-1: Prevention and Benefits for Enhanced Value (P-BEV) and BA#12: Evidence Guided Utilization Review (EGUR)	($887,437)	($887,437)	($764,595)	$122,842	$122,842	Delayed implementation	Exhibit F
Annualization of FY 2010-11 BRI-2: Coordinated Payment and Payment Reform	($5,060,838)	($5,060,838)	($1,555,000)	$3,505,838	$3,505,838	Revised per capita and initiative participation assumptions	Exhibit F
Annualization of FY 2010-11 BRI-6: Medicaid Program Reductions DME Reductions	($125,098)	($125,098)	($125,098)	$0	$0		Exhibit F
Annualization of FY 2010-11 BRI-6: 1% Rate Reduction Effective July 1, 2010	($2,698,858)	($2,698,858)	($2,698,858)	$0	$0		Exhibit F
Annualization of FY 2010-11 S-6: Accountable Care Collaborative	($20,085,549)	($20,085,549)	($11,989,569)	$8,095,980	$8,095,980	Delayed implementation and case mix	Exhibit F
Annualization of FY 2010-11 BA-16: Implementation of Family Planning Waiver	$0	$0	$0	$0	$0		Exhibit F
Annualization of Increased Drug Rebates due to the Affordable Care Act	($2,226,190)	($2,226,190)	($493,247)	$1,732,943	$1,732,943	Revised based on current data	Exhibit F
HB 10-1005: Telemedicine Changes	$189,306	$234,432	$130,240	($59,066)	($104,192)	Delayed implementation	Exhibit F
Annualization of HB 10-1033: Add SBIRT to Optional Services	$360,130	$360,130	$360,130	$0	$0		Exhibit F
Annualization of SB 10-167: NCCI	($200,325)	($200,325)	($12,500)	$187,825	$187,825	Delayed implementation	Exhibit F
Annualization of SB 10-167: HIBI	($1,310,349)	($1,310,349)	($244,599)	$1,065,750	$1,065,750	Delay implementation and revised enrollment assumptions	Exhibit F
Annualization of SB 10-167: Colorado False Claims Act - PARIS	($215,404)	($215,404)	($215,404)	$0	$0		Exhibit F
Annualization of SB 10-167: Colorado False Claims Act - RX COB	$0	$0	$0	$0	$0	Delayed implementation	Exhibit F
Annualization of FY 2009-10 BA-33: PA of Anti-Convulsants	($720,000)	($720,000)	($180,000)	$540,000	$540,000	Diminished potential savings	Exhibit F
Annualization of FY 2009-10 BRI-1: Auto PA	($1,217,310)	($1,217,310)	($405,770)	$811,540	$811,540	Delayed implementation	Exhibit F
Annnualization of FY 2009-10 BRI-2: Oxygen Restrictions	($586,667)	($586,667)	($586,667)	$0	$0		Exhibit F
ACA 4107 Smoking Cessation Counseling for Pregnant Women	$0	$0	($46,357)	($46,357)	($46,357)	Provision of the Affordable Care Act	Exhibit F
Total Acute Care	**$1,718,850,632**	**$1,804,376,597**	**$1,817,494,423**	**$98,643,791**	**$13,117,826**		

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills
FY 2011-12

Item	Long Bill and Special Bills	R-1 Request (November 2011)	S-1A Request (February 2012)	Difference from Appropriation	Difference from R-1 Request	Description of Difference from R-1 Request	Department Source
Community Based Long Term Care							
Base CBLTC Cost	$337,461,805	$343,871,356	$341,867,636	$4,405,831	($2,003,720)	Different caseload and per capita cost assumptions	Exhibit G
Bottom Line Impacts							
BRI-5: Medicaid Reductions - Cap CDASS Wage Rates	($1,549,846)	($1,065,519)	($473,564)	$1,076,282	$591,955	Delayed implementation	
BA-9: Medicaid Reductions - 0.50% Rate Reduction	($2,260,830)	($1,561,829)	($1,561,829)	$699,001	$0		Exhibit G
BA-9: Medicaid Reductions - Clients Moved from Nursing Home	$191,372	$0	$0	($191,372)	$0		Exhibit G
Estimated Impact of Increased PACE Enrollment	($1,342,987)	($1,342,987)	($984,506)	$358,481	$358,481	Revised case mix estimate	Exhibit G
Annualization of FY 2010-11 BRI-2: "Coordinated Payment and Payment Reform"	($616,405)	($616,405)	($311,000)	$305,405	$305,405	Revised per capita and initiative participation assumptions	Exhibit G
Annualization of FY 2010-11 BRI-6: "Medicaid Program Reductions"	($441,287)	($441,287)	($441,287)	$0	$0		Exhibit G
Annualization of FY 2009-10 ES-2: HCBS Waiver Transportation Limitations	($563,425)	($563,425)	($563,425)	$0	$0		Exhibit G
Annualization of HB 10-1146 State-funded Public Assistance Programs	$296,481	$296,481	$296,481	$0	$0		Exhibit G
HB 09-1047 Alternative Therapies for Clients with Spinal Cord Injuries	$93,720	$93,720	$0	($93,720)	($93,720)	Delayed implementation	Exhibit G
Total Community Based Long Term Care	**$332,818,444**	**$339,735,624**	**$338,302,070**	**$5,483,626**	**($1,433,554)**		
Long Term Care and Insurance							
Class I Nursing Facilities							
Base Class I Nursing Facility Cost	$513,914,153	$522,879,421	$519,877,760	$5,963,607	($3,001,661)	Different caseload and per capita cost assumptions	Exhibit H
Bottom Line Impacts							
BA-5: "Nursing Facility Audits"	($24,840)	($24,840)	($24,840)	$0	$0		Exhibit H
BRI-5 Clients Moved From Nursing Home	($817,075)	$0	$0	$817,075	$0		Exhibit H
SB 11-215: 1.5% Nursing Facility Rate Reduction	($8,865,830)	($8,969,027)	($8,889,323)	($23,493)	$79,704	SB 11-125 fiscal note - Different caseload assumptions	Exhibit H
Hospital Back Up Program	$4,258,324	$4,923,096	$4,258,324	$0	($664,772)	Revised based on most current program enrollment	Exhibit H
Recoveries from Department Overpayment Review	($1,977,766)	($1,977,766)	($1,977,766)	$0	$0		Exhibit H
Savings from days incurred in FY 2010-11 and paid in FY 2011-12 under HB 10-1324	($709,179)	($722,050)	($709,179)	$0	$12,871	Annualization adjusted based on revised days forecast	Exhibit H
Savings from days incurred in FY 2010-11 and paid in FY 2011-12 under HB 10-1379	($472,786)	($481,367)	($472,786)	$0	$8,581	Annualization adjusted based on revised days forecast	Exhibit H
Total Class I Nursing Facilities	**$505,305,001**	**$515,627,467**	**$512,062,190**	**$6,757,189**	**($3,565,277)**		**Exhibit H**
Class II Nursing Facilities							
Base Class II Nursing Facilities Cost	$2,518,879	$2,320,072	$3,878,892	$1,360,013	$1,558,820	Figure Setting, Page 89 imputed	Exhibit H
Total Class II Nursing Facilities	**$2,518,879**	**$2,320,072**	**$3,878,892**	**$1,360,013**	**$1,558,820**		

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills
FY 2011-12

Item	Long Bill and Special Bills	R-1 Request (November 2011)	S-1A Request (February 2012)	Difference from Appropriation	Difference from R-1 Request	Description of Difference from R-1 Request	Department Source
Program of All Inclusive Care for the Elderly (PACE)							
Base PACE Cost	$85,150,515	$84,757,246	$82,788,665	($2,361,850)	($1,968,581)	Different caseload and per capita cost assumptions	Exhibit H
Bottom Line Impacts							
Annualization of FY 2010-11 BRI#6: 1% Rate Reduction Effective July 1, 2010	$0	$0	$0	$0	$0		Exhibit H
Total Program of All-Inclusive Care for the Elderly	**$85,150,515**	**$84,757,246**	**$82,788,665**	**($2,361,850)**	**($1,968,581)**		
Supplemental Medicare Insurance Benefit (SMIB)							
Base SMIB Cost	$130,649,240	$134,751,970	$113,621,017	($17,028,223)	($21,130,953)	Figure Setting, Page 89 imputed	Exhibit H
Total Supplemental Medicare Insurance Benefit	**$130,649,240**	**$134,751,970**	**$113,621,017**	**($17,028,223)**	**($21,130,953)**		
Health Insurance Buy-In Program (HIBI)							
Base HIBI Cost	$1,727,706	$1,244,583	$1,125,233	($602,473)	($119,350)	Figure Setting, Page 89 imputed	Exhibit H
Bottom Line Impacts					$0		
Annualization of SB 10-167	$0	$799,879	$115,183	$115,183	($684,696)	Delay implementation and revised enrollment assumptions	Exhibit H
Total Health Insurance Buy-In Program	**$1,727,706**	**$2,044,462**	**$1,240,416**	**($487,290)**	**($804,046)**		
Total Long Term Care and Insurance	**$725,351,341**	**$739,501,217**	**$713,591,180**	**($11,760,161)**	**($25,910,037)**		
Service Management							
Single Entry Points (SEP)							
Single Entry Points (SEP) Base	$25,399,319	$25,399,319	$25,399,319	$0	$0		Exhibit I
Total Single Entry Points	**$25,399,319**	**$25,399,319**	**$25,399,319**	**$0**	**$0**		**Exhibit I**
Disease Management							
Base Disease Management	$500,000	$500,000	$500,000	$0	$0		Exhibit I
Total Disease Management	**$500,000**	**$500,000**	**$500,000**	**$0**	**$0**		**Exhibit I**
Prepaid Inpatient Health Plan Administration							
Estimated FY 2010-11 Base Expenditures	$28,540,781	$27,602,421	$24,969,928	($3,570,853)	($2,632,493)	Different Caseload and Per Capita Cost Assumptions	Exhibit I
Bottom Line Impacts					*$0*		
Estimated Contract Payment to PIHP for Cost Avoidance	$956,606	$1,721,116	$2,535,728	$1,579,122	$814,612	Revised for updated cost avoidance calculation	Exhibit I
Total Prepaid Inpatient Health Plan Administration	**$29,497,387**	**$29,323,537**	**$27,505,656**	**($1,991,731)**	**($1,817,881)**		
Total Service Management	**$55,396,706**	**$55,222,856**	**$53,404,975**	**($1,991,731)**	**($1,817,881)**		
Expansion Populations							
Disabled Buy-In	$60,887,688	$525,479	$566,364	($60,321,324)	$40,885	The Department has revised caseload estimates as a result of	Exhibit J
Adults Without Dependent Children	$51,474,921	$29,439,789	$6,626,200	($44,848,721)	($22,813,589)	revised implementation timelines.	Exhibit J
Total Expansion Populations	**$112,362,609**	**$29,965,268**	**$7,192,564**	**($105,170,045)**	**($22,772,704)**		
Grand Total Services	**$2,944,779,732**	**$2,968,801,562**	**$2,929,985,212**	**($14,794,520)**	**($38,816,350)**		
Bottom Line Financing							
Upper Payment Limit Financing	$3,395,239	$5,135,883	$4,748,099	$1,352,860	($387,784)	Revised Department Forecast	Exhibit K
Department Recoveries Adjustment	$0	$0	$0	$0	$0		Exhibit A
Denver Health Outstationing	$3,520,253	$5,485,699	$5,485,699	$1,965,446	$0		Exhibit A
Hospital Provider Fee Supplemental Payments	$502,848,939	$538,782,512	$614,029,587	$111,180,648	$75,247,075	Revised Department Forecast	Exhibit J
Nursing Facility Provider Fee Supplemental Payments	$83,952,006	$83,952,006	$85,145,251	($1,193,245)	$1,193,245	Revised Department Forecast	Exhibit H
Physician Supplemental Payments	$5,367,584	$4,075,759	$5,422,712	$55,128	$1,346,953	Revised Department Forecast	Exhibit A
Cash Funds Financing	$0	$0	$0	$0	$0		Exhibit A
Total Bottom Line Financing	**$515,132,015**	**$553,479,853**	**$714,831,348**	**$199,699,333**	**$161,351,495**		

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills
FY 2011-12

Item	Long Bill and Special Bills	R-1 Request (November 2011)	S-1A Request (February 2012)	Difference from Appropriation	Difference from R-1 Request	Description of Difference from R-1 Request	Department Source
Grand Total[(1)]	**$3,459,911,747**	**$3,522,281,415**	**$3,644,816,560**	**$184,904,813**	**$122,535,145**		
Total Acute Care	$1,718,850,632	$1,804,376,597	$1,817,494,423	$98,643,791	$13,117,826		
Total Community Based Long Term Care	$332,818,444	$339,735,624	$338,302,070	$5,483,626	($1,433,554)		
Total Class I Nursing Facilities	$505,305,001	$515,627,467	$512,062,190	$6,757,189	($3,565,277)		
Total Class II Nursing Facilities	$2,518,879	$2,320,072	$3,878,892	$1,360,013	$1,558,820		
Total Program of All-Inclusive Care for the Elderly	$85,150,515	$84,757,246	$82,788,665	($2,361,850)	($1,968,581)		
Total Supplemental Medicare Insurance Benefit	$130,649,240	$134,751,970	$113,621,017	($17,028,223)	($21,130,953)		
Total Health Insurance Buy-In Program	$1,727,706	$2,044,462	$1,240,416	($487,290)	($804,046)		
Total Single Entry Point	$25,399,319	$25,399,319	$25,399,319	$0	$0		
Total Disease Management	$500,000	$500,000	$500,000	$0	$0		
Total Prepaid Inpatient Health Plan Administration	$29,497,387	$29,323,537	$27,505,656	($1,991,731)	($1,817,881)		
Total Expansion Populations	$112,362,609	$29,965,268	$7,192,564	($105,170,045)	($22,772,704)		
Total Bottom Line Financing	$515,132,015	$637,431,859	$714,831,348	$199,699,333	$77,399,489		
Rounding Adjustment	($4)	$0	$0	$0	$0		
Grand Total[(1)]	**$3,459,911,743**	**$3,606,233,421**	**$3,644,816,560**	**$184,904,813**	**$38,583,139**		

Footnotes

(1) The Department Request is the sum of all the pieces in this document and comprises the summation of this Budget Request for Medical Services Premiums. This total matches the totals presented on the Schedule 13 and Exhibit A of this Request.

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills FY 2012-13

Item	R-1 Request (November 2011)	BA-1 Request (February 2012)	Difference	Description of Difference from R-1 Request
Acute Care				
Base Acute Cost	$1,954,340,253	$1,991,149,102	$36,808,849	Different caseload and per capita cost assumptions
Bottom Line Impacts				
Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act)	$6,298,666	$6,298,666	$0	
Annualization of FY 2010-11 S-6: Accountable Care Collaborative	($5,683,694)	($3,013,670)	$2,670,024	Delayed implementation and enrollment case mix
Annualization of BRI-1: Client Overutilization Program Expansion	($1,098,200)	($823,650)	$274,550	Delayed implementation to full ramp up of expansion
Annualization of FY 2011-12 BRI-5: State Allowable Cost	($166,666)	($166,666)	$0	
Annualization of FY 2011-12 BRI-5: Reduce Rates for Diabetes Supplies	($150,066)	($150,066)	$0	
Annualization of FY 2011-12 BRI-5: Reduce Payment for Uncomplicated C-Section	($811,545)	($811,545)	$0	
Annualization of FY 2011-12 BRI-5: Reduce Payments for Renal Dialysis	($183,455)	($183,455)	$0	
Annualization of FY 2011-12 BRI-5: Deny Payment of Hospital Readmissions 48 hrs	($320,094)	($320,094)	$0	
Annualization of FY 2011-12 BRI-5: Prior Authorize Certain Radiology	($3,720,409)	($3,720,409)	$0	
Annualization of FY 2011-12 BRI-5: Limit Acute Home Health Services	($286,551)	($286,551)	$0	
Annualization of FY 2011-12 BRI-5: HMO Impact to Rates	($81,968)	($81,968)	$0	
Annualization of FY 2011-12 BA-9: 0.75% Provider Rate Reduction	($2,904,019)	($2,904,019)	$0	
Annualization of FY 2011-12 BA-9: Estimated ACC Savings	($8,520,553)	($9,404,898)	($884,345)	Case mix adjustments
Annualization of FY 2011-12 BA-9: Limit Fluoride Application	($6,101)	($6,101)	$0	
Annualization of FY 2011-12 BA-9: Limit Dental Prophylaxis	($31,892)	($31,892)	$0	
Annualization of FY 2011-12 BA-9: Limit Oral Hygiene Instruction	($835,251)	($835,251)	$0	
Annualization of FY 2011-12 BA-9: Limit Physical and	($208,056)	($400,840)	($192,784)	Delayed implementation
Annualization of FY 2011-12 BA-9: Home Health Billing Changes	($636,809)	($636,809)	$0	
Estimated Impact of Increasing PACE Enrollment	($1,145,853)	($1,337,761)	($191,908)	Revised case mix estimate
Annualization of Wound Therapy DME Reduction	$0	$0	$0	
Annualization of HB 10-1005: Telemedicine Changes	$78,144	$182,336	$104,192	Delayed implementation
Annualization of SB 11-177: "Sunset of Pregnancy Prevention Program"	$542,168	$157,953	($384,215)	Delayed implementation
Annualization of SB 10-167: Colorado False Claims Act - NCCI	($600,975)	($838,800)	($237,825)	Delayed implementation
Annualization of SB 10-167: Colorado False Claims Act - HIBI	($5,248,385)	($3,340,516)	$1,907,869	Delay implementation and revised enrollment assumptions
Annualization of SB 10-167: Colorado False Claims Act - COB	($351,262)	($351,262)	$0	
Annualization of FY 2010-11 BRI-1: Prevention and Benefits for Enhanced Value (P-BEV) and BA#12: Evidence Guided Utilization Review (EGUR)	($259,465)	($382,297)	($122,832)	Delayed implementation
Annualization of FY 2010-11 BA-16: Implementation of Family Planning Waiver	$1,903,500	$0	($1,903,500)	Removed waiver application
Annualization of FY 2009-10 BA-33: Prior Authorization of Anti-Convulsants	($240,000)	($60,000)	$180,000	Diminished potential savings
Annualization of FY 2009-10 BRI-1: Auto PA	($405,770)	($1,217,310)	($811,540)	Delayed implementation
Total Bottom Line Impacts	($24,923,995)	($19,910,370)	$5,013,625	
Total Acute Care	**$1,904,642,018**	**$1,946,571,857**	**$41,929,839**	

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills FY 2012-13

Item	R-1 Request (November 2011)	BA-1 Request (February 2012)	Difference	Description of Difference from R-1 Request
Community Based Long Term Care				
Base CBLTC Cost	$359,356,403	$359,825,205	$468,802	Different caseload and per capita cost assumptions
Bottom Line Impacts				
Estimated Impact of Increased PACE Enrollment	($1,241,772)	($998,980)	$242,792	Revised case mix estimate
Annualization of BRI-5: Medicaid Reductions - 0.50% Rate	($361,468)	($361,468)	$0	
Annualization of BA-9: Medicaid Reductions - Cap CDASS Wage Rates	($612,189)	($1,204,144)	($591,955)	Delayed implementation
Annualization of BA-9: Medicaid Reductions - Clients Moved from Nursing Home	$0	$0	$0	
Annualization of FY 2010-11 BRI-2: "Coordinated Payment and Payment Reform"	$0	($55,000)	($55,000)	Revised per capita and initiative participation assumptions
Annualization of HB 10-1146 State-funded Public Assistance	$376,827	$376,827	$0	
Annualization of HB 09-1047 Alternative Therapies for Clients with Spinal Cord Injuries	$79,415	$187,440	$108,025	Delayed implementation
Colorado Choice Transitions	$0	$1,910,160	$1,910,160	Added to reflect program implementation
Total Community Based Long Term Care	**$358,838,988**	**$358,768,860**	**($70,128)**	
Long Term Care and Insurance				
Class I Nursing Facilities				
Base Class I Nursing Facility Cost	$537,333,213	$537,345,661	$12,448	Revised patient days, patient payment, and core per diem
Bottom Line Impacts				
Hospital Back Up Program	$5,122,481	$4,258,324	($864,157)	Revised caseload
Recoveries from Department Overpayment Review	($2,076,753)	($2,076,753)	$0	
Savings from days incurred in FY 2011-12 and paid in FY 2012-13 under SB 11-215	($748,228)	($723,874)	$24,354	Revised patient days
Total Class I Nursing Facilities	**$625,177,807**	**$538,803,358**	**($86,374,449)**	
Class II Nursing Facilities				
Base Class II Nursing Facilities	$2,366,473	$5,216,775	$2,850,302	Revised rate based on most recent cost reports
Total Class II Nursing Facilities	**$2,366,473**	**$5,216,775**	**$2,850,302**	
Program of All Inclusive Care for the Elderly (PACE)				
Base PACE Cost	$92,964,284	$89,649,719	($3,314,565)	Difference in enrollment assumptions
Total Program of All-Inclusive Care for the Elderly	**$92,964,284**	**$89,649,719**	**($3,314,565)**	
Supplemental Medicare Insurance Benefit (SMIB)				
Base SMIB	$148,181,677	$118,755,863	($29,425,814)	Revised based on decrease to Part B premiums
Total Supplemental Medicare Insurance Benefit	**$148,181,677**	**$118,755,863**	**($29,425,814)**	
Health Insurance Buy-In Program (HIBI)				
Base HIBI Cost	$2,111,249	$1,280,937	($830,312)	Difference in caseload assumptions
Bottom Line Impacts				
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$484,000	$369,325	($114,675)	Delay implementation and revised enrollment assumptions
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$3,203,784	$2,073,287	($1,130,497)	Delay implementation and revised enrollment assumptions
Total Health Insurance Buy-In Program	**$5,799,033**	**$3,723,549**	**($2,075,484)**	
Total Long Term Care and Insurance	**$874,489,274**	**$756,149,264**	**($118,340,010)**	

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills FY 2012-13

Item	R-1 Request (November 2011)	BA-1 Request (February 2012)	Difference	Description of Difference from R-1 Request
Service Management				
Single Entry Points (SEP)				
FY 2011-12 Base Contracts	$26,862,436	$26,976,561	$114,125	Increased enrollment assumption
Total Single Entry Points	**$26,862,436**	**$26,976,561**	**$114,125**	
Disease Management				
Base Disease Management	$500,000	$500,000	$0	
Total Disease Management	**$500,000**	**$500,000**	**$0**	
Prepaid Inpatient Health Plan Administration				
Estimated FY 2010-11 Base Expenditures	$34,629,177	$34,841,314	$212,137	Increased enrollment and cost avoidance payment assumptions
Bottom Line Impacts				
Estimated Contract Payment to PIHP for Cost Avoidance	$860,558	$1,267,864	$407,306	
Total Prepaid Inpatient Health Plan Administration	**$35,489,735**	**$36,109,178**	**$619,443**	
Total Service Management	**$62,852,171**	**$63,585,739**	$733,568	
Expansion Populations				
Disabled Buy-In	$22,542,913	$23,492,951	$950,038	Revised caseload and per capita assumptions
Adults Without Dependent Children	$114,135,800	$98,333,000	($15,802,800)	Revised caseload and per capita assumptions
Total Expansion Populations	**$136,678,713**	**$121,825,951**	**($14,852,762)**	
Grand Total Services	**$3,337,501,164**	**$3,246,901,671**	**($90,599,493)**	
Bottom Line Financing				
Upper Payment Limit Financing	$4,594,020	$4,111,163	($482,857)	Revised cost information
Department Recoveries Adjustment	$0	$0	$0	
Denver Health Outstationing	$5,485,699	$5,485,699	$0	
Hospital Provider Fee Supplemental Payments	$538,782,512	$651,089,802	$112,307,290	Update to request year figures based on most current model
Nursing Facility Provider Fee Supplemental Payments	$85,547,094	$86,763,011	$1,215,917	Revised based on final model approved by CMS
Physician Supplemental Payments	$4,238,789	$7,161,512	$2,922,723	Payments now include Memorial Hospital
Cash Funds Financing[(1)]	$0	$0	$0	
Total Bottom Line Financing	**$553,101,020**	**$754,611,187**	**$201,510,167**	
Grand Total[(2)]	**$3,890,602,184**	**$4,001,512,858**	**$110,910,674**	
Total Acute Care	$1,904,642,018	$1,946,571,857	$41,929,839	
Total Community Based Long Term Care	$358,838,988	$358,768,860	($70,128)	
Total Class I Nursing Facilities	$625,177,807	$538,803,358	($86,374,449)	
Total Class II Nursing Facilities	$2,366,473	$5,216,775	$2,850,302	
Total Program of All-Inclusive Care for the Elderly	$92,964,284	$89,649,719	($3,314,565)	
Total Supplemental Medicare Insurance Benefit	$148,181,677	$118,755,863	($29,425,814)	
Total Health Insurance Buy-In Program	$5,799,033	$3,723,549	($2,075,484)	
Total Single Entry Point	$26,862,436	$26,976,561	$114,125	
Total Disease Management	$500,000	$500,000	$0	
Total Prepaid Inpatient Health Plan Administration	$35,489,735	$36,109,178	$619,443	
Total Expansion Populations	$136,678,713	$121,825,951	($14,852,762)	
Total Bottom Line Financing	$553,101,020	$754,611,187	$201,510,167	
Grand Total[(2)]	**$3,890,602,184**	**$4,001,512,858**	**$110,910,674**	

Footnotes

(1) The Department has not received an FY 2012-13 appropriation as of this Budget Request. No annualizations are included.

(2) The Department Request is the sum of all the pieces in this document and comprises the summation of this Budget Request for Medical Services Premiums. This total matches the totals presented on the Schedule 13 and Exhibit A of this Request.

Exhibit F - ACUTE CARE - Cash-Based Actuals and Projections

Cash Based Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$127,969,752	$39,813,094	$385,226,750	$139,553,510	-	-	$1,428,780	$227,550,173	$34,701,970	$42,510,204	$48,724,102	$1,897,397	$1,049,375,733
FY 2003-04	$135,749,025	$46,119,779	$412,299,443	$182,825,434	-	-	$2,668,859	$229,743,284	$42,169,663	$63,935,230	$55,128,983	$2,089,094	$1,172,728,792
FY 2004-05	$134,189,229	$46,642,619	$385,860,624	$191,063,789	-	-	$2,490,150	$299,544,670	$42,706,006	$42,027,702	$44,696,256	$1,893,780	$1,191,114,826
FY 2005-06	$112,419,226	$45,351,381	$387,591,606	$198,695,066	-	-	$6,809,762	$312,707,761	$44,927,120	$41,011,299	$55,307,093	$2,067,371	$1,206,887,685
FY 2006-07	$83,410,163	$44,481,575	$383,750,038	$196,349,132	$7,480,884	-	$5,555,696	$327,210,370	$49,460,226	$48,460,189	$54,457,447	$2,748,118	$1,203,363,838
FY 2007-08	$91,223,938	$50,717,725	$450,621,054	$187,505,340	$18,427,719	-	$7,089,560	$360,156,073	$58,954,606	$54,344,094	$53,633,572	$3,330,605	$1,336,004,286
FY 2008-09	$102,239,226	$56,004,946	$492,622,774	$206,446,267	$30,913,086	-	$7,043,287	$428,647,150	$61,714,145	$60,515,451	$59,182,087	$3,886,476	$1,509,214,896
FY 2009-10 (DA)	$94,978,885	$54,197,977	$489,172,778	$218,768,176	$40,898,817	$3,085,476	$9,006,411	$462,761,448	$60,444,300	$68,066,557	$48,429,084	$3,328,831	$1,553,138,739
FY 2010-11 (DA)	$97,388,620	$61,036,898	$529,213,760	$218,112,253	$56,117,509	$61,707,804	$9,817,196	$497,319,012	$62,802,717	$67,507,543	$45,331,275	$5,066,688	$1,711,421,275
Estimated FY 2011-12	$95,282,838	$64,887,710	$555,306,053	$239,069,757	$64,470,579	$86,986,136	$11,042,638	$529,762,351	$61,715,027	$62,282,652	$40,558,194	$6,130,488	$1,817,494,423
Estimated FY 2012-13	$97,140,941	$69,330,549	$585,446,274	$258,647,322	$70,583,329	$108,772,292	$12,110,906	$570,962,062	$62,681,711	$62,801,573	$41,065,615	$7,029,283	$1,946,571,857
Estimated FY 2013-14	$100,072,525	$74,805,802	$620,977,140	$272,271,341	$76,152,391	$121,639,961	$13,108,008	$618,265,933	$64,633,079	$71,935,296	$44,628,118	$8,031,175	$2,086,520,769

Percent Change in Cash Based Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	6.08%	15.84%	7.03%	31.01%	-	-	86.79%	0.96%	21.52%	50.40%	13.15%	10.10%	11.75%
FY 2004-05	**-1.15%**	1.13%	-6.41%	4.51%	-	-	-6.70%	30.38%	1.27%	-34.27%	-18.92%	-9.35%	1.57%
FY 2005-06	-16.22%	-2.77%	0.45%	3.99%	-	-	173.47%	4.39%	5.20%	-2.42%	23.74%	9.17%	1.32%
FY 2006-07	-25.80%	-1.92%	-0.99%	-1.18%	-	-	-18.42%	4.64%	10.09%	18.16%	-1.54%	32.93%	-0.29%
FY 2007-08	9.37%	14.02%	17.43%	-4.50%	146.33%	-	27.61%	10.07%	19.20%	12.14%	-1.51%	21.20%	11.02%
FY 2008-09	12.07%	10.42%	9.32%	10.10%	67.75%	-	-0.65%	19.02%	4.68%	11.36%	10.35%	16.69%	12.96%
FY 2009-10 (DA)	-7.10%	-3.23%	-0.70%	5.97%	32.30%	-	27.87%	7.96%	-2.06%	12.48%	-18.17%	-14.35%	2.91%
FY 2010-11 (DA)	2.54%	12.62%	8.19%	-0.30%	37.21%	1899.94%	9.00%	7.47%	3.90%	-0.82%	-6.40%	52.21%	10.19%
Estimated FY 2011-12	-2.16%	6.31%	4.93%	9.61%	14.88%	40.96%	12.48%	6.52%	-1.73%	-7.74%	-10.53%	21.00%	6.20%
Estimated FY 2012-13	1.95%	6.85%	5.43%	8.19%	9.48%	25.05%	9.67%	7.78%	1.57%	0.83%	1.25%	14.66%	7.10%
Estimated FY 2013-14	3.02%	7.90%	6.07%	5.27%	7.89%	11.83%	8.23%	8.28%	3.11%	14.54%	8.68%	14.25%	7.19%

Per Capita Cost

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$3,687.46	$7,330.71	$8,258.34	$3,420.60	-	-	$30,399.56	$1,343.98	$2,484.57	$5,434.00	$11,930.49	$211.10	$3,162.68
FY 2003-04	$3,954.35	$8,312.87	$8,811.89	$3,843.94	-	-	$25,417.70	$1,176.49	$2,827.52	$7,613.15	$11,501.98	$212.26	$3,190.59
FY 2004-05	$3,750.40	$7,668.96	$8,050.67	$3,343.78	-	-	$28,622.42	$1,346.44	$2,703.77	$7,023.35	$8,678.88	$197.17	$2,933.61
FY 2005-06	$3,104.90	$7,506.02	$8,099.29	$3,374.29	-	-	$36,222.14	$1,460.17	$2,729.47	$8,011.58	$8,903.27	$186.38	$3,000.58
FY 2006-07	$2,324.18	$7,341.41	$7,863.89	$3,873.76	$1,449.22	-	$24,367.09	$1,593.12	$2,957.44	$9,351.64	$10,470.57	$212.90	$3,068.02
FY 2007-08	$2,514.16	$8,252.15	$9,024.51	$4,208.40	$2,066.35	-	$26,257.63	$1,765.28	$3,439.39	$8,642.51	$12,797.32	$234.32	$3,408.50
FY 2008-09	$2,717.76	$8,686.98	$9,592.50	$4,200.59	$2,428.94	-	$22,218.57	$1,823.03	$3,422.29	$8,674.81	$14,843.76	$257.81	$3,455.07
FY 2009-10 (DA)	$2,467.82	$7,688.75	$9,183.93	$3,794.04	$2,380.88	$952.90	$21,191.56	$1,678.67	$3,288.41	$8,693.05	$13,113.75	$209.11	$3,113.77
FY 2010-11 (DA)	$2,502.21	$7,858.49	$9,402.39	$3,577.96	$2,784.44	$2,271.43	$18,488.13	$1,644.52	$3,414.49	$8,580.01	$14,108.71	$296.47	$3,051.97
Estimated FY 2011-12	$2,390.02	$7,725.65	$9,318.94	$3,400.76	$2,680.69	$2,456.82	$18,102.69	$1,573.95	$3,401.96	$8,335.47	$15,253.18	$326.16	$2,922.63
Estimated FY 2012-13	$2,379.74	$7,748.16	$9,427.78	$3,339.32	$2,663.72	$2,566.53	$17,836.39	$1,553.01	$3,451.83	$8,322.50	$16,237.89	$342.84	$2,882.68
Estimated FY 2013-14	$2,387.57	$7,881.76	$9,674.95	$3,346.87	$2,736.24	$2,597.20	$17,642.00	$1,546.18	$3,538.82	$8,491.20	$17,508.09	$361.26	$2,883.00

Percent Change in Per Capita Cost

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	7.24%	13.40%	6.70%	12.38%	-	-	-16.39%	-12.46%	13.80%	40.10%	-3.59%	0.55%	0.88%
FY 2004-05	-5.16%	-7.75%	-8.64%	-13.01%	-	-	12.61%	14.45%	-4.38%	-7.75%	-24.54%	-7.11%	-8.05%
FY 2005-06	-17.21%	-2.12%	0.60%	0.91%	-	-	26.55%	8.45%	0.95%	14.07%	2.59%	-5.47%	2.28%
FY 2006-07	-25.14%	-2.19%	-2.91%	14.80%	-	-	-32.73%	9.11%	8.35%	16.73%	17.60%	14.23%	2.25%
FY 2007-08	8.17%	12.41%	14.76%	8.64%	42.58%	-	7.76%	10.81%	16.30%	-7.58%	22.22%	10.06%	11.10%
FY 2008-09	8.10%	5.27%	6.29%	-0.19%	17.55%	-	-15.38%	3.27%	-0.50%	0.37%	15.99%	10.02%	1.37%
FY 2009-10 (DA)	-9.20%	-11.49%	-4.26%	-9.68%	-1.98%	-	-4.62%	-7.92%	-3.91%	0.21%	-11.65%	-18.89%	-9.88%
FY 2010-11 (DA)	**1.39%**	2.21%	**2.38%**	-5.70%	16.95%	138.37%	-12.76%	**-2.03%**	3.83%	-1.30%	**7.59%**	41.78%	-1.98%
Estimated FY 2011-12	-4.48%	-1.69%	-0.89%	-4.95%	-3.73%	8.16%	-2.08%	-4.29%	-0.37%	-2.85%	8.11%	10.01%	-4.24%
Estimated FY 2012-13	-0.43%	0.29%	1.17%	-1.81%	-0.63%	4.47%	-1.47%	-1.33%	1.47%	-0.16%	6.46%	5.11%	-1.37%
Estimated FY 2013-14	0.33%	1.72%	2.62%	0.23%	2.72%	1.19%	-1.09%	-0.44%	2.52%	2.03%	7.82%	5.37%	0.01%

Per Capita Trends

Per Capita Trends	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Actual FY 2010-11 Per Capita	$2,502.21	$7,858.49	$9,402.39	$3,577.96	$2,784.44	$2,271.43	$18,488.13	$1,644.52	$3,414.49	$8,580.01	$14,108.71	$296.47	$3,051.97
Average of FY 2004-05 through FY 2008-09[4]	-	-	-	2.23%	12.03%	-	-0.24%	9.22%	4.14%	3.17%	6.77%	4.35%	1.79%
Average of FY 2005-06 through FY 2008-09[4]	-	-	-	6.04%	15.03%	-	-3.45%	7.91%	6.28%	5.90%	**14.60%**	7.21%	4.25%
Average of FY 2006-07 through FY 2008-09	-2.96%	5.16%	6.05%	7.75%	20.04%	-	-13.45%	7.73%	8.05%	3.17%	18.60%	11.44%	4.91%
Average of FY 2007-08 through FY 2008-09	8.14%	8.84%	10.53%	4.23%	30.07%	-	-3.81%	7.04%	7.90%	-3.61%	19.11%	10.04%	6.24%
Average of FY 2005-06 through FY 2009-10[4]	-	-	-	2.90%	11.63%	-	-3.68%	4.74%	4.24%	4.76%	9.35%	1.99%	1.42%
Average of FY 2006-07 through FY 2009-10	-4.52%	1.00%	3.47%	3.39%	14.54%	-	-11.24%	3.82%	5.06%	**2.43%**	11.04%	3.86%	1.21%
Average of FY 2007-08 through FY 2009-10	2.36%	**2.06%**	5.60%	**-0.41%**	19.38%	-	-4.08%	2.05%	3.96%	-2.33%	8.85%	0.40%	0.86%
Average of FY 2008-09 through FY 2009-10	-0.55%	-3.11%	1.02%	-4.94%	7.79%	-	-10.00%	-2.33%	-2.21%	0.29%	2.17%	-4.44%	-4.26%
Average of FY 2006-07 through FY 2010-11	-3.34%	1.24%	3.25%	1.57%	15.02%	27.67%	-11.55%	2.65%	4.81%	1.69%	10.35%	11.44%	0.57%
Average of FY 2007-08 through FY 2010-11	2.12%	2.10%	4.79%	-1.73%	18.78%	34.59%	-6.25%	1.03%	**3.93%**	-2.08%	8.54%	**10.74%**	0.15%
Average of FY 2008-09 through FY 2010-11	0.10%	-1.34%	1.47%	-5.19%	10.84%	46.12%	-10.92%	-2.23%	-0.19%	-0.24%	3.98%	10.97%	-3.50%
Average of FY 2009-10 through FY 2010-11	-3.91%	-4.64%	-0.94%	-7.69%	7.49%	69.19%	-8.69%	-4.98%	-0.04%	-0.55%	-2.03%	11.45%	-5.93%

Exhibit F - ACUTE CARE - Cash-Based Actuals and Projections

Current Year Projection													
ACUTE CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Percentage Selected to Modify Per Capita[1]	-1.15%	2.06%	2.38%	-0.41%	2.18%	12.73%	-1.08%	-1.02%	1.97%	1.22%	14.60%	10.74%	
Estimated FY 2011-12 Base Per Capita	$2,473.43	$8,020.37	$9,626.17	$3,563.29	$2,845.14	$2,560.63	$18,289.03	$1,627.83	$3,481.58	$8,684.26	$16,168.58	$328.31	$3,031.88
Estimated FY 2011-12 Eligibles	39,867	8,399	59,589	70,299	24,050	35,406	610	336,582	18,141	7,472	2,659	18,796	621,870
Estimated FY 2011-12 Base Expenditures	$98,608,234	$67,363,088	$573,613,844	$250,495,724	$68,425,636	$90,661,549	$11,156,308	$547,898,277	$63,159,343	$64,888,791	$42,992,254	$6,170,915	$1,885,433,963
Bottom Line Impacts													
FY 2011-12 BRI-1: Client Overutilization Program Expansion	($5,646)	($5,313)	($45,007)	($19,062)	($4,838)	($6,312)	$0	($40,336)	($4,884)	($5,202)	$0	$0	($136,600)
FY 2011-12 BRI-5: State Allowable Cost Expansion	($94,658)	($68,136)	($577,197)	($244,458)	($62,043)	($80,948)	($10,935)	($517,292)	($62,632)	($66,718)	($44,469)	($3,848)	($1,833,334)
FY 2011-12 BRI-5: Reduce Rates for Diabetes Supplies	($171,835)	($47,244)	($450,562)	($26,509)	($9,832)	($11,014)	$0	($84,565)	($41,167)	$0	$0	$0	($842,728)
FY 2011-12 BRI-5: Reduce Payment for Uncomplicated C-Section	$0	$0	$0	($2,457,645)	($424,396)	($567,855)	$0	$0	$0	($1,241,010)	($1,585,098)	$0	($6,276,004)
FY 2011-12 BRI-5: Reduce Payments for Renal Dialysis	($57,007)	($60,779)	($484,374)	($228,010)	($39,374)	($52,683)	$0	($330,087)	($19,360)	$0	($147,059)	$0	($1,418,733)
FY 2011-12 BRI-5: Deny Payment of Hospital Readmissions 48 hrs	($92,006)	($98,094)	($781,755)	($367,997)	($63,547)	($85,028)	$0	($532,743)	($31,247)	($185,823)	($237,346)	$168	($2,475,418)
FY 2011-12 BRI-5: Prior Authorize Certain Radiology	($8,056)	($14,528)	($120,784)	($198,280)	($52,258)	($65,075)	$0	($121,802)	($27,733)	($61,307)	($2,315)	$2	($672,136)
FY 2011-12 BRI-5: Limit Acute Home Health Services	($159,554)	($53,296)	($807,898)	($2,872)	($951)	($1,192)	$0	($29,181)	($76,611)	$0	$0	$0	($1,131,555)
FY 2011-12 BRI-5: HMO Impact to Rates	($105,682)	($76,072)	($644,428)	($272,932)	($69,270)	($90,376)	$0	($577,545)	($69,928)	$0	$0	$0	($1,906,233)
FY 2011-12 BA-9: 0.75% Provider Rate Reduction	($624,364)	($449,432)	($3,807,250)	($1,612,470)	($409,243)	($533,939)	($72,130)	($3,412,111)	($413,129)	($440,078)	($293,320)	($25,381)	($12,092,847)
FY 2011-12 BA-9: Estimated ACC Savings	($92,200)	($291,040)	($2,560,656)	($1,376,745)	($669,065)	($454,470)	$0	($464,972)	($63,161)	($217,453)	$0	$0	($6,189,762)
FY 2011-12 BA-9: Limit Fluoride Application Benefit	$0	$0	$0	$0	$0	$0	$0	($30,982)	$0	$0	$0	$0	($30,982)
FY 2011-12 BA-9: Limit Dental Prophylaxis Benefit	$0	$0	$0	$0	$0	$0	$0	($161,936)	$0	$0	$0	$0	($161,936)
FY 2011-12 BA-9: Limit Oral Hygiene Instruction	$0	$0	$0	$0	$0	$0	$0	($4,241,026)	$0	$0	$0	$0	($4,241,026)
FY 2011-12 BA-9: Limit Physical and Occupational Therapy	($23,990)	($8,013)	($121,470)	($432)	($143)	($179)	$0	$0	$0	$0	$0	$0	($154,227)
FY 2011-12 BA-9: Home Health Billing Changes	($390,643)	($130,487)	($1,978,031)	($7,033)	($2,330)	($2,919)	$0	$0	$0	$0	$0	$0	($2,511,443)
Estimated Impact of Increasing PACE Enrollment	($478,357)	($477,194)	($362,831)	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1,318,382)
Eliminate Circumcision Benefit	$0	$0	$0	$0	$0	$0	$0	($344,154)	($28,846)	$0	$0	$0	($373,000)
Wound Therapy DME Reduction	($20,389)	($5,606)	($53,465)	($3,146)	($1,167)	($1,307)	$0	($10,035)	($4,885)	$0	$0	$0	($100,000)
SB 11-177: "Sunset of Pregnancy Prevention Program"	$0	$0	$0	$0	$0	$0	$0	$125,756	$15,226	$0	$0	$0	$140,982
Managed Care Organization Reconciliations	($298,650)	($214,975)	($1,821,108)	($771,287)	($195,752)	($255,397)	$0	($1,632,103)	($197,610)	$0	$0	$0	($5,386,882)
Annualization of FY 2010-11 BRI-1: Prevention and Benefits for Enhanced Value (P-BEV) and BA#12: Evidence Guided Utilization Review (EGUR)	($39,476)	($28,416)	($240,721)	($101,952)	($25,875)	($33,759)	($4,561)	($215,738)	($26,121)	($27,825)	($18,546)	($1,605)	($764,595)
Annualization of FY 2010-11 BRI-2: Coordinated Payment and Payment Reform	($80,285)	($57,792)	($489,568)	($207,345)	($52,624)	($68,658)	($9,275)	($438,758)	($53,124)	($56,589)	($37,718)	($3,264)	($1,555,000)
Annualization of FY 2010-11 BRI-6: Medicaid Program Reductions DME Reductions	($25,509)	($7,013)	($66,883)	($3,935)	($1,459)	($1,635)	$0	($12,553)	($6,111)	$0	$0	$0	($125,098)
Annualization of FY 2010-11 BRI-6: 1% Rate Reduction Effective July 1, 2010	($139,343)	($100,303)	($849,695)	($359,868)	($91,334)	($119,164)	($16,098)	($761,508)	($92,201)	($98,216)	($65,463)	($5,665)	($2,698,858)
Annualization of FY 2010-11 S-6: Accountable Care Collaborative	($267,168)	($180,643)	($1,328,045)	($3,012,979)	($1,715,707)	($1,165,986)	$0	($3,996,523)	($131,685)	($190,234)	$0	($599)	($11,989,569)
Annualization of FY 2010-11 BA-16: Implementation of Family Planning Waiver	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Annualization of Increased Drug Rebates due to the Affordable Care Act	($11,553)	($29,259)	($209,229)	($64,856)	($22,169)	($26,397)	$0	($92,907)	($33,072)	($3,805)	$0	$0	($493,247)
HB 10-1005: Telemedicine Changes	$0	$0	$91,491	$38,749	$0	$0	$0	$0	$0	$0	$0	$0	$130,240
Annualization of HB 10-1033: Add SBIRT to Optional Services	$18,595	$13,384	$113,381	$48,020	$12,187	$15,901	$2,148	$101,614	$12,303	$13,106	$8,735	$756	$360,130
Annualization of SB 10-167: NCCI	($645)	($465)	($3,935)	($1,667)	($423)	($552)	($75)	($3,527)	($427)	($455)	($303)	($26)	($12,500)
Annualization of SB 10-167: HIBI	($12,629)	($9,091)	($77,008)	($32,615)	($8,278)	($10,800)	($1,459)	($69,016)	($8,356)	($8,901)	($5,933)	($513)	($244,599)
Annualization of SB 10-167: Colorado False Claims Act - PARIS	($11,120)	($8,006)	($67,817)	($28,722)	($7,290)	($9,511)	($1,285)	($60,778)	($7,359)	($7,839)	($5,225)	($452)	($215,404)
Annualization of SB 10-167: Colorado False Claims Act - RX COB	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Annualization of FY 2009-10 BA-33: PA of Anti-Convulsants	($4,214)	($10,678)	($76,354)	($23,668)	($8,090)	($9,633)	$0	($33,905)	($12,069)	($1,389)	$0	$0	($180,000)
Annualization of FY 2009-10 BRI-1: Auto PA	($9,505)	($24,070)	($172,122)	($53,354)	($18,237)	($21,715)	$0	($76,430)	($27,207)	($3,130)	$0	$0	($405,770)
Annualization of FY 2009-10 BRI-2: Oxygen Restrictions	($119,507)	($32,817)	($312,976)	($18,414)	($6,829)	($7,651)	$0	($58,742)	($28,596)	($1,135)	$0	$0	($586,667)
ACA 4107 Smoking Cessation Counseling for Pregnant Women	$0	$0	($1,494)	($14,483)	($4,720)	($7,159)	$0	($12,041)	($4,324)	($2,136)	$0	$0	($46,357)
Total Bottom Line Impacts	($3,325,396)	($2,475,378)	($18,307,791)	($11,425,967)	($3,955,057)	($3,675,413)	($113,670)	($18,135,926)	($1,444,316)	($2,606,139)	($2,434,060)	($40,427)	($67,939,540)
Estimated FY 2011-12 Expenditures	**$95,282,838**	**$64,887,710**	**$555,306,053**	**$239,069,757**	**$64,470,579**	**$86,986,136**	**$11,042,638**	**$529,762,351**	**$61,715,027**	**$62,282,652**	**$40,558,194**	**$6,130,488**	**$1,817,494,423**
Estimated FY 2011-12 Per Capita	$2,390.02	$7,725.65	$9,318.94	$3,400.76	$2,680.69	$2,456.82	$18,102.69	$1,573.95	$3,401.96	$8,335.47	$15,253.18	$326.16	$2,922.63
% Change over FY 2010-11 (DA) Per Capita	-4.48%	-1.69%	-0.89%	-4.95%	-3.73%	8.16%	-2.08%	-4.29%	-0.37%	-2.85%	8.11%	10.01%	-4.24%

Exhibit F - ACUTE CARE - Cash-Based Actuals and Projections

Request Year Projection													
ACUTE CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Percentage Selected to Modify Per Capita[2]	0.70%	2.06%	2.38%	-0.41%	2.18%	5.92%	-1.08%	-1.02%	1.97%	1.22%	7.30%	5.37%	
Estimated FY 2012-13 Base Per Capita	$2,406.63	$7,884.80	$9,540.73	$3,386.81	$2,739.13	$2,602.17	$17,907.74	$1,557.97	$3,468.81	$8,437.17	$16,366.66	$343.67	$2,912.16
Estimated FY 2012-13 Eligibles	40,820	8,948	62,098	77,455	26,498	42,381	679	367,649	18,159	7,546	2,529	20,503	675,265
Estimated FY 2012-13 Base Expenditure	$98,238,637	$70,553,190	$592,460,252	$262,325,369	$72,581,424	$110,282,650	$12,159,355	$572,786,795	$62,990,121	$63,666,885	$41,391,283	$7,046,266	$1,966,482,227
Bottom Line Impacts													
Implementation of SB 10-117: Over the Counter Medications	($3,508)	($8,883)	($63,524)	($19,691)	($6,731)	($8,014)	$0	($28,208)	($10,041)	($1,155)	$0	$0	($149,755)
Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act)	$79,666	$162,213	$1,202,384	$1,140,255	$266,560	$356,794	$0	$2,349,853	$229,285	$372,727	$138,845	$84	$6,298,666
Annualization of FY 2010-11 S-6: Accountable Care Collaborative	($67,155)	($45,406)	($333,814)	($757,335)	($431,256)	($293,079)	$0	($1,004,557)	($33,100)	($47,817)	$0	($151)	($3,013,670)
Annualization of BRI-1: Client Overutilization Program Expansion	($34,043)	($32,035)	($271,378)	($114,936)	($29,171)	($38,059)	$0	($243,213)	($29,447)	($31,368)	$0	$0	($823,650)
Annualization of FY 2011-12 BRI-5: State Allowable Cost Expansion	($8,606)	($6,194)	($52,472)	($22,223)	($5,640)	($7,359)	($994)	($47,026)	($5,694)	($6,065)	($4,043)	($350)	($166,666)
Annualization of FY 2011-12 BRI-5: Reduce Rates for Diabetes Supplies	($30,599)	($8,413)	($80,232)	($4,720)	($1,751)	($1,961)	$0	($15,059)	($7,331)	$0	$0	$0	($150,066)
Annualization of FY 2011-12 BRI-5: Reduce Payment for Uncomplicated C-Section	$0	$0	$0	($317,796)	($54,878)	($73,429)	$0	$0	$0	($160,474)	($204,968)	$0	($811,545)
Annualization of FY 2011-12 BRI-5: Reduce Payments for Renal Dialysis	($7,373)	($7,859)	($62,634)	($29,484)	($5,091)	($6,812)	$0	($42,683)	($2,503)	$0	($19,016)	$0	($183,455)
Annualization of FY 2011-12 BRI-5: Deny Payment of Hospital Readmissions 48 hrs	($11,899)	($12,684)	($101,088)	($47,585)	($8,217)	($10,995)	$0	($68,888)	($4,040)	($24,029)	($30,691)	$22	($320,094)
Annualization of FY 2011-12 BRI-5: Prior Authorize Certain Radiology	($44,587)	($80,416)	($668,564)	($1,097,517)	($289,259)	($360,204)	$0	($674,198)	($153,509)	($339,348)	($12,816)	$9	($3,720,409)
Annualization of FY 2011-12 BRI-5: Limit Acute Home Health Services	($40,405)	($13,496)	($204,589)	($727)	($241)	($302)	$0	($7,390)	($19,401)	$0	$0	$0	($286,551)
Annualization of FY 2011-12 BRI-5: HMO Impact to Rates	($4,545)	($3,271)	($27,710)	($11,736)	($2,979)	($3,886)	$0	($24,834)	($3,007)	$0	$0	$0	($81,968)
Annualization of FY 2011-12 BA-9: 0.75% Provider Rate Reduction	($149,938)	($107,928)	($914,286)	($387,224)	($98,277)	($128,222)	($17,322)	($819,396)	($99,210)	($105,682)	($70,439)	($6,095)	($2,904,019)
Annualization of FY 2011-12 BA-9: Estimated ACC Savings	($142,472)	($455,732)	($4,020,720)	($1,882,527)	($1,272,103)	($864,090)	$0	($344,452)	($101,491)	($321,311)	$0	$0	($9,404,898)
Annualization of FY 2011-12 BA-9: Limit Fluoride Application Benefit	$0	$0	$0	$0	$0	$0	$0	($6,101)	$0	$0	$0	$0	($6,101)
Annualization of FY 2011-12 BA-9: Limit Dental Prophylaxis Benefit	$0	$0	$0	$0	$0	$0	$0	($31,892)	$0	$0	$0	$0	($31,892)
Annualization of FY 2011-12 BA-9: Limit Oral Hygiene Instruction	$0	$0	$0	$0	$0	$0	$0	($835,251)	$0	$0	$0	$0	($835,251)
Annualization of FY 2011-12 BA-9: Limit Physical and Occupational Therapy	($62,349)	($20,826)	($315,705)	($1,122)	($372)	($466)	$0	$0	$0	$0	$0	$0	($400,840)
Annualization of FY 2011-12 BA-9: Home Health Billing Changes	($99,052)	($33,087)	($501,556)	($1,783)	($591)	($740)	$0	$0	$0	$0	$0	$0	($636,809)
Estimated Impact of Increasing PACE Enrollment	($485,389)	($484,208)	($368,164)	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1,337,761)
Annualization of Wound Therapy DME Reduction	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Annualization of HB 10-1005: Telemedicine Changes	$0	$0	$158,023	$24,313	$0	$0	$0	$0	$0	$0	$0	$0	$182,336
Annualization of SB 11-177: "Sunset of Pregnancy Prevention Program"	$0	$0	$0	$0	$0	$0	$0	$140,894	$17,059	$0	$0	$0	$157,953
Annualization of Managed Care Organization Reconciliations	$298,650	$214,975	$1,821,108	$771,287	$195,752	$255,397	$0	$1,632,103	$197,610	$0	$0	$0	$5,386,882
Annualization of SB 10-167: Colorado False Claims Act - NCCI	($43,309)	($31,174)	($264,083)	($111,846)	($28,386)	($37,036)	($5,003)	($236,675)	($28,656)	($30,525)	($20,346)	($1,761)	($838,800)
Annualization of SB 10-167: Colorado False Claims Act - HIBI	($172,474)	($124,151)	($1,051,711)	($445,427)	($113,049)	($147,495)	($19,925)	($942,558)	($114,122)	($121,567)	($81,026)	($7,011)	($3,340,516)
Annualization of SB 10-167: Colorado False Claims Act - COB	($8,226)	($20,837)	($149,001)	($46,187)	($15,788)	($18,798)	$0	($66,163)	($23,552)	($2,710)	$0	$0	($351,262)
Annualization of SB 10-167: Colorado False Claims Act - PARIS	($11,120)	($8,006)	($67,817)	($28,722)	($7,290)	($9,511)	($1,285)	($60,778)	($7,359)	($7,839)	($5,225)	($452)	($215,404)
Annualization of FY 2010-11 BRI-1: Prevention and Benefits for Enhanced Value (P-BEV) and BA#12: Evidence Guided Utilization Review (EGUR)	($19,739)	($14,208)	($120,360)	($50,976)	($12,938)	($16,880)	($2,280)	($107,869)	($13,060)	($13,912)	($9,273)	($802)	($382,297)
Annualization of FY 2010-11 BRI-2: Coordinated Payment and Payment Reform	($14,199)	($10,220)	($86,580)	($36,669)	($9,306)	($12,142)	($1,640)	($77,594)	($9,395)	($10,008)	($6,670)	($577)	($275,000)
Annualization of FY 2010-11 BA-16: Implementation of Family Planning Waiver	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Annualization of FY 2009-10 BA-33: Prior Authorization of Anti-Convulsants	($1,405)	($3,559)	($25,451)	($7,889)	($2,697)	($3,211)	$0	($11,302)	($4,023)	($463)	$0	$0	($60,000)
Annualization of FY 2009-10 BRI-1: Auto PA	($28,512)	($72,210)	($516,367)	($160,062)	($54,712)	($65,146)	$0	($229,291)	($81,620)	($9,390)	$0	$0	($1,217,310)
Annualization of ACA 4107 Smoking Cessation Counseling for Pregnant Women	$0	$0	($3,091)	($29,986)	($9,773)	($14,823)	$0	($24,929)	($8,953)	($4,421)	$0	$0	($95,976)
Community Choice Transitions	$14,892	$4,974	$75,404	$268	$89	$111	$0	$2,724	$7,150	$45	$0	$101	$105,758
Total Bottom Line Impacts	($1,097,696)	($1,222,641)	($7,013,978)	($3,678,047)	($1,998,095)	($1,510,358)	($48,449)	($1,824,733)	($308,410)	($865,312)	($325,668)	($16,983)	($19,910,370)
Estimated FY 2012-13 Expenditure	**$97,140,941**	**$69,330,549**	**$585,446,274**	**$258,647,322**	**$70,583,329**	**$108,772,292**	**$12,110,906**	**$570,962,062**	**$62,681,711**	**$62,801,573**	**$41,065,615**	**$7,029,283**	**$1,946,571,857**
Estimated FY 2012-13 Per Capita	$2,379.74	$7,748.16	$9,427.78	$3,339.32	$2,663.72	$2,566.53	$17,836.39	$1,553.01	$3,451.83	$8,322.50	$16,237.89	$342.84	$2,882.68
% Change over FY 2011-12 Per Capita	-0.43%	0.29%	1.17%	-1.81%	-0.63%	4.47%	-1.47%	-1.33%	1.47%	-0.16%	6.46%	5.11%	-1.37%

Exhibit F - ACUTE CARE - Cash-Based Actuals and Projections

Out Year Projection													
ACUTE CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Percentage Selected to Modify Per Capita[3]	0.70%	2.06%	2.38%	-0.41%	2.18%	0.75%	-1.08%	-1.02%	1.97%	1.22%	7.30%	5.37%	
Estimated FY 2013-14 Base Per Capita	$2,396.28	$7,907.77	$9,652.16	$3,325.63	$2,721.79	$2,585.70	$17,644.31	$1,537.25	$3,519.66	$8,424.03	$17,423.26	$361.25	$2,871.64
Estimated FY 2013-14 Eligibles	41,914	9,491	64,184	81,351	27,831	46,835	743	399,867	18,264	8,472	2,549	22,231	723,732
Estimated FY 2013-14 Base Expenditure	$100,437,680	$75,052,645	$619,514,237	$270,543,326	$75,750,137	$121,101,283	$13,109,722	$614,695,767	$64,283,070	$71,366,276	$44,411,890	$8,030,949	$2,078,296,982
Bottom Line Impacts													
Estimated Impact of Increasing PACE Enrollment	($492,523)	($491,327)	($373,576)	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1,357,426)
Annualization of Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act)	$124,065	$252,618	$1,872,507	$1,775,752	$415,121	$555,646	$0	$3,659,493	$357,072	$580,458	$216,228	$132	$9,809,092
Annualization of FY 2010-11 BA-16: Implementation of Family Planning Waiver	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Annualization of SB 10-117: "Over the Counter Medications"	($809)	($2,048)	($14,645)	($4,540)	($1,552)	($1,848)	$0	($6,503)	($2,315)	($266)	$0	$0	($34,526)
Annualization of BRI-1: Client Overutilization Program Expansion	($9,634)	($10,678)	($90,459)	($38,312)	($9,724)	($12,686)	($1,714)	($81,071)	($9,816)	($10,456)	$0	$0	($274,550)
Annualization of ACA 4107 Smoking Cessation Counseling for Pregnant Women	$0	$0	($528)	($5,132)	($1,673)	($2,537)	$0	($4,267)	($1,532)	($757)	$0	$0	($16,426)
Annualization of Community Choice Transitions	$13,746	$4,592	$69,604	$247	$82	$103	$0	$2,514	$6,600	$41	$0	$94	$97,623
Total Bottom Line Impacts	($365,155)	($246,843)	$1,462,903	$1,728,015	$402,254	$538,678	($1,714)	$3,570,166	$350,009	$569,020	$216,228	$226	$8,223,787
Estimated FY 2013-14 Expenditure	**$100,072,525**	**$74,805,802**	**$620,977,140**	**$272,271,341**	**$76,152,391**	**$121,639,961**	**$13,108,008**	**$618,265,933**	**$64,633,079**	**$71,935,296**	**$44,628,118**	**$8,031,175**	**$2,086,520,769**
Estimated FY 2013-14 Per Capita	$2,387.57	$7,881.76	$9,674.95	$3,346.87	$2,736.24	$2,597.20	$17,642.00	$1,546.18	$3,538.82	$8,491.20	$17,508.09	$361.26	$2,883.00
% Change over FY 2012-13 Per Capita	0.33%	1.72%	2.62%	0.23%	2.72%	1.19%	-1.09%	-0.44%	2.52%	2.03%	7.82%	5.37%	0.01%

Footnotes

(1) Percentage selected to modify Per Capita amounts for Estimated FY 2011-12: Where applicable, percentage selections have been bolded for clarification.	**OAP-A**	The per capita growth from FY 2003-04 to FY 2004-05	**Exp. Adults to 60%**	2.18% or a continuation of the forecasted growth for all expansion adults as reported in the February, 2011 forecast	**Foster Care**	One half the average per capita growth rate from FY 2007-08 through FY 2010-11
	OAP-B	The average per capita growth from FY 2007-08 through FY 2009-10	**Exp. Adults to 100%**	12.73% or the percentage necessary to achieve convergence to 90% of the Expansion to 60% population	**BC Adults**	One half the average per capita growth from FY 2006-07 through FY 2009-10
	AND/AB	The per capita growth from FY 2009-10 to FY 2010-11	**BCCP**	See EF-8	**Non-Citizens**	The average per capita growth from FY 2005-06 through FY 2008-09
	AFDC-A	The average per capita growth from FY 2007-08 through FY 2009-10	**Elig. Children**	One half the per capita growht rate from FY 2009-10 to FY 2010-11	**Partial Dual Eligibles**	Average of FY 2007-08 through FY 2010-11
(2) Percentage selected to modify Per Capita amounts for Estimated FY 2012-13: Where applicable, percentage selections have been italicized for clarification.	**OAP-A**	One half the per capita growth rate from FY 2009-10 to FY 2010-11	**Exp. Adults to 60%**	2.18% or a continuation of the forecasted growth for all expansion adults as reported in the February, 2011 forecast	**Foster Care**	One half the average per capita growth rate from FY 2007-08 through FY 2010-11
	OAP-B	The average per capita growth from FY 2007-08 through FY 2009-10	**Exp. Adults to 100%**	5.92% or the percentage necessary to achieve convergence to 90% of the Expansion to 60% population	**BC Adults**	One half the average per capita growth from FY 2006-07 through FY 2009-10
	AND/AB	The per capita growth from FY 2009-10 to FY 2010-11	**BCCP**	See EF-8	**Non-Citizens**	One half the FY 2011-12 trend selection
	AFDC-A	One half the trend selected for FY 2011-12	**Elig. Children**	One half the per capita growht rate from FY 2009-10 to FY 2010-11	**Partial Dual**	One half the FY 2011-12 trend selection
(3) Percentage selected to modify Per Capita amounts for Estimated FY 2013-14: Where applicable, percentage selections have been italicized for clarification.	**OAP-A**	One half the per capita growth rate from FY 2009-10 to FY 2010-11	**Exp. Adults to 60%**	2.18% or a continuation of the forecasted growth for all expansion adults as reported in the February, 2011 forecast	**Foster Care**	One half the average per capita growth rate from FY 2007-08 through FY 2010-11
	OAP-B	The average per capita growth from FY 2007-08 through FY 2009-10	**Exp. Adults to 100%**	0.75% or the percentage necessary to achieve convergence to 90% of the Expansion to 60% population	**BC Adults**	One half the average per capita growth from FY 2006-07 through FY 2009-10
	AND/AB	The per capita growth from FY 2009-10 to FY 2010-11	**BCCP**	See EF-8	**Non-Citizens**	One half the FY 2011-12 trend selection
	AFDC-A	One half the trend selected for FY 2011-12	**Elig. Children**	One half the per capita growht rate from FY 2009-10 to FY 2010-11	**Partial Dual**	One half the FY 2011-12 trend selection

(4) Due to changes in Part D Medicare prescription coverage, historical per capita trends do not incorporate data prior to FY 2005-06 for the OAP-A and OAP-B eligibility types.

Exhibit F - ACUTE CARE - Breast and Cervical Cancer Program - Per Capita Detail and Fund Splits

Breast and Cervical Cancer Program Costs

Month	Total[(1)]	Caseload	Monthly Per Capita	Rolling 3-Month Per Capita	Percent Change
October 2010	$731,130	505	$1,447.78	-	-
November 2010	$838,350	511	$1,640.61	-	-
December 2010	$641,895	526	$1,220.33	$4,308.72	-
January 2011	$858,219	532	$1,613.19	$4,474.13	3.84%
February 2011	$860,735	535	$1,608.85	$4,442.37	-0.71%
March 2011	$758,865	556	$1,364.87	$4,586.91	3.25%
April 2011	$842,553	569	$1,480.76	$4,454.48	-2.89%
May 2011	$977,078	587	$1,664.53	$4,510.16	1.25%
June 2011	$796,240	589	$1,351.85	$4,497.14	-0.29%
July 2011	$905,622	587	$1,542.80	$4,559.18	1.38%
August 2011	$1,098,058	586	$1,873.82	$4,768.47	4.59%
September 2011	$806,654	590	$1,367.21	$4,783.83	0.32%
October 2011	$840,959	592	$1,420.54	$4,661.57	-2.56%
November 2011	$777,937	602	$1,292.25	$4,080.00	-12.48%
December 2011	$948,163	606	$1,564.63	$4,277.42	4.84%
Selected Trend Factor[(2)]					**-1.08%**
FY 2011-12 Totals[(3)]	$11,042,638	610	$18,102.69		
FY 2012-13 Totals[(3)]	$12,110,906	679	$17,836.39		
FY 2013-14 Totals[(3)]	$13,108,008	743	$17,642.00		

Breast and Cervical Cancer Program Costs Footnotes:

(1) Totals taken from the Department's monthly report to the Joint Budget Committee on the Health Care Policy and Financing Medical Services Premiums Expenditures and Medicaid Caseload.

(2) The selected trend factor was calculated using a regression model of the rolling 3-month per capita expenditures from April 2007 to June 2011. The model controls for caseload, time, and seasonality. The trend factor is the average of the rolling average percent changes of the predicted values from the regression model for each fiscal year, annualized to adjust for a full-year effect.

(3) The FY 2011-12, FY 2012-13, and FY 2013-14 totals are calculated on pages EF-2 through EF-4 and include bottom line impacts. Caseload totals are taken from Exhibit B.

Exhibit F - ACUTE CARE - Breast and Cervical Cancer Program - Per Capita Detail and Fund Splits

Breast and Cervical Cancer Program Fund Splits

FY 2011-12 Fund Splits	Per Capita	Allocation	Caseload	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Medicaid Breast and Cervical Cancer Program Clients[4]		70.00%	427	$7,729,847	$0	$2,705,446	$0	$5,024,401
Health Care Expansion Breast and Cervical Cancer Program Clients[5]		30.00%	183	$3,312,791	$0	$0	$1,159,477	$2,153,314
Total	**$18,102.69**	**100.00%**	**610**	**$11,042,638**	**$0**	**$2,705,446**	**$1,159,477**	**$7,177,715**

FY 2012-13 Fund Splits	Per Capita	Allocation[7]	Caseload	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Medicaid Breast and Cervical Cancer Program Clients[6]		71.33%	484	$8,638,506	$1,511,738	$1,511,739	$0	$5,615,029
Health Care Expansion Breast and Cervical Cancer Program Clients[5]		28.67%	195	$3,472,400	$0	$0	$1,215,340	$2,257,060
Total	**$17,836.39**	**100.00%**	**679**	**$12,110,906**	**$1,511,738**	**$1,511,739**	**$1,215,340**	**$7,872,089**

FY 2013-14 Fund Splits	Per Capita	Allocation[7]	Caseload	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Medicaid Breast and Cervical Cancer Program Clients[6]		73.51%	546	$9,635,608	$1,686,232	$1,686,231	$0	$6,263,145
Health Care Expansion Breast and Cervical Cancer Program Clients[5]		26.49%	197	$3,472,400	$0	$0	$1,215,340	$2,257,060
Total	**$17,642.00**	**100.00%**	**743**	**$13,108,008**	**$1,686,232**	**$1,686,231**	**$1,215,340**	**$8,520,205**

(4) 25.5-5-308 (9) (e), C.R.S. (2011). 35% Cash Funds from the Breast and Cervical Cancer Prevention and Treatment Fund, 65% FFP.

(5) 24-22-117 (2) (d) (II), C.R.S. (2011). 35% RF from the Prevention, Early Detection, and Treatment fund, 65% FFP.

(6) 25.5-5-308 (9) (f), C.R.S. (2011). 17.5% GF, 17.5% Cash Funds from the Breast and Cervical Cancer Prevention and Treatment Funds, 65% FFP.

(7) The fund split allocation for Health Care Expansion Breast and Cervical Cancer Program Clients is reduced to 28.67% in FY 2012-13 and 26.49% in FY 2013-14 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. Expenditure from reappropriated funds for physical and mental health services for Health Care Expansion Breast and Cervical Cancer Program Clients cannot exceed $1,215,340

Exhibit F - ACUTE CARE - Antipsychotic Drug Expenditure (Reference)

Cash Based Actuals

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$4,664,387	$916,979	$17,700,825	$519,527	$0	$0	$2,839	$783,549	$3,789,992	$11,356	$0	$0	$28,389,454
FY 2003-04	$6,372,432	$1,298,597	$25,500,975	$1,057,440	$0	$0	$3,389	$1,296,760	$5,340,219	$29,882	$0	$0	$40,899,694
FY 2004-05	$6,629,621	$1,760,042	$28,042,949	$1,378,076	$0	$0	$3,654	$1,795,300	$6,321,954	$22,953	$0	$0	$45,954,548
FY 2005-06	$4,033,428	$1,685,933	$24,178,645	$1,633,973	$0	$0	$326	$1,935,729	$7,189,609	$22,633	$0	$0	$40,680,277
FY 2006-07	$479,529	$1,222,769	$19,965,507	$2,000,023	$110,237	$0	$183	$2,688,319	$7,814,333	$13,828	$0	$0	$34,294,729
FY 2007-08	$476,587	$1,416,439	$22,587,953	$2,257,237	$326,303	$0	$7,201	$3,116,761	$8,901,950	$23,191	$0	$0	$39,113,622
FY 2008-09	$574,003	$1,594,319	$22,596,632	$3,156,992	$432,485	$0	$13,539	$3,477,458	$8,956,851	$50,359	$0	$0	$40,852,638
FY 2009-10[1]	$624,336	$1,845,804	$23,477,770	$3,457,524	$786,684	$66,514	$31,055	$3,652,240	$8,663,502	$61,246	$0	$0	$42,666,675
FY 2010-11[1]	$528,892	$2,236,572	$27,074,670	$3,220,104	$1,549,338	$469,727	$41,477	$3,795,327	$8,465,862	$77,588	$0	$0	$47,459,557

Percent Change in Cash Based Actuals

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	4.04%	35.53%	9.97%	30.32%	0.00%	0.00%	7.85%	38.44%	18.38%	-23.19%	0.00%	0.00%	12.36%
FY 2005-06	-39.16%	-4.21%	-13.78%	18.57%	0.00%	0.00%	-91.07%	7.82%	13.72%	-1.39%	0.00%	0.00%	-11.48%
FY 2006-07	-88.11%	-27.47%	-17.43%	22.40%	0.00%	0.00%	-44.00%	38.88%	8.69%	-38.90%	0.00%	0.00%	-15.70%
FY 2007-08	-0.61%	15.84%	13.13%	12.86%	196.00%	0.00%	3839.28%	15.94%	13.92%	67.71%	0.00%	0.00%	14.05%
FY 2008-09	20.44%	12.56%	0.04%	39.86%	32.54%	0.00%	88.02%	11.57%	0.62%	117.15%	0.00%	0.00%	4.45%
FY 2009-10	8.77%	15.77%	3.90%	9.52%	81.90%	0.00%	129.37%	5.03%	-3.28%	21.62%	0.00%	0.00%	4.44%
FY 2010-11	-15.29%	21.17%	15.32%	-6.87%	96.95%	606.21%	33.56%	3.92%	-2.28%	26.68%	0.00%	0.00%	11.23%

Per Capita Cost

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$185.63	$234.07	$545.02	$22.23	$0.00	$0.00	$32.27	$6.64	$358.07	$3.56	$0.00	$0.00	$111.27
FY 2004-05	$185.29	$289.39	$585.09	$24.12	$0.00	$0.00	$42.01	$8.07	$400.25	$3.84	$0.00	$0.00	$113.18
FY 2005-06	$111.40	$279.04	$505.25	$27.75	$0.00	$0.00	$1.74	$9.04	$436.79	$4.42	$0.00	$0.00	$101.14
FY 2006-07	$13.36	$201.81	$409.14	$39.46	$21.36	$0.00	$0.80	$13.09	$467.25	$2.67	$0.00	$0.00	$87.44
FY 2007-08	$13.13	$230.47	$452.37	$50.66	$36.59	$0.00	$26.67	$15.28	$519.34	$3.69	$0.00	$0.00	$99.79
FY 2008-09	$15.26	$247.30	$440.01	$64.24	$33.98	$0.00	$42.71	$14.79	$496.69	$7.22	$0.00	$0.00	$93.52
FY 2009-10	$16.22	$261.85	$440.78	$59.96	$45.80	$20.54	$73.07	$13.25	$471.33	$7.82	$0.00	$0.00	$85.54
FY 2010-11	$13.59	$287.96	$481.03	$52.82	$76.87	$17.29	$78.11	$12.55	$460.28	$9.86	$0.00	$0.00	$84.63

Percent Change in Per Capita Cost

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-0.18%	23.63%	7.35%	8.50%	0.00%	0.00%	30.18%	21.54%	11.78%	7.87%	0.00%	0.00%	1.72%
FY 2005-06	-39.88%	-3.58%	-13.65%	15.05%	0.00%	0.00%	-95.86%	12.02%	9.13%	15.10%	0.00%	0.00%	-10.64%
FY 2006-07	-88.01%	-27.68%	-19.02%	42.20%	0.00%	0.00%	-54.02%	44.80%	6.97%	-39.59%	0.00%	0.00%	-13.55%
FY 2007-08	-1.72%	14.20%	10.57%	28.38%	71.30%	0.00%	3233.75%	16.73%	11.15%	38.20%	0.00%	0.00%	14.12%
FY 2008-09	16.22%	7.30%	-2.73%	26.81%	-7.13%	0.00%	60.14%	-3.21%	-4.36%	95.66%	0.00%	0.00%	-6.28%
FY 2009-10	6.29%	5.88%	0.17%	-6.66%	34.79%	0.00%	71.08%	-10.41%	-5.11%	8.31%	0.00%	0.00%	-8.53%
FY 2010-11	-16.21%	9.97%	9.13%	-11.91%	67.84%	-15.82%	6.90%	-5.28%	-2.34%	26.09%	0.00%	0.00%	-1.06%

Exhibit F - ACUTE CARE - Antipsychotic Drug Expenditure (Reference)

Cash Based Actuals

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$5,090,144	$1,037,288	$20,369,563	$844,658	$0	$0	$2,707	$1,035,821	$4,265,638	$23,869	$0	$0	$32,669,688
FY 2004-05	$4,938,612	$1,311,110	$20,890,071	$1,026,572	$0	$0	$2,722	$1,337,375	$4,709,421	$17,098	$0	$0	$34,232,981
FY 2005-06	$2,687,488	$1,123,343	$16,110,320	$1,088,722	$0	$0	$217	$1,289,783	$4,790,463	$15,081	$0	$0	$27,105,417
FY 2006-07	$331,389	$845,022	$13,797,610	$1,382,161	$76,182	$0	$126	$1,857,823	$5,400,269	$9,556	$0	$0	$23,700,138
FY 2007-08	$354,695	$1,054,171	$16,810,867	$1,679,927	$242,848	$0	$5,359	$2,319,619	$6,625,191	$17,260	$0	$0	$29,109,937
FY 2008-09	$358,015	$994,403	$14,093,890	$1,969,068	$269,748	$0	$8,444	$2,168,948	$5,586,535	$31,410	$0	$0	$25,480,461
FY 2009-10	$359,915	$1,064,063	$13,534,393	$1,993,183	$453,505	$38,344	$17,902	$2,105,432	$4,994,309	$35,307	$0	$0	$24,596,353
FY 2010-11	$288,997	$1,222,105	$14,794,110	$1,759,526	$846,587	$256,668	$22,664	$2,073,838	$4,625,906	$42,396	$0	$0	$25,932,797

Percent Change in Cash Based Actuals

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-2.98%	26.40%	2.56%	21.54%	0.00%	0.00%	0.55%	29.11%	10.40%	-28.37%	0.00%	0.00%	4.79%
FY 2005-06	-45.58%	-14.32%	-22.88%	6.05%	0.00%	0.00%	-92.03%	-3.56%	1.72%	-11.80%	0.00%	0.00%	-20.82%
FY 2006-07	-87.67%	-24.78%	-14.36%	26.95%	0.00%	0.00%	-41.94%	44.04%	12.73%	-36.64%	0.00%	0.00%	-12.56%
FY 2007-08	7.03%	24.75%	21.84%	21.54%	218.77%	0.00%	4153.17%	24.86%	22.68%	80.62%	0.00%	0.00%	22.83%
FY 2008-09	0.94%	-5.67%	-16.16%	17.21%	11.08%	0.00%	57.57%	-6.50%	-15.68%	81.98%	0.00%	0.00%	-12.47%
FY 2009-10	0.53%	7.01%	-3.97%	1.22%	68.12%	0.00%	112.01%	-2.93%	-10.60%	12.41%	0.00%	0.00%	-3.47%
FY 2010-11	-19.70%	14.85%	9.31%	-11.72%	86.68%	569.38%	26.60%	-1.50%	-7.38%	20.08%	0.00%	0.00%	5.43%

Per Capita Cost

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$148.28	$186.97	$435.35	$17.76	$0.00	$0.00	$25.78	$5.30	$286.02	$2.84	$0.00	$0.00	$88.88
FY 2004-05	$138.03	$215.57	$435.85	$17.97	$0.00	$0.00	$31.29	$6.01	$298.16	$2.86	$0.00	$0.00	$84.31
FY 2005-06	$74.23	$185.92	$336.65	$18.49	$0.00	$0.00	$1.15	$6.02	$291.04	$2.95	$0.00	$0.00	$67.39
FY 2006-07	$9.23	$139.47	$282.74	$27.27	$14.76	$0.00	$0.55	$9.05	$322.91	$1.84	$0.00	$0.00	$60.42
FY 2007-08	$9.78	$171.52	$336.67	$37.70	$27.23	$0.00	$19.85	$11.37	$386.51	$2.74	$0.00	$0.00	$74.27
FY 2008-09	$9.52	$154.24	$274.44	$40.06	$21.19	$0.00	$26.64	$9.22	$309.80	$4.50	$0.00	$0.00	$58.33
FY 2009-10	$9.35	$150.95	$254.10	$34.57	$26.40	$11.84	$42.12	$7.64	$271.71	$4.51	$0.00	$0.00	$49.31
FY 2010-11	$7.43	$157.35	$262.84	$28.86	$42.01	$9.45	$42.68	$6.86	$251.50	$5.39	$0.00	$0.00	$46.25

Percent Change in Per Capita Cost

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-6.91%	15.30%	0.11%	1.18%	0.00%	0.00%	21.37%	13.40%	4.24%	0.70%	0.00%	0.00%	-5.14%
FY 2005-06	-46.22%	-13.75%	-22.76%	2.89%	0.00%	0.00%	-96.32%	0.17%	-2.39%	3.15%	0.00%	0.00%	-20.07%
FY 2006-07	-87.57%	-24.98%	-16.01%	47.49%	0.00%	0.00%	-52.17%	50.33%	10.95%	-37.63%	0.00%	0.00%	-10.34%
FY 2007-08	5.96%	22.98%	19.07%	38.25%	84.49%	0.00%	3509.09%	25.64%	19.70%	48.91%	0.00%	0.00%	22.92%
FY 2008-09	-2.66%	-10.07%	-18.48%	6.26%	-22.18%	0.00%	34.21%	-18.91%	-19.85%	64.23%	0.00%	0.00%	-21.46%
FY 2009-10	-1.79%	-2.13%	-7.41%	-13.70%	24.59%	0.00%	58.11%	-17.14%	-12.30%	0.22%	0.00%	0.00%	-15.46%
FY 2010-11	-20.53%	4.24%	3.44%	-16.52%	59.13%	-20.19%	1.33%	-10.21%	-7.44%	19.51%	0.00%	0.00%	-6.21%

(1) Totals for FY 2009-10 and FY 2010-11 are adjusted to account for the June 2010 payment delays.

Exhibit F - ACUTE CARE - Pharmacy Rebates

Estimated Increase in Rebates Attributable to the Affordable Care Act						
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Total**	**Percentage Change[2]**
FY 2010-11	$3,170,128	$3,551,490	$3,711,664	$3,495,596	$13,928,878	-
FY 2011-12[1]	$3,643,459	$3,316,184	$3,731,241	$3,731,241	$14,422,125	3.54%
FY 2012-13[2]	$3,398,624	$3,807,473	$3,979,192	$3,747,551	$14,932,840	3.54%
FY 2013-14[2]	$3,518,975	$3,942,303	$4,120,103	$3,880,258	$15,461,640	3.54%
(1) FY 2011-12 Q3 and Q4 were estimated by applying the same percentage growth that occurred from the first half of FY 2010-11 to the second half on the first half of FY 2011-12 expenditure.						
(2) The estimated FY 2011-12 growth rate is held constant for the request and out years.						

Exhibit F - ACUTE CARE - Calculation of Enhanced Federal Match for Family Planning

Total Expenditure						
Fiscal Year	**Total Reported Expenditures**	**General Fund**	**Cash Funds [1]**	**Federal Funds (90% FMAP)**	**Change**	**% Change**
FY 2000-01	$2,438,198	$243,820	$0	$2,194,378	($1,518,369)	-38.38%
FY 2001-02	$5,111,123	$511,112	$0	$4,600,011	$2,672,925	109.63%
FY 2002-03	$6,538,073	$653,807	$0	$5,884,266	$1,426,950	27.92%
FY 2003-04	$6,061,856	$606,186	$0	$5,455,670	($476,217)	-7.28%
FY 2004-05	$8,019,717	$801,972	$0	$7,217,745	$1,957,861	32.30%
FY 2005-06	$8,260,397	$826,040	$0	$7,434,357	$240,680	3.00%
FY 2006-07	$8,343,188	$834,319	$0	$7,508,869	$82,791	1.00%
FY 2007-08	$9,902,250	$990,225	$0	$8,912,025	$1,559,062	18.69%
FY 2008-09	$13,893,561	$1,389,356	$0	$12,504,205	$3,991,311	40.31%
FY 2009-10	$12,619,883	$1,261,988	$0	$11,357,895	($1,273,678)	-9.17%
FY 2010-11	$13,895,800	$1,389,580	$0	$12,506,220	$1,275,917	10.11%
FY 2011-12 Estimated Total	$14,925,914	$1,472,829	$19,763	$13,433,322	$2,306,031	7.41%
FY 2012-13 Estimated Total	$16,019,337	$1,561,066	$40,869	$14,417,402	$1,093,423	7.33%
FY 2013-14 Estimated Total	$17,244,054	$1,654,587	$69,819	$15,519,648	$1,224,717	7.65%

To forecast expenditure, a regression of FY 2000-01 to FY 2010-11 data was constructed to model changes over time. Expenditure was then estimated forward and the percentage change between those estimates was used to calculate expenditure for FY 2011-12, FY 2012-13 and FY 2013-14, 5.99%.

[1] SB 11-177 extended and expanded the Teen Pregnancy and Dropout Prevention program. The Department receives local funds to provide services for the program. In FY 2011-12 the Department anticipates receiving $19,763 local funds, $40,869 in FY 2012-13 and $69,819 in FY 2013-14.

Breakdown of Total Expenditure
Fee-for-Service and Managed Care Components

Fiscal Year	Fee-for-Service Family Planning	Change in Fee-for-Service Expenditure	Percent Change in Fee-for-Service Expenditure	Managed Care Family Planning	Change in Managed Care Expenditure	Percent Change in Managed Care Expenditure
FY 2000-01	$2,438,198	($1,518,369)	-38.38%	$0	$0	0.00%
FY 2001-02	$2,763,372	$325,174	13.34%	$2,347,751	$2,347,751	0.00%
FY 2002-03	$3,094,894	$331,522	12.00%	$3,443,179	$1,095,428	100.00%
FY 2003-04	$4,058,413	$963,519	31.13%	$2,003,442	($1,439,737)	-41.81%
FY 2004-05	$6,902,883	$2,844,470	70.09%	$1,116,833	($886,609)	-44.25%
FY 2005-06	$7,013,966	$111,083	1.61%	$1,246,431	$129,598	11.60%
FY 2006-07	$7,431,084	$417,118	5.95%	$912,103	($334,328)	-26.82%
FY 2007-08	$9,139,367	$1,708,283	22.99%	$762,883	($149,220)	-16.36%
FY 2008-09	$13,472,771	$4,333,404	47.41%	$420,790	($342,093)	-44.84%
FY 2009-10	$12,533,203	($939,568)	-6.97%	$86,680	($334,110)	-79.40%
FY 2010-11	$12,375,827	($157,376)	-1.26%	$1,519,973	$1,433,293	1653.55%

Totals for fee-for-service and managed care are taken from the Department's quarterly report to the Centers for Medicare and Medicaid Services for total expenditure, known as the CMS-64. The sum of the fee-for-service and managed care totals by year equals the Total Reported Expenditures at the top of this page.

Exhibit F - ACUTE CARE - Indian Health Services

Total Expenditure for Indian Health Service			
Fiscal Year	**Total Reported Expenditures: 100% FF**	**Change**	**% Change**
FY 2001-02	$100,299	$100,299	-
FY 2002-03	$511,451	$411,152	409.93%
FY 2003-04	$813,791	$302,340	59.11%
FY 2004-05	$922,761	$108,970	13.39%
FY 2005-06	$840,371	($82,390)	-8.93%
FY 2006-07	$899,521	$59,149	7.04%
FY 2007-08	$1,061,989	$162,469	18.06%
FY 2008-09	$1,534,327	$472,338	44.48%
FY 2009-10	$1,536,532	$2,205	0.14%
FY 2010-11	$1,672,353	$135,821	8.84%
FY 2011-12 YTD	$596,769	-	-
FY 2011-12 Estimated Total	$1,176,502	($495,851)	-29.65%
FY 2012-13 Estimated Total	$1,386,155	$209,653	17.82%
FY 2013-14 Estimated Total	$1,633,168	$247,013	17.82%

Note: Indian Health Service expenditure in the first half of the year was an average of 50.72% of total annual expenditure from FY 2005-06 to FY 2010-11. FY 2011-12 expenditure is assumed to follow that pattern and is calculated as year-to-date expenditure divided by 50.72%. Trend selected for FY 2012-13 and FY 2013-14 is the growth from FY 2007-08 to FY 2010-11.

Exhibit F - ACUTE CARE - Expenditure by Half-Year

FY 2011-12 July-December COFRS Total Actuals													
Acute Care	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Physician Services & EPSDT	$1,827,938	$3,721,993	$27,588,875	$26,163,326	$6,116,254	$8,186,695	$0	$53,917,725	$5,260,980	$8,552,272	$3,185,827	$1,938	$144,523,823
Emergency Transportation	$58,217	$132,985	$1,050,433	$583,358	$132,745	$154,893	$0	$807,908	$108,965	$106,867	$44,155	$0	$3,180,526
Non-Emergency Medical Transportation	$986,931	$483,881	$2,478,453	$185,591	$43,113	$53,065	$0	$580,862	$70,738	$30,984	$955	$0	$4,914,573
Dental Services	$582,895	$137,606	$2,555,922	$2,129,656	$547,886	$702,005	$0	$43,463,649	$2,610,687	$185,506	$1,782	$0	$52,917,594
Family Planning	$0	$0	$7,166	$69,513	$22,656	$34,362	$0	$57,791	$20,755	$10,250	$0	$0	$222,493
Health Maintenance Organizations	$3,646,478	$3,540,861	$21,158,832	$9,458,058	$2,716,063	$4,065,910	$0	$19,016,005	$454,866	$612,606	$0	$0	$64,669,679
Inpatient Hospitals	$6,887,529	$7,343,286	$58,522,136	$27,548,232	$4,757,139	$6,365,197	$0	$39,881,082	$2,339,122	$13,910,731	$17,767,681	($12,548)	$185,309,587
Outpatient Hospitals	$1,439,631	$2,994,575	$25,298,006	$22,559,226	$6,768,544	$8,648,462	$0	$34,014,041	$2,850,961	$2,624,026	$584,184	$0	$107,781,656
Lab & X-Ray	$236,177	$425,968	$3,541,440	$5,813,639	$1,532,229	$1,908,032	$0	$3,571,283	$813,148	$1,797,553	$67,887	($47)	$19,707,309
Durable Medical Equipment	$9,472,628	$2,604,386	$24,837,658	$1,461,328	$541,978	$607,153	$0	$4,661,719	$2,269,344	$90,091	$0	$11,441	$46,557,726
Prescription Drugs	$3,629,896	$9,193,355	$65,740,485	$20,378,113	$6,965,625	$8,294,003	$0	$29,191,796	$10,391,284	$1,195,522	$0	$0	$154,980,079
Drug Rebate	($1,629,673)	($4,127,434)	($29,514,746)	($9,148,926)	($3,127,276)	($3,723,663)	$0	($13,105,904)	($4,665,255)	($536,740)	$0	$0	($69,579,617)
Rural Health Centers	$30,606	$126,749	$603,170	$755,314	$258,700	$312,990	$0	$2,744,845	$169,529	$152,302	$14,208	$0	$5,168,413
Federally Qualified Health Centers	$461,234	$536,096	$4,257,418	$7,002,072	$1,711,267	$2,367,572	$0	$28,071,118	$1,001,045	$2,542,573	$200,662	$0	$48,151,057
Co-Insurance (Title XVIII-Medicare)	$5,809,534	$967,030	$3,883,614	$54,852	$104,669	$219,155	$0	$13,070	$7,633	$16,763	$23	$1,810,497	$12,886,840
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$5,377,394	$0	$0	$0	$0	$0	$5,377,394
Administrative Service Organizations - Services	$1,213,823	$1,451,664	$11,604,595	$4,984,093	$1,347,051	$1,521,134	$0	$5,314,760	$1,384,734	$1,481,212	$0	$0	$30,303,066
Other Medical Services	($1)	$0	($4)	($2)	$0	($1)	$0	($3)	$0	$0	$0	$0	($11)
Home Health	$11,893,229	$3,972,707	$60,221,569	$214,110	$70,924	$88,859	$0	$2,175,168	$5,710,699	$35,824	$0	$80,915	$84,464,004
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$46,547,073	$33,505,706	$283,835,020	$120,211,552	$30,509,567	$39,805,824	$5,377,394	$254,376,914	$30,799,233	$32,808,342	$21,867,365	$1,892,196	$901,536,186
Caseload	39,635	8,277	58,964	67,889	22,937	33,529	594	327,398	18,112	7,581	2,771	18,304	605,989
Half -Year Per Capita	$1,174.41	$4,048.13	$4,813.70	$1,770.71	$1,330.15	$1,187.21	$9,055.39	$776.97	$1,700.47	$4,327.71	$7,891.03	$103.38	$1,487.71
Estimated Contribution of Bottom Line Impacts to First Half Expenditure	($1,662,698)	($1,237,689)	($9,153,896)	($5,712,984)	($1,977,529)	($1,837,707)	($56,835)	($9,067,963)	($722,158)	($1,303,070)	($1,217,030)	($20,214)	($33,969,770)
Estimated Total Without Bottom Line Impacts	$48,209,771	$34,743,395	$292,988,916	$125,924,536	$32,487,096	$41,643,531	$5,434,229	$263,444,877	$31,521,391	$34,111,412	$23,084,395	$1,912,410	$935,505,956
Half -Year Per Capita without Bottom Line Impacts	$1,216.36	$4,197.67	$4,968.95	$1,854.86	$1,416.36	$1,242.02	$9,151.10	$804.66	$1,740.34	$4,499.59	$8,330.21	$104.48	$1,543.77
FY 2011-12 Rough Estimated Per Capita	$2,432.72	$8,395.34	$9,937.89	$3,709.72	$2,832.72	$2,484.04	$18,302.20	$1,609.33	$3,480.69	$8,999.19	$16,660.42	$208.97	$3,087.53
Acute Care	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
FY 2010-11(A)	$45,275,849	$29,044,178	$252,812,440	$105,362,460	$25,299,890	$26,534,011	$4,724,599	$238,577,790	$31,117,663	$33,378,788	$22,285,685	$1,500,857	$815,914,210
FY 2010-11 Full Year	$97,388,620	$61,036,898	$529,213,760	$218,112,253	$56,117,509	$61,707,804	$9,817,196	$497,319,012	$62,802,717	$67,507,543	$45,331,275	$5,066,688	$1,711,421,275
FY 2011-12(A) Base	$48,209,771	$34,743,395	$292,988,916	$125,924,536	$32,487,096	$41,643,531	$5,434,229	$263,444,877	$31,521,391	$34,111,412	$23,084,395	$1,912,410	$935,505,956
FY 2011-12(A) Total	$46,547,073	$33,505,706	$283,835,020	$120,211,552	$30,509,567	$39,805,824	$5,377,394	$254,376,914	$30,799,233	$32,808,342	$21,867,365	$1,892,196	$901,536,186
FY 2011-12(A) Base Annualized	$96,419,542	$69,486,790	$585,977,831	$251,849,071	$64,974,191	$83,287,061	$10,868,458	$526,889,754	$63,042,782	$68,222,823	$46,168,790	$3,824,819	$1,871,011,912
FY 2011-12(A) Total Annualized	$93,094,146	$67,011,412	$567,670,040	$240,423,104	$61,019,134	$79,611,648	$10,754,788	$508,753,828	$61,598,466	$65,616,684	$43,734,730	$3,784,392	$1,803,072,372
Selected Percent Changes (November Request	0.70%	2.06%	2.39%	-4.94%	2.18%	25.17%	-3.67%	-1.01%	3.93%	2.43%	3.80%	4.52%	
FY 2010-11(A) to FY 2011-12(A) Base	6.48%	19.62%	15.89%	19.52%	28.41%	56.94%	15.02%	10.42%	1.30%	2.19%	3.58%	27.42%	14.66%
FY 2010-11(A) to FY 2011-12(A) Total	2.81%	15.36%	12.27%	14.09%	20.59%	50.02%	13.82%	6.62%	-1.02%	-1.71%	-1.88%	26.07%	10.49%
FY 2010-11 Total to FY 2011-12 Per Capita Growth Based on Rough Estimate	**-4.41%**	**9.79%**	**7.27%**	**10.23%**	**8.73%**	**29.01%**	**9.55%**	**2.30%**	**-1.92%**	**-2.80%**	**-3.52%**	**-25.31%**	**5.36%**

This is a rough projection utilizing year-to-date expenditure patterns as a guide to future expenditures. The Half-Year Expenditure Pattern is one forecasting tool used to estimate final expenditures on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

In titles, the suffix (A) denotes the period July through December, and the suffix (B) denotes the period January through June. For example, "FY 2011-12(A)" implies the period July 2011 through December 2011.

In titles, "base" implies estimated expenditure before bottom line impacts, while "total" implies total expenditure including bottom line impacts.

Exhibit G - COMMUNITY BASED LONG TERM CARE - Cash-Based Actuals and Projections

Cash Based Actuals

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$78,719,107	$7,549,034	$56,806,389	$70,931	$0	$0	$0	$389,329	$2,854,975	$109	$0	$0	$146,389,874
FY 2003-04	$85,726,658	$8,298,496	$61,272,991	$167,620	$0	$0	$0	$213,385	$3,044,165	$0	$0	$1	$158,723,316
FY 2004-05	$86,505,276	$8,689,937	$61,264,884	$126,591	$0	$0	$0	$689,933	$3,665,603	$2,461	$0	$224	$160,944,908
FY 2005-06	$95,295,727	$12,130,404	$71,302,410	$150,551	$0	$0	$0	$529,206	$4,121,260	$0	$0	$41,208	$183,570,766
FY 2006-07	$112,939,443	$14,106,731	$82,896,656	$88,469	$5,134	$0	$0	$704,094	$3,990,308	$0	$0	$395,653	$215,126,488
FY 2007-08	$124,223,595	$16,355,185	$94,673,897	$113,310	$8,054	$0	$0	$590,675	$4,856,636	$0	$0	$920,662	$241,742,014
FY 2008-09	$135,681,964	$18,792,943	$119,790,925	$52,885	$8,935	$0	$0	$328,265	$5,552,618	$2,017	$0	$302,145	$280,512,697
FY 2009-10 (DA)	$143,987,940	$21,115,178	$126,535,468	$192,432	$30,774	$0	$0	$836,398	$6,789,088	$0	$1,279	$201,179	$299,689,736
FY 2010-11 (DA)	$142,698,517	$22,313,208	$144,648,196	$181,275	$79,355	$51,269	$0	$566,227	$8,341,459	$0	$0	$137,560	$319,017,067
Estimated FY 2011-12	$147,569,232	$25,084,978	$155,477,265	$87,787	$51,724	$112,638	$0	$640,471	$8,978,060	$0	$0	$299,915	$338,302,070
Estimated FY 2012-13	$153,976,923	$27,436,796	$166,700,311	$95,712	$59,151	$139,798	$0	$707,108	$9,408,501	$0	$0	$244,560	$358,768,860
Estimated FY 2013-14	$161,630,612	$29,914,054	$177,562,915	$100,062	$64,568	$161,112	$0	$779,741	$9,941,278	$0	$0	$265,216	$380,419,558

Percent Change in Cash Based Actuals

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	8.90%	9.93%	7.86%	136.32%	0.00%	0.00%	0.00%	-45.19%	6.63%	-100.00%	0.00%	100.00%	8.43%
FY 2004-05	0.91%	4.72%	-0.01%	-24.48%	0.00%	0.00%	0.00%	223.33%	20.41%	100.00%	0.00%	32623.62%	1.40%
FY 2005-06	10.16%	39.59%	16.38%	18.93%	0.00%	0.00%	0.00%	-23.30%	12.43%	-100.00%	0.00%	18323.90%	14.06%
FY 2006-07	18.51%	16.29%	16.26%	-41.24%	100.00%	0.00%	0.00%	33.05%	-3.18%	0.00%	0.00%	860.14%	17.19%
FY 2007-08	9.99%	15.94%	14.21%	28.08%	56.87%	0.00%	0.00%	-16.11%	21.71%	0.00%	0.00%	132.69%	12.37%
FY 2008-09	9.22%	14.91%	26.53%	-53.33%	10.95%	0.00%	0.00%	-44.43%	14.33%	100.00%	0.00%	-67.18%	16.04%
FY 2009-10 (DA)	6.12%	12.36%	5.63%	263.87%	244.41%	0.00%	0.00%	154.79%	22.27%	-100.00%	100.00%	-33.42%	6.84%
FY 2010-11 (DA)	-0.90%	5.67%	14.31%	-5.80%	157.86%	100.00%	0.00%	-32.30%	22.87%	0.00%	-100.00%	-31.62%	6.45%
Estimated FY 2011-12	3.41%	12.42%	7.49%	-51.57%	-34.82%	119.70%	0.00%	13.11%	7.63%	0.00%	0.00%	118.02%	6.05%
Estimated FY 2012-13	4.34%	9.38%	7.22%	9.03%	14.36%	24.11%	0.00%	10.40%	4.79%	0.00%	0.00%	-18.46%	6.05%
Estimated FY 2013-14	4.97%	9.03%	6.52%	4.54%	9.16%	15.25%	0.00%	10.27%	5.66%	0.00%	0.00%	8.45%	6.03%

Per Capita Cost

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$2,268.30	$1,389.99	$1,217.79	$1.74	$0.00	$0.00	$0.00	$2.30	$204.41	$0.01	$0.00	$0.00	$441.20
FY 2003-04	$2,497.21	$1,495.76	$1,309.56	$3.52	$0.00	$0.00	$0.00	$1.09	$204.11	$0.00	$0.00	$0.00	$431.83
FY 2004-05	$2,417.70	$1,428.80	$1,278.24	$2.22	$0.00	$0.00	$0.00	$3.10	$232.07	$0.41	$0.00	$0.02	$396.39
FY 2005-06	$2,631.97	$2,007.68	$1,489.97	$2.56	$0.00	$0.00	$0.00	$2.47	$250.38	$0.00	$0.00	$3.72	$456.40
FY 2006-07	$3,147.00	$2,328.23	$1,698.74	$1.75	$0.99	$0.00	$0.00	$3.43	$238.60	$0.00	$0.00	$30.65	$548.47
FY 2007-08	$3,423.65	$2,661.11	$1,896.02	$2.54	$0.90	$0.00	$0.00	$2.90	$283.33	$0.00	$0.00	$64.77	$616.75
FY 2008-09	$3,606.74	$2,914.99	$2,332.60	$1.08	$0.70	$0.00	$0.00	$1.40	$307.91	$0.29	$0.00	$20.04	$642.18
FY 2009-10 (DA)	$3,741.21	$2,995.49	$2,375.63	$3.34	$1.79	$0.00	$0.00	$3.03	$369.35	$0.00	$0.35	$12.64	$600.83
FY 2010-11 (DA)	$3,666.36	$2,872.82	$2,569.92	$2.97	$3.94	$1.89	$0.00	$1.87	$453.51	$0.00	$0.00	$8.05	$568.90
Estimated FY 2011-12	$3,701.54	$2,986.66	$2,609.16	$1.25	$2.15	$3.18	$0.00	$1.90	$494.90	$0.00	$0.00	$15.96	$544.01
Estimated FY 2012-13	$3,772.10	$3,066.25	$2,684.47	$1.24	$2.23	$3.30	$0.00	$1.92	$518.12	$0.00	$0.00	$11.93	$531.30
Estimated FY 2013-14	$3,856.24	$3,151.83	$2,766.47	$1.23	$2.32	$3.44	$0.00	$1.95	$544.31	$0.00	$0.00	$11.93	$525.64

Percent Change in Per Capita Cost

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	10.09%	7.61%	7.54%	102.30%	0.00%	0.00%	0.00%	-52.61%	-0.15%	-100.00%	0.00%	0.00%	-2.12%
FY 2004-05	-3.18%	-4.48%	-2.39%	-36.93%	0.00%	0.00%	0.00%	184.40%	13.70%	100.00%	0.00%	100.00%	-8.21%
FY 2005-06	8.86%	40.52%	16.56%	15.32%	0.00%	0.00%	0.00%	-20.32%	7.89%	-100.00%	0.00%	18500.00%	15.14%
FY 2006-07	19.57%	15.97%	14.01%	-31.64%	100.00%	0.00%	0.00%	38.87%	-4.70%	0.00%	0.00%	723.92%	20.17%
FY 2007-08	8.79%	14.30%	11.61%	45.14%	-9.09%	0.00%	0.00%	-15.45%	18.75%	0.00%	0.00%	111.32%	12.45%
FY 2008-09	5.35%	9.54%	23.03%	-57.48%	-22.22%	0.00%	0.00%	-51.72%	8.68%	100.00%	0.00%	-69.06%	4.12%
FY 2009-10 (DA)	3.73%	2.76%	1.84%	209.26%	155.71%	0.00%	0.00%	116.43%	19.95%	-100.00%	100.00%	-36.93%	-6.44%
FY 2010-11 (DA)	-2.00%	-4.10%	8.18%	-11.08%	120.11%	100.00%	0.00%	-38.28%	22.79%	0.00%	-100.00%	-36.31%	-5.31%
Estimated FY 2011-12	0.96%	3.96%	1.53%	-57.91%	-45.43%	68.25%	0.00%	1.60%	9.13%	0.00%	0.00%	98.26%	-4.38%
Estimated FY 2012-13	1.91%	2.66%	2.89%	-0.80%	3.72%	3.77%	0.00%	1.05%	4.69%	0.00%	0.00%	-25.25%	-2.34%
Estimated FY 2013-14	2.23%	2.79%	3.05%	-0.81%	4.04%	4.24%	0.00%	1.56%	5.05%	0.00%	0.00%	0.00%	-1.07%

Exhibit G - COMMUNITY BASED LONG TERM CARE - Cash-Based Actuals and Projections

Per Capita Trends													
Per Capita Trends	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Actual FY 2010-11 Per Capita	$3,666.36	$2,872.82	$2,569.92	$2.97	$3.94	$1.89	$0.00	$1.87	$453.51	$0.00	$0.00	$8.05	$568.90
Average of FY 2004-05 through FY 2008-09	7.88%	15.17%	12.56%	-13.12%	13.74%	0.00%	0.00%	27.16%	8.86%	20.00%	0.00%	3873.24%	8.73%
Average of FY 2005-06 through FY 2008-09	10.64%	20.08%	16.30%	-7.17%	17.17%	0.00%	0.00%	-12.16%	7.66%	0.00%	0.00%	4816.55%	12.97%
Average of FY 2006-07 through FY 2008-09	11.24%	13.27%	16.22%	-14.66%	22.90%	0.00%	0.00%	-9.43%	7.58%	33.33%	0.00%	255.39%	12.25%
Average of FY 2007-08 through FY 2008-09	7.88%	15.17%	12.56%	-13.12%	13.74%	0.00%	0.00%	27.16%	8.86%	20.00%	0.00%	3873.24%	8.73%
Average of FY 2005-06 through FY 2009-10	9.26%	16.62%	13.41%	36.12%	44.88%	0.00%	0.00%	13.56%	10.11%	-20.00%	20.00%	3845.85%	9.09%
Average of FY 2006-07 through FY 2009-10	9.36%	10.64%	12.62%	41.32%	56.10%	0.00%	0.00%	22.03%	10.67%	0.00%	25.00%	182.31%	7.58%
Average of FY 2007-08 through FY 2009-10	5.96%	8.87%	12.16%	65.64%	41.47%	0.00%	0.00%	16.42%	15.79%	0.00%	33.33%	1.78%	3.38%
Average of FY 2008-09 through FY 2009-10	4.54%	6.15%	12.44%	75.89%	66.75%	0.00%	0.00%	32.36%	14.32%	0.00%	50.00%	-53.00%	-1.16%
Average of FY 2006-07 through FY 2010-11	7.09%	7.69%	11.73%	30.84%	68.90%	20.00%	0.00%	9.97%	13.09%	0.00%	0.00%	138.59%	5.00%
Average of FY 2007-08 through FY 2010-11	3.97%	5.63%	11.17%	46.46%	61.13%	25.00%	0.00%	2.75%	17.54%	0.00%	0.00%	-7.75%	1.21%
Average of FY 2008-09 through FY 2010-11	2.36%	2.73%	11.02%	46.90%	84.53%	33.33%	0.00%	8.81%	17.14%	0.00%	0.00%	-47.43%	-2.54%
Average of FY 2009-10 through FY 2010-11	0.87%	-0.67%	5.01%	99.09%	137.91%	50.00%	0.00%	39.08%	21.37%	-50.00%	0.00%	-36.62%	-5.88%

Current Year Projection													
COMMUNITY BASED LONG TERM CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Percentage Selected to Modify Per Capita[1]	2.36%	5.63%	2.51%	-57.48%	-45.00%	70.00%	0.00%	2.75%	10.11%	0.00%	0.00%	100.00%	
Estimated FY 2011-12 Base Per Capita	$3,752.89	$3,034.56	$2,634.30	$1.26	$2.17	$3.21	$0.00	$1.92	$499.36	$0.00	$0.00	$16.10	$550.50
Estimated FY 2011-12 Eligibles	39,867	8,399	59,589	70,299	24,050	35,406	610	336,582	18,141	7,472	2,659	18,796	621,870
Estimated FY 2011-12 Base Expenditures	$149,616,466	$25,487,269	$156,975,303	$88,577	$52,189	$113,653	$0	$646,237	$9,058,890	$0	$0	$302,616	$342,341,200
Bottom Line Impacts													
BRI-5: Medicaid Reductions - Cap CDASS Wage Rates	($206,965)	($35,257)	($217,146)	($123)	($72)	($157)	$0	($894)	($12,531)	$0	$0	($419)	($473,564)
BA-9: Medicaid Reductions - 0.50% Rate Reduction	($682,580)	($116,278)	($716,153)	($404)	($238)	($519)	$0	($2,948)	($41,328)	$0	$0	($1,381)	($1,561,829)
BA-9: Medicaid Reductions - Clients Moved from Nursing Home	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Impact of Increased PACE Enrollmen	($712,245)	($174,874)	($97,387)	$0	$0	$0	$0	$0	$0	$0	$0	$0	($984,506)
Annualization of FY 2010-11 BRI-2: "Coordinated Payment and Payment Reform"	($135,920)	($23,154)	($142,604)	($80)	($47)	($103)	$0	($587)	($8,230)	$0	$0	($275)	($311,000)
Annualization of FY 2010-11 BRI-6: "Medicaid Program Reductions"	($192,860)	($32,854)	($202,345)	($114)	($67)	($147)	$0	($833)	($11,677)	$0	$0	($390)	($441,287)
Annualization of FY 2009-10 ES-2: HCBS Waiver Transportation Limitations	($246,238)	($41,947)	($258,350)	($146)	($86)	($187)	$0	($1,064)	($14,909)	$0	$0	($498)	($563,425)
Annualization of HB 10-1146 State-funded Public Assistance Programs	$129,574	$22,073	$135,947	$77	$45	$98	$0	$560	$7,845	$0	$0	$262	$296,481
HB 09-1047 Alternative Therapies for Clients with Spinal Cord Injuries	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Bottom Line Impacts	($2,047,234)	($402,291)	($1,498,038)	($790)	($465)	($1,015)	$0	($5,766)	($80,830)	$0	$0	($2,701)	($4,039,130)
Estimated FY 2011-12 Expenditures	**$147,569,232**	**$25,084,978**	**$155,477,265**	**$87,787**	**$51,724**	**$112,638**	**$0**	**$640,471**	**$8,978,060**	**$0**	**$0**	**$299,915**	**$338,302,070**
Estimated FY 2011-12 Per Capita	$3,701.54	$2,986.66	$2,609.16	$1.25	$2.15	$3.18	$0.00	$1.90	$494.90	$0.00	$0.00	$15.96	$544.01
% Change over FY 2010-11 (DA) Per Capita	0.96%	3.96%	1.53%	-57.91%	-45.43%	68.25%	0.00%	1.60%	9.13%	0.00%	0.00%	98.26%	-4.38%

Exhibit G - COMMUNITY BASED LONG TERM CARE - Cash-Based Actuals and Projections

Request Year Projection

Per Capita Trends	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Percentage Selected to Modify Per Capita[2]	2.36%	2.82%	2.51%	-1.16%	4.12%	4.12%	0.00%	1.38%	5.06%	0.00%	0.00%	-25.00%	
Estimated FY 2012-13 Base Per Capita	$3,788.90	$3,070.73	$2,674.52	$1.24	$2.24	$3.31	$0.00	$1.93	$519.92	$0.00	$0.00	$11.97	$544.01
Estimated FY 2012-13 Eligibles	40,820	8,948	62,098	77,455	26,498	42,381	679	367,649	18,159	7,546	2,529	20,503	675,265
Estimated FY 2012-13 Base Expenditures	$154,662,898	$27,476,892	$166,082,343	$96,044	$59,356	$140,281	$0	$709,563	$9,441,227	$0	$0	$245,421	$358,914,025
Bottom Line Impacts													
Estimated Impact of Increased PACE Enrollmen	($722,715)	($177,445)	($98,820)	$0	$0	$0	$0	$0	$0	$0	$0	$0	($998,980)
Annualization of BRI-5: Medicaid Reductions - 0.50% Rate Reduction	($155,764)	($27,672)	($167,264)	($97)	($60)	($141)	$0	($715)	($9,508)	$0	$0	($247)	($361,468)
Annualization of BA-9: Medicaid Reductions - Ca CDASS Wage Rates	($518,889)	($92,184)	($557,200)	($322)	($199)	($471)	$0	($2,381)	($31,675)	$0	$0	($823)	($1,204,144)
Annualization of BA-9: Medicaid Reductions - Client Moved from Nursing Home	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Annualization of FY 2010-11 BRI-2: "Coordinated Payment and Payment Reform"	($24,038)	($4,095)	($25,219)	($14)	($8)	($18)	$0	($104)	($1,455)	$0	$0	($49)	($55,000)
Annualization of HB 10-1146 State-funded Public Assistance Programs	$162,383	$28,848	$174,371	$101	$62	$147	$0	$745	$9,912	$0	$0	$258	$376,827
Annualization of HB 09-1047 Alternative Therapies fo Clients with Spinal Cord Injuries	$0	$41,436	$146,004	$0	$0	$0	$0	$0	$0	$0	$0	$0	$187,440
Colorado Choice Transitions Program	$573,048	$191,016	$1,146,096	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,910,160
Total Bottom Line Impacts	($685,975)	($40,096)	$617,968	($332)	($205)	($483)	$0	($2,455)	($32,726)	$0	$0	($861)	($145,165)
Estimated FY 2012-13 Expenditures	**$153,976,923**	**$27,436,796**	**$166,700,311**	**$95,712**	**$59,151**	**$139,798**	**$0**	**$707,108**	**$9,408,501**	**$0**	**$0**	**$244,560**	**$358,768,860**
Estimated FY 2012-13 Per Capita	$3,772.10	$3,066.25	$2,684.47	$1.24	$2.23	$3.30	$0.00	$1.92	$518.12	$0.00	$0.00	$11.93	$531.30
% Change over FY 2010-11 (DA) Per Capita	1.91%	2.66%	2.89%	-0.80%	3.72%	3.77%	0.00%	1.05%	4.69%	0.00%	0.00%	-25.25%	-2.34%

Out Year Projection

Per Capita Trends	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Percentage Selected to Modify Per Capita[2]	2.36%	2.82%	2.51%	-1.16%	4.12%	4.12%	0.00%	1.38%	5.06%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2013-14 Base Per Capita	$3,861.12	$3,152.56	$2,751.72	$1.23	$2.32	$3.44	$0.00	$1.95	$544.31	$0.00	$0.00	$11.93	$531.30
Estimated FY 2013-14 Eligibles	41,914	9,491	64,184	81,351	27,831	46,835	743	399,867	18,264	8,472	2,549	22,231	723,732
Estimated FY 2013-14 Base Expenditures	$161,834,984	$29,920,947	$176,616,396	$100,062	$64,568	$161,112	$0	$779,741	$9,941,278	$0	$0	$265,216	$379,684,304
Bottom Line Impacts													
Annualization of HB 09-1047 Alternative Therapies fo Clients with Spinal Cord Injuries	$0	($3,162)	($11,143)	$0	$0	$0	$0	$0	$0	$0	$0	$0	($14,305)
Estimated Impact of Increased PACE Enrollmen	($733,339)	($180,053)	($100,273)	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1,013,665)
Annualization of Colorado Choice Transitions Program	$528,967	$176,322	$1,057,935	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,763,224
Total Bottom Line Impacts	($204,372)	($6,893)	$946,519	$0	$0	$0	$0	$0	$0	$0	$0	$0	$735,254
Estimated FY 2013-14 Expenditures	**$161,630,612**	**$29,914,054**	**$177,562,915**	**$100,062**	**$64,568**	**$161,112**	**$0**	**$779,741**	**$9,941,278**	**$0**	**$0**	**$265,216**	**$380,419,558**
Estimated FY 2013-14 Per Capita	$3,856.24	$3,151.83	$2,766.47	$1.23	$2.32	$3.44	$0.00	$1.95	$544.31	$0.00	$0.00	$11.93	$525.64
% Change over Estimated FY 2012-13 Per Capita	2.23%	2.79%	3.05%	-0.81%	4.04%	4.24%	0.00%	1.56%	5.05%	0.00%	0.00%	0.00%	-1.07%

Footnotes

(1) Percentage selected to modify Per Capita amounts for FY 2011-12	**OAP-A**	Average of FY 2008-09 through FY 2010-11	**Exp. Adults**	Trend selected to adjust for half year actuals (see narrative	**BC Adults**	0.00%
	OAP-B	Average of FY 2007-08 through FY 2010-11	**BCCP**	0.00%	**Non-Citizens**	0.00%
	AND/AB	Half the average of FY 2009-10 through FY 2010-11	**Elig. Children**	Average of FY 2007-08 through FY 2010-11	**Partial Dual**	Trend selected to adjust for half year actuals (see narrative
	AFDC-A	FY 2008-09 change in per capita costs	**Foster Care**	Average of FY 2005-06 through FY 2009-10		
(2) Percentage selected to modify Per Capita amounts for FY 2012-13 and FY 2013-14	**OAP-A**	Average of FY 2008-09 through FY 2010-11	**Exp. Adults**	FY 2008-09 total growth in per capita costs	**BC Adults**	0.00%
	OAP-B	Half the average of FY 2007-08 through FY 2010-11	**BCCP**	0.00%	**Non-Citizens**	0.00%
	AND/AB	Half the FY 2011-12 Trend	**Elig. Children**	Half of the FY 2011-12 trend	**Partial Dual**	Trends selected to demonstrate expenditure moving from thi
	AFDC-A	Total average of FY 2008-09 through FY 2009-10	**Foster Care**	Half of the FY 2011-12 trend		

Exhibit G - COMMUNITY BASED LONG TERM CARE - Cash-Based Actuals and Projections

FY 2010-11 July-December COFRS Total Actuals													
Community Based Long Term Care	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
HCBS - Elderly, Blind, and Disabled	$53,732,719	$8,207,658	$42,158,348	$15,839	$14,614	$0	$0	$0	$28,651	$0	$0	$64,424	$104,222,253
HCBS - Mental Illness	$1,856,638	$1,297,696	$9,472,703	$2,994	$2,848	$0	$0	$0	$8,981	$0	$0	$5,532	$12,647,393
HCBS - Disabled Children	$0	$0	$932,746	$0	$0	$0	$0	$454	$577	$0	$0	$0	$933,778
HCBS - Persons Living with AIDS	$15,354	$1,909	$284,531	$0	$0	$0	$0	$0	$0	$0	$0	$0	$301,794
HCBS - Consumer Directed Attendant Support	$727,394	$110,838	$565,896	$207	$0	$0	$0	$0	$390	$0	$0	$898	$1,405,624
HCBS - Brain Injury	$8,987	$39,327	$581,300	$0	$0	$0	$0	$0	$0	$0	$0	$61	$629,675
HCBS - Children with Autism	$0	$0	$800,181	$0	$0	$0	$0	$2,504	$0	$0	$0	$0	$802,685
HCBS - Pediatric Hospice	$0	$0	$66,819	$0	$0	$0	$0	$215	$519	$0	$0	$0	$67,553
Private Duty Nursing	$647,606	$0	$8,263,827	$0	$0	$0	$0	$283,257	$3,887,537	$0	$0	$0	$13,082,226
Hospice	$15,297,600	$1,118,966	$3,195,289	$147,434	$48,919	$0	$0	$40,145	$0	$0	$0	($35,849)	$19,812,504
Total	$72,286,297	$10,776,395	$66,321,640	$166,474	$66,380	$0	$0	$326,576	$3,926,656	$0	$0	$35,067	$153,905,485
Caseload	38,914	7,576	55,374	57,403	19,468	25,208	502	293,379	18,518	7,922	3,209	16,760	544,232
Half -Year Per Capita	$1,857.60	$1,422.50	$1,197.70	$2.90	$3.41	$0.00	$0.00	$1.11	$212.05	$0.00	$0.00	$2.09	$282.79

FY 2010-11 January - June COFRS Total Actuals													
Community Based Long Term Care	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
HCBS - Elderly, Blind, and Disabled	$52,135,435	$8,303,517	$43,756,129	($12,383)	$1,351	$11,962	$0	$0	$42,521	$0	$0	$65,531	$104,304,063
HCBS - Mental Illness	$1,730,729	$1,354,314	$8,844,340	($2,994)	$6,570	$0	$0	$0	$4,617	$0	$0	$2,565	$11,940,143
HCBS - Disabled Children	$0	$0	$953,306	$0	$0	$0	$0	$117	$0	$0	$0	$0	$953,423
HCBS - Persons Living with AIDS	$13,692	$1,561	$231,668	$0	$0	$0	$0	$0	$0	$0	$0	$1,682	$248,603
HCBS - Consumer Directed Attendant Support	$779,336	$123,767	$650,973	($207)	$0	$167	$0	$0	$621	$0	$0	$978	$1,555,635
HCBS - Brain Injury	$149,181	$770,000	$10,630,370	$0	$3,254	$0	$0	$0	$0	$0	$0	$436	$11,553,241
HCBS - Children with Autism	$0	$0	$525,851	$0	$0	$0	$0	$41	$0	$0	$0	$0	$525,892
HCBS - Pediatric Hospice	$0	$0	$51,848	$0	$0	$0	$0	($4)	($124)	$0	$0	$0	$51,720
Private Duty Nursing	$672,209	$0	$8,988,335	$0	$0	$0	$0	$219,535	$4,363,651	$0	$0	$0	$14,243,730
Hospice	$14,931,637	$983,655	$3,693,735	$30,385	$1,799	$39,141	$0	$19,962	$3,517	$0	$0	$31,300	$19,735,132
Total	$70,412,220	$11,536,814	$78,326,556	$14,801	$12,975	$51,269	$0	$239,652	$4,414,803	$0	$0	$102,493	$165,111,583
Caseload	38,929	7,957	57,195	64,516	20,839	29,126	561	311,441	18,268	7,814	3,218	17,420	577,284
Half -Year Per Capita	$1,808.73	$1,449.89	$1,369.47	$0.23	$0.62	$1.76	$0.00	$0.77	$241.67	$0.00	$0.00	$5.88	$286.01

FY 2011-12 July-December COFRS Total Actuals													
Community Based Long Term Care	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
HCBS - Elderly, Blind, and Disabled	$56,549,506	$9,493,911	$46,777,284	$610	$0	$5,599	$0	$0	$35,985	$0	$0	$111,087	$112,973,982
HCBS - Mental Illness	$1,814,065	$1,588,596	$9,521,924	$0	$516	$1,639	$0	$0	$7,763	$0	$0	$8,342	$12,942,845
HCBS - Disabled Children	$0	$0	$1,367,563	$0	$0	$0	$0	$273	$0	$0	$0	$0	$1,367,836
HCBS - Persons Living with AIDS	$14,616	$1,631	$245,614	$0	$0	$0	$0	$0	$0	$0	$0	$8,233	$270,094
HCBS - Consumer Directed Attendant Support	$903,311	$151,654	$747,211	$10	$0	$89	$0	$0	$575	$0	$0	$1,774	$1,804,624
HCBS - Brain Injury	$80,699	$468,773	$5,949,560	$0	$5,248	$0	$0	$0	$0	$0	$0	$0	$6,504,280
HCBS - Children with Autism	$0	$0	$502,938	$0	$0	$0	$0	$0	$0	$0	$0	$0	$502,938
HCBS - Pediatric Hospice	$0	$0	$103,084	$0	$0	$0	$0	$0	$499	$0	$0	$0	$103,583
Private Duty Nursing	$824,723	$18,486	$10,427,619	$0	$0	$0	$0	$214,415	$4,298,593	$0	$0	$0	$15,783,836
Hospice	$15,539,694	$1,424,883	$3,428,202	$40,180	$18,736	$51,369	$0	$53,692	$1,224	$0	$0	$28,180	$20,586,160
Total	$75,726,614	$13,147,934	$79,070,999	$40,800	$24,500	$58,696	$0	$268,380	$4,344,639	$0	$0	$157,616	$172,840,178
Caseload	39,635	8,277	58,964	67,889	22,937	33,529	594	327,398	18,112	7,581	2,771	18,304	605,991
Half -Year Per Capita	$1,910.60	$1,588.49	$1,341.00	$0.60	$1.07	$1.75	$0.00	$0.82	$239.88	$0.00	$0.00	$8.61	$285.22

Exhibit G - COMMUNITY BASED LONG TERM CARE - Cash-Based Actuals and Projections

Colorado Choice Transitions Budget Impact						
Fiscal Year	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Location of Budget Impact**
FY 2012-13	Demonstration Services (New Services)	$1,612,462	$806,231	$0	$806,231	Exhibit G
	Qualified Services (Existing Waiver Services)	$297,698	$148,849	$0	$148,849	Exhibit G
	Home Health	$105,758	$52,879	$0	$52,879	Exhibit F
	Total Estimated Cost of Services	$2,015,918	$1,007,959	$0	$1,007,959	
	Estimated Savings from Avoided Nursing Facility Expenditure	($2,240,829)	($1,120,414)	$0	($1,120,414)	Exhibit H
	Total Medical Services Premiums Impact	**($224,911)**	**($112,456)**	**$0**	**($112,455)**	
	Rebalancing Fund [(1)]	$503,979	$0	$0	$503,979	Non-Appropriated Line Item
	Total Budget Impact	$279,068	($112,456)	$0	$391,524	
FY 2013-14	Demonstration Services (New Services)	$3,100,888	$1,550,445	$0	$1,550,443	Exhibit G
	Qualified Services (Existing Waiver Services)	$572,496	$286,248	$0	$286,248	Exhibit G
	Home Health	$203,381	$101,691	$0	$101,690	Exhibit F
	Total Estimated Cost of Services	$3,876,765	$1,938,384	$0	$1,938,381	
	Estimated Savings from Avoided Nursing Facility Expenditure	($4,514,170)	($2,257,085)	$0	($2,257,085)	Exhibit H
	Total Medical Services Premiums Impact	**($637,405)**	**($318,701)**	**$0**	**($318,704)**	
	Rebalancing Fund [(1)]	$969,191	$0	$0	$969,191	Non-Appropriated Line Item
	Total Budget Impact	$331,786	($318,701)	$0	$650,487	

[(1)] The rebalancing fund is a 25% enhanced federal match for Money Follows the Person (MFP) services. These funds will be deposited into a non-appropriated line item and may only be used for projects identified in the Operational Protocol submitted to Center for Medicare and Medicaid Services in the Money Follows the Person grant application.

Exhibit H - Long Term Care and Insurance Summary

FY 2011-12 Long Term Care and Insurance Request													
FY 2011-12	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Class I Nursing Facilities	$400,580,930	$32,432,578	$78,462,165	$7,809	$0	$0	$0	$0	$0	$0	$0	$578,708	$512,062,190
Class II Nursing Facilities	$0	$980,278	$2,898,614	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,878,892
Program for All-Inclusive Care for the Elderly	$70,871,391	$8,311,727	$3,605,547	$0	$0	$0	$0	$0	$0	$0	$0	$0	$82,788,665
Subtotal Long Term Care	**$471,452,321**	**$41,724,583**	**$84,966,326**	**$7,809**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$578,708**	**$598,729,747**
Supplemental Medicare Insurance Benefit	$62,490,976	$3,412,827	$30,235,091	$202,090	$0	$0	$0	$0	$0	$0	$0	$17,280,033	$113,621,017
Health Insurance Buy-In	$2,367	$748	$1,227,548	$6,101	$0	$0	$0	$2,419	$1,233	$0	$0	$0	$1,240,416
Subtotal Insurance	**$62,493,343**	**$3,413,575**	**$31,462,639**	**$208,191**	**$0**	**$0**	**$0**	**$2,419**	**$1,233**	**$0**	**$0**	**$17,280,033**	**$114,861,433**
Total Long Term Care and Insurance	**$533,945,664**	**$45,138,158**	**$116,428,965**	**$216,000**	**$0**	**$0**	**$0**	**$2,419**	**$1,233**	**$0**	**$0**	**$17,858,741**	**$713,591,180**
Class I Nursing Facility Supplemental Payments	$66,608,245	$5,392,861	$13,046,620	$1,298	$0	$0	$0	$0	$0	$0	$0	$96,227	$85,145,251
Total Long Term Care and Insurance Including Financing	**$600,553,909**	**$50,531,019**	**$129,475,585**	**$217,298**	**$0**	**$0**	**$0**	**$2,419**	**$1,233**	**$0**	**$0**	**$17,954,968**	**$798,736,431**

FY 2012-13 Long Term Care and Insurance Request													
FY 2012-13	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Class I Nursing Facilities	$421,500,268	$34,126,288	$82,559,655	$8,217	$0	$0	$0	$0	$0	$0	$0	$608,930	$538,803,358
Class II Nursing Facilities	$0	$1,318,389	$3,898,386	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,216,775
Program for All-Inclusive Care for the Elderly	$75,943,739	$9,471,930	$4,234,050	$0	$0	$0	$0	$0	$0	$0	$0	$0	$89,649,719
Subtotal Long Term Care	**$497,444,007**	**$44,916,607**	**$90,692,091**	**$8,217**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$608,930**	**$633,669,852**
Supplemental Medicare Insurance Benefit	$61,689,343	$3,808,862	$33,219,016	$230,400	$0	$0	$0	$0	$0	$0	$0	$19,808,242	$118,755,863
Health Insurance Buy-In	$7,105	$2,245	$3,684,962	$18,315	$0	$0	$0	$7,261	$3,661	$0	$0	$0	$3,723,549
Subtotal Insurance	**$61,696,448**	**$3,811,107**	**$36,903,978**	**$248,715**	**$0**	**$0**	**$0**	**$7,261**	**$3,661**	**$0**	**$0**	**$19,808,242**	**$122,479,412**
Total Long Term Care and Insurance	**$559,140,455**	**$48,727,714**	**$127,596,069**	**$256,932**	**$0**	**$0**	**$0**	**$7,261**	**$3,661**	**$0**	**$0**	**$20,417,172**	**$756,149,264**
Class I Nursing Facility Supplemental Payments	$67,873,802	$5,495,325	$13,294,506	$1,323	$0	$0	$0	$0	$0	$0	$0	$98,055	$86,763,011
Total Long Term Care and Insurance Including Financing	**$627,014,257**	**$54,223,039**	**$140,890,575**	**$258,255**	**$0**	**$0**	**$0**	**$7,261**	**$3,661**	**$0**	**$0**	**$20,515,227**	**$842,912,275**

Exhibit H - Long Term Care and Insurance Summary

FY 2013-14 Long Term Care and Insurance Request													
FY 2013-14	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Class I Nursing Facilities	$437,898,325	$35,453,939	$85,771,558	$8,537	$0	$0	$0	$0	$0	$0	$0	$632,620	$559,764,979
Class II Nursing Facilities	$0	$1,545,754	$4,570,689	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,116,443
Program for All-Inclusive Care for the Elderly	$81,149,891	$10,664,446	$4,880,253	$0	$0	$0	$0	$0	$0	$0	$0	$0	$96,694,590
Subtotal Long Term Care	**$519,048,216**	**$47,664,139**	**$95,222,500**	**$8,537**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$632,620**	**$662,576,012**
Supplemental Medicare Insurance Benefit	$67,454,803	$4,302,339	$36,564,205	$257,700	$0	$0	$0	$0	$0	$0	$0	$22,872,428	$131,451,475
Health Insurance Buy-In	$11,202	$3,539	$5,809,611	$28,875	$0	$0	$0	$11,447	$5,652	$0	$0	$0	$5,870,326
Subtotal Insurance	**$67,466,005**	**$4,305,878**	**$42,373,816**	**$286,575**	**$0**	**$0**	**$0**	**$11,447**	**$5,652**	**$0**	**$0**	**$22,872,428**	**$137,321,801**
Total Long Term Care and Insurance	**$586,514,221**	**$51,970,017**	**$137,596,316**	**$295,112**	**$0**	**$0**	**$0**	**$11,447**	**$5,652**	**$0**	**$0**	**$23,505,048**	**$799,897,813**
Class I Nursing Facility Supplemental Payments	$69,163,404	$5,599,736	$13,547,101	$1,348	$0	$0	$0	$0	$0	$0	$0	$99,919	$88,411,508
Total Long Term Care and Insurance Including Financing	**$655,677,625**	**$57,569,753**	**$151,143,417**	**$296,460**	**$0**	**$0**	**$0**	**$11,447**	**$5,652**	**$0**	**$0**	**$23,604,967**	**$888,309,321**

Class I Nursing Home Calculations for FY 2011-12, FY 2012-13 and FY 2013-14

FY 2011-12 Calculation

Service Expenditures:	Core Components	Reference
Estimate of FY 2011-12 General Fund Portion of Per Diem Rate	$183.02	Footnote 1
Estimate of FY 2011-12 Patient Payment (per day)	($34.08)	Footnote 1
Estimated FY 2011-12 Medicaid Reimbursement (per day)	**$148.94**	
Estimate of Patient Days (without Hospital Back Up)	3,495,708	Footnote 2
Total Estimated Costs for FY 2011-12 Days of Service	$520,650,750	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.47%	Footnote 4
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$481,445,749	
Estimated Expenditures for FY 2010-11 Dates of Service	$38,407,171	Footnote 5
Estimated Expenditures in FY 2011-12 Prior to Adjustments	**$519,852,920**	
Bottom Line Adjustments:		
Hospital Back Up Program	$4,258,324	Footnote 6
Recoveries from Department Overpayment Review	($1,977,766)	Footnote 7
Savings from days incurred in FY 2010-11 and paid in FY 2011-12 under HB 10-1324	($709,179)	Footnote 9
Savings from days incurred in FY 2010-11 and paid in FY 2011-12 under HB 10-1379	($472,786)	Footnote 9
SB 11-215 Nursing Facility Rate Reduction: 1.5% reduction Effective July 1, 2011	($8,889,323)	Footnote 9
Total Bottom Line Adjustments:	**($7,790,730)**	
Total Estimated FY 2011-12 General Fund Expenditures	**$512,062,190**	
Percentage Change in Core Component Expenditure Over Prior Year	2.55%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$43,446,400	Page EH-10
Prior Year Rate Reconciliation	$3,635,420	Page EH-10
Rate Cut Backfill	$0	Page EH-10
Cognitive Performance Scale	$807,125	Page EH-10
PASRR - Resident	$2,773,147	Page EH-10
PASRR - Facility	$641,003	Page EH-10
Medicaid Supplemental Payment	$29,614,476	Page EH-10
Pay for Performance	$4,227,680	Page EH-10
Total Estimated Supplemental Payments	**$85,145,251**	
Total Estimated FY 2011-12 Expenditures	**$597,207,441**	

Class I Nursing Home Calculations for FY 2011-12, FY 2012-13 and FY 2013-14		
FY 2012-13 Calculation		
Service Expenditures:	**Core Components**	**Reference**
Estimate of FY 2012-13 General Fund Portion of Per Diem Rate	$188.39	Footnote 1
Estimate of FY 2012-13 Patient Payment (per day)	($34.98)	Footnote 1
Estimated FY 2012-13 Medicaid Reimbursement (per day)	**$153.41**	
Estimate of Patient Days (without Hospital Back Up)	3,527,335	Footnote 2
Total Estimated Costs for FY 2012-13 Days of Service	$541,128,462	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.47%	Footnote 4
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$500,381,489	
Estimated Expenditures for FY 2011-12 Dates of Service	$39,205,001	Footnote 5
Estimated Expenditures in FY 2012-13 Prior to Adjustments	**$539,586,490**	
Bottom Line Adjustments:		
Hospital Back Up Program	$4,258,324	Footnote 6
Recoveries from Department Overpayment Review	($2,076,753)	Footnote 7
Savings from days incurred in FY 2011-12 and paid in FY 2012-13 under SB 11-215	($723,874)	Footnote 9
Colorado Choice Transitions	($2,240,829)	
Total Bottom Line Adjustments:	**($783,132)**	
Total Estimated FY 2012-13 Expenditures	**$538,803,358**	
Percentage Change in Core Component Expenditure Over Prior Year	5.22%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$44,271,882	Page EH-10
Prior Year Rate Reconciliation	$3,704,493	Page EH-10
Rate Cut Backfill	$0	Page EH-10
Cognitive Performance Scale	$822,460	Page EH-10
PASRR - Resident	$2,825,837	Page EH-10
PASRR - Facility	$653,182	Page EH-10
Medicaid Supplemental Payment	$30,177,151	Page EH-10
Pay for Performance	$4,308,006	Page EH-10
Total Estimated Supplemental Payments	**$86,763,011**	
Total Estimated FY 2012-13 Expenditures	**$625,566,369**	

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES

FY 2013-14 Calculation		
Service Expenditures:	**Core Components**	**Reference**
Estimate of FY 2013-14 General Fund Portion of Per Diem Rate	$193.91	Footnote 1
Estimate of FY 2013-14 Patient Payment (per day)	($35.90)	Footnote 1
Estimated FY 2013-14 Medicaid Reimbursement (per day)	**$158.01**	
Estimate of Patient Days (without Hospital Back Up)	3,568,958	Footnote 2
Total Estimated Costs for FY 2013-14 Days of Service	$563,917,537	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.47%	Footnote 4
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$521,454,546	
Estimated Expenditures for FY 2012-13 Dates of Service	$40,746,973	Footnote 5
Estimated Expenditures in FY 2013-14 Prior to Adjustments	**$562,201,519**	
Bottom Line Adjustments:		
Hospital Back Up Program	$4,258,324	Footnote 6
Recoveries from Department Overpayment Review	($2,180,694)	Footnote 7
Colorado Choice Transitions	($4,514,170)	
Total Bottom Line Adjustments:	**($2,436,540)**	
Total Estimated FY 2013-14 Expenditures	**$559,764,979**	
Percentage Change in Core Component Expenditure Over Prior Year	3.89%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$45,113,047	Page EH-10
Prior Year Rate Reconciliation	$3,774,878	Page EH-10
Rate Cut Backfill	$0	Page EH-10
Cognitive Performance Scale	$838,087	Page EH-10
PASRR - Resident	$2,879,528	Page EH-10
PASRR - Facility	$665,593	Page EH-10
Medicaid Supplemental Payment	$30,750,517	Page EH-10
Pay for Performance	$4,389,858	Page EH-10
Total Estimated Supplemental Payments	**$88,411,508**	
Total Estimated FY 2013-14 Expenditures	**$648,176,487**	

Class I Nursing Home Calculations for FY 2011-12 , FY 2012-13 and FY 2013-14 Footnotes:

(1) Per HB 08-1114 and SB 09-263, the Department implemented significant changes in the reimbursement rate methodology for nursing facilities. Beginning in FY 2008-09, instead of reimbursement based on an overall per diem rate, facilities are reimbursed based on a per diem rate for core components as well as supplemental per diem rates for eligible facilities. The core components include fair rental value; direct and indirect health care; and administrative and general costs. Supplemental payments are made for providers who have residents with moderate to severe mental health conditions, cognitive dementia, or acquired brain injury; and to providers who meet performance standards. In addition, supplemental payments are made for growth above the General Fund growth cap and as a provider fee offset. The following table includes the historical per diem reimbursement rates and the estimated and projected per diem rates for FY 2002-03 through FY 2013-14. The Core Per Diem less patient payment represents the General Fund portion of nursing facility reimbursement. It is to this figure that the General Fund Growth cap outlined in statute is applied.

Year	Core Per Diem	Patient Payment	General Fund Portion	Maximum Allowable Growth in General Fund Portion	Rate Reduction	Core Rate Less Reductions	Percentage Change in Core Rate Less Reductions
FY 2002-03	$131.06	$24.75	-	-	-	-	-
FY 2003-04	$143.49	$24.93	-	-	-	-	-
FY 2004-05	$150.15	$25.89	-	-	-	-	-
FY 2005-06	$157.34	$27.52	-	-	-	-	-
FY 2006-07	$166.30	$30.25	-	-	-	-	-
FY 2007-08	$169.28	$30.94	-	-	-	-	-
FY 2008-09	$182.96	$33.11	$149.85	-	-	$182.96	-
FY 2009-10	$178.83	$33.62	$145.21	3.00%	0.50%	$177.94	-2.75%
FY 2010-11	$177.86	$33.26	$144.60	1.90%	2.50%	$173.41	-2.54%
Estimated FY 2011-12	$183.02	$34.08	$148.94	3.00%	1.50%	$180.27	3.96%
Estimated FY 2012-13	$188.39	$34.98	$153.41	3.00%	-	$188.39	4.50%
Estimated FY 2013-14	$193.91	$35.90	$158.01	3.00%	-	$193.91	2.93%

(2) The patient days estimate is a trended value using incurred but not reported (IBNR) adjusted data. Values for prior years differ slightly from prior Budget Requests due to the inclusion of claims paid between those Requests and this Request. Additionally, historical statistics for FY 2006-07 through FY 2010-11 have been restated to reflect a change in forecast methodology. Hospital Back Up days are removed from this calculation. Because FY 2011-12 is a leap year, estimated patient days for FY 2011-12 are inflated to account for an additional calendar day; this adds approximatley 9,551 days to the projection.

Fiscal Year	Patient Days	Percentage Change	Full Time Equivalent Clients	Percentage Change
FY 2000-01	3,712,731	-	10,172	-
FY 2001-02	3,618,218	-2.55%	9,913	-2.55%
FY 2002-03	3,538,295	-2.21%	9,694	-2.21%
FY 2003-04	3,502,849	-1.00%	9,571	-1.27%
FY 2004-05	3,519,234	0.47%	9,642	0.74%
FY 2005-06	3,529,589	0.29%	9,670	0.29%
FY 2006-07	3,546,807	0.49%	9,717	0.49%
FY 2007-08	3,435,068	-3.15%	9,385	-3.42%
FY 2008-09	3,426,808	-0.24%	9,389	0.04%
FY 2009-10	3,451,924	0.73%	9,457	0.72%
FY 2010-11	3,527,354	2.19%	9,664	2.19%
Estimated FY 2011-12	3,495,708	-0.90%	9,551	-1.17%
Estimated FY 2012-13	3,527,335	0.90%	9,664	1.18%
Estimated FY 2013-14	3,568,958	1.18%	9,778	1.18%

(3) Estimated costs for current year dates of service is the amount the Department expects to pay for services rendered in the current fiscal year regardless of which fiscal year the payment is made.

(4) Of the estimated costs for the current year dates of service, a portion of those claims will be paid during the same fiscal year in which they were incurred while the rest of the claims will be paid in a future period. In order to estimate how much of the total expenditure incurred in the current year will be paid in the current year, expenditure patterns must be analyzed by month. This is because, for example, a claim incurred in July 2008 has 11 more months to pay during FY 2008-09 (from August 2008 to June 2009), while a claim incurred in May 2009 only has one additional month to pay during FY 2008-09 (June 2009). Thus, more claims from May 2009 will pay in FY 2009-10 than claims from July 2008. Based on the Department's estimate of incurred but not reported (IBNR) claims, the Department estimates in the table below the portion of claims outstanding for any given fiscal year by analyzing estimated IBNR (based on 4 years of data) and averages the total to provide an estimate of the total percentage of claims that will pay in the same fiscal year that the claim was incurred.

Estimate of Claims Incurred and Paid in the Same Fiscal Year

Month Incurred	Additional Months Until End of Fiscal Year	Estimated Percent Complete at End of Fiscal Year
July	11	99.84%
August	10	99.77%
September	9	99.66%
October	8	99.51%
November	7	99.28%
December	6	98.76%
January	5	98.04%
February	4	97.26%
March	3	95.99%
April	2	93.91%
May	1	90.49%
June	0	37.18%
Average		92.47%

The IBNR factor does not apply to Supplemental Payments since these payments are calculated and paid once per year with no retroactive adjustments.

(5) As calculated in the table below, the estimated FY 2011-12 expenditure for core components with FY 2010-11 dates of service is the estimated FY 2010-11 core components per diem rate, less the estimated per diem patient payment rate, multiplied by the estimated number of patient days. This calculation is then multiplied by one minus the calculated IBNR rate.

Calculation of Expenditures From Claims in Previous Fiscal Year	FY 2010-11	Source
IBNR Factor	92.47%	Footnote (4)
Estimated Patient Days from previous fiscal year	3,527,354	Footnote (2)
Estimated Per Diem Rate for Core Components for previous fiscal year	$177.86	Footnote (1)
Less: Estimated Patient Payment Rate for previous fiscal year	$33.26	Footnote (1)
Estimated claims expenditures for core components from previous fiscal year to be paid in the current fiscal year	$38,407,171	As described in Footnote (5) narrative

(6) Hospital Back Up and out of state placements are programs where the Department pays a much higher per diem for specialized clients which can be several times the statewide average Nursing Facilities Medicaid reimbursement rate. This is an intermediate level of care in between the hospital and a skilled nursing facility. Types of clients treated under this program include ventilator, wound care, medically complex and traumatic brain injury with severe behaviors. This group is difficult to budget for due to the fluctuation in client base. FY 2007-08 expenditures to date are lower than previous years due to a facility which was placed under a "Denial of Payment for New Admissions" status for failure to comply with certain standards, although this has since been rectified. In FY 2008-09, expenditures rose sharply due to an increase in billed patient days. In FY 2009-10 no facilities were accepting new clients. In FY 2010-11 one new client was added to the program. Currently, the Department is working to evaluate the efficacy and design of the HBU program. As the Department continues through this process, client admission into the program will be evaluated on a case by case basis.

Fiscal Year	Hospital Back Up	Percent Difference
FY 2003-04	$4,907,936	-
FY 2004-05	$5,731,131	16.77%
FY 2005-06	$5,033,659	-12.17%
FY 2006-07	$5,615,794	11.56%
FY 2007-08	$5,309,178	-5.46%
FY 2008-09	$6,920,964	30.36%
FY 2009-10	$4,376,832	-36.76%
FY 2010-11	$4,731,471	8.10%
Estimated FY 2011-12	$4,258,324	-10.00%
Estimated FY 2012-13	$4,258,324	0.00%
Estimated FY 2013-14	$4,258,324	0.00%

Effective with the February 2009 Budget Request, this table has been revised to show totals per paid fiscal year. Previous Requests have used incurred totals. This change is incorporated in both the projection of total expenditure and the projection of the General Fund cap.

(7) Overpayment review recoveries are amounts that the Department recovers from nursing homes. The Department contracted with a contingency based contractor to do a five year historical audit of all the facilities, and the contract expired at the end of FY 2005-06. The Department continues to do internal audits of nursing facilities, and estimates that, on average, each audit recovers approximately $22,000.

FY 2010-11 BRI-2 "Coordinated Payment and Payment Reform" provided the Department with additional resources for performing audits of nursing facilities. The estimated impact of this initiative is an increase in recoveries totaling $360,000 in FY 2010-11 and $540,000 in FY 2011-12. Trends have been adjusted to reflect the impact of this initiative as appropriate.

Fiscal Year	Overpayment	Percent Difference
FY 2010-11	$1,797,766	-
Estimated FY 2011-12	$1,977,766	10.01%
Estimated FY 2012-13	$2,076,753	5.01%
Estimated FY 2013-14	$2,180,694	5.01%

(8) Due to a change in the methodology in how the Department accounts for estate and trust recoveries, effective with the February 1, 2011 Medical Services Premiums Supplemental request, these two categories of recoveries will not be recorded as an offset to Class I nursing facility expenditure; estate and trust recoveries are shown in Exhibit L.

(9) HB 10-1324 imposed a rate reduction of 1.5% effective March 1, 2010 and effective until June 30, 2011. HB 10-1379 imposed a rate reduction of 1% in addition to the rate reduction of HB 10-1324 for the period of July 1, 2010 to June 30, 2011. SB 11-215 imposed a rate reduction of 1.5% effective July 1, 2011. The rate reductions apply to all days incurred under the effective periods of each bill. As not all days will be reported in the fiscal year in which they are incurred, the impact of the rate cuts extends over multiple fiscal years. The tables below show the incremental impact of the three bills. These figures may vary from previous submissions of the Department's requests due to revised forecasts for rates and patient days.

HB 10-1324	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
FY 2010-11 Rates	1.50%	$177.86	$175.19	($2.67)
FY 2010-11 Patient Days				3,527,354
Estimated FY 2010-11 Days Paid in FY 2011-12				265,610
Total FY 2011-12 Impact				**($709,179)**

HB 10-1379	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
FY 2010-11 Rates	1.00%	$177.86	$176.08	($1.78)
FY 2010-11 Patient days				3,527,354
Estimated FY 2010-11 Days Paid in FY 2011-12				265,610
Total FY 2011-12 Impact				**($472,786)**

SB 11-215	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
FY 2011-12 Rates	1.50%	$183.02	$180.27	($2.75)
FY 2011-12 Patient days				3,495,708
Estimated FY 2011-12 Days Paid in FY 2011-12				3,232,481
Total FY 2011-12 Impact				**($8,889,323)**
Estimated FY 2011-12 Days Paid in FY 2012-13				263,227
Total FY 2012-13 Impact				**($723,874)**

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES
Detailed Core Component and Supplemental Payment Per Diem Rates

Components of Nursing Facility Per Diem Rate											
			Add-on Payments (FY 2008-09) and Supplemental Payments (FY 2009-10 Forward)								
Year	Provider Fee Per Non Medicare Day Paid by Low Medicaid Volume Facilities	Provider Fee Per Non Medicare Day Paid by High Medicaid Volume Facilities	Growth Beyond General Fund Cap	Prior Year Rate Reconciliation	Rate Cut Backfill	Cognitive Performance Scale	PASRR - Resident[(2)]	PASRR - Facility[(2)]	Medicaid Supplemental Payment	Pay for Performance	Total Effective Add-on/ Supplemental
FY 2009-10	$5.90	$0.28	$31,277,211	$0	$2,995,689	$958,621	$2,713,717	$418,432	$12,830,094	$2,525,948	**$53,719,712**
FY 2010-11	$7.62	$1.17	$48,220,038	$6,575,460	$0	$81,245	$198,782	$49,344	$17,743,388	$1,174,416	**$74,042,673**
Projected FY 2011-12	$12.35	$1.90	$43,446,400	$3,635,420	$0	$807,125	$2,773,147	$641,003	$29,614,476	$4,227,680	**$85,145,251**
Projected FY 2012-13	$12.58	$1.94	$44,271,882	$3,704,493	$0	$822,460	$2,825,837	$653,182	$30,177,151	$4,308,006	**$86,763,011**
Projected FY 2013-14	$12.82	$1.98	$45,113,047	$3,774,878	$0	$838,087	$2,879,528	$665,593	$30,750,517	$4,389,858	**$88,411,508**
Percent Change	Provider Fee Per Non Medicare Day Paid by Low Medicaid Volume Facilities	Provider Fee Per Non Medicare Day Paid by High Medicaid Volume Facilities	Growth Beyond General Fund Cap	Prior Year Rate Reconciliation	Rate Cut Backfill	Cognitive Performance Scale	PASRR - Resident[(2)]	PASRR - Facility[(2)]	Medicaid Supplemental Payment	Pay for Performance	Total Effective Add-on/ Supplemental
FY 2010-11	29.24%	317.86%	54.17%	-	-100.00%	-91.52%	-92.67%	-88.21%	38.30%	-53.51%	**37.83%**
Projected FY 2011-12	61.97%	62.4%	-9.90%	-44.71%	-	893.45%	1295.07%	1199.05%	66.90%	259.98%	**14.99%**
Projected FY 2012-13	1.86%	2.1%	1.90%	1.90%	-	1.90%	1.90%	1.90%	1.90%	1.90%	**1.90%**
Projected FY 2013-14	1.91%	2.1%	1.90%	1.90%	-	1.90%	1.90%	1.90%	1.90%	1.90%	**1.90%**

[(1)]The Core Component Rate excludes the impact of rate reductions. Rate reductions are included as bottom line impacts.
[(2)]PASRR: Preadmission Screening and Resident Review

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES - Cash-Based Actuals and Projections (Reference Only)

Cash Based Actuals

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$310,462,191	$14,101,811	$55,720,354	$20,259	$0	$0	$0	$0	$0	$0	$3,078	$47,162	$380,354,855
FY 2003-04	$336,650,323	$16,720,841	$62,600,540	$12,286	$0	$0	$0	$0	$0	$0	$0	$27,022	$416,011,012
FY 2004-05	$342,142,204	$19,699,056	$61,974,535	$56,072	$0	$0	$0	$0	$0	$0	$0	$6,466	$423,878,333
FY 2005-06	$370,539,529	$22,631,623	$63,039,217	($10,541)	$0	$0	$0	$1,810	$0	$0	$0	$318,690	$456,520,328
FY 2006-07	$384,275,629	$24,171,304	$68,903,820	$1,596	$0	$0	$0	$0	$0	$0	$0	$951,138	$478,303,487
FY 2007-08	$389,399,454	$25,395,243	$69,952,848	$6,325	$0	$0	$0	$0	$0	$0	$0	$1,814,628	$486,568,498
FY 2008-09	$423,682,370	$29,953,087	$77,004,135	$22,194	$0	$0	$0	$0	$0	$0	$0	$256,886	$530,918,672
FY 2009-10 (DA)	$393,028,828	$28,956,277	$73,847,716	$5,285	$0	$0	$0	$0	$0	$0	$0	$62,685	$495,900,792
FY 2010-11 (DA)	$390,609,241	$31,625,232	$76,509,001	$7,615	$0	$0	$0	$0	$0	$0	$0	$564,302	$499,315,391
Estimated FY 2011-12	$400,580,930	$32,432,578	$78,462,165	$7,809	$0	$0	$0	$0	$0	$0	$0	$578,708	$512,062,190
Estimated FY 2012-13	$421,500,268	$34,126,288	$82,559,655	$8,217	$0	$0	$0	$0	$0	$0	$0	$608,930	$538,803,358
Estimated FY 2013-14	$437,898,325	$35,453,939	$85,771,558	$8,537	$0	$0	$0	$0	$0	$0	$0	$632,620	$559,764,979

Percent Change in Cash Based Actuals

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	8.44%	18.57%	12.35%	-39.35%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	-42.70%	9.37%
FY 2004-05	1.63%	17.81%	-1.00%	356.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-76.07%	1.89%
FY 2005-06	8.30%	14.89%	1.72%	-118.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4828.72%	7.70%
FY 2006-07	3.71%	6.80%	9.30%	-115.14%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	198.45%	4.77%
FY 2007-08	1.33%	5.06%	1.52%	296.31%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	90.78%	1.73%
FY 2008-09	8.80%	17.95%	10.08%	250.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-85.84%	9.11%
FY 2009-10 (DA)	-7.24%	-3.33%	-4.10%	-76.19%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-75.60%	-6.60%
FY 2010-11 (DA)	-0.62%	9.22%	3.60%	44.08%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	800.21%	0.69%
Estimated FY 2011-12	2.55%	2.55%	2.55%	2.55%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.55%	2.55%
Estimated FY 2012-13	5.22%	5.22%	5.22%	5.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.22%	5.22%
Estimated FY 2013-14	3.89%	3.89%	3.89%	3.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.89%	3.89%

Per Capita Cost

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$8,946.01	$2,596.54	$1,194.51	$0.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.75	$5.25	$1,146.34
FY 2003-04	$9,806.59	$3,013.85	$1,337.93	$0.26	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.75	$1,131.82
FY 2004-05	$9,562.39	$3,238.91	$1,293.05	$0.98	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.67	$1,043.97
FY 2005-06	$10,233.92	$3,745.72	$1,317.30	($0.18)	$0.00	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$28.73	$1,135.01
FY 2006-07	$10,707.64	$3,989.32	$1,411.99	$0.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$73.69	$1,219.45
FY 2007-08	$10,731.99	$4,132.00	$1,400.93	$0.14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$127.66	$1,241.37
FY 2008-09	$11,262.46	$4,646.05	$1,499.45	$0.45	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.04	$1,215.44
FY 2009-10 (DA)	$10,211.99	$4,107.86	$1,386.45	$0.09	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.94	$994.19
FY 2010-11 (DA)	$10,035.95	$4,071.74	$1,359.31	$0.12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$33.02	$890.43
Estimated FY 2011-12	$10,047.93	$3,861.48	$1,316.72	$0.11	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$30.79	$823.42
Estimated FY 2012-13	$10,325.83	$3,813.85	$1,329.51	$0.11	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$29.70	$797.91
Estimated FY 2013-14	$10,447.54	$3,735.53	$1,336.34	$0.10	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$28.46	$773.44

Percent Change in Per Capita Cost

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	9.62%	16.07%	12.01%	-48.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	-47.62%	-1.27%
FY 2004-05	-2.49%	7.47%	-3.35%	276.92%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-75.64%	-7.76%
FY 2005-06	7.02%	15.65%	1.88%	-118.37%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	4188.06%	8.72%
FY 2006-07	4.63%	6.50%	7.19%	-116.67%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	156.49%	7.44%
FY 2007-08	0.23%	3.58%	-0.78%	366.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	73.24%	1.80%
FY 2008-09	4.94%	12.44%	7.03%	221.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-86.65%	-2.09%
FY 2009-10 (DA)	-9.33%	-11.58%	-7.54%	-80.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-76.88%	-18.20%
FY 2010-11 (DA)	-1.72%	-0.88%	-1.96%	33.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	738.07%	-10.44%
Estimated FY 2011-12	0.12%	-5.16%	-3.13%	-8.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-6.75%	-7.53%
Estimated FY 2012-13	2.77%	-1.23%	0.97%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-3.54%	-3.10%
Estimated FY 2013-14	1.18%	-2.05%	0.51%	-9.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-4.18%	-3.07%

Totals do not include supplemental payments funded by the Medicaid Nursing Facility Cash Fund.

Exhibit H - LONG TERM CARE - CLASS II NURSING FACILITIES - Cash-Based Actuals and Projections

Cash Based Actuals

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$0	$0	$1,320,373	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,320,373
FY 2003-04	$0	$0	$1,104,554	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,104,554
FY 2004-05	$0	$0	$1,383,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,383,445
FY 2005-06	$69,154	$0	$1,367,696	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,436,850
FY 2006-07	$106,064	$27,660	$2,100,702	$0	$0	$0	$0	$0	$0	$0	$0	$35,710	$2,270,136
FY 2007-08	$74,970	$191,024	$1,924,394	$0	$0	$0	$0	$0	$0	$0	$0	$45,248	$2,235,636
FY 2008-09	$0	$335,754	$1,935,960	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,271,714
FY 2009-10	$78,087	$345,366	$1,592,381	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,015,835
FY 2010-11	($200,939)	$647,887	$1,915,758	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,362,706
Estimated FY 2011-12	$0	$980,278	$2,898,614	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,878,892
Estimated FY 2012-13	$0	$1,318,389	$3,898,386	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,216,775
Estimated FY 2013-14	$0	$1,545,754	$4,570,689	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,116,443

Percent Change in Cash Based Actuals

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	-	-	-16.35%	-	-	-	-	-	-	-	-	-	-16.35%
FY 2004-05	-	-	25.25%	-	-	-	-	-	-	-	-	-	25.25%
FY 2005-06	-	-	-1.14%	-	-	-	-	-	-	-	-	-	3.86%
FY 2006-07	53.37%	-	53.59%	-	-	-	-	-	-	-	-	-	57.99%
FY 2007-08	-29.32%	590.61%	-8.39%	-	-	-	-	-	-	-	-	26.71%	-1.52%
FY 2008-09	-100.00%	75.77%	0.60%	-	-	-	-	-	-	-	-	-100.00%	1.61%
FY 2009-10	-	2.86%	-17.75%	-	-	-	-	-	-	-	-	-	-11.26%
FY 2010-11	-357.33%	87.59%	20.31%	-	-	-	-	-	-	-	-	-	17.21%
Estimated FY 2011-12	-100.00%	51.30%	51.30%	-	-	-	-	-	-	-	-	-	64.17%
Estimated FY 2012-13	-	34.49%	34.49%	-	-	-	-	-	-	-	-	-	34.49%
Estimated FY 2013-14	-	17.25%	17.25%	-	-	-	-	-	-	-	-	-	17.25%

Per Capita Cost

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$0.00	$0.00	$28.31	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.98
FY 2003-04	$0.00	$0.00	$23.61	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.01
FY 2004-05	$0.00	$0.00	$28.86	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.41
FY 2005-06	$1.91	$0.00	$28.58	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.57
FY 2006-07	$2.96	$4.57	$43.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.77	$5.79
FY 2007-08	$2.07	$31.08	$38.54	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.18	$5.70
FY 2008-09	$0.00	$52.08	$37.70	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.20
FY 2009-10	$2.03	$49.00	$29.90	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.04
FY 2010-11	($5.16)	$83.42	$34.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.21
Estimated FY 2011-12	$0.00	$116.71	$48.64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.24
Estimated FY 2012-13	$0.00	$147.34	$62.78	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.73
Estimated FY 2013-14	$0.00	$162.87	$71.21	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.45

Percent Change in Per Capita Cost

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	-	-	-16.60%	-	-	-	-	-	-	-	-	-	-24.37%
FY 2004-05	-	-	22.24%	-	-	-	-	-	-	-	-	-	13.29%
FY 2005-06	-	-	-0.97%	-	-	-	-	-	-	-	-	-	4.69%
FY 2006-07	54.97%	-	50.63%	-	-	-	-	-	-	-	-	-	62.18%
FY 2007-08	-30.07%	580.09%	-10.48%	-	-	-	-	-	-	-	-	14.80%	-1.55%
FY 2008-09	-100.00%	67.57%	-2.18%	-	-	-	-	-	-	-	-	-100.00%	-8.77%
FY 2009-10	-	-5.91%	-20.69%	-	-	-	-	-	-	-	-	-	-22.31%
FY 2010-11	-354.19%	70.24%	13.85%	-	-	-	-	-	-	-	-	-	4.21%
Estimated FY 2011-12	-100.00%	39.91%	42.89%	-	-	-	-	-	-	-	-	-	48.22%
Estimated FY 2012-13	-	26.24%	29.07%	-	-	-	-	-	-	-	-	-	23.88%
Estimated FY 2013-14	-	10.54%	13.43%	-	-	-	-	-	-	-	-	-	9.31%

Exhibit H - LONG TERM CARE - CLASS II NURSING FACILITIES - Cash-Based Actuals and Projections

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Current Year Projection													
FY 2010-11 Expenditure	($200,939)	$647,887	$1,915,758	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,362,706
Percentage Selected to Modify Expenditure[2]	-100.00%	51.30%	51.30%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	64.17%
Estimated FY 2011-12 Base Expenditures	$0	$980,278	$2,898,614	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,878,892
Bottom Line Impacts													
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2011-12 Total Expenditures	**$0**	**$980,278**	**$2,898,614**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$3,878,892**
Estimated FY 2011-12 Per Capita	$0.00	$116.71	$48.64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.24
% Change over FY 2010-11 Per Capita	0.00%	39.91%	42.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	48.22%
Request Year Projection													
FY 2011-12 Expenditure	$0	$980,278	$2,898,614	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,878,892
Percentage Selected to Modify Expenditure[2]	0.00%	34.49%	34.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	34.49%
Estimated FY 2012-13 Base Expenditures	$0	$1,318,389	$3,898,386	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,216,775
Bottom Line Impacts													
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2012-13 Total Expenditure	**$0**	**$1,318,389**	**$3,898,386**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$5,216,775**
Estimated FY 2012-13 Per Capita	$0.00	$138.91	$60.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.21
% Change over FY 2011-12 Per Capita	0.00%	19.02%	24.88%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.54%
Out Year Projection													
FY 2012-13 Expenditure	$0	$1,318,389	$3,898,386	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,216,775
Percentage Selected to Modify Expenditure[2]	0.00%	17.25%	17.25%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.25%
Estimated FY 2013-14 Base Expenditures	$0	$1,545,754	$4,570,689	$0	$0	$0	$0	$0	$0	$0	$0	$0	$6,116,443
Bottom Line Impacts													
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2013-14 Total Expenditure	**$0**	**$1,545,754**	**$4,570,689**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$6,116,443**
Estimated FY 2013-14 Per Capita	$0.00	$162.87	$71.21	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$8.45
% Change over FY 2012-13 Per Capita	0.00%	17.25%	17.24%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.20%

Footnotes

(1) Actuals for this specific service category are not adjusted for the June 2010 payment delay.

(2) The percentages selected to trend expenditure for FY 2011-12, FY 2012-13 and FY 2013-14 are 51.30%, 34.49%, and 17.25% respectively. This trends are equal to the percentage change in per diem rates as determined by audited costs by the Department's rate contractor.

Exhibit H - LONG TERM CARE - PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) - Cash-Based Actuals and Projections

Cash Based Actuals

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$18,818,222	$943,551	$604,368	$0	$0	$0	$0	$0	$0	$0	$0	$0	$20,366,142
FY 2003-04	$24,097,092	$1,864,579	$1,067,498	$0	$0	$0	$0	$0	$0	$0	$0	$0	$27,029,169
FY 2004-05	$31,140,652	$2,557,598	$1,461,755	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,160,005
FY 2005-06	$35,666,638	$2,962,484	$1,841,368	$0	$0	$0	$0	$0	$0	$0	$0	$0	$40,470,490
FY 2006-07	$37,878,793	$3,182,900	$1,810,588	$0	$0	$0	$0	$0	$0	$0	$0	$0	$42,872,281
FY 2007-08	$44,272,143	$3,549,809	$1,596,904	$0	$0	$0	$0	$0	$0	$0	$0	$0	$49,418,855
FY 2008-09	$54,470,714	$4,395,937	$2,183,184	$0	$0	$0	$0	$0	$0	$0	$0	$0	$61,049,836
FY 2009-10 (DA)	$61,924,560	$4,986,130	$2,345,339	$0	$0	$0	$0	$0	$0	$0	$0	$0	$69,256,028
FY 2010-11 (DA)	$73,232,307	$7,892,082	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$0	$84,414,277
Estimated FY 2011-12	$70,871,391	$8,311,727	$3,605,547	$0	$0	$0	$0	$0	$0	$0	$0	$0	$82,788,665
Estimated FY 2012-13	$75,943,739	$9,471,930	$4,234,050	$0	$0	$0	$0	$0	$0	$0	$0	$0	$89,649,719
Estimated FY 2013-14	$81,149,891	$10,664,446	$4,880,253	$0	$0	$0	$0	$0	$0	$0	$0	$0	$96,694,590

Percent Change in Cash Based Actuals

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	28.05%	97.61%	76.63%	-	-	-	-	-	-	-	-	-	32.72%
FY 2004-05	29.23%	37.17%	36.93%	-	-	-	-	-	-	-	-	-	30.08%
FY 2005-06	14.53%	15.83%	25.97%	-	-	-	-	-	-	-	-	-	15.10%
FY 2006-07	6.20%	7.44%	-1.67%	-	-	-	-	-	-	-	-	-	5.93%
FY 2007-08	16.88%	11.53%	-11.80%	-	-	-	-	-	-	-	-	-	15.27%
FY 2008-09	23.04%	23.84%	36.71%	-	-	-	-	-	-	-	-	-	23.54%
FY 2009-10 (DA)	13.68%	13.43%	7.43%	-	-	-	-	-	-	-	-	-	13.44%
FY 2010-11 (DA)	18.26%	58.28%	40.27%	-	-	-	-	-	-	-	-	-	21.89%
Estimated FY 2011-12	-3.22%	5.32%	9.59%	-	-	-	-	-	-	-	-	-	-1.93%
Estimated FY 2012-13	7.16%	13.96%	17.43%	-	-	-	-	-	-	-	-	-	8.29%
Estimated FY 2013-14	6.86%	12.59%	15.26%	-	-	-	-	-	-	-	-	-	7.86%

Per Capita Cost

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$542.25	$173.73	$12.96	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$61.38
FY 2003-04	$701.95	$336.08	$22.82	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$73.54
FY 2004-05	$870.34	$420.52	$30.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$86.60
FY 2005-06	$985.08	$490.32	$38.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$100.62
FY 2006-07	$1,055.47	$525.32	$37.10	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$109.30
FY 2007-08	$1,220.16	$577.58	$31.98	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$126.08
FY 2008-09	$1,447.96	$681.86	$42.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$139.76
FY 2009-10 (DA)	$1,608.97	$707.35	$44.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$138.85
FY 2010-11 (DA)	$1,747.51	$943.71	$54.29	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$150.54
Estimated FY 2011-12	$1,777.70	$989.61	$60.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$133.13
Estimated FY 2012-13	$1,860.45	$1,058.55	$68.18	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$132.76
Estimated FY 2013-14	$1,936.10	$1,123.64	$76.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$133.61

Percent Change in Per Capita Cost

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	29.45%	93.45%	76.08%	-	-	-	-	-	-	-	-	-	19.81%
FY 2004-05	23.99%	25.12%	33.65%	-	-	-	-	-	-	-	-	-	17.76%
FY 2005-06	13.18%	16.60%	26.16%	-	-	-	-	-	-	-	-	-	16.19%
FY 2006-07	7.15%	7.14%	-3.59%	-	-	-	-	-	-	-	-	-	8.63%
FY 2007-08	15.60%	9.95%	-13.80%	-	-	-	-	-	-	-	-	-	15.35%
FY 2008-09	18.67%	18.05%	32.93%	-	-	-	-	-	-	-	-	-	10.85%
FY 2009-10 (DA)	11.12%	3.74%	3.58%	-	-	-	-	-	-	-	-	-	-0.65%
FY 2010-11 (DA)	8.61%	33.41%	23.30%	-	-	-	-	-	-	-	-	-	8.42%
Estimated FY 2011-12	1.73%	4.86%	11.46%	-	-	-	-	-	-	-	-	-	-11.57%
Estimated FY 2012-13	4.65%	6.97%	12.68%	-	-	-	-	-	-	-	-	-	-0.28%
Estimated FY 2013-14	4.07%	6.15%	11.53%	-	-	-	-	-	-	-	-	-	0.64%

Exhibit H - LONG TERM CARE - PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) - Cash-Based Actuals and Projections

PACE Enrollment and Cost Per Enrollee													
PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
PACE Average Monthly Paid Enrollment[1]													
FY 2003-04	717	47	25	-	-	-	-	-	-	-	-	-	789
FY 2004-05	845	62	31	-	-	-	-	-	-	-	-	-	938
FY 2005-06	943	64	40	-	-	-	-	-	-	-	-	-	1,047
FY 2006-07	1,020	69	40	-	-	-	-	-	-	-	-	-	1,129
FY 2007-08	1,121	82	37	-	-	-	-	-	-	-	-	-	1,240
FY 2008-09	1,273	100	48	-	-	-	-	-	-	-	-	-	1,421
FY 2009-10 (DA)	1,439	120	60	-	-	-	-	-	-	-	-	-	1,619
FY 2010-11 (DA)	1,600	171	75	-	-	-	-	-	-	-	-	-	1,846
FY 2011-12 Half Year Actuals	1,636	184	86	-	-	-	-	-	-	-	-	-	1,906
Estimated FY 2011-12	1,695	195	89	-	-	-	-	-	-	-	-	-	1,979
Estimated FY 2012-13	1,790	219	103	-	-	-	-	-	-	-	-	-	2,112
Estimated FY 2013-14	1,885	243	117	-	-	-	-	-	-	-	-	-	2,245
Percent Changes in Enrollment													
FY 2004-05	17.85%	31.91%	24.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.88%
FY 2005-06	11.60%	3.23%	29.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.62%
FY 2006-07	8.17%	7.81%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.83%
FY 2007-08	9.90%	18.84%	-7.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.83%
FY 2008-09	13.56%	21.95%	29.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	14.60%
FY 2009-10 (DA)	13.04%	20.00%	25.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.93%
FY 2010-11 (DA)	11.19%	42.50%	25.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	14.02%
FY 2011-12 Half Year Growth	2.25%	7.60%	14.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.25%
Estimated FY 2011-12	5.94%	14.04%	18.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.20%
Estimated FY 2012-13	5.60%	12.31%	15.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.72%
Estimated FY 2013-14	5.31%	10.96%	13.59%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.30%
Average Cost Per Enrollee													
FY 2003-04	$33,608.22	$39,671.89	$42,699.92	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$34,257.50
FY 2004-05	$36,852.84	$41,251.59	$47,153.37	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37,484.01
FY 2005-06	$37,822.52	$46,288.81	$46,034.20	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$38,653.76
FY 2006-07	$37,136.07	$46,128.99	$45,264.70	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37,973.68
FY 2007-08	$39,493.44	$43,290.35	$43,159.57	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$39,853.92
FY 2008-09	$42,789.25	$43,959.37	$45,483.01	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,962.59
FY 2009-10 (DA)	$43,033.05	$41,551.08	$39,088.98	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,777.04
FY 2010-11 (DA) [4]	$42,509.18	$42,864.28	$40,739.90	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,470.19
Estimated FY 2011-12	$41,812.03	$42,624.24	$40,511.76	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$41,833.59
Estimated FY 2012-13	$42,426.67	$43,250.82	$41,107.28	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,447.78
Estimated FY 2013-14	$43,050.34	$43,886.61	$41,711.56	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$43,071.09
Percent Changes in Cost Per Enrollee													
FY 2004-05	9.65%	3.98%	10.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.42%
FY 2005-06	2.63%	12.21%	-2.37%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.12%
FY 2006-07	-1.81%	-0.35%	-1.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.76%
FY 2007-08	6.35%	-6.15%	-4.65%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.95%
FY 2008-09	8.35%	1.55%	5.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.80%
FY 2009-10 (DA)	0.57%	-5.48%	-14.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.43%
FY 2010-11 (DA) [4]	-1.22%	3.16%	4.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.72%
Estimated FY 2011-12	-1.64%	-0.56%	-0.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.50%
Estimated FY 2012-13	1.47%	1.47%	1.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.47%
Estimated FY 2013-14	1.47%	1.47%	1.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.47%

Exhibit H - LONG TERM CARE - PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) - Cash-Based Actuals and Projections

Current Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2010-11 Average Monthly Paid Enrollmen	1,600	171	75	-	-	-	-	-	-	-	-	-	1,846
Estimated Increase in Average Monthly Paid Enrollmen Due to Additional Providers	95	24	14	-	-	-	-	-	-	-	-	-	133
FY 2011-12 Estimated Monthly Paid Enrollment	**1,695**	**195**	**89**	-	-	-	-	-	-	-	-	-	**1,979**
FY 2010-11 Cost Per Enrollee	$42,509.18	$42,864.28	$40,739.90	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,470.19
Estimated Increase in Cost Per Enrollee[3]	-1.64%	-0.56%	-0.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-
FY 2011-12 Estimated Base Cost Per Enrollee	**$41,812.03**	**$42,624.24**	**$40,511.76**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$41,833.59**
Estimated FY 2011-12 Base Expenditure	$70,871,391	$8,311,727	$3,605,547	$0	$0	$0	$0	$0	$0	$0	$0	$0	$82,788,665
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2011-12 Total Expenditure	**$70,871,391**	**$8,311,727**	**$3,605,547**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$82,788,665**
Estimated FY 2011-12 Per Capita	$1,777.70	$989.61	$60.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$133.13
% Change over FY 2010-11Per Capita	1.73%	4.86%	11.46%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-11.57%

Request Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2011-12 Average Monthly Paid Enrollmen (Base Enrollment Only	1,695	195	89	-	-	-	-	-	-	-	-	-	1,979
Estimated Increase in Average Monthly Paid Enrollmen Due to Additional Providers	95	24	14	-	-	-	-	-	-	-	-	-	133
FY 2012-13 Estimated Monthly Paid Enrollment	**1,790**	**219**	**103**	-	-	-	-	-	-	-	-	-	**2,112**
FY 2011-12 Cost Per Enrollee	$41,812.03	$42,624.24	$40,511.76	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$41,833.59
Estimated Increase in Cost Per Enrollee[3]	1.47%	1.47%	1.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
FY 2012-13 Estimated Base Cost Per Enrollee	**$42,426.67**	**$43,250.82**	**$41,107.28**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$42,447.78**
Estimated FY 2012-13 Base Expenditure	$75,943,739	$9,471,930	$4,234,050	$0	$0	$0	$0	$0	$0	$0	$0	$0	$89,649,719
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2012-13 Total Expenditure	**$75,943,739**	**$9,471,930**	**$4,234,050**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$89,649,719**
Estimated FY 2012-13 Per Capita	$1,860.45	$1,058.55	$68.18	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$132.76
% Change over FY 2011-12 Per Capita	4.65%	6.97%	12.68%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.28%

Out Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2012-13 Average Monthly Paid Enrollmen (Base Enrollment Only	1,790	219	103	-	-	-	-	-	-	-	-	-	2,112
Estimated Increase in Average Monthly Paid Enrollmen Due to Additional Providers	95	24	14	-	-	-	-	-	-	-	-	-	133
FY 2013-14 Estimated Monthly Paid Enrollment	**1,885**	**243**	**117**	**-**	-	-	-	-	-	-	-	-	**2,245**
FY 2012-13 Cost Per Enrollee	$42,426.67	$43,250.82	$41,107.28	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,447.78
Estimated Increase in Cost Per Enrollee[3]	1.47%	1.47%	1.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
FY 2013-14 Estimated Base Cost Per Enrollee	**$43,050.34**	**$43,886.61**	**$41,711.56**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$43,071.09**
Estimated FY 2013-14 Base Expenditure	$81,149,891	$10,664,446	$4,880,253	$0	$0	$0	$0	$0	$0	$0	$0	$0	$96,694,590
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2013-14 Total Expenditure	**$81,149,891**	**$10,664,446**	**$4,880,253**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$96,694,590**
Estimated FY 2013-14 Per Capita	$1,936.10	$1,123.64	$76.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$133.61
% Change over FY 2012-13 Per Capita	4.07%	6.15%	11.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.64%

Footnotes

(1) The Average Monthly Paid Enrollment is not the actual enrollment in the Department's PACE program. This figure reflects the number of capitations paid in each month, not the distinct number of clients enrolled. For further information, please see the Budget Line Item Descri

(2) Percentage selected to modify Per Enrollee amounts for FY 2011-12	**Cost Per Enrollee Growth**	
	OAP-A	The growth rate in OAP-A rates from FY 2010-11 to FY 2011-12
	OAP-B	The growth rate in OAP-B/AND/AB rates from FY 2010-11 to FY 2011-13
	AND/AB	The growth rate in OAP-B/AND/AB rates from FY 2010-11 to FY 2011-14
(3) Percentage selected to modify Per Enrollee amounts for FY 2012-13 andFY 2013-14	**Cost Per Enrollee Growth**	
	OAP-A	Average of FY 2008-09 to FY 2010-11 OAP-A yearly rate growth
	OAP-B	Average of FY 2008-09 to FY 2010-11 OAP-A yearly rate growth
	AND/AB	Average of FY 2008-09 to FY 2010-11 OAP-A yearly rate growth

(4) The FY 2010-11 Per Enrollee costs are adjusted for the PACE reconciliation with providers from FY 2009-10. These figures subtract out the reconciliation to keep trends consistent historically.

Exhibit H - INSURANCE - SUPPLEMENTAL MEDICARE INSURANCE BENEFIT - Cash-Based Actuals and Projections

Cash Based Actuals

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$20,688,182	$1,206,415	$10,844,450	$67,832	$0	$0	$0	$0	$0	$0	$0	$5,986,403	$38,793,282
FY 2003-04	$25,391,796	$1,480,703	$13,310,017	$83,254	$0	$0	$0	$0	$0	$0	$0	$7,347,457	$47,613,226
FY 2004-05	$31,170,839	$1,817,703	$16,339,309	$102,202	$0	$0	$0	$0	$0	$0	$0	$9,019,700	$58,449,753
FY 2005-06	$37,744,128	$2,201,019	$19,784,933	$123,754	$0	$0	$0	$0	$0	$0	$0	$10,921,770	$70,775,604
FY 2006-07	$44,106,993	$2,572,065	$23,120,257	$144,616	$0	$0	$0	$0	$0	$0	$0	$12,762,950	$82,706,881
FY 2007-08	$43,978,504	$2,564,572	$23,052,905	$144,195	$0	$0	$0	$0	$0	$0	$0	$12,725,770	$82,465,946
FY 2008-09	$49,992,538	$2,915,276	$26,205,375	$163,913	$0	$0	$0	$0	$0	$0	$0	$14,466,011	$93,743,114
FY 2009-10 (DA)	$54,965,748	$3,205,285	$28,812,261	$180,219	$0	$0	$0	$0	$0	$0	$0	$15,905,077	$103,068,590
FY 2010-11 (DA)	$63,751,826	$3,717,638	$33,417,798	$209,027	$0	$0	$0	$0	$0	$0	$0	$18,447,446	$119,543,734
Estimated FY 2011-12	$62,490,976	$3,412,827	$30,235,091	$202,090	$0	$0	$0	$0	$0	$0	$0	$17,280,033	$113,621,017
Estimated FY 2012-13	$61,689,343	$3,808,862	$33,219,016	$230,400	$0	$0	$0	$0	$0	$0	$0	$19,808,242	$118,755,863
Estimated FY 2013-14	$67,454,803	$4,302,339	$36,564,205	$257,700	$0	$0	$0	$0	$0	$0	$0	$22,872,428	$131,451,475

Percent Change in Cash Based Actuals

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	22.74%	22.74%	22.74%	22.74%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	22.74%	22.74%
FY 2004-05	22.76%	22.76%	22.76%	22.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	22.76%	22.76%
FY 2005-06	21.09%	21.09%	21.09%	21.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	21.09%	21.09%
FY 2006-07	16.86%	16.86%	16.86%	16.86%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.86%	16.86%
FY 2007-08	-0.29%	-0.29%	-0.29%	-0.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.29%	-0.29%
FY 2008-09	13.67%	13.67%	13.67%	13.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.67%	13.67%
FY 2009-10 (DA)	9.95%	9.95%	9.95%	9.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.95%	9.95%
FY 2010-11 (DA)	15.98%	15.98%	15.98%	15.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.98%	15.98%
Estimated FY 2011-12	-1.98%	-8.20%	-9.52%	-3.32%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-6.33%	-4.95%
Estimated FY 2012-13	-1.28%	11.60%	9.87%	14.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	14.63%	4.52%
Estimated FY 2013-14	9.35%	12.96%	10.07%	11.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.47%	10.69%

Per Capita Cost

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$596.13	$222.13	$232.48	$1.66	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$666.04	$116.92
FY 2003-04	$739.66	$266.89	$284.47	$1.75	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$746.54	$129.54
FY 2004-05	$871.18	$298.87	$340.91	$1.79	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$939.06	$143.96
FY 2005-06	$1,042.45	$364.29	$413.44	$2.10	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$984.65	$175.96
FY 2006-07	$1,229.02	$424.50	$473.79	$2.85	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$988.76	$210.86
FY 2007-08	$1,212.06	$417.27	$461.68	$3.24	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$895.30	$210.39
FY 2008-09	$1,328.92	$452.19	$510.28	$3.34	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$959.60	$214.61
FY 2009-10 (DA)	$1,428.16	$454.71	$540.93	$3.13	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$999.13	$206.63
FY 2010-11 (DA)	$1,637.98	$478.65	$593.72	$3.43	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,079.43	$213.18
Estimated FY 2011-12	$1,567.49	$406.34	$507.39	$2.87	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$919.35	$182.71
Estimated FY 2012-13	$1,511.25	$425.67	$534.95	$2.97	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$966.11	$175.87
Estimated FY 2013-14	$1,609.36	$453.31	$569.68	$3.17	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,028.85	$181.63

Percent Change in Per Capita Cost

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	24.08%	20.15%	22.36%	5.42%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	12.09%	10.79%
FY 2004-05	17.78%	11.98%	19.84%	2.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	25.79%	11.13%
FY 2005-06	19.66%	21.89%	21.28%	17.32%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.85%	22.23%
FY 2006-07	17.90%	16.53%	14.60%	35.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.42%	19.83%
FY 2007-08	-1.38%	-1.70%	-2.56%	13.68%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-9.45%	-0.22%
FY 2008-09	9.64%	8.37%	10.53%	3.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.18%	2.01%
FY 2009-10 (DA)	7.47%	0.56%	6.01%	-6.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.12%	-3.72%
FY 2010-11 (DA)	14.69%	5.26%	9.76%	9.58%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.04%	3.17%
Estimated FY 2011-12	-4.30%	-15.11%	-14.54%	-16.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-14.83%	-14.29%
Estimated FY 2012-13	-3.59%	4.76%	5.43%	3.48%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.09%	-3.74%
Estimated FY 2013-14	6.49%	6.49%	6.49%	6.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.49%	3.28%

Exhibit H - INSURANCE - SUPPLEMENTAL MEDICARE INSURANCE BENEFIT - Cash-Based Actuals and Projections

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Current Year Projection													
FY 2011-12 First Half Expenditure	$33,313,385	$1,942,644	$17,462,401	$109,227	$0	$0	$0	$0	$0	$0	$0	$9,639,675	$62,467,332
Estimated FY 2011-12 Second Half Caseload Trend	1.17%	2.95%	2.12%	7.10%	9.70%	11.20%	5.42%	5.61%	0.32%	-2.88%	-8.09%	5.38%	
Estimated Increase in Medicare Part B Premium (Effective January 1, 2012)[1]	-13.43%	-13.43%	-13.43%	-13.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-13.43%	
Estimated FY 2011-12 Second Half Expenditure	$29,177,591	$1,731,328	$15,437,401	$101,269	$0	$0	$0	$0	$0	$0	$0	$8,794,226	$55,241,815
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2011-12 Total Expenditure[2]	**$62,490,976**	**$3,412,827**	**$30,235,091**	**$202,090**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$17,280,033**	**$113,621,017**
Estimated FY 2011-12 Per Capita	$1,567.49	$406.34	$507.39	$2.87	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$919.35	$182.71
% Change over FY 2010-11 Per Capita	-4.30%	-15.11%	-14.54%	-16.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-14.83%	-14.29%
Request Year Projection													
Estimated FY 2011-12 Expenditure	$62,490,976	$3,412,827	$30,235,091	$202,090	$0	$0	$0	$0	$0	$0	$0	$17,280,033	$113,621,017
FY 2011-12 First Half Expenditure	$33,313,385	$1,681,499	$14,797,690	$100,821	$0	$0	$0	$0	$0	$0	$0	$8,485,807	$58,379,202
Estimated FY 2011-12 Second Half Expenditure	$29,177,591	$1,731,328	$15,437,401	$101,269	$0	$0	$0	$0	$0	$0	$0	$8,794,226	$55,241,815
Estimated FY 2012-13 Caseload Trend	2.39%	6.54%	4.21%	10.18%	10.18%	19.70%	11.31%	9.23%	0.10%	0.99%	-4.89%	9.08%	8.59%
Estimated FY 2012-13 First Half Expenditure	$29,874,935	$1,844,557	$16,087,316	$111,578	$0	$0	$0	$0	$0	$0	$0	$9,592,742	$57,511,128
Estimated Increase in Medicare Part B Premium (Effective January 1, 2013)[1]	6.49%	6.49%	6.49%	6.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.49%	
Estimated FY 2012-13 Second Half Expenditure	$31,814,408	$1,964,305	$17,131,700	$118,822	$0	$0	$0	$0	$0	$0	$0	$10,215,500	$61,244,735
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2012-13 Total Expenditure[2]	**$61,689,343**	**$3,808,862**	**$33,219,016**	**$230,400**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$19,808,242**	**$118,755,863**
Estimated FY 2012-13 Per Capita	$1,511.25	$425.67	$534.95	$2.97	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$966.11	$175.87
% Change over FY 2011-12 Per Capita	-3.59%	4.76%	5.43%	3.48%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.09%	-3.74%
Out Year Projection													
Estimated FY 2012-13 Expenditure	$61,689,343	$3,808,862	$33,219,016	$230,400	$0	$0	$0	$0	$0	$0	$0	$19,808,242	$118,755,863
Estimated FY 2012-13 First Half Expenditure	$29,874,935	$1,844,557	$16,087,316	$111,578	$0	$0	$0	$0	$0	$0	$0	$9,592,742	$57,511,128
Estimated FY 2012-13 Second Half Expenditure	$31,814,408	$1,964,305	$17,131,700	$118,822	$0	$0	$0	$0	$0	$0	$0	$10,215,500	$61,244,735
Estimated FY 2013-14 Caseload Trend	2.68%	6.07%	3.36%	5.03%	5.03%	10.51%	9.43%	8.76%	0.58%	12.27%	0.79%	8.43%	7.18%
Estimated FY 2013-14 First Half Expenditure	$32,667,034	$2,083,538	$17,707,325	$124,799	$0	$0	$0	$0	$0	$0	$0	$11,076,667	$63,659,363
Estimated Increase in Medicare Part B Premium (Effective January 1, 2014)[1]	6.49%	6.49%	6.49%	6.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.49%	
Estimated FY 2013-14 Second Half Expenditure	$34,787,769	$2,218,801	$18,856,880	$132,901	$0	$0	$0	$0	$0	$0	$0	$11,795,761	$67,792,112
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2013-14 Total Expenditure[2]	**$67,454,803**	**$4,302,339**	**$36,564,205**	**$257,700**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$22,872,428**	**$131,451,475**
Estimated FY 2013-14 Per Capita	$1,609.36	$453.31	$569.68	$3.17	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,028.85	$181.63
% Change over Estimated FY 2012-13 Per Capita	6.49%	6.49%	6.49%	6.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.49%	3.28%

Footnotes

[1] The Part B premium decreased to $99.90 from $115.40 effective January 1, 2012.

[2] Total Expenditure is calculated as the estimated first half expenditure plus the estimated second half expenditure. See the Budget Narrative for further information.

Exhibit H - INSURANCE - HEALTH INSURANCE BUY-IN - Cash-Based Actuals and Projections

Cash Based Actuals

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$179,279	$15,633	$132,420	$31,836	$0	$0	$0	$53,127	$8,906	$11,152	$6,912	$2,574	$441,840
FY 2003-04	$280,042	$24,420	$206,845	$49,728	$0	$0	$0	$82,987	$13,912	$17,420	$10,796	$4,021	$690,172
FY 2004-05	$246,429	$21,489	$182,018	$43,760	$0	$0	$0	$73,026	$12,242	$15,329	$9,501	$3,538	$607,332
FY 2005-06	$212,695	$18,547	$157,102	$37,769	$0	$0	$0	$63,030	$10,566	$13,231	$8,200	$3,054	$524,194
FY 2006-07	$1,797	$20,389	$704,579	$2,008	$0	$0	$0	$9,795	$651	$3,133	$0	$0	$742,352
FY 2007-08	$3,274	$1,762	$877,995	$1,605	$0	$0	$0	$16,916	$1,188	$2,208	$0	$0	$904,947
FY 2008-09	($177)	$3,200	$917,027	$5,034	$0	$0	$0	$16,561	$0	$500	$0	$0	$942,145
FY 2009-10 (DA)	$3,552	$8,332	$993,385	$3,197	$0	$0	$0	$11,314	$210	$0	$0	$0	$1,019,989
FY 2010-11 (DA)	$1,979	$625	$1,025,861	$5,099	$0	$0	$0	$2,021	$1,059	$0	$0	$0	$1,036,644
Estimated FY 2011-12	$2,367	$748	$1,227,548	$6,101	$0	$0	$0	$2,419	$1,233	$0	$0	$0	$1,240,416
Estimated FY 2012-13	$7,105	$2,245	$3,684,962	$18,315	$0	$0	$0	$7,261	$3,661	$0	$0	$0	$3,723,549
Estimated FY 2013-14	$11,202	$3,539	$5,809,611	$28,875	$0	$0	$0	$11,447	$5,652	$0	$0	$0	$5,870,326

Percent Change in Cash Based Actuals

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	56.20%	56.20%	56.20%	56.20%	0.00%	0.00%	0.00%	56.20%	56.20%	56.20%	56.20%	56.20%	56.20%
FY 2004-05	-12.00%	-12.00%	-12.00%	-12.00%	0.00%	0.00%	0.00%	-12.00%	-12.00%	-12.00%	-12.00%	-12.00%	-12.00%
FY 2005-06	-13.69%	-13.69%	-13.69%	-13.69%	0.00%	0.00%	0.00%	-13.69%	-13.69%	-13.69%	-13.69%	-13.68%	-13.69%
FY 2006-07	-99.16%	9.93%	348.49%	-94.68%	0.00%	0.00%	0.00%	-84.46%	-93.84%	-76.32%	-100.00%	-100.00%	41.62%
FY 2007-08	82.18%	-91.36%	24.61%	-20.08%	0.00%	0.00%	0.00%	72.70%	82.42%	-29.53%	0.00%	0.00%	21.90%
FY 2008-09	-105.40%	81.58%	4.45%	213.73%	0.00%	0.00%	0.00%	-2.10%	-100.00%	-77.35%	0.00%	0.00%	4.11%
FY 2009-10 (DA)	-2108.60%	160.41%	8.33%	-36.50%	0.00%	0.00%	0.00%	-31.69%	0.00%	-100.00%	0.00%	0.00%	8.26%
FY 2010-11 (DA)	-44.28%	-92.50%	3.27%	59.49%	0.00%	0.00%	0.00%	-82.14%	404.09%	0.00%	0.00%	0.00%	1.63%
Estimated FY 2011-12	19.61%	19.63%	19.66%	19.66%	0.00%	0.00%	0.00%	19.69%	16.42%	0.00%	0.00%	0.00%	19.66%
Estimated FY 2012-13	200.17%	200.13%	200.19%	200.20%	0.00%	0.00%	0.00%	200.17%	196.92%	0.00%	0.00%	0.00%	200.19%
Estimated FY 2013-14	57.66%	57.64%	57.66%	57.66%	0.00%	0.00%	0.00%	57.65%	54.38%	0.00%	0.00%	0.00%	57.65%

Per Capita Cost

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$5.17	$2.88	$2.84	$0.78	$0.00	$0.00	$0.00	$0.31	$0.64	$1.43	$1.69	$0.29	$1.33
FY 2003-04	$8.16	$4.40	$4.42	$1.05	$0.00	$0.00	$0.00	$0.42	$0.93	$2.07	$2.25	$0.41	$1.88
FY 2004-05	$6.89	$3.53	$3.80	$0.77	$0.00	$0.00	$0.00	$0.33	$0.78	$2.56	$1.84	$0.37	$1.50
FY 2005-06	$5.87	$3.07	$3.28	$0.64	$0.00	$0.00	$0.00	$0.29	$0.64	$2.58	$1.32	$0.28	$1.30
FY 2006-07	$0.05	$3.37	$14.44	$0.04	$0.00	$0.00	$0.00	$0.05	$0.04	$0.60	$0.00	$0.00	$1.89
FY 2007-08	$0.09	$0.29	$17.58	$0.04	$0.00	$0.00	$0.00	$0.08	$0.07	$0.35	$0.00	$0.00	$2.31
FY 2008-09	$0.00	$0.50	$17.86	$0.10	$0.00	$0.00	$0.00	$0.07	$0.00	$0.07	$0.00	$0.00	$2.16
FY 2009-10 (DA)	$0.09	$1.18	$18.65	$0.06	$0.00	$0.00	$0.00	$0.04	$0.01	$0.00	$0.00	$0.00	$2.04
FY 2010-11 (DA)	$0.05	$0.08	$18.23	$0.08	$0.00	$0.00	$0.00	$0.01	$0.06	$0.00	$0.00	$0.00	$1.85
Estimated FY 2011-12	$0.06	$0.09	$20.60	$0.09	$0.00	$0.00	$0.00	$0.01	$0.07	$0.00	$0.00	$0.00	$1.99
Estimated FY 2012-13	$0.17	$0.25	$59.34	$0.24	$0.00	$0.00	$0.00	$0.02	$0.20	$0.00	$0.00	$0.00	$5.51
Estimated FY 2013-14	$0.27	$0.37	$90.51	$0.35	$0.00	$0.00	$0.00	$0.03	$0.31	$0.00	$0.00	$0.00	$8.11

Percent Change in Per Capita Cost

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	57.83%	52.78%	55.63%	34.62%	0.00%	0.00%	0.00%	35.48%	45.31%	44.76%	33.14%	41.38%	41.35%
FY 2004-05	-15.56%	-19.77%	-14.03%	-26.67%	0.00%	0.00%	0.00%	-21.43%	-16.13%	23.67%	-18.22%	-9.76%	-20.21%
FY 2005-06	-14.80%	-13.03%	-13.68%	-16.88%	0.00%	0.00%	0.00%	-12.12%	-17.95%	0.78%	-28.26%	-24.32%	-13.33%
FY 2006-07	-99.15%	9.77%	340.24%	-93.75%	0.00%	0.00%	0.00%	-82.76%	-93.75%	-76.74%	-100.00%	-100.00%	45.38%
FY 2007-08	80.00%	-91.39%	21.75%	0.00%	0.00%	0.00%	0.00%	60.00%	75.00%	-41.67%	0.00%	0.00%	22.22%
FY 2008-09	-100.00%	72.41%	1.59%	150.00%	0.00%	0.00%	0.00%	-12.50%	-100.00%	-80.00%	0.00%	0.00%	-6.49%
FY 2009-10 (DA)	0.00%	136.00%	4.42%	-40.00%	0.00%	0.00%	0.00%	-42.86%	0.00%	-100.00%	0.00%	0.00%	-5.56%
FY 2010-11 (DA)	-44.44%	-93.22%	-2.25%	33.33%	0.00%	0.00%	0.00%	-75.00%	500.00%	0.00%	0.00%	0.00%	-9.31%
Estimated FY 2011-12	20.00%	12.50%	13.00%	12.50%	0.00%	0.00%	0.00%	0.00%	16.67%	0.00%	0.00%	0.00%	7.57%
Estimated FY 2012-13	183.33%	177.78%	188.06%	166.67%	0.00%	0.00%	0.00%	100.00%	185.71%	0.00%	0.00%	0.00%	176.88%
Estimated FY 2013-14	58.82%	48.00%	52.53%	45.83%	0.00%	0.00%	0.00%	50.00%	55.00%	0.00%	0.00%	0.00%	47.19%

Exhibit H - INSURANCE - HEALTH INSURANCE BUY-IN - Cash-Based Actuals and Projections

Expenditure Trends	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Expenditure Trends													
Actual FY 2010-11 Expenditure	$0.05	$0.08	$18.23	$0.08	$0.00	$0.00	$0.00	$0.01	$0.06	$0.00	$0.00	$0.00	$1.85
Average of FY 2004-05 through FY 2008-09	-29.61%	-5.11%	70.37%	14.66%	0.00%	0.00%	0.00%	-7.91%	-27.42%	-41.78%	-25.14%	-25.14%	8.39%
Average of FY 2005-06 through FY 2008-09	-34.02%	-3.39%	90.97%	21.32%	0.00%	0.00%	0.00%	-6.89%	-31.28%	-49.22%	-28.42%	-28.42%	13.49%
Average of FY 2006-07 through FY 2008-09	-40.79%	0.05%	125.85%	32.99%	0.00%	0.00%	0.00%	-4.62%	-37.14%	-61.07%	-33.33%	-33.33%	22.54%
Average of FY 2007-08 through FY 2008-09	-11.61%	-4.89%	14.53%	96.83%	0.00%	0.00%	0.00%	35.30%	-8.79%	-53.44%	0.00%	0.00%	13.01%
Average of FY 2005-06 through FY 2009-10	-448.93%	29.37%	74.44%	9.76%	0.00%	0.00%	0.00%	-11.85%	-25.02%	-59.38%	-22.74%	-22.74%	12.44%
Average of FY 2006-07 through FY 2009-10	-557.75%	40.14%	96.47%	15.62%	0.00%	0.00%	0.00%	-11.39%	-27.86%	-70.80%	-25.00%	-25.00%	18.97%
Average of FY 2007-08 through FY 2009-10	-710.61%	50.21%	12.46%	52.38%	0.00%	0.00%	0.00%	12.97%	-5.86%	-68.96%	0.00%	0.00%	11.42%
Average of FY 2008-09 through FY 2009-10	-1107.00%	121.00%	6.39%	88.62%	0.00%	0.00%	0.00%	-16.90%	-50.00%	-88.68%	0.00%	0.00%	6.19%
Average of FY 2006-07 through FY 2010-11	-455.05%	13.61%	77.83%	24.39%	0.00%	0.00%	0.00%	-25.54%	58.53%	-56.64%	-20.00%	-20.00%	15.50%
Average of FY 2007-08 through FY 2010-11	-544.03%	14.53%	10.17%	54.16%	0.00%	0.00%	0.00%	-10.81%	96.63%	-51.72%	0.00%	0.00%	8.98%
Average of FY 2008-09 through FY 2010-11	-752.76%	49.83%	5.35%	78.91%	0.00%	0.00%	0.00%	-38.64%	101.36%	-59.12%	0.00%	0.00%	4.67%
Average of FY 2009-10 through FY 2010-11	-1076.44%	33.96%	5.80%	11.50%	0.00%	0.00%	0.00%	-56.92%	202.05%	-50.00%	0.00%	0.00%	4.95%
Current Year Projection													
FY 2010-11 Expenditure	$1,979	$625	$1,025,861	$5,099	$0	$0	$0	$2,021	$1,059	$0	$0	$0	$1,036,644
Percentage Selected to Modify Expenditure[1]	3.27%	3.27%	3.27%	3.27%	0.00%	0.00%	0.00%	3.27%	0.00%	3.27%	0.00%	0.00%	
Estimated FY 2011-12 Base Expenditure	$2,044	$646	$1,059,407	$5,265	$0	$0	$0	$2,087	$1,059	$0	$0	$0	$1,070,508
Bottom Line Impacts													
SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$104	$33	$54,156	$269	$0	$0	$0	$107	$56	$0	$0	$0	$54,725
SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$219	$69	$113,985	$567	$0	$0	$0	$225	$118	$0	$0	$0	$115,183
Total Bottom Line Impacts	$323	$102	$168,141	$836	$0	$0	$0	$332	$174	$0	$0	$0	$169,908
Estimated FY 2011-12 Total Expenditure	**$2,367**	**$748**	**$1,227,548**	**$6,101**	**$0**	**$0**	**$0**	**$2,419**	**$1,233**	**$0**	**$0**	**$0**	**$1,240,416**
Estimated FY 2011-12 Per Capita	$0.06	$0.09	$20.60	$0.09	$0.00	$0.00	$0.00	$0.01	$0.07	$0.00	$0.00	$0.00	$1.99
% Change over FY 2010-11 Per Capita	20.00%	12.50%	13.00%	12.50%	0.00%	0.00%	0.00%	0.00%	16.67%	0.00%	0.00%	0.00%	7.57%
Request Year Projection													
Estimated FY 2011-12 Expenditure	$2,367	$748	$1,227,548	$6,101	$0	$0	$0	$2,419	$1,233	$0	$0	$0	$1,240,416
Percentage Selected to Modify Expenditure[1]	3.27%	3.27%	3.27%	3.27%	0.00%	0.00%	0.00%	3.27%	0.00%	3.27%	0.00%	0.00%	
Estimated FY 2012-13 Base Expenditures	$2,444	$772	$1,267,689	$6,301	$0	$0	$0	$2,498	$1,233	$0	$0	$0	$1,280,937
Bottom Line Impacts													
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$704	$223	$365,494	$1,817	$0	$0	$0	$720	$367	$0	$0	$0	$369,325
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$3,957	$1,250	$2,051,779	$10,197	$0	$0	$0	$4,043	$2,061	$0	$0	$0	$2,073,287
Total Bottom Line Impacts	$4,661	$1,473	$2,417,273	$12,014	$0	$0	$0	$4,763	$2,428	$0	$0	$0	$2,442,612
Estimated FY 2012-13 Total Expenditure	**$7,105**	**$2,245**	**$3,684,962**	**$18,315**	**$0**	**$0**	**$0**	**$7,261**	**$3,661**	**$0**	**$0**	**$0**	**$3,723,549**
Estimated FY 2012-13 Per Capita	$0.17	$0.25	$59.34	$0.24	$0.00	$0.00	$0.00	$0.02	$0.20	$0.00	$0.00	$0.00	$5.51
% Change over FY 2011-12 Per Capita	183.33%	177.78%	188.06%	166.67%	0.00%	0.00%	0.00%	100.00%	185.71%	0.00%	0.00%	0.00%	176.88%
Out Year Projection													
Estimated FY 2012-13 Expenditure	$7,105	$2,245	$3,684,962	$18,315	$0	$0	$0	$7,261	$3,661	$0	$0	$0	$3,723,549
Percentage Selected to Modify Expenditure[1]	3.27%	3.27%	3.27%	3.27%	0.00%	0.00%	0.00%	3.27%	0.00%	3.27%	0.00%	0.00%	
Estimated FY 2013-14 Base Expenditures	$7,337	$2,318	$3,805,460	$18,914	$0	$0	$0	$7,498	$3,661	$0	$0	$0	$3,845,188
Bottom Line Impacts													
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$442	$139	$228,878	$1,138	$0	$0	$0	$451	$227	$0	$0	$0	$231,275
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$3,423	$1,082	$1,775,273	$8,823	$0	$0	$0	$3,498	$1,764	$0	$0	$0	$1,793,863
Total Bottom Line Impacts	$3,865	$1,221	$2,004,151	$9,961	$0	$0	$0	$3,949	$1,991	$0	$0	$0	$2,025,138
Estimated FY 2013-14 Total Expenditure	**$11,202**	**$3,539**	**$5,809,611**	**$28,875**	**$0**	**$0**	**$0**	**$11,447**	**$5,652**	**$0**	**$0**	**$0**	**$5,870,326**
Estimated FY 2013-14 Per Capita	$0.27	$0.37	$90.51	$0.35	$0.00	$0.00	$0.00	$0.03	$0.31	$0.00	$0.00	$0.00	$8.11
% Change over FY 2012-13 Per Capita	58.82%	48.00%	52.53%	45.83%	0.00%	0.00%	0.00%	50.00%	55.00%	0.00%	0.00%	0.00%	47.19%

Footnotes

(1) Percentage selected to modify expenditure for FY 2011-12

OAP-A	FY 2010-11 expenditure growth rate for AND/AB clients	**Exp. Adults**	0.00%	**BC Adults**	FY 2010-11 expenditure growth rate for AND/AB clients
OAP-B	FY 2010-11 expenditure growth rate for AND/AB clients	**BCCP**	0.00%	**Non-Citizens**	0.00%
AND/AB	FY 2010-11 expenditure growth rate for AND/AB clients	**Elig. Children**	FY 2010-11 expenditure growth rate for AND/AB clients	**Partial Dual**	0.00%
AFDC-A	FY 2010-11 expenditure growth rate for AND/AB clients	**Foster Care**	0.00%		

(2) Percentage selected to modify expenditure for FY 2012-13 and FY 2013-14

OAP-A	FY 2010-11 expenditure growth rate for AND/AB clients	**Exp. Adults**	0.00%	**BC Adults**	FY 2010-11 expenditure growth rate for AND/AB clients
OAP-B	FY 2010-11 expenditure growth rate for AND/AB clients	**BCCP**	0.00%	**Non-Citizens**	0.00%
AND/AB	FY 2010-11 expenditure growth rate for AND/AB client	**Elig. Children**	FY 2010-11 expenditure growth rate for AND/AB clients	**Partial Dual**	0.00%
AFDC-A	FY 2010-11 expenditure growth rate for AND/AB clients	**Foster Care**	0.00%		

Exhibit I - Service Management - Summary

FY 2011-12 Service Management Request

Service Management	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Single Entry Points	$12,336,806	$2,195,204	$10,783,329	$4,271	$0	$0	$0	$1,424	$8,541	$0	$62,626	$7,118	$25,399,319
Disease Management	$34,947	$19,544	$172,808	$82,772	$0	$0	$2,354	$144,905	$22,865	$19,805	$0	$0	$500,000
Prepaid Inpatient Health Plan	$1,129,934	$546,761	$3,581,622	$6,026,000	$3,662,374	$2,862,214	$0	$8,675,343	$555,802	$465,606	$0	$0	$27,505,656
Total Service Management	**$13,501,687**	**$2,761,509**	**$14,537,759**	**$6,113,043**	**$3,662,374**	**$2,862,214**	**$2,354**	**$8,821,672**	**$587,208**	**$485,411**	**$62,626**	**$7,118**	**$53,404,975**

FY 2012-13 Service Management Request

Service Management	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Single Entry Points	$12,863,588	$2,497,923	$11,526,300	$4,514	$0	$0	$0	$1,505	$9,026	$0	$66,183	$7,522	$26,976,561
Disease Management	$34,947	$19,544	$172,808	$82,772	$0	$0	$2,354	$144,905	$22,865	$19,805	$0	$0	$500,000
Prepaid Inpatient Health Plan	$1,542,927	$772,251	$4,853,564	$9,383,797	$5,507,233	$4,124,743	$0	$8,597,886	$661,838	$664,939	$0	$0	$36,109,178
Total Service Management	**$14,441,462**	**$3,289,718**	**$16,552,672**	**$9,471,083**	**$5,507,233**	**$4,124,743**	**$2,354**	**$8,744,296**	**$693,729**	**$684,744**	**$66,183**	**$7,522**	**$63,585,739**

FY 2013-14 Service Management Request

Service Management	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Single Entry Points	$13,412,863	$2,842,387	$12,320,462	$4,770	$0	$0	$0	$1,590	$9,539	$0	$69,942	$7,949	$28,669,502
Disease Management	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepaid Inpatient Health Plan	$1,545,021	$771,548	$4,844,253	$9,383,797	$5,507,233	$4,124,743	$0	$8,597,886	$661,838	$664,939	$0	$0	$36,101,258
Total Service Management	**$14,957,884**	**$3,613,935**	**$17,164,715**	**$9,388,567**	**$5,507,233**	**$4,124,743**	**$0**	**$8,599,476**	**$671,377**	**$664,939**	**$69,942**	**$7,949**	**$64,770,760**

Exhibit I - SERVICE MANAGEMENT - SINGLE ENTRY POINTS - Cash-Based Actuals and Projections

Cash Based Actuals

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$7,791,287	$1,050,130	$5,784,183	$1,059	$0	$0	$0	$0	$2,117	$0	$0	$0	$14,628,776
FY 2003-04	$7,810,601	$1,041,413	$5,676,359	$1,094	$0	$0	$0	$0	$1,094	$0	$0	$0	$14,530,561
FY 2004-05	$9,077,168	$1,312,201	$6,855,305	$4,865	$0	$0	$0	$1,216	$0	$0	$0	$6,081	$17,256,835
FY 2005-06	$8,671,602	$1,294,860	$6,568,161	$2,262	$0	$0	$0	$2,262	$0	$0	$0	$7,916	$16,547,063
FY 2006-07	$9,171,616	$1,415,981	$7,352,685	$4,528	$0	$0	$0	$0	$1,132	$0	$0	$56,594	$18,002,536
FY 2007-08	$10,894,815	$1,743,587	$8,992,484	$2,602	$0	$0	$0	$1,301	$2,602	$0	$0	$119,709	$21,757,100
FY 2008-09	$11,356,087	$1,927,170	$9,708,485	$3,228	$0	$0	$0	$1,507	$7,102	$0	$56,818	$6,779	$23,067,175
FY 2009-10 (DA)	$11,622,897	$2,068,951	$9,956,430	$2,637	$0	$0	$0	$1,458	$8,329	$0	$41,435	$5,414	$23,707,551
FY 2010-11 (DA)	$11,482,516	$2,211,295	$10,261,280	$4,841	$1,210	$0	$0	$4,841	$9,683	$0	$38,731	$7,262	$24,021,660
Estimated FY 2011-12	$12,336,806	$2,195,204	$10,783,329	$4,271	$0	$0	$0	$1,424	$8,541	$0	$62,626	$7,118	$25,399,319
Estimated FY 2012-13	$12,863,588	$2,497,923	$11,526,300	$4,514	$0	$0	$0	$1,505	$9,026	$0	$66,183	$7,522	$26,976,561
Estimated FY 2013-14	$13,412,863	$2,842,387	$12,320,462	$4,770	$0	$0	$0	$1,590	$9,539	$0	$69,942	$7,949	$28,669,502

Percent Change in Cash Based Actuals

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	0.25%	-0.83%	-1.86%	3.34%	0.00%	0.00%	0.00%	0.00%	-48.33%	0.00%	0.00%	0.00%	-0.67%
FY 2004-05	16.22%	26.00%	20.77%	344.69%	0.00%	0.00%	0.00%	100.00%	-100.00%	0.00%	0.00%	100.00%	18.76%
FY 2005-06	-4.47%	-1.32%	-4.19%	-53.50%	0.00%	0.00%	0.00%	86.00%	0.00%	0.00%	0.00%	30.18%	-4.11%
FY 2006-07	5.77%	9.35%	11.94%	100.18%	0.00%	0.00%	0.00%	-100.00%	100.00%	0.00%	0.00%	614.93%	8.80%
FY 2007-08	18.79%	23.14%	22.30%	-42.53%	0.00%	0.00%	0.00%	100.00%	129.89%	0.00%	0.00%	111.52%	20.86%
FY 2008-09	4.23%	10.53%	7.96%	24.05%	0.00%	0.00%	0.00%	15.78%	172.91%	0.00%	100.00%	-94.34%	6.02%
FY 2009-10 (DA)	2.35%	7.36%	2.55%	-18.30%	0.00%	0.00%	0.00%	-3.25%	17.27%	0.00%	-27.07%	-20.15%	2.78%
FY 2010-11 (DA)	-1.21%	6.88%	3.06%	83.56%	100.00%	0.00%	0.00%	232.16%	16.26%	0.00%	-6.53%	34.14%	1.32%
Estimated FY 2011-12	7.44%	-0.73%	5.09%	-11.78%	-100.00%	0.00%	0.00%	-70.59%	-11.79%	0.00%	61.69%	-1.98%	5.74%
Estimated FY 2012-13	4.27%	13.79%	6.89%	5.69%	0.00%	0.00%	0.00%	5.69%	5.68%	0.00%	5.68%	5.68%	6.21%
Estimated FY 2013-14	4.27%	13.79%	6.89%	5.67%	0.00%	0.00%	0.00%	5.65%	5.68%	0.00%	5.68%	5.68%	6.28%

Per Capita Cost

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$224.51	$193.36	$124.00	$0.03	$0.00	$0.00	$0.00	$0.00	$0.15	$0.00	$0.00	$0.00	$44.09
FY 2003-04	$227.52	$187.71	$121.32	$0.02	$0.00	$0.00	$0.00	$0.00	$0.07	$0.00	$0.00	$0.00	$39.53
FY 2004-05	$253.69	$215.75	$143.03	$0.09	$0.00	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.63	$42.50
FY 2005-06	$239.50	$214.31	$137.25	$0.04	$0.00	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.71	$41.14
FY 2006-07	$255.56	$233.70	$150.67	$0.09	$0.00	$0.00	$0.00	$0.00	$0.07	$0.00	$0.00	$4.38	$45.90
FY 2007-08	$300.26	$283.69	$180.09	$0.06	$0.00	$0.00	$0.00	$0.01	$0.15	$0.00	$0.00	$8.42	$55.51
FY 2008-09	$301.87	$298.93	$189.05	$0.07	$0.00	$0.00	$0.00	$0.01	$0.39	$0.00	$14.25	$0.45	$52.81
FY 2009-10 (DA)	$302.00	$293.51	$186.93	$0.05	$0.00	$0.00	$0.00	$0.01	$0.45	$0.00	$11.22	$0.34	$47.53
FY 2010-11 (DA)	$295.02	$284.70	$182.31	$0.08	$0.06	$0.00	$0.00	$0.02	$0.53	$0.00	$12.05	$0.42	$42.84
Estimated FY 2011-12	$309.45	$261.36	$180.96	$0.06	$0.00	$0.00	$0.00	$0.00	$0.47	$0.00	$23.55	$0.38	$40.84
Estimated FY 2012-13	$315.13	$279.16	$185.61	$0.06	$0.00	$0.00	$0.00	$0.00	$0.50	$0.00	$26.17	$0.37	$39.95
Estimated FY 2013-14	$320.01	$299.48	$191.96	$0.06	$0.00	$0.00	$0.00	$0.00	$0.52	$0.00	$27.44	$0.36	$39.61

Percent Change in Per Capita Cost

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	1.34%	-2.92%	-2.16%	-33.33%	0.00%	0.00%	0.00%	0.00%	-53.33%	0.00%	0.00%	0.00%	-10.34%
FY 2004-05	11.50%	14.94%	17.89%	350.00%	0.00%	0.00%	0.00%	100.00%	-100.00%	0.00%	0.00%	100.00%	7.51%
FY 2005-06	-5.59%	-0.67%	-4.04%	-55.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	12.70%	-3.20%
FY 2006-07	6.71%	9.05%	9.78%	125.00%	0.00%	0.00%	0.00%	-100.00%	100.00%	0.00%	0.00%	516.90%	11.57%
FY 2007-08	17.49%	21.39%	19.53%	-33.33%	0.00%	0.00%	0.00%	100.00%	114.29%	0.00%	0.00%	92.24%	20.94%
FY 2008-09	0.54%	5.37%	4.98%	16.67%	0.00%	0.00%	0.00%	0.00%	160.00%	0.00%	100.00%	-94.66%	-4.86%
FY 2009-10 (DA)	0.04%	-1.81%	-1.12%	-28.57%	0.00%	0.00%	0.00%	0.00%	15.38%	0.00%	-21.26%	-24.44%	-10.00%
FY 2010-11 (DA)	-2.31%	-3.00%	-2.47%	60.00%	100.00%	0.00%	0.00%	100.00%	17.78%	0.00%	7.40%	23.53%	-9.87%
Estimated FY 2011-12	4.89%	-8.20%	-0.74%	-25.00%	-100.00%	0.00%	0.00%	-100.00%	-11.32%	0.00%	95.44%	-9.52%	-4.67%
Estimated FY 2012-13	1.84%	6.81%	2.57%	0.00%	0.00%	0.00%	0.00%	0.00%	6.38%	0.00%	11.13%	-2.63%	-2.18%
Estimated FY 2013-14	1.55%	7.28%	3.42%	0.00%	0.00%	0.00%	0.00%	0.00%	4.00%	0.00%	4.85%	-2.70%	-0.85%

Exhibit I - SERVICE MANAGEMENT - SINGLE ENTRY POINTS - Cash-Based Actuals and Projections

Home and Community Based Services (HCBS) Utilization[1]

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
HCBS Average Monthly Paid Enrollment[2]													
FY 2002-03	7,360	992	5,464	2	-	-	-	-	2	1	-	9	13,830
FY 2003-04	7,140	952	5,189	1	-	-	-	1	1	-	1	8	13,293
FY 2004-05	7,464	1,079	5,637	4	-	-	-	1	1	-	5	8	14,199
FY 2005-06	7,668	1,145	5,808	2	-	-	-	2	1	-	9	5	14,640
FY 2006-07	8,103	1,251	6,496	4	-	-	1	1	2	-	50	6	15,914
FY 2007-08	8,373	1,340	6,911	2	-	-	-	3	2	-	92	8	16,731
FY 2008-09	8,794	1,492	7,518	3	-	-	-	1	6	-	44	5	17,863
FY 2009-10 (DA)	9,304	1,656	7,970	2	-	-	-	1	7	-	33	4	18,977
FY 2010-11 (DA)	9,487	1,827	8,478	4	1	-	-	4	8	-	32	6	19,847
FY 2011-12 YTD Utilization	9,870	2,079	9,023	4	-	-	-	1	7	-	38	3	21,025
Estimated FY 2011-12	10,034	2,122	9,242	6	1	-	-	4	8	-	39	6	21,462
Estimated FY 2012-13	10,462	2,415	9,879	6	1	-	-	4	8	-	41	6	22,822
Estimated FY 2013-14	10,909	2,748	10,560	6	1	-	-	4	8	-	43	6	24,285
Percent Changes in Utilization													
FY 2002-03 to FY 2003-04	-2.99%	-4.03%	-5.03%	-50.00%	0.00%	0.00%	0.00%	0.00%	-50.00%	-100.00%	0.00%	-11.11%	-3.88%
FY 2003-04 to FY 2004-05	4.54%	13.34%	8.63%	300.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	400.00%	0.00%	6.82%
FY 2004-05 to FY 2005-06	2.73%	6.12%	3.03%	-50.00%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	80.00%	-37.50%	3.11%
FY 2005-06 to FY 2006-07	5.67%	9.26%	11.85%	100.00%	0.00%	0.00%	0.00%	-50.00%	100.00%	0.00%	455.56%	20.00%	8.70%
FY 2006-07 to FY 2007-08	3.33%	7.11%	6.39%	-50.00%	0.00%	0.00%	-100.00%	200.00%	0.00%	0.00%	84.00%	33.33%	5.13%
FY 2007-08 to FY 2008-09	5.03%	11.34%	8.78%	50.00%	0.00%	0.00%	0.00%	-66.67%	200.00%	0.00%	-52.17%	-37.50%	6.77%
FY 2008-09 to FY 2009-10	5.80%	10.99%	6.01%	-33.33%	0.00%	0.00%	0.00%	0.00%	16.67%	0.00%	-25.00%	-20.00%	6.24%
FY 2009-10 to FY 2010-11	1.97%	10.33%	6.37%	100.00%	0.00%	0.00%	0.00%	300.00%	14.29%	0.00%	-3.03%	50.00%	4.58%
FY 2010-11 to FY 2011-12 YTD	4.04%	13.79%	6.43%	0.00%	-100.00%	0.00%	0.00%	-75.00%	-12.50%	0.00%	18.75%	-50.00%	5.94%
Estimated FY 2011-12	5.77%	16.15%	9.01%	50.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	21.88%	0.00%	8.14%
Estimated FY 2012-13	4.27%	13.81%	6.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.13%	0.00%	6.34%
Estimated FY 2013-14	4.27%	13.79%	6.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.88%	0.00%	6.41%
Cost per Enrollee													
SINGLE ENTRY POINTS	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
FY 2002-03	$1,058.60	$1,058.60	$1,058.60	$529.30	$0.00	$0.00	$0.00	$0.00	$1,058.60	$0.00	$0.00	$0.00	$1,057.76
FY 2003-04	$1,093.92	$1,093.92	$1,093.92	$1,093.92	$0.00	$0.00	$0.00	$0.00	$1,093.92	$0.00	$0.00	$0.00	$1,093.10
FY 2004-05	$1,216.13	$1,216.13	$1,216.13	$1,216.13	$0.00	$0.00	$0.00	$1,216.13	$0.00	$0.00	$0.00	$760.08	$1,215.36
FY 2005-06	$1,130.88	$1,130.88	$1,130.88	$1,131.00	$0.00	$0.00	$0.00	$1,131.00	$0.00	$0.00	$0.00	$1,583.20	$1,130.26
FY 2006-07	$1,131.88	$1,131.88	$1,131.88	$1,132.00	$0.00	$0.00	$0.00	$0.00	$566.00	$0.00	$0.00	$9,432.33	$1,131.24
FY 2007-08	$1,301.18	$1,301.18	$1,301.18	$1,301.18	$0.00	$0.00	$0.00	$433.73	$1,301.18	$0.00	$0.00	$14,963.62	$1,300.41
FY 2008-09	$1,291.34	$1,291.67	$1,291.37	$1,076.09	$0.00	$0.00	$0.00	$1,506.53	$1,183.70	$0.00	$1,291.31	$1,355.87	$1,291.34
FY 2009-10 (DA)	$1,249.24	$1,249.37	$1,249.24	$1,318.71	$0.00	$0.00	$0.00	$1,457.52	$1,189.81	$0.00	$1,255.61	$1,353.41	$1,249.28
FY 2010-11 (DA)	$1,210.34	$1,210.34	$1,210.34	$1,210.34	$1,210.34	$0.00	$0.00	$1,210.34	$1,210.34	$0.00	$1,210.34	$1,210.34	$1,210.34
Estimated FY 2011-12	$1,229.50	$1,034.50	$1,166.77	$711.83	$0.00	$0.00	$0.00	$356.00	$1,067.63	$0.00	$1,605.79	$1,186.33	$1,183.46
Estimated FY 2012-13	$1,229.55	$1,034.34	$1,166.75	$752.33	$0.00	$0.00	$0.00	$376.25	$1,128.25	$0.00	$1,614.22	$1,253.67	$1,182.04
Estimated FY 2013-14	$1,229.52	$1,034.35	$1,166.71	$795.00	$0.00	$0.00	$0.00	$397.50	$1,192.38	$0.00	$1,626.56	$1,324.83	$1,180.54
Percentage Change in Cost per Enrollee													
SINGLE ENTRY POINTS	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
FY 2002-03	0.51%	-3.70%	-2.88%	-48.14%	0.00%	0.00%	0.00%	0.00%	55.59%	0.00%	0.00%	0.00%	-1.06%
FY 2003-04	3.34%	3.34%	3.34%	106.67%	0.00%	0.00%	0.00%	0.00%	3.34%	0.00%	0.00%	0.00%	3.34%
FY 2004-05	11.17%	11.17%	11.17%	11.17%	0.00%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	11.18%
FY 2005-06	-7.01%	-7.01%	-7.01%	-7.00%	0.00%	0.00%	0.00%	-7.00%	0.00%	0.00%	0.00%	108.29%	-7.00%
FY 2006-07	0.09%	0.09%	0.09%	0.09%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	495.78%	0.09%
FY 2007-08	14.96%	14.96%	14.96%	14.95%	0.00%	0.00%	0.00%	0.00%	129.89%	0.00%	0.00%	58.64%	14.95%
FY 2008-09	-0.76%	-0.73%	-0.75%	-17.30%	0.00%	0.00%	0.00%	247.34%	-9.03%	0.00%	0.00%	-90.94%	-0.70%
FY 2009-10 (DA)	-3.26%	-3.27%	-3.26%	22.55%	0.00%	0.00%	0.00%	-3.25%	0.52%	0.00%	-2.76%	-0.18%	-3.26%
FY 2010-11 (DA)	-3.11%	-3.12%	-3.11%	-8.22%	0.00%	0.00%	0.00%	-16.96%	1.73%	0.00%	-3.61%	-10.57%	-3.12%
Estimated FY 2011-12	1.58%	-14.53%	-3.60%	-41.19%	0.00%	0.00%	0.00%	-70.59%	-11.79%	0.00%	32.67%	-1.98%	-2.22%
Estimated FY 2012-13	0.00%	-0.02%	0.00%	5.69%	0.00%	0.00%	0.00%	5.69%	5.68%	0.00%	0.52%	5.68%	-0.12%
Estimated FY 2013-14	0.00%	0.00%	0.00%	5.67%	0.00%	0.00%	0.00%	5.65%	5.68%	0.00%	0.76%	5.68%	-0.13%

Exhibit I - SERVICE MANAGEMENT - SINGLE ENTRY POINTS - Cash-Based Actuals and Projections

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Current Year Projection													
FY 2011-12 Base Contracts	$12,336,806	$2,195,204	$10,783,329	$4,271	$0	$0	$0	$1,424	$8,541	$0	$62,626	$7,118	$25,399,319
Estimated FY 2009-10 Base Expenditure	$12,521,858	$2,247,230	$11,012,295	$6,407	$0		$0	$1,424	$8,541	$0	$71,989	$7,118	$25,876,862
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2011-12 Total Expenditure	**$12,336,806**	**$2,195,204**	**$10,783,329**	**$4,271**	**$0**	**$0**	**$0**	**$1,424**	**$8,541**	**$0**	**$62,626**	**$7,118**	**$25,399,319**
Estimated FY 2011-12 Per Capita	$309.45	$261.36	$180.96	$0.06	$0.00	$0.00	$0.00	$0.00	$0.47	$0.00	$23.55	$0.38	$40.84
% Change over FY 2010-11 Per Capita	4.89%	-8.20%	-0.74%	-25.00%	0.00%	0.00%	0.00%	0.00%	-11.32%	0.00%	95.44%	-9.52%	-4.67%
Request Year Projection													
Estimated FY 2012-13 Base Contracts	$12,336,806	$2,195,204	$10,783,329	$4,271	$0	$0	$0	$1,424	$8,541	$0	$62,626	$7,118	$25,399,319
Estimated Increase in HCBS Utilization[3]	4.27%	13.79%	6.89%	5.68%	0.00%	0.00%	0.00%	5.68%	5.68%	0.00%	5.68%	5.68%	
Estimated FY 2012-13 Base Expenditure	$12,863,588	$2,497,923	$11,526,300	$4,514	$0	$0	$0	$1,505	$9,026	$0	$66,183	$7,522	$26,976,561
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2012-13 Total Expenditure	**$12,863,588**	**$2,497,923**	**$11,526,300**	**$4,514**	**$0**	**$0**	**$0**	**$1,505**	**$9,026**	**$0**	**$66,183**	**$7,522**	**$26,976,561**
Estimated FY 2012-13 Per Capita	$315.13	$279.16	$185.61	$0.06	$0.00	$0.00	$0.00	$0.00	$0.50	$0.00	$26.17	$0.37	$39.95
% Change over FY 2011-12 Per Capita	1.84%	6.81%	2.57%	0.00%	0.00%	0.00%	0.00%	0.00%	6.38%	0.00%	11.13%	-2.63%	-2.18%
Out Year Projection													
FY 2013-14 Base Contracts	$12,863,588	$2,497,923	$11,526,300	$4,514	$0		$0	$1,505	$9,026	$0	$66,183	$7,522	$26,976,561
Estimated Increase in HCBS Utilization[3]	4.27%	13.79%	6.89%	5.68%	0.00%	0.00%	0.00%	5.68%	5.68%	0.00%	5.68%	5.68%	
Estimated FY 2013-14 Base Expenditure	$13,412,863	$2,842,387	$12,320,462	$4,770	$0	$0	$0	$1,590	$9,539	$0	$69,942	$7,949	$28,669,502
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2013-14 Total Expenditure	**$13,412,863**	**$2,842,387**	**$12,320,462**	**$4,770**	**$0**	**$0**	**$0**	**$1,590**	**$9,539**	**$0**	**$69,942**	**$7,949**	**$28,669,502**
Estimated FY 2013-14 Per Capita	$320.01	$299.48	$191.96	$0.06	$0.00	$0.00	$0.00	$0.00	$0.52	$0.00	$27.44	$0.36	$39.61
% Change over FY 2012-13 Per Capita	1.55%	7.28%	3.42%	0.00%	0.00%	0.00%	0.00%	0.00%	4.00%	0.00%	4.85%	-2.70%	-0.85%

Footnotes

(1) Home and Community Based Services (HCBS) utilization is not the only factor which influences Single Entry Point expenditure. However, the Department believes that utilization trends are a good proxy for other Single Entry Point functions. Please see the Budget Narrative for further information.

(2) The Average Monthly Paid Enrollment is not the actual enrollment in the Department's HCBS programs. This figure reflects the number of clients for who claims were paid in each month, not the distinct number of clients enrolled. For further information, please see the Budget Line Item Description.

(3) To trend expenditure the Department selected the average of the growth rate in enrollment from FY 2007-08 to FY 2010-11 for the OAP-A eligibility category. For the OAP-B category the Department selected the year to date enrollment growth. For the remaining eligibility categories the Department selected the three-year average in enrollment growth from FY 2006-07 through FY 2010-11 to trend expenditure forward

Exhibit I - SERVICE MANAGEMENT - DISEASE MANAGEMENT - Cash-Based Actuals and Projections

Cash Based Actuals

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	$26,163	$8,253	$73,925	$30,257	$0	$0	$420	$38,813	$7,351	$9,889	$9,202	$408	$204,682
FY 2005-06	$38,074	$13,320	$114,902	$52,228	$0	$0	$637	$80,668	$12,989	$9,537	$0	$0	$322,355
FY 2006-07	$31,652	$16,971	$146,541	$76,859	$0	$0	$2,053	$120,548	$19,962	$14,413	$0	$0	$428,999
FY 2007-08	$165,996	$92,931	$833,085	$378,473	$0	$0	$12,812	$645,653	$113,811	$87,964	$0	$0	$2,330,726
FY 2008-09	$201,459	$112,661	$996,159	$477,141	$0	$0	$13,568	$835,312	$131,805	$114,165	$0	$0	$2,882,271
FY 2009-10 (DA)	$4,570	$2,655	$23,534	$12,589	$0	$0	$409	$21,785	$3,047	$3,027	$0	$0	$71,616
FY 2010-11 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2011-12	$34,947	$19,544	$172,808	$82,772	$0	$0	$2,354	$144,905	$22,865	$19,805	$0	$0	$500,000
Estimated FY 2012-13	$34,947	$19,544	$172,808	$82,772	$0	$0	$2,354	$144,905	$22,865	$19,805	$0	$0	$500,000
Estimated FY 2013-14	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Percent Change in Cash Based Actuals

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2005-06	45.53%	61.39%	55.43%	72.62%	0.00%	0.00%	51.58%	107.83%	76.70%	-3.56%	-100.00%	-100.00%	57.49%
FY 2006-07	-16.87%	27.41%	27.54%	47.16%	0.00%	0.00%	222.29%	49.44%	53.68%	51.13%	0.00%	0.00%	33.08%
FY 2007-08	424.44%	447.59%	468.50%	392.43%	0.00%	0.00%	524.08%	435.60%	470.14%	510.31%	0.00%	0.00%	443.29%
FY 2008-09	21.36%	21.23%	19.57%	26.07%	0.00%	0.00%	5.90%	29.37%	15.81%	29.79%	0.00%	0.00%	23.66%
FY 2009-10 (DA)	-97.73%	-97.64%	-97.64%	-97.36%	0.00%	0.00%	-96.99%	-97.39%	-97.69%	-97.35%	0.00%	0.00%	-97.52%
FY 2010-11 (DA)	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%
Estimated FY 2011-12	100.00%	100.00%	100.00%	100.00%	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%	0.00%	0.00%	100.00%
Estimated FY 2012-13	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2013-14	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%

Per Capita Cost

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	$0.73	$1.36	$1.54	$0.53	$0.00	$0.00	$4.83	$0.17	$0.47	$1.65	$1.79	$0.04	$0.50
FY 2005-06	$1.05	$2.20	$2.40	$0.89	$0.00	$0.00	$3.39	$0.38	$0.79	$1.86	$0.00	$0.00	$0.80
FY 2006-07	$0.88	$2.80	$3.00	$1.52	$0.00	$0.00	$9.00	$0.59	$1.19	$2.78	$0.00	$0.00	$1.09
FY 2007-08	$4.57	$15.12	$16.68	$8.49	$0.00	$0.00	$47.45	$3.16	$6.64	$13.99	$0.00	$0.00	$5.95
FY 2008-09	$5.36	$17.47	$19.40	$9.71	$0.00	$0.00	$42.80	$3.55	$7.31	$16.37	$0.00	$0.00	$6.60
FY 2009-10 (DA)	$0.12	$0.38	$0.44	$0.22	$0.00	$0.00	$0.96	$0.08	$0.17	$0.39	$0.00	$0.00	$0.14
FY 2010-11 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Estimated FY 2011-12	$0.88	$2.33	$2.90	$1.18	$0.00	$0.00	$0.01	$7.99	$3.06	$7.45	$0.00	$0.00	$0.00
Estimated FY 2012-13	$0.86	$2.18	$2.78	$1.07	$0.00	$0.00	$0.01	$7.98	$3.03	$7.83	$0.00	$0.00	$0.00
Estimated FY 2013-14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Percent Change in Per Capita Cost

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2005-06	43.84%	61.76%	55.84%	67.92%	0.00%	0.00%	-29.81%	123.53%	68.09%	12.73%	-100.00%	-100.00%	60.00%
FY 2006-07	-16.19%	27.27%	25.00%	70.79%	0.00%	0.00%	165.49%	55.26%	50.63%	49.46%	0.00%	0.00%	36.25%
FY 2007-08	419.32%	440.00%	456.00%	458.55%	0.00%	0.00%	427.22%	435.59%	457.98%	403.24%	0.00%	0.00%	445.87%
FY 2008-09	17.29%	15.54%	16.31%	14.37%	0.00%	0.00%	-9.80%	12.34%	10.09%	17.01%	0.00%	0.00%	10.92%
FY 2009-10 (DA)	-97.76%	-97.82%	-97.73%	-97.73%	0.00%	0.00%	-97.76%	-97.75%	-97.67%	-97.62%	0.00%	0.00%	-97.88%
FY 2010-11 (DA)	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%
Estimated FY 2011-12	100.00%	100.00%	100.00%	100.00%	0.00%	0.00%	100.00%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%
Estimated FY 2012-13	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	0.00%
Estimated FY 2013-14	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Exhibit I - SERVICE MANAGEMENT - Prepaid Inpatient Health Plan Administration

Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	$373,290	$76,345	$697,995	$487,706	$0	$0	$0	$2,458,050	$114,363	$77,587	$22	$88	$4,285,446
FY 2005-06	$518,021	$113,193	$895,454	$617,504	$0	$0	$0	$2,912,859	$202,140	$81,570	$0	$0	$5,340,741
FY 2006-07	$505,046	$102,136	$772,630	$518,429	$1,000	$0	$0	$2,412,273	$223,401	$85,502	$0	$0	$4,620,417
FY 2007-08	$366,151	$74,505	$536,817	$430,680	$66,075	$0	$0	$1,873,683	$176,254	$85,306	$0	$0	$3,609,472
FY 2008-09	$352,841	$75,159	$520,646	$530,811	$95,675	$0	$0	$2,101,664	$184,279	$74,059	$0	$0	$3,935,134
FY 2009-10 (DA)	$331,989	$116,999	$938,116	$543,252	$170,250	$0	$0	$2,715,378	$208,304	$87,465	$0	$0	$5,111,753
FY 2010-11 (DA)	$423,286	$228,214	$1,552,759	$773,206	$267,440	$311,525	$0	$3,471,301	$230,751	$104,173	$0	$0	$7,362,655
Estimated FY 2011-12	$1,129,934	$546,761	$3,581,622	$6,026,000	$3,662,374	$2,862,214	$0	$8,675,343	$555,802	$465,606	$0	$0	$27,505,656
Estimated FY 2012-13	$1,542,927	$772,251	$4,853,564	$9,383,797	$5,507,233	$4,124,743	$0	$8,597,886	$661,838	$664,939	$0	$0	$36,109,178
Estimated FY 2013-14	$1,545,021	$771,548	$4,844,253	$9,383,797	$5,507,233	$4,124,743	$0	$8,597,886	$661,838	$664,939	$0	$0	$36,101,258

Percent Change in Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2005-06	38.77%	48.27%	28.29%	26.61%	0.00%	0.00%	0.00%	18.50%	76.75%	5.13%	-100.00%	-100.00%	24.63%
FY 2006-07	-2.50%	-9.77%	-13.72%	-16.04%	100.00%	0.00%	0.00%	-17.19%	10.52%	4.82%	0.00%	0.00%	-13.49%
FY 2007-08	-27.50%	-27.05%	-30.52%	-16.93%	6507.50%	0.00%	0.00%	-22.33%	-21.10%	-0.23%	0.00%	0.00%	-21.88%
FY 2008-09	-3.64%	0.88%	-3.01%	23.25%	44.80%	0.00%	0.00%	12.17%	4.55%	-13.18%	0.00%	0.00%	9.02%
FY 2009-10 (DA)	-5.91%	55.67%	80.18%	2.34%	77.95%	0.00%	0.00%	29.20%	13.04%	18.10%	0.00%	0.00%	29.90%
FY 2010-11 (DA)	27.50%	95.06%	65.52%	42.33%	57.09%	100.00%	0.00%	27.84%	10.78%	19.10%	0.00%	0.00%	44.03%
Estimated FY 2011-12	166.94%	139.58%	130.66%	679.35%	1269.42%	818.77%	0.00%	149.92%	140.87%	346.96%	0.00%	0.00%	273.58%
Estimated FY 2012-13	36.55%	41.24%	35.51%	55.72%	50.37%	44.11%	0.00%	-0.89%	19.08%	42.81%	0.00%	0.00%	31.28%
Estimated FY 2013-14	0.14%	-0.09%	-0.19%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.02%

Per Capita Cost

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	$10.87	$13.76	$14.92	$10.25	$0.00	$0.00	$0.00	$12.59	$7.67	$9.24	$0.00	$0.01	$11.66
FY 2005-06	$14.48	$18.61	$18.68	$10.81	$0.00	$0.00	$0.00	$13.09	$12.80	$13.63	$0.00	$0.00	$13.15
FY 2006-07	$13.95	$16.90	$16.15	$8.80	$0.00	$0.00	$0.00	$11.26	$13.57	$16.70	$0.00	$0.00	$11.49
FY 2007-08	$10.20	$12.30	$11.00	$8.50	$12.80	$0.00	$0.00	$9.12	$10.54	$16.46	$0.00	$0.00	$9.20
FY 2008-09	$9.72	$12.23	$10.43	$11.91	$10.73	$0.00	$0.00	$10.30	$10.75	$11.78	$0.00	$0.00	$10.04
FY 2009-10 (DA)	$8.83	$18.15	$18.27	$11.05	$13.38	$0.00	$0.00	$11.55	$11.55	$12.54	$0.00	$0.00	$11.70
FY 2010-11 (DA)	$11.00	$32.38	$29.15	$13.41	$15.57	$96.21	$0.00	$12.59	$12.55	$13.30	$0.00	$0.00	$14.76
Estimated FY 2011-12	$29.03	$70.40	$63.63	$98.85	$181.72	$105.36	$0.00	$28.69	$30.22	$59.18	$0.00	$0.00	$49.05
Estimated FY 2012-13	$38.70	$91.95	$81.45	$133.48	$228.99	$116.50	$0.00	$25.54	$36.48	$88.99	$0.00	$0.00	$58.07
Estimated FY 2013-14	$37.85	$86.23	$78.01	$121.15	$207.84	$97.33	$0.00	$23.39	$36.45	$88.12	$0.00	$0.00	$53.46

Percent Change in Per Capita Cost

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2005-06	33.21%	35.25%	25.20%	5.46%	0.00%	0.00%	0.00%	3.97%	66.88%	47.51%	0.00%	-100.00%	12.78%
FY 2006-07	-3.66%	-9.19%	-13.54%	-18.59%	0.00%	0.00%	0.00%	-13.98%	6.02%	22.52%	0.00%	0.00%	-12.62%
FY 2007-08	-26.88%	-27.22%	-31.89%	-3.41%	100.00%	0.00%	0.00%	-19.01%	-22.33%	-1.44%	0.00%	0.00%	-19.93%
FY 2008-09	-4.71%	-0.57%	-5.18%	40.12%	-16.17%	0.00%	0.00%	12.94%	1.99%	-28.43%	0.00%	0.00%	9.13%
FY 2009-10 (DA)	-9.16%	48.41%	75.17%	-7.22%	24.70%	0.00%	0.00%	12.14%	7.44%	6.45%	0.00%	0.00%	16.53%
FY 2010-11 (DA)	24.58%	78.40%	59.55%	21.36%	16.37%	100.00%	0.00%	9.00%	8.66%	6.06%	0.00%	0.00%	26.15%
Estimated FY 2011-12	163.91%	117.42%	118.28%	637.14%	1067.12%	9.51%	0.00%	127.88%	140.80%	344.96%	0.00%	0.00%	232.32%
Estimated FY 2012-13	33.31%	30.61%	28.01%	35.03%	26.01%	10.57%	0.00%	-10.98%	20.71%	50.37%	0.00%	0.00%	18.39%
Estimated FY 2013-14	-2.20%	-6.22%	-4.22%	-9.24%	-9.24%	-16.45%	0.00%	-8.42%	-0.08%	-0.98%	0.00%	0.00%	-7.94%

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Current Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RMHP	$456,603	$134,589	$993,414	$554,106	$592,524	$696,964	$0	$4,804,908	$316,944	$121,244	$0	$0	$8,671,296
Estimated Expenditure for Colorado Access	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for Kaiser Foundation Health	$4,375	$22,387	$144,358	$0	$0	$0	$0	$0	$0	$0	$0	$0	$171,120
Estimated Expenditure for CAHI	$181,614	$61,069	$30,917	$0	$0	$0	$0	$0	$0	$0	$0	$0	$273,600
Estimated Expenditure for RCCOs in the ACC	$317,957	$214,464	$1,574,271	$3,570,030	$2,002,863	$1,412,675	$0	$2,525,190	$155,838	$224,672	$0	$0	$11,997,960
Estimated Expenditure for PCMPs in the ACC	$97,833	$65,989	$484,391	$1,098,471	$616,266	$434,669	$0	$776,981	$47,950	$69,130	$0	$0	$3,691,680
Estimated Expenditure for SDAC in the ACC	$71,552	$48,263	$354,271	$803,393	$450,721	$317,906	$0	$568,264	$35,070	$50,560	$0	$0	$2,700,000
Estimated FY 2011-12 Total Expenditure	$1,129,934	$546,761	$3,581,622	$6,026,000	$3,662,374	$2,862,214	$0	$8,675,343	$555,802	$465,606	$0	$0	$27,505,656
Estimated FY 2011-12 Per Capita Cost	$29.03	$70.40	$63.63	$98.85	$181.72	$105.36	$0.00	$28.69	$30.22	$59.18	$0.00	$0.00	$49.05

Request Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RMHP	$393,306	$115,932	$855,704	$477,295	$510,387	$600,349	$0	$4,138,839	$273,009	$104,437	$0	$0	$7,469,258
Estimated Expenditure for Colorado Access	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for Kaiser Foundation Health	$295	$1,507	$9,718	$0	$0	$0	$0	$0	$0	$0	$0	$0	$11,520
Estimated Expenditure for CAHI	$356,061	$119,726	$60,613	$0	$0	$0	$0	$0	$0	$0	$0	$0	$536,400
Estimated Expenditure for RCCOs in the ACC	$541,833	$365,486	$2,682,665	$6,083,510	$3,413,053	$2,407,307	$0	$3,045,714	$265,586	$382,846	$0	$0	$19,188,000
Estimated Expenditure for PCMPs in the ACC	$166,718	$112,457	$825,435	$1,871,849	$1,050,170	$740,710	$0	$937,143	$81,719	$117,799	$0	$0	$5,904,000
Estimated Expenditure for SDAC in the ACC	$84,714	$57,143	$419,429	$951,143	$533,623	$376,377	$0	$476,190	$41,524	$59,857	$0	$0	$3,000,000
Estimated FY 2012-13 Total Expenditure	$1,542,927	$772,251	$4,853,564	$9,383,797	$5,507,233	$4,124,743	$0	$8,597,886	$661,838	$664,939	$0	$0	$36,109,178
Estimated FY 2012-13 Per Capita Cost	$38.70	$91.95	$81.45	$133.48	$228.99	$116.50	$0.00	$25.54	$36.48	$88.99	$0.00	$0.00	$58.07

Out Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RMHP	$393,306	$115,932	$855,704	$477,295	$510,387	$600,349	$0	$4,138,839	$273,009	$104,437	$0	$0	$7,469,258
Estimated Expenditure for Colorado Access	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for Kaiser Foundation Health	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for CAHI	$358,450	$120,530	$61,020	$0	$0	$0	$0	$0	$0	$0	$0	$0	$540,000
Estimated Expenditure for RCCOs in the ACC	$541,833	$365,486	$2,682,665	$6,083,510	$3,413,053	$2,407,307	$0	$3,045,714	$265,586	$382,846	$0	$0	$19,188,000
Estimated Expenditure for PCMPs in the ACC	$166,718	$112,457	$825,435	$1,871,849	$1,050,170	$740,710	$0	$937,143	$81,719	$117,799	$0	$0	$5,904,000
Estimated Expenditure for SDAC in the ACC	$84,714	$57,143	$419,429	$951,143	$533,623	$376,377	$0	$476,190	$41,524	$59,857	$0	$0	$3,000,000
Estimated FY 2013-14 Total Expenditure	$1,545,021	$771,548	$4,844,253	$9,383,797	$5,507,233	$4,124,743	$0	$8,597,886	$661,838	$664,939	$0	$0	$36,101,258
Estimated FY 2013-14 Per Capita Cost	$37.85	$86.23	$78.01	$121.15	$207.84	$97.33	$0.00	$23.39	$36.45	$88.12	$0.00	$0.00	$53.46

Note: Current and Request Year Projections are calculated in pages EI-8 and EI-9.

Exhibit I - SERVICE MANAGEMENT - Prepaid Inpatient Health Plan Administration

Cash Based Actuals by Provider

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2002-03	$0	$0	$0	$0	$0	$0	$0	$0
FY 2003-04	$3,308,119	$0	$0	$0	$0	$0	$0	$3,308,119
FY 2004-05	$4,285,446	$0	$0	$0	$0	$0	$0	$4,285,446
FY 2005-06	$5,340,741	$0	$0	$0	$0	$0	$0	$5,340,741
FY 2006-07	$4,620,417	$0	$0	$0	$0	$0	$0	$4,620,417
FY 2007-08	$3,609,472	$0	$0	$0	$0	$0	$0	$3,609,472
FY 2008-09	$3,935,134	$0	$0	$0	$0	$0	$0	$3,935,134
FY 2009-10	$4,744,734	$258,779	$65,940	$42,300	$0	$0	$0	$5,111,753
FY 2010-11	$5,437,512	$705,541	$130,440	$201,750	$182,819	$54,592	$650,000	$7,362,655
Estimated FY 2011-12	$8,671,296	$0	$171,120	$273,600	$11,997,960	$3,691,680	$2,700,000	$27,505,656
Estimated FY 2012-13	$7,469,258	$0	$11,520	$536,400	$19,188,000	$5,904,000	$3,000,000	$36,109,178
Estimated FY 2013-14	$7,469,258	$0	$0	$540,000	$19,188,000	$5,904,000	$3,000,000	$36,101,258

Percent Change in Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2003-04	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
FY 2004-05	29.54%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	29.54%
FY 2005-06	24.63%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	24.63%
FY 2006-07	-13.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-13.49%
FY 2007-08	-21.88%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-21.88%
FY 2008-09	9.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.02%
FY 2009-10	20.57%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	29.90%
FY 2010-11	14.60%	172.64%	97.82%	376.95%	100.00%	100.00%	100.00%	44.03%
Estimated FY 2011-12	59.47%	-100.00%	31.19%	35.61%	6462.75%	6662.31%	315.38%	273.58%
Estimated FY 2012-13	-13.86%	0.00%	-93.27%	96.05%	59.93%	59.93%	11.11%	31.28%
Estimated FY 2013-14	0.00%	0.00%	-100.00%	0.67%	0.00%	0.00%	0.00%	-0.02%

Prepaid Inpatient Health Plan Enrollment

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL[1]
Enrollment in Current Prepaid Inpatient Health Plan								
FY 2003-04	11,681	-	-	-	-	-	-	11,681
FY 2004-05	13,086	-	-	-	-	-	-	13,086
FY 2005-06	13,025	-	-	-	-	-	-	13,025
FY 2006-07	11,794	-	-	-	-	-	-	11,794
FY 2007-08	11,955	-	-	-	-	-	-	11,955
FY 2008-09	13,051	-	-	-	-	-	-	13,051
FY 2009-10	16,123	2,186	275	24	-	-	-	18,608
FY 2010-11	19,045	1,826	544	112	1,172	1,172	1,172	22,699
FY 2011-12 YTD	20,748	-	844	120	42,830	42,830	42,830	64,542
Estimated FY 2011-12	20,972	-	713	152	76,910	76,910	76,910	98,747
Estimated FY 2012-13	21,197	-	48	298	123,000	123,000	123,000	144,543
Estimated FY 2013-14	21,197	-	-	300	123,000	123,000	123,000	144,497
Annual Percent Change in Enrollment								
FY 2004-05	12.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	12.03%
FY 2005-06	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%
FY 2006-07	-9.45%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-9.45%
FY 2007-08	1.37%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.37%
FY 2008-09	9.17%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.17%
FY 2009-10	23.54%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	42.58%
FY 2010-11	18.12%	-16.47%	97.82%	366.67%	100.00%	100.00%	100.00%	21.99%
FY 2010-11 First Half to FY 2011-12 YTD	14.01%	-100.00%	37.01%	27.66%	100.00%	100.00%	100.00%	210.31%
Estimated FY 2011-12[2]	10.12%	-100.00%	31.07%	35.71%	6462.29%	6462.29%	6462.29%	335.03%
Estimated FY 2012-13[2]	1.07%	0.00%	-93.21%	96.05%	59.93%	59.93%	59.93%	46.38%
Estimated FY 2013-14[2]	0.00%	0.00%	-100.00%	0.67%	0.00%	0.00%	0.00%	-0.03%

Exhibit I - SERVICE MANAGEMENT - Prepaid Inpatient Health Plan Administration

Cost Per Enrollee

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2002-03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2003-04	$283.21	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$283.21
FY 2004-05	$327.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$327.48
FY 2005-06	$410.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$410.04
FY 2006-07	$391.76	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$391.76
FY 2007-08	$301.92	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$301.92
FY 2008-09	$301.52	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$301.52
FY 2009-10	$294.28	$118.38	$239.78	$1,762.50	$0.00	$0.00	$0.00	$274.71
FY 2010-11	$285.51	$386.39	$239.78	$1,801.34	$155.99	$46.58	$554.61	$324.36
Estimated FY 2011-12	$413.47	$0.00	$240.00	$1,800.00	$156.00	$48.00	$35.11	$278.55
Estimated FY 2012-13	$352.37	$0.00	$240.00	$1,800.00	$156.00	$48.00	$24.39	$249.82
Estimated FY 2013-14	$352.37	$0.00	$0.00	$1,800.00	$156.00	$48.00	$24.39	$249.84

Percent Change in Cost Per Enrollee

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2003-04	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
FY 2004-05	15.63%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.63%
FY 2005-06	25.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	25.21%
FY 2006-07	-4.46%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-4.46%
FY 2007-08	-22.93%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-22.93%
FY 2008-09	-0.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.13%
FY 2009-10	-2.40%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	-8.89%
FY 2010-11	-2.98%	226.40%	0.00%	2.20%	100.00%	100.00%	100.00%	18.07%
Estimated FY 2011-12	44.82%	-100.00%	0.09%	-0.07%	0.01%	3.05%	-93.67%	-14.12%
Estimated FY 2012-13	-14.78%	0.00%	0.00%	0.00%	0.00%	0.00%	-30.53%	-10.31%
Estimated FY 2013-14	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.01%

Current Year Projection

Estimated FY 2011-12 Enrollmen	20,972	0	713	152	76,910	76,910	N/A	98,747
FY 2011-12 PMPM Administration Fee	$24.38	$0.00	$20.00	$150.00	$13.00	$4.00	N/A	
Number of Months Paid	12	12	12	12	12	12	N/A	
Estimated FY 2011-12 Base Expenditures	$6,135,568	$0	$171,120	$273,600	$11,997,960	$3,691,680	$2,700,000	$24,969,928
Estimated Contract Payment to PIHP for Cost Avoidance	$2,535,728	$0	$0	$0	$0	$0	$0	$2,535,728
Estimated FY 2011-12 Total Expenditur	**$8,671,296**	**$0**	**$171,120**	**$273,600**	**$11,997,960**	**$3,691,680**	**$2,700,000**	**$27,505,656**
Estimated FY 2011-12 Cost Per Enrollee	$413.47	$0.00	$240.00	$1,800.00	$156.00	$48.00	$35.11	$278.55
% Change over FY 2010-11 Cost Per Enrollee	44.82%	-100.00%	0.09%	-0.07%	0.01%	3.05%	-93.67%	-14.12%

Request Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
Estimated 2012-13 Enrollmen	21,197	0	48	298	123,000	123,000	N/A	144,543
FY 2012-13 PMPM Administration Fee	$24.38	$0.00	$20.00	$150.00	$13.00	$4.00	N/A	
Number of Months Paid	12	12	12	12	12	12	N/A	
Estimated FY 2012-13 Base Expenditures	$6,201,394	$0	$11,520	$536,400	$19,188,000	$5,904,000	$3,000,000	$34,841,314
Estimated Contract Payment to PIHP for Cost Avoidance	$1,267,864	$0	$0	$0	$0	$0	$0	$1,267,864
Estimated FY 2012-13 Total Expenditur	**$7,469,258**	**$0**	**$11,520**	**$536,400**	**$19,188,000**	**$5,904,000**	**$3,000,000**	**$36,109,178**
Estimated FY 2012-13 Cost Per Enrollee	$352.37	-	$0.00	$1,800.00	$156.00	$48.00	$24.39	$249.82
% Change over FY 2011-12 Cost Per Enrollee	-14.78%	-	-100.00%	0.00%	0.00%	0.00%	-30.53%	-10.31%

Out Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
Estimated 2013-14 Enrollmen	21,197	0	0	300	123,000	123,000	N/A	144,497
FY 2013-14 PMPM Administration Fee	$24.38	$0.00	$0.00	$150.00	$13.00	$4.00	N/A	
Number of Months Paid	12	12	12	12	12	12	N/A	
Estimated FY 2013-14 Base Expenditures	$6,201,394	$0	$0	$540,000	$19,188,000	$5,904,000	$3,000,000	$34,833,394
Estimated Contract Payment to PIHP for Cost Avoidance	$1,267,864	$0	$0	$0	$0	$0	$0	$1,267,864
Estimated FY 2013-14 Total Expenditur	**$7,469,258**	**$0**	**$0**	**$540,000**	**$19,188,000**	**$5,904,000**	**$3,000,000**	**$36,101,258**
Estimated FY 2013-14 Cost Per Enrollee	$352.37	-	-	$1,800.00	$156.00	$48.00	$24.39	$249.84
% Change over FY 2012-13 Cost Per Enrollee	0.00%	-	-	0.00%	0.00%	0.00%	0.00%	0.01%

(1) Total enrollment only counts ACC enrollment once and therefore does not equal the sum of the columns.

(2) Percentages selected to modify enrollment:

RMHP: FY 2011-12: Base trend from December 2011 level. FY 2012-13 and FY 2013-14: No growth is assumed.

Colorado Access: Program ended June 30, 2011, at which time all clients were disenrolled from the program. Please see narrative for more informatic

Kaiser Foundation Health Plan: FY 2011-12: Current projections for capped enrollment and lag in time for invoice payments. FY 2012-13 and FY 2013-14: Program ends June 30, 2012, at which time all clients will be disenrolled from program.

Colorado Alliance Health & Independence Current projections for capped enrollment

Accountable Care Collaborative Estimates for enrollment are based on Department's implementation plan. SDAC is paid on a fixed-price contract and is not a function of enrollme

Exhibit J - Health Care Affordability Act of 2009 Estimates

Cash Funded Expansion Populations
Source of Funding

FY 2011-12 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Hospital Provider Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
HB 09-1293 Medicaid Expansion Clients							
Expansion Adults to 100%	35,406	$89,960,981	$0	$44,980,492	$0	$44,980,489	50.00%
Buy-In for Individuals with Disabilities	58	$566,364	$0	$235,431	$147,975	$182,958	50.00%
Adults Without Dependent Children	1,667	$6,626,200	$0	$3,313,100	$0	$3,313,100	50.00%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$97,153,545	$0	$48,529,023	$147,975	$48,476,547	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates	-	$149,589,064	$0	$74,794,532	$0	$74,794,532	50.00%
Outpatient Hospital Rates	-	$147,076,048	$0	$73,538,024	$0	$73,538,024	50.00%
Supplemental Hospital Payments (Upper Payment Limit	-	$279,037,754	$0	$139,518,877	$0	$139,518,877	50.00%
Supplemental Hospital Payments (DSH)	-	$38,326,721	$0	$19,163,360	$0	$19,163,361	50.00%
Subtotal from HB 09-1293 Supplemental Payments		$614,029,587	$0	$307,014,793	$0	$307,014,794	
Cash Fund Financing		$0	($50,000,000)	$50,000,000	$0	$0	
HB 09-1293 Total		**$711,183,132**	**($50,000,000)**	**$405,543,816**	**$147,975**	**$355,491,341**	

FY 2012-13 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Hospital Provider Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
HB 09-1293 Medicaid Expansion Clients							
Expansion Adults to 100%	42,381	$113,036,908	$0	$56,518,453	$0	$56,518,455	50.00%
Buy-in for Individuals with Disabilities	2,208	$23,492,951	$0	$10,305,385	$4,531,955	$8,655,611	50.00%
Adults Without Dependent Children	10,000	$98,333,000	$0	$49,166,500	$0	$49,166,500	50.00%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$234,862,859	$0	$115,990,338	$4,531,955	$114,340,566	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates	-	$164,038,715	$0	$82,019,357	$0	$82,019,358	50.00%
Outpatient Hospital Rates	-	$155,580,564	$0	$77,790,282	$0	$77,790,282	50.00%
Supplemental Hospital Payments (Upper Payment Limit)	-	$294,431,117	$0	$147,215,559	$0	$147,215,558	50.00%
Supplemental Hospital Payments (DSH)	-	$37,039,406	$0	$18,519,703	$0	$18,519,703	50.00%
Subtotal from HB 09-1293 Supplemental Payments		$651,089,802	$0	$325,544,901	$0	$325,544,901	
Cash Fund Financing		$0	($25,000,000)	$25,000,000	$0	$0	
HB 09-1293 Total		**$885,952,661**	**($25,000,000)**	**$466,535,239**	**$4,531,955**	**$439,885,467**	

Exhibit J - Health Care Affordability Act of 2009 Estimates

FY 2013-14 Summary							
Eligibility Category	**Expenditure**		**Fund Calculations**				
	Caseload	**Expenditure**	**General Fund**	**Hospital Provider Fee Cash Fund**	**Medicaid Buy-in Cash Fund**	**Federal Funds**	**FMAP**
HB 09-1293 Medicaid Expansion Clients							
Expansion Adults to 100%	46,835	$125,925,732	$0	$31,481,434	$0	$94,444,298	75.00%
Buy-in for Individuals with Disabilities	5,671	$62,777,782	$0	$28,074,881	$10,740,500	$23,962,401	50.00%
Adults Without Dependent Children	10,000	$105,367,200	$0	$26,341,800	$0	$79,025,400	75.00%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$294,070,714	$0	$85,898,115	$10,740,500	$197,432,099	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$164,038,715	$0	$82,019,357	$0	$82,019,358	50.00%
Outpatient Hospital Rates		$155,580,564	$0	$77,790,282	$0	$77,790,282	50.00%
Supplemental Hospital Payments (Upper Payment Limit)		$294,431,117	$0	$147,215,559	$0	$147,215,558	50.00%
Supplemental Hospital Payments (DSH)		$37,039,406	$0	$18,519,703	$0	$18,519,703	50.00%
Subtotal from HB 09-1293 Supplemental Payments		$651,089,802	$0	$325,544,901	$0	$325,544,901	
HB 09-1293 Total		**$945,160,516**	**$0**	**$411,443,016**	**$10,740,500**	**$522,977,000**	

Exhibit J - Health Care Affordability Act of 2009 Expansion Populations

Hospital Provider Fee - Fund Splits and Service Category Impacts by Expansion Population
FY 2011-12

Expansion Adults to 100%							
	Caseload	Per Capita	Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$2,456.82	$86,986,169	$0	$43,493,085	$0	$43,493,084
Community Based Long Term Care		$3.18	$112,591	$0	$56,296	$0	$56,295
Long Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$80.84	$2,862,221	$0	$1,431,111	$0	$1,431,110
Total	**35,406**	**$2,540.84**	**$89,960,981**	**$0**	**$44,980,492**	**$0**	**$44,980,489**
Buy-In for Individuals with Disabilities							
	Caseload	Per Capita	Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Total	**58**	**$9,764.90**	**$566,364**	**$0**	**$235,431**	**$147,975**	**$182,958**
Notes	See HB 09-1293 Colorado Health Care Affordability Act Update for derivation of these estimates.						
Adults Without Dependent Children							
	Caseload	Per Capita	Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Total	**1,667**	**$3,974.93**	**$6,626,200**	**$0**	**$3,313,100**	**$0**	**$3,313,100**
Notes	Expansion of eligibility to this population is scheduled for implementation in March 2012.						
FY 2011-12 Summary							
	Caseload	Per Capita	Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Total	**37,131**	**$2,616.51**	**$97,153,545**	**$0**	**$48,529,023**	**$147,975**	**$48,476,547**

Hospital Provider Fee - Fund Splits and Service Category Impacts by Expansion Population
FY 2012-13

Expansion Adults to 100%								
	Caseload	Per Capita		Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$2,566.53		$108,772,108	$0	$54,386,054	$0	$54,386,054
Community Based Long Term Care		$3.30		$139,857	$0	$69,928	$0	$69,929
Long Term Care		$0.00		$0	$0	$0	$0	$0
Insurance		$0.00		$0	$0	$0	$0	$0
Service Management		$97.33		$4,124,943	$0	$2,062,471	$0	$2,062,472
Total	**42,381**	**$2,667.16**		**$113,036,908**	**$0**	**$56,518,453**	**$0**	**$56,518,455**
Buy-In for Individuals with Disabilities								
	Caseload	Per Capita		Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Total	**2,208**	**$10,639.92**		**$23,492,951**	**$0**	**$10,305,385**	**$4,531,955**	**$8,655,611**
Notes	See HB 09-1293 Colorado Health Care Affordability Act Update for derivation of these estimates.							
Adults Without Dependent Children								
	Caseload	Per Capita		Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Total	**10,000**	**$9,833.30**		**$98,333,000**	**$0**	**$49,166,500**	**$0**	**$49,166,500**
	See HB 09-1293 Colorado Health Care Affordability Act Update for derivation of these estimates.							
FY 2012-13 Summary								
	Caseload	Per Capita		Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Total	**54,589**	**$4,302.38**		**$234,862,859**	**$0**	**$115,990,338**	**$4,531,955**	**$114,340,566**

Exhibit J - Health Care Affordability Act of 2009 Expansion Populations

Hospital Provider Fee - Fund Splits and Service Category Impacts by Expansion Population
FY 2013-14

Expansion Adults to 100%							
	Caseload	Per Capita	Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$2,597.20	$121,639,862	$0	$30,409,966	$0	$91,229,896
Community Based Long Term Care		$3.44	$161,112	$0	$40,278	$0	$120,834
Long Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$88.07	$4,124,758	$0	$1,031,190	$0	$3,093,568
Total	**46,835**	**$2,688.71**	**$125,925,732**	**$0**	**$31,481,434**	**$0**	**$94,444,298**
Buy-In for Individuals with Disabilities							
	Caseload	Per Capita	Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Total	**5,671**	**$11,069.97**	**$62,777,782**	**$0**	**$28,074,881**	**$10,740,500**	**$23,962,401**
Notes	See HB 09-1293 Colorado Health Care Affordability Act Update for derivation of these estimates.						
Adults Without Dependent Children							
	Caseload	Per Capita	Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Total	**10,000**	**$10,536.72**	**$105,367,200**	**$0**	**$26,341,800**	**$0**	**$79,025,400**
	See HB 09-1293 Colorado Health Care Affordability Act Update for derivation of these estimates.						
FY 2013-14 Summary							
	Caseload	Per Capita	Total Funds	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Total	**62,506**	**$4,704.68**	**$294,070,714**	**$0**	**$85,898,115**	**$10,740,500**	**$197,432,099**

Exhibit K - Upper Payment Limit Financing

Summary of Upper Payment Limit Financing

Nursing Facilities UPL	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**
Total Funds	$3,512,345	$2,572,436	$2,896,157
General Fund	($5,252,677)	($3,009,198)	($2,896,157)
Cash Funds	$3,512,345	$2,572,436	$2,896,157
Federal Funds	$5,252,677	$3,009,198	$2,896,157
Home Health UPL			
Total Funds	$1,235,754	$1,538,727	$1,732,364
General Fund	($1,981,518)	($1,799,981)	($1,732,364)
Cash Funds	$1,235,754	$1,538,727	$1,732,364
Federal Funds	$1,981,518	$1,799,981	$1,732,364
Total Upper Payment Limit Financing			
Total Funds	$4,748,099	$4,111,163	$4,628,521
General Fund	($7,234,195)	($4,809,179)	($4,628,521)
Cash Funds	$4,748,099	$4,111,163	$4,628,521
Federal Funds	$7,234,195	$4,809,179	$4,628,521

Exhibit K - Upper Payment Limit Financing

Nursing Facilities Upper Payment Limit Calculation
Estimate Based on Calendar Year 2010 Actual Upper Payment Limit

Provider Name	Upper Payment Limit (Amount Remaining after Medicaid Payment)	Certified Uncompensated Cost
Colorado St. Veterans - Fitzsimmons	$1,855,086	$4,437,453
Colorado St. Veterans - Florence	$693,985	$2,114,319
Colorado St. Veterans - Homelake	$119,364	($853,136)
Colorado St. Veterans - Rifle	$906,846	$2,991,252
Colorado St. Veterans - Walsenburg	$977,196	$9,827,642
Trinidad State Nursing Home	$258,277	$297,161
State Nursing Facilities Total	**$4,810,754**	**$18,814,691**

Arkansas Valley	($106,506)	$407,426
Bent County Healthcare Center	$59,246	$1,544,804
Cheyenne Manor	($83,681)	($1,083,811)
Cripple Creek Rehabilitation & Wellness Center	($211,356)	$512,109
E. Dene Moore Care Center	$333,340	$197,410
Gunnison Health Care	$85,178	$1,077,497
Lincoln Community Nursing Home	$404,657	$493,708
Prospect Park Living Center	$151,792	$950,394
Sedgwick County Memorial Nursing Home	($85,581)	($1,619,765)
Southeast Colorado Hospital-LTC	($91,870)	$1,217,079
Walbridge Memorial Convalescent	($190,712)	$1,055,929
Walsh Healthcare Center	$118,782	$381,520
Washington County Nursing	$42,290	($18,589)
Weisbrod Memorial County Nursing Home	$142,285	$1,116,377
Government Nursing Facilities Total	**$567,864**	**$6,232,089**

Exhibit K - Upper Payment Limit Financing

Supplemental Medicaid Nursing Facilities Payment	
Estimated CY 2010 Upper Payment Limit	$5,378,618
Estimated CY 2011 Upper Payment Limit	$5,581,634
Estimated CY 2012 Upper Payment Limit	$5,792,313

Supplemental Medicaid Nursing Facility Payment FY 2011-12[(1)]	
Total Funds	$3,512,345
General Fund (offset by Federal Funds)	($5,252,677)
Cash Funds	$3,512,345
Federal Funds	$5,252,677

(1) Totals include adjustments for FY 2010-11 totaling $1,939,986 federal funds and $1,446,418 cash funds.

Supplemental Medicaid Nursing Facility Payment FY 2012-13	
Total Funds	$2,572,436
General Fund (offset by Federal Funds)	($3,009,198)
Cash Funds	$2,572,436
Federal Funds	$3,009,198

Supplemental Medicaid Nursing Facility Payment FY 2013-14	
Total Funds	$2,896,157
General Fund (offset by Federal Funds)	($2,896,157)
Cash Funds	$2,896,157
Federal Funds	$2,896,157

CY 2010 Inflation Factor	**3.77%**

Consumer Price Index for Urban Wage Earners and Clerical Workers, Medical Care, US City Average

Exhibit K - Upper Payment Limit Financing

Home Health Upper Payment Limit Calculation
Estimate Based on Calendar Year 2010 Actual Upper Payment Limit

Provider Name	TOTAL COMPUTABLE CY 2010 Uncompensated Medicaid Costs Based on Filed Cost Report for Interim Payment
Alamosa County Nursing Service	$37,168
Bent County Nursing Service	($2,946)
Delta Montrose Home Health Services	$119,184
Estes Park Home Health	$57,259
Fremont County Nursing Service	$160,530
Grand County Nursing Service	$53,614
Kiowa Home Health Services	$80,930
Kit Carson County Home Health	$77,193
Lincoln Community Home Health	$40,329
Mountain Home Health (Gunnison)	$47,529
Pioneers Hospital Home Health	$15,463
Prowers Home Health	$75,657
Rangely District Home Health	$2,079
Southeast Colorado Hospital HHA	$3,525
Southwest Memorial Hospital HHA	$117,206
St Vincent Home Health Care	$2,244,490
Yuma District Home Health Care	$88,062
Home Health Total	**$3,217,272**

Exhibit K - Upper Payment Limit Financing

Supplemental Medicaid Home Health Payment	
CY 2010 Upper Payment Limit	$3,217,272
CY 2011 Upper Payment Limit	$3,338,708
CY 2012 Upper Payment Limit	$3,464,728

Supplemental Medicaid Home Health Payment FY 2011-12	
Total Funds	$1,235,754
General Fund	($1,981,518)
Cash Funds	$1,235,754
Federal Funds	$1,981,518

Supplemental Medicaid Home Health Payment FY 2012-13	
Total Funds	$1,538,727
General Fund	($1,799,981)
Cash Funds	$1,538,727
Federal Funds	$1,799,981

Supplemental Medicaid Home Health Payment FY 2013-14	
Total Funds	$1,732,364
General Fund	($1,732,364)
Cash Funds	$1,732,364
Federal Funds	$1,732,364

CY 2010 Inflation Factor	**3.77%**

Consumer Price Index for Urban Wage Earners and Clerical Workers, Medical Care, US City Average.

Exhibit K - Upper Payment Limit Financing

Medicaid Eligible Inpatient Days for Calendar Year 2009 for FY 2011-12 Participating Colorado Indigent Care Program Providers per HB 04-1438

Hospitals	Medicaid Eligible Inpatient Days	Total Inpatient Days	Percent of Medicaid Eligible Inpatient Days
State Owned			
University of Colorado Hospital	38,877	118,643	32.77%
Non State Owned Public			
Arkansas Valley Regional Medical Center	3,474	7,820	44.42%
Aspen Valley Hospital	426	3,380	12.60%
Delta County Memorial Hospital	2,239	9,514	23.53%
Denver Health Medical Center	62,119	110,659	56.14%
East Morgan County Hospital	338	1,149	29.42%
Estes Park Medical Center	196	2,226	8.81%
Grand River Medical Center	298	1,412	21.10%
Gunnison Valley Hospital	196	1,341	14.62%
Heart of the Rockies Regional Medical Center	619	3,900	15.87%
Kremmling Memorial Hospital	36	303	11.88%
Melissa Memorial Hospital	184	658	27.96%
The Memorial Hosptial	499	2,839	17.58%
Memorial Hospital	40,582	141,177	28.75%
Montrose Memorial Hospital	3,140	11,467	27.38%
North Colorado Medical Center	16,236	61,351	26.46%
Poudre Valley Hospital	14,737	64,874	22.72%
Prowers Medical Center	890	4,881	18.23%
Sedgwick County Memorial Hospital	162	527	30.74%
Southeast Colorado Hospital	346	1,552	22.29%
Southwest Memorial Hospital	1,523	5,537	27.51%
Spanish Peaks Regional Health Center	352	1,118	31.48%
St. Vincent General Hospital District	166	675	24.59%
Wray Community District Hospital	296	1,561	18.96%
Yuma District Hospital	233	1,038	22.45%

Exhibit K - Upper Payment Limit Financing

Medicaid Eligible Inpatient Days for Calendar Year 2009 for FY 2011-12 Participating Colorado Indigent Care Program Providers per HB 04-1438

Hospitals	Medicaid Eligible Inpatient Days	Total Inpatient Days	Percent of Medicaid Eligible Inpatient Days
Private			
Boulder Community Hospital	4,967	42,437	11.70%
Centura Health - Penrose -St. Francis Health Services	12,726	85,787	14.83%
Centura Health - St. Mary-Corwin Medical Center	11,130	38,892	28.62%
Centura Health - St. Thomas More Hospital	2,700	8,010	33.71%
Colorado Plains Medical Center	1,950	8,048	24.23%
Community Hospital	1,373	7,740	17.74%
Conejos County Hospital	278	1,222	22.75%
Longmont United Hospital	8,222	36,887	22.29%
McKee Medical Center	5,279	18,815	28.06%
Medical Center of the Rockies	2,647	24,456	10.82%
Mercy Medical Center	3,419	15,066	22.69%
Mount San Rafael Hospital	613	3,927	15.61%
National Jewish Health	116	295	39.32%
Parkview Medical Center	23,322	71,144	32.78%
Pikes Peak Regional Hospital	197	2,138	9.21%
Platte Valley Medical Center	5,795	14,077	41.17%
Rio Grande Hospital	358	884	40.50%
San Luis Valley Regional Medical Center	4,167	9,936	41.94%
St. Mary's Hospital and Medical Center	18,650	62,197	29.99%
Sterling Regional MedCenter	1,148	5,746	19.98%
Children's Hospital Colorado	45,223	80,520	56.16%
Valley View Hospital	5,294	13,569	39.02%
Yampa Valley Medical Center	1,024	5,437	18.83%

Exhibit L - Recoveries

Department Recovery Revenue

Recovery Category	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12 July 1 - December 31	Estimated FY 2011-12	Estimated FY 2012-13	Estimated FY 2013-14
Estate Recoveries[1]	$3,168,376	$3,682,865	$3,006,302	$2,019,277	$4,038,554	$3,862,736	$4,003,147
Income Trust and Repayments[1]	$3,242,100	$3,217,373	$4,021,065	$1,196,095	$2,392,190	$5,166,585	$5,354,390
Third Party Health Insurance	$8,705,554	$14,857,476	$17,714,457	$11,032,868	$22,065,736	$22,760,946	$23,588,307
Third Party Casualty	$3,812,718	$3,917,944	$4,664,590	$3,980,980	$7,961,960	$5,993,437	$6,211,298
Subtotal	**$18,928,748**	**$25,675,658**	**$29,406,414**	**$18,229,220**	**$36,458,440**	**$37,783,704**	**$39,157,142**
Bottom Line Impacts							
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0
Total Recoveries Including Bottom Line Impacts[2]	**$18,928,748**	**$25,675,658**	**$29,406,414**	**$18,229,220**	**$36,458,440**	**$37,783,704**	**$39,157,142**

(1) Historical Estate and Income Trust recoveries have been restated to reflect changes in accounting classifications.

(2) Figures represent only recovery types classified as revenue by the Department. Additionally, figures are adjusted for cash flow. As a result, differences may exist between historical recovery totals reported here and totals reported elsewhere by the Department.

Contingency and Contractor Payments

Recovery Category	Contingency Amount[4]	FY 2009-10	FY 2010-11	Estimated FY 2011-12	Estimated FY 2012-13	Estimated FY 2013-14
Estate Recoveries	11.50%	$423,529	$345,725	$464,434	$444,215	$460,362
Income Trust and Repayments[3]	0.00%	$0	$0	$0	$0	$0
Third Party Health Insurance	6.90%	$1,025,166	$1,222,298	$1,522,536	$1,570,505	$1,627,593
Third Party Casualty	9.40%	$368,287	$438,471	$748,424	$563,383	$583,862
Total		**$1,816,982**	**$2,006,494**	**$2,735,394**	**$2,578,103**	**$2,671,817**

(3) Income Trust and Repayments are processed by Department staff. No contingency fee is paid.

(4) The Department's recovery contract was reprocured at the end of CY 2010. Contingency rates shown reflect the new contract amounts.

Net Medical Services Premiums Fiscal Impact

Total Medical Services Premiums Impact	Total Funds	General Fund	Cash Funds	Federal Funds	FFP
FY 2011-12	$0	($16,375,911)	$33,723,046	($17,347,135)	51.44%
FY 2012-13	$0	($17,602,800)	$35,205,601	($17,602,801)	50.00%
FY 2013-14	$0	($18,242,662)	$36,485,325	($18,242,663)	50.00%

Exhibit M

Cash-based Actuals													
FY 2011-12 YTD	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care													
Physician Services & EPSDT	$1,827,938	$3,721,993	$27,588,875	$26,163,326	$6,116,254	$8,186,695	$0	$53,917,725	$5,260,980	$8,552,272	$3,185,827	$1,938	$144,523,823
Emergency Transportation	$58,217	$132,985	$1,050,433	$583,358	$132,745	$154,893	$0	$807,908	$108,965	$106,867	$44,155	$0	$3,180,526
Non-Emergency Medical Transportation	$986,931	$483,881	$2,478,453	$185,591	$43,113	$53,065	$0	$580,862	$70,738	$30,984	$955	$0	$4,914,573
Dental Services	$582,895	$137,606	$2,555,922	$2,129,656	$547,886	$702,005	$0	$43,463,649	$2,610,687	$185,506	$1,782	$0	$52,917,594
Family Planning	$0	$0	$7,166	$69,513	$22,656	$34,362	$0	$57,791	$20,755	$10,250	$0	$0	$222,493
Health Maintenance Organizations	$3,646,478	$3,540,861	$21,158,832	$9,458,058	$2,716,063	$4,065,910	$0	$19,016,005	$454,866	$612,606	$0	$0	$64,669,679
Inpatient Hospitals	$6,887,529	$7,343,286	$58,522,136	$27,548,232	$4,757,139	$6,365,197	$0	$39,881,082	$2,339,122	$13,910,731	$17,767,681	($12,548)	$185,309,587
Outpatient Hospitals	$1,439,631	$2,994,575	$25,298,006	$22,559,226	$6,768,544	$8,648,462	$0	$34,014,041	$2,850,961	$2,624,026	$584,184	$0	$107,781,656
Lab & X-Ray	$236,177	$425,968	$3,541,440	$5,813,639	$1,532,229	$1,908,032	$0	$3,571,283	$813,148	$1,797,553	$67,887	($47)	$19,707,309
Durable Medical Equipment	$9,472,628	$2,604,386	$24,837,658	$1,461,328	$541,978	$607,153	$0	$4,661,719	$2,269,344	$90,091	$0	$11,441	$46,557,726
Prescription Drugs	$3,629,896	$9,193,355	$65,740,485	$20,378,113	$6,965,625	$8,294,003	$0	$29,191,796	$10,391,284	$1,195,522	$0	$0	$154,980,079
Drug Rebate	($1,629,673)	($4,127,434)	($29,514,746)	($9,148,926)	($3,127,276)	($3,723,663)	$0	($13,105,904)	($4,665,255)	($536,740)	$0	$0	($69,579,617)
Rural Health Centers	$30,606	$126,749	$603,170	$755,314	$258,700	$312,990	$0	$2,744,845	$169,529	$152,302	$14,208	$0	$5,168,413
Federally Qualified Health Centers	$461,234	$536,096	$4,257,418	$7,002,072	$1,711,267	$2,367,572	$0	$28,071,118	$1,001,045	$2,542,573	$200,662	$0	$48,151,057
Co-Insurance (Title XVIII-Medicare	$5,809,534	$967,030	$3,883,614	$54,852	$104,669	$219,155	$0	$13,070	$7,633	$16,763	$23	$1,810,497	$12,886,840
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$5,377,394	$0	$0	$0	$0	$0	$5,377,394
Prepaid Inpatient Health Plan Services	$1,213,823	$1,451,664	$11,604,595	$4,984,093	$1,347,051	$1,521,134	$0	$5,314,760	$1,384,734	$1,481,212	$0	$0	$30,303,066
Other Medical Services	($1)	$0	($4)	($2)	$0	($1)	$0	($3)	$0	$0	$0	$0	($11)
Home Health	$11,893,229	$3,972,707	$60,221,569	$214,110	$70,924	$88,859	$0	$2,175,168	$5,710,699	$35,824	$0	$80,915	$84,464,004
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$46,547,073**	**$33,505,706**	**$283,835,020**	**$120,211,552**	**$30,509,567**	**$39,805,824**	**$5,377,394**	**$254,376,914**	**$30,799,233**	**$32,808,342**	**$21,867,365**	**$1,892,196**	**$901,536,186**
Community Based Long Term Care													
HCBS - Elderly, Blind, and Disabled	$56,549,506	$9,493,911	$46,777,284	$610	$0	$5,599	$0	$0	$35,985	$0	$0	$111,087	$112,973,982
HCBS - Mental Illness	$1,814,065	$1,588,596	$9,521,924	$0	$516	$1,639	$0	$0	$7,763	$0	$0	$8,342	$12,942,845
HCBS - Disabled Children	$0	$0	$1,367,563	$0	$0	$0	$0	$273	$0	$0	$0	$0	$1,367,836
HCBS - Persons Living with AIDS	$14,616	$1,631	$245,614	$0	$0	$0	$0	$0	$0	$0	$0	$8,233	$270,094
HCBS - Consumer Directed Attendant Support	$903,311	$151,654	$747,211	$10	$0	$89	$0	$0	$575	$0	$0	$1,774	$1,804,624
HCBS - Brain Injury	$80,699	$468,773	$5,949,560	$0	$5,248	$0	$0	$0	$0	$0	$0	$0	$6,504,280
HCBS - Children with Autism	$0	$0	$502,938	$0	$0	$0	$0	$0	$0	$0	$0	$0	$502,938
HCBS - Pediatric Hospice	$0	$0	$103,084	$0	$0	$0	$0	$0	$499	$0	$0	$0	$103,583
Private Duty Nursing	$824,723	$18,486	$10,427,619	$0	$0	$0	$0	$214,415	$4,298,593	$0	$0	$0	$15,783,836
Hospice	$15,539,694	$1,424,883	$3,428,202	$40,180	$18,736	$51,369	$0	$53,692	$1,224	$0	$0	$28,180	$20,586,160
Subtotal Community Based Long Term Care	**$75,726,613**	**$13,147,934**	**$79,071,001**	**$40,799**	**$24,499**	**$58,697**	**$0**	**$268,380**	**$4,344,638**	**$0**	**$0**	**$157,617**	**$172,840,178**
Long Term Care													
Class I Nursing Facilities	$200,643,113	$15,966,628	$37,155,352	$0	$0	$0	$0	$0	$0	$0	$0	$263,750	$254,028,843
Class II Nursing Facilities	$0	$142,928	$648,525	$0	$0	$0	$0	$0	$0	$0	$0	$0	$791,453
Program of All-Inclusive Care for the Elderly	$34,638,028	$3,807,976	$1,766,863	$0	$0	$0	$0	$0	$0	$0	$0	$0	$40,212,867
Subtotal Long Term Care	**$235,281,142**	**$19,917,532**	**$39,570,741**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$263,750**	**$295,033,165**
Insurance													
Supplemental Medicare Insurance Benefit	$33,313,385	$1,942,644	$17,462,401	$109,227	$0	$0	$0	$0	$0	$0	$0	$9,639,675	$62,467,332
Health Insurance Buy-In Program	$0	$3,439	$574,994	$5,055	$0	$0	$0	$8,812	$1,477	$0	$0	$0	$593,778
Subtotal Insurance	**$33,314,592**	**$1,943,355**	**$18,049,272**	**$112,064**	**$0**	**$0**	**$0**	**$1,584**	**$569**	**$0**	**$0**	**$9,639,675**	**$63,061,111**
Service Management													
Single Entry Points	$5,665,481	$1,193,367	$5,179,294	$2,296	$0	$0	$0	$574	$4,018	$0	$21,812	$1,722	$12,068,565
Disease Management	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$232,829	$84,096	$442,627	$192,405	$205,745	$242,010	$0	$1,668,434	$110,054	$42,100	$0	$0	$3,220,300
Accountable Care Collaborative	$109,011	$82,792	$606,184	$1,253,213	$470,813	$661,146	$0	$1,821,965	$61,701	$87,385	$0	$124	$5,154,334
Subtotal Service Management	**$6,082,275**	**$1,299,075**	**$6,483,930**	**$1,545,099**	**$570,487**	**$775,815**	**$0**	**$3,357,858**	**$174,292**	**$131,137**	**$19,459**	**$3,774**	**$20,443,201**
Total Services	**$396,951,694**	**$69,813,601**	**$427,009,963**	**$121,909,514**	**$31,104,554**	**$40,640,336**	**$5,377,394**	**$258,004,737**	**$35,318,732**	**$32,939,479**	**$21,886,824**	**$11,957,011**	**$1,452,913,839**
Financing & Supplemental Payments													
Upper Payment Limit Financing	$2,076,017	$223,862	$1,199,799	$233,170	$70,024	$89,455	$0	$369,411	$84,220	$27,227	$5,985	$3,338	$4,382,508
Hospital Supplemental Payments	$7,139,234	$8,936,045	$72,515,617	$43,798,958	$10,170,044	$13,237,590	$0	$64,636,798	$4,567,730	$14,161,789	$15,577,439	($10,626)	$254,730,618
Nursing Facility Supplemental Payments	$30,071,966	$2,393,044	$5,568,766	$0	$0	$0	$0	$0	$0	$0	$0	$39,530	$38,073,306
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$1,350	$2,808	$23,719	$21,151	$6,346	$8,109	$0	$31,891	$2,673	$2,460	$548	$0	$101,055
Accounting Adjustments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Financing & Supplemental Payments	**$39,288,567**	**$11,555,759**	**$79,307,900**	**$44,053,279**	**$10,246,413**	**$13,335,154**	**$0**	**$65,038,099**	**$4,654,624**	**$14,191,476**	**$15,583,972**	**$32,242**	**$297,287,485**
Total	**$436,240,261**	**$81,369,360**	**$506,317,863**	**$165,962,793**	**$41,350,967**	**$53,975,490**	**$5,377,394**	**$323,042,836**	**$39,973,356**	**$47,130,955**	**$37,470,796**	**$11,989,253**	**$1,750,201,324**

Exhibit M

Cash-based Actuals													
FY 2010-11	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care													
Physician Services & EPSDT	$4,269,992	$6,951,129	$52,819,492	$50,085,655	$11,308,835	$12,531,062	$0	$108,898,551	$10,934,900	$18,198,453	$6,592,130	$1,842	$282,592,042
Emergency Transportation	$135,881	$262,494	$2,067,025	$1,113,009	$234,561	$236,352	$0	$1,665,110	$236,484	$196,837	$88,493	$5	$6,236,250
Non-emergency Medical Transportation	$2,248,809	$1,043,480	$5,199,711	$467,146	$33,609	$72,340	$0	$1,156,790	$195,450	$48,109	$3,420	$243	$10,469,107
Dental Services	$980,947	$296,165	$5,001,214	$4,174,547	$1,157,479	$1,211,640	$0	$89,583,233	$5,780,945	$379,656	$4,838	$30	$108,570,692
Family Planning	$0	$16	$12,731	$135,883	$57,487	$60,160	$0	$120,830	$38,845	$15,461	$0	$0	$441,414
Health Maintenance Organizations	$6,832,995	$6,431,178	$38,459,466	$17,071,028	$4,633,065	$6,456,182	$0	$35,589,978	$823,759	$1,190,805	$0	$0	$117,488,456
Inpatient Hospitals	$13,928,315	$14,401,355	$109,555,355	$55,493,112	$9,468,394	$10,000,540	$0	$83,895,044	$6,584,854	$30,244,597	$38,292,048	($1,668)	$371,861,948
Outpatient Hospitals	$3,159,881	$5,575,085	$50,038,984	$43,305,503	$13,993,351	$14,717,844	$0	$73,155,361	$6,071,798	$6,013,521	$1,460,551	$1,031	$217,492,911
Lab & X-Ray	$558,717	$853,427	$6,862,072	$10,646,487	$2,686,262	$2,936,506	$0	$7,589,083	$1,757,292	$3,807,140	$164,351	$784	$37,862,120
Durable Medical Equipment	$19,960,510	$4,911,081	$48,169,450	$2,614,617	$891,190	$797,869	$0	$8,735,552	$4,353,214	$180,213	$5	$14,245	$90,627,945
Prescription Drugs	$8,014,198	$16,245,119	$119,835,487	$34,341,854	$11,793,377	$11,840,965	$0	$56,157,223	$20,762,963	$2,287,737	$23	$4	$281,278,949
Drug Rebate	($3,615,910)	($7,329,604)	($54,068,344)	($15,464,886)	($5,350,781)	($5,342,502)	$0	($25,337,470)	($9,368,002)	($1,032,200)	($10)	($2)	($126,909,710)
Rural Health Centers	$53,270	$206,418	$1,122,812	$1,353,631	$518,031	$557,927	$0	$5,357,537	$698,495	$285,879	$33,931	$75	$10,188,005
Federally Qualified Health Centers	$916,375	$1,051,613	$7,588,335	$12,816,739	$3,068,899	$3,802,322	$0	$53,308,981	$2,132,545	$5,192,824	$427,890	$0	$90,306,523
Co-Insurance (Title XVIII-Medicare)	$16,505,219	$2,494,667	$11,474,583	$105,696	$243,827	$446,438	$0	$43,461	$31,683	$56,279	$44	$4,985,517	$36,387,414
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$10,106,643	$0	$0	$0	$0	$0	$10,106,643
Prepaid Inpatient Health Plan Services	$2,221,510	$2,361,149	$19,107,158	$8,181,803	$2,188,948	$2,076,156	$0	$9,365,354	$2,583,913	$2,763,503	$0	$0	$50,849,494
Other Medical Services	$770	$518	$4,450	$1,809	$466	$509	$78	$4,077	$555	$525	$361	$40	$14,158
Home Health	$24,477,150	$7,498,890	$123,874,168	$438,181	$129,783	$159,040	$0	$4,219,760	$11,551,887	$48,684	$0	$236,226	$172,633,768
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$100,648,630**	**$63,254,181**	**$547,124,148**	**$226,881,815**	**$57,056,782**	**$62,561,349**	**$10,106,721**	**$513,508,455**	**$65,171,579**	**$69,878,023**	**$47,068,074**	**$5,238,372**	**$1,768,498,130**
Community Based Long Term Care													
HCBS - Elderly, Blind, and Disabled	$107,968,359	$16,811,191	$87,178,265	$3,498	$15,966	$11,962	$0	$0	$72,439	$0	$0	$134,462	$212,196,143
HCBS - Mental Illness	$3,642,260	$2,685,012	$18,587,746	$1	$9,418	$0	$0	$0	$14,257	$0	$0	$8,097	$24,946,790
HCBS - Disabled Children	$0	$0	$1,963,855	$0	$0	$0	$0	$572	$577	$0	$0	$0	$1,965,004
HCBS - Persons Living with AIDS	$29,837	$3,598	$532,418	$0	$0	$0	$0	$0	$0	$0	$0	$1,682	$567,535
HCBS - Consumer Directed Attendant Support	$1,506,730	$234,605	$1,216,870	$0	$0	$167	$0	$0	$1,011	$0	$0	$1,876	$2,961,259
HCBS - Brain Injury	$158,989	$815,885	$11,318,639	$0	$3,254	$0	$0	$0	$0	$0	$0	$497	$12,297,265
HCBS - Children with Autism	$0	$0	$1,355,067	$0	$0	$0	$0	$2,545	$0	$0	$0	$0	$1,357,612
HCBS - Pediatric Hospice	$0	$0	$126,097	$0	$0	$0	$0	$211	$395	$0	$0	$0	$126,702
Private Duty Nursing	$1,328,952	$0	$17,573,121	$0	$0	$0	$0	$521,410	$8,338,212	$0	$0	$0	$27,761,694
Hospice	$30,470,765	$2,124,046	$6,934,493	$184,727	$50,718	$39,141	$0	$60,107	$3,517	$0	$0	($4,548)	$39,862,966
Subtotal Community Based Long Term Care	**$145,105,892**	**$22,674,337**	**$146,786,571**	**$188,226**	**$79,355**	**$51,269**	**$0**	**$584,845**	**$8,430,408**	**$0**	**$0**	**$142,067**	**$324,042,970**
Long Term Care													
Class I Nursing Facilities	$397,056,172	$32,228,696	$78,280,022	$7,615	$0	$0	$0	$0	$0	$0	$0	$569,344	$508,141,849
Class II Nursing Facilities	($200,939)	$647,887	$1,915,758	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,362,706
Program of All-Inclusive Care for the Elderly	$73,242,922	$7,896,872	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$0	$84,429,683
Subtotal Long Term Care	**$470,098,154**	**$40,773,456**	**$83,485,668**	**$7,615**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$569,344**	**$594,934,237**
Insurance													
Supplemental Medicare Insurance Benefit	$63,751,826	$3,717,638	$33,417,798	$209,027	$0	$0	$0	$0	$0	$0	$0	$18,447,446	$119,543,734
Health Insurance Buy-In Program	$2,287	$1,347	$1,111,909	$5,375	$0	$0	$0	$3,001	$1,077	$0	$0	$0	$1,124,996
Subtotal Insurance	**$63,754,113**	**$3,718,985**	**$34,529,707**	**$214,402**	**$0**	**$0**	**$0**	**$3,001**	**$1,077**	**$0**	**$0**	**$18,447,446**	**$120,668,731**
Service Management													
Single Entry Points	$11,482,516	$2,211,295	$10,261,280	$4,841	$1,210	$0	$0	$4,841	$9,683	$0	$38,731	$7,262	$24,021,660
Disease Management	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$411,355	$211,517	$1,451,791	$590,948	$202,779	$238,521	$0	$3,063,511	$216,554	$88,268	$0	$0	$6,475,244
Accountable Care Collaborative	$11,931	$16,697	$100,967	$182,258	$64,661	$73,004	$0	$407,790	$14,196	$15,905	$0	$0	$887,411
Subtotal Service Management	**$11,905,802**	**$2,439,509**	**$11,814,039**	**$778,047**	**$268,650**	**$311,525**	**$0**	**$3,476,143**	**$240,433**	**$104,173**	**$38,731**	**$7,262**	**$31,384,315**
Total Services	**$791,512,591**	**$132,860,467**	**$823,740,133**	**$228,070,105**	**$57,404,788**	**$62,924,144**	**$10,106,721**	**$517,572,443**	**$73,843,497**	**$69,982,196**	**$47,106,805**	**$24,404,491**	**$2,839,528,383**
Financing & Supplemental Payments													
Upper Payment Limit Financing	$7,676,810	$823,929	$4,599,470	$849,050	$256,470	$284,166	$0	$1,474,141	$323,850	$115,813	$27,916	$14,559	$16,446,173
Hospital Supplemental Payments	$13,043,327	$15,343,201	$122,857,357	$77,168,595	$17,909,429	$19,381,431	$0	$122,110,435	$9,849,776	$27,640,610	$30,044,552	($428)	$455,348,284
Nursing Facility Supplemental Payments	$59,632,155	$4,840,289	$11,756,539	$1,144	$0	$0	$0	$0	$0	$0	$0	$85,507	$76,315,634
Physician Supplemental Payments	$41,037	$66,804	$507,620	$480,219	$109,810	$120,429	$0	$1,046,566	$105,090	$174,896	$63,353	$18	$2,715,842
Outstationing Payments	$76,764	$135,437	$1,215,606	$1,068,961	$323,010	$357,543	$0	$1,777,176	$147,503	$146,088	$35,481	$25	$5,283,594
Accounting Adjustments	($2,643)	($483)	($3,002)	($876)	($226)	($247)	($38)	($1,975)	($299)	($254)	($175)	($22)	($10,239)
Subtotal Financing & Supplemental Payments	**$80,467,449**	**$21,209,175**	**$140,933,589**	**$79,567,093**	**$18,598,494**	**$20,143,323**	**($38)**	**$126,406,344**	**$10,425,920**	**$28,077,153**	**$30,171,128**	**$99,658**	**$556,099,288**
Grand Total	**$871,980,040**	**$154,069,643**	**$964,673,722**	**$307,637,198**	**$76,003,282**	**$83,067,467**	**$10,106,683**	**$643,978,787**	**$84,269,417**	**$98,059,349**	**$77,277,933**	**$24,504,150**	**$3,395,627,671**

Exhibit M

Cash-based Actuals													
FY 2010-11 Adjusted Totals for June 2010 Payment Delay	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care													
Physician Services & EPSDT	$4,130,719	$6,703,561	$51,097,852	$48,201,137	$11,090,522	$12,375,689	$0	$105,296,010	$10,585,051	$17,581,872	$6,320,750	$1,842	$273,385,005
Emergency Transportation	$132,219	$249,128	$1,981,658	$1,077,205	$231,588	$234,530	$0	$1,614,807	$227,759	$191,791	$83,441	$5	$6,024,130
Non-emergency Medical Transportation	$2,229,276	$1,030,710	$5,146,701	$463,897	$33,379	$72,195	$0	$1,144,273	$191,774	$47,504	$3,420	$243	$10,363,372
Dental Services	$955,956	$287,848	$4,837,631	$4,022,721	$1,139,559	$1,188,067	$0	$86,467,469	$5,552,512	$362,347	$4,838	$30	$104,818,977
Family Planning	$0	$16	$12,280	$129,473	$55,802	$59,388	$0	$117,776	$38,636	$15,103	$0	$0	$428,473
Health Maintenance Organizations	$6,832,995	$6,431,178	$38,459,477	$17,071,001	$4,633,065	$6,456,182	$0	$35,589,962	$823,759	$1,190,805	$0	$0	$117,488,424
Inpatient Hospitals	$13,226,398	$13,708,601	$104,724,509	$53,310,198	$9,389,744	$9,835,760	$0	$80,955,351	$6,191,811	$29,151,219	$36,914,044	$3,263	$357,410,898
Outpatient Hospitals	$3,056,720	$5,426,119	$48,146,249	$41,342,955	$13,733,770	$14,489,889	$0	$70,566,037	$5,827,169	$5,797,920	$1,403,889	$510	$209,791,226
Lab & X-Ray	$536,134	$822,885	$6,615,374	$10,221,967	$2,632,247	$2,895,486	$0	$7,328,814	$1,689,199	$3,680,612	$157,642	$784	$36,581,144
Durable Medical Equipment	$19,273,724	$4,734,880	$46,704,499	$2,519,710	$875,117	$780,295	$0	$8,456,549	$4,218,565	$167,275	$5	$14,696	$87,745,314
Prescription Drugs	$7,696,196	$15,713,437	$116,023,969	$32,895,349	$11,580,039	$11,693,984	$0	$54,593,081	$20,062,946	$2,210,846	$23	$4	$272,469,874
Drug Rebate	($3,615,910)	($7,329,604)	($54,068,344)	($15,464,886)	($5,350,781)	($5,342,502)	$0	($25,337,470)	($9,368,002)	($1,032,200)	($10)	($2)	($126,909,710)
Rural Health Centers	$51,237	$201,149	$1,081,153	$1,292,935	$509,279	$549,705	$0	$5,208,165	$685,199	$277,916	$30,833	$75	$9,887,646
Federally Qualified Health Centers	$877,182	$1,014,344	$7,353,061	$12,319,325	$3,009,623	$3,746,392	$0	$51,735,998	$2,065,438	$4,996,706	$411,996	$0	$87,530,065
Co-Insurance (Title XVIII-Medicare)	$15,904,615	$2,389,850	$11,036,287	$95,315	$237,494	$438,293	$0	$42,212	$30,660	$55,401	$44	$4,813,375	$35,043,547
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$9,817,118	$0	$0	$0	$0	$0	$9,817,118
Prepaid Inpatient Health Plan Services	$2,221,510	$2,361,149	$19,107,158	$8,181,803	$2,188,948	$2,076,156	$0	$9,365,354	$2,583,913	$2,763,503	$0	$0	$50,849,494
Other Medical Services	$770	$518	$4,450	$1,809	$466	$509	$78	$4,077	$555	$525	$361	$40	$14,158
Home Health	$23,878,879	$7,291,128	$120,949,799	$430,338	$127,646	$157,786	$0	$4,170,550	$11,395,772	$48,399	$0	$231,822	$168,682,120
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$97,388,620**	**$61,036,898**	**$529,213,760**	**$218,112,253**	**$56,117,509**	**$61,707,804**	**$9,817,196**	**$497,319,012**	**$62,802,717**	**$67,507,543**	**$45,331,275**	**$5,066,688**	**$1,711,421,275**
Community Based Long Term Care													
HCBS - Elderly, Blind, and Disabled	$105,868,153	$16,511,174	$85,914,477	$3,456	$15,966	$11,962	$0	$0	$71,172	$0	$0	$129,956	$208,526,316
HCBS - Mental Illness	$3,587,367	$2,652,010	$18,317,043	$1	$9,418	$0	$0	$0	$13,599	$0	$0	$8,097	$24,587,535
HCBS - Disabled Children	$0	$0	$1,886,052	$0	$0	$0	$0	$572	$577	$0	$0	$0	$1,887,201
HCBS - Persons Living with AIDS	$29,046	$3,470	$516,199	$0	$0	$0	$0	$0	$0	$0	$0	$1,682	$550,397
HCBS - Consumer Directed Attendant Support	$1,506,730	$234,605	$1,216,870	$0	$0	$167	$0	$0	$1,011	$0	$0	$1,876	$2,961,259
HCBS - Brain Injury	$158,168	$809,327	$11,211,671	$0	$3,254	$0	$0	$0	$0	$0	$0	$497	$12,182,916
HCBS - Children with Autism	$0	$0	$1,326,032	$0	$0	$0	$0	$2,545	$0	$0	$0	$0	$1,328,577
HCBS - Pediatric Hospice	$0	$0	$118,667	$0	$0	$0	$0	$211	$395	$0	$0	$0	$119,273
Private Duty Nursing	$1,319,815	$0	$17,252,161	$0	$0	$0	$0	$502,792	$8,251,188	$0	$0	$0	$27,325,957
Hospice	$30,229,237	$2,102,622	$6,889,023	$177,819	$50,718	$39,141	$0	$60,107	$3,517	$0	$0	($4,548)	$39,547,635
Subtotal Community Based Long Term Care	**$142,698,517**	**$22,313,208**	**$144,648,196**	**$181,275**	**$79,355**	**$51,269**	**$0**	**$566,227**	**$8,341,459**	**$0**	**$0**	**$137,560**	**$319,017,067**
Long Term Care													
Class I Nursing Facilities	$390,609,241	$31,625,232	$76,509,001	$7,615	$0	$0	$0	$0	$0	$0	$0	$564,302	$499,315,391
Class II Nursing Facilities	($84,407)	$729,155	$2,518,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,163,194
Program of All-Inclusive Care for the Elderly	$73,232,307	$7,892,082	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$0	$84,414,277
Subtotal Long Term Care	**$463,757,141**	**$40,246,469**	**$82,317,334**	**$7,615**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$564,302**	**$586,892,862**
Insurance													
Supplemental Medicare Insurance Benefit	$63,751,826	$3,717,638	$33,417,798	$209,027	$0	$0	$0	$0	$0	$0	$0	$18,447,446	$119,543,734
Health Insurance Buy-In Program	$1,979	$625	$1,025,861	$5,099	$0	$0	$0	$2,021	$1,059	$0	$0	$0	$1,036,644
Subtotal Insurance	**$63,753,805**	**$3,718,263**	**$34,443,659**	**$214,125**	**$0**	**$0**	**$0**	**$2,021**	**$1,059**	**$0**	**$0**	**$18,447,446**	**$120,580,378**
Service Management													
Single Entry Points	$11,482,516	$2,211,295	$10,261,280	$4,841	$1,210	$0	$0	$4,841	$9,683	$0	$38,731	$7,262	$24,021,660
Disease Management	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$411,355	$211,517	$1,451,791	$590,948	$202,779	$238,521	$0	$3,063,511	$216,554	$88,268	$0	$0	$6,475,244
Accountable Care Collaborative	$11,931	$16,697	$100,967	$182,258	$64,661	$73,004	$0	$407,790	$14,196	$15,905	$0	$0	$887,411
Subtotal Service Management	**$11,905,802**	**$2,439,509**	**$11,814,039**	**$778,047**	**$268,650**	**$311,525**	**$0**	**$3,476,143**	**$240,433**	**$104,173**	**$38,731**	**$7,262**	**$31,384,315**
Total Services	**$779,503,885**	**$129,754,347**	**$802,436,988**	**$219,293,316**	**$56,465,514**	**$62,070,599**	**$9,817,196**	**$501,363,403**	**$71,385,668**	**$67,611,716**	**$45,370,006**	**$24,223,258**	**$2,769,295,897**
Financing & Supplemental Payments													
Upper Payment Limit Financing	$7,676,810	$823,929	$4,599,470	$849,050	$256,470	$284,166	$0	$1,474,141	$323,850	$115,813	$27,916	$14,559	$16,446,173
Hospital Supplemental Payments	$13,043,327	$15,343,201	$122,857,357	$77,168,595	$17,909,429	$19,381,431	$0	$122,110,435	$9,849,776	$27,640,610	$30,044,552	($428)	$455,348,284
Nursing Facility Supplemental Payments	$59,632,155	$4,840,289	$11,756,539	$1,144	$0	$0	$0	$0	$0	$0	$0	$85,507	$76,315,634
Physician Supplemental Payments	$41,037	$66,804	$507,620	$480,219	$109,810	$120,429	$0	$1,046,566	$105,090	$174,896	$63,353	$18	$2,715,842
Outstationing Payments	$76,764	$135,437	$1,215,606	$1,068,961	$323,010	$357,543	$0	$1,777,176	$147,503	$146,088	$35,481	$25	$5,283,594
Accounting Adjustments	($2,643)	($483)	($3,002)	($876)	($226)	($247)	($38)	($1,975)	($299)	($254)	($175)	($22)	($10,239)
Subtotal Financing & Supplemental Payments	**$80,467,449**	**$21,209,175**	**$140,933,589**	**$79,567,093**	**$18,598,494**	**$20,143,323**	**($38)**	**$126,406,344**	**$10,425,920**	**$28,077,153**	**$30,171,128**	**$99,658**	**$556,099,288**
Grand Total	**$859,971,334**	**$150,963,522**	**$943,370,577**	**$298,860,409**	**$75,064,008**	**$82,213,922**	**$9,817,158**	**$627,769,747**	**$81,811,588**	**$95,688,869**	**$75,541,134**	**$24,322,917**	**$3,325,395,185**

Exhibit M

Cash-based Actuals													
FY 2009-10	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care													
Physician Services & EPSDT	$4,504,959	$5,841,290	$45,027,403	$49,005,879	$8,242,831	$379,950	$0	$97,071,331	$9,752,159	$16,382,526	$6,720,532	$553	$242,929,414
Emergency Transportation	$132,013	$206,450	$1,629,961	$1,035,662	$179,937	$5,733	$0	$1,553,739	$202,199	$184,865	$87,075	$0	$5,217,633
Non-emergency Medical Transportation	$2,230,609	$868,873	$4,556,037	$344,058	$21,112	$463	$0	$964,382	$100,146	$44,731	$1,244	$0	$9,131,655
Dental Services	$790,484	$236,617	$4,188,551	$3,595,409	$769,005	$54,703	$0	$73,534,295	$5,281,907	$353,118	$2,724	$43	$88,806,857
Family Planning	$0	$24	$11,970	$107,725	$41,710	$1,828	$0	$110,955	$30,688	$17,076	$0	$0	$321,975
Health Maintenance Organizations	$6,690,235	$6,808,868	$45,687,858	$17,679,228	$3,528,957	$149,518	$0	$35,072,614	$902,745	$1,131,694	$0	$0	$117,651,717
Inpatient Hospitals	$15,121,066	$10,933,612	$94,203,357	$54,090,071	$6,226,870	$225,968	$0	$82,963,155	$5,813,909	$29,535,689	$38,240,653	$4,098	$337,358,448
Outpatient Hospitals	$2,483,053	$3,912,610	$33,983,522	$32,186,041	$9,830,617	$591,764	$0	$51,528,633	$4,616,132	$4,813,849	$1,009,919	$0	$144,956,141
Lab & X-Ray	$542,175	$702,690	$5,366,358	$9,847,442	$1,749,800	$113,194	$0	$6,592,607	$1,625,242	$3,462,744	$145,427	$638	$30,148,317
Durable Medical Equipment	$18,160,548	$3,979,784	$40,816,114	$2,357,217	$678,683	$21,565	$0	$8,177,251	$3,905,570	$172,313	$559	$3,359	$78,272,962
Prescription Drugs	$7,741,380	$13,544,934	$97,612,578	$33,482,234	$7,733,934	$524,963	$618	$44,622,098	$18,661,722	$2,189,164	$0	$462	$226,114,086
Drug Rebate	($3,418,708)	($5,981,643)	($43,107,160)	($14,786,250)	($3,415,420)	($231,831)	($273)	($19,705,779)	($8,241,293)	($966,767)	$0	($204)	($99,855,328)
Rural Health Centers	$40,614	$147,085	$904,243	$1,253,860	$331,301	$22,504	$0	$4,562,102	$405,207	$300,495	$26,268	$142	$7,993,821
Federally Qualified Health Centers	$903,859	$792,591	$6,070,348	$11,539,676	$2,165,229	$182,692	$0	$47,091,192	$1,962,149	$5,080,079	$456,394	$154	$76,244,360
Co-Insurance (Title XVIII-Medicare)	$9,563,469	$1,441,719	$6,576,134	($69,754)	$339,111	$4,014	$0	$21,034	$17,428	$24,075	$32	$2,934,912	$20,852,175
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$8,716,269	$0	$0	$0	$0	$0	$8,716,269
Prepaid Inpatient Health Plan Services	$2,375,072	$2,021,423	$17,073,019	$7,910,314	$1,445,249	$183,288	$0	$8,648,317	$2,128,848	$2,918,289	$0	$0	$44,703,819
Other Medical Services	$3,033	$1,762	$15,618	$8,354	$0	$0	$271	$14,457	$2,022	$2,008	$1,457	$158	$49,140
Home Health	$23,855,013	$6,522,006	$110,646,480	$411,449	$90,617	$1,616	$0	$3,749,623	$10,908,657	$50,128	$0	$212,833	$156,448,421
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$91,718,875**	**$51,980,694**	**$471,262,390**	**$209,998,614**	**$39,959,544**	**$2,231,930**	**$8,716,886**	**$446,572,005**	**$58,075,438**	**$65,696,077**	**$46,692,284**	**$3,157,147**	**$1,496,061,883**
Community Based Long Term Care													
HCBS - Elderly, Blind, and Disabled	$101,286,005	$14,326,522	$70,577,472	$8,512	$4,831	$0	$0	$0	$77,881	$0	$0	$144,853	$186,426,075
HCBS - Mental Illness	$3,418,565	$2,358,037	$16,839,277	$80	$0	$0	$0	$0	$22,942	$0	$0	$42,459	$22,681,360
HCBS - Disabled Children	$0	$0	$1,762,739	$0	$0	$0	$0	$0	$471	$0	$0	$0	$1,763,210
HCBS - Persons Living with AIDS	$19,745	$28,343	$533,292	$0	$0	$0	$0	$0	$0	$0	$0	$25	$581,405
HCBS - Consumer Directed Attendant Support	$1,910,755	$270,269	$1,331,531	$161	$0	$0	$0	$0	$1,469	$0	$0	$2,733	$3,516,917
HCBS - Brain Injury	$143,522	$526,310	$10,806,523	$2,859	$2,859	$0	$0	$0	$0	$0	$0	$0	$11,482,073
HCBS - Children with Autism	$0	$0	$1,565,700	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,565,700
HCBS - Pediatric Hospice	$0	$0	$94,295	$0	$0	$0	$0	$0	$485	$0	$0	$0	$94,781
Private Duty Nursing	$1,026,115	$240,541	$14,816,119	$0	$0	$0	$0	$586,102	$6,561,939	$0	$0	$0	$23,230,817
Hospice	$33,775,857	$3,004,027	$6,070,145	$173,870	$23,084	$0	$0	$231,678	$34,952	$0	$1,279	$6,603	$43,321,496
Subtotal Community Based Long Term Care	**$141,580,564**	**$20,754,049**	**$124,397,093**	**$185,482**	**$30,774**	**$0**	**$0**	**$817,780**	**$6,700,139**	**$0**	**$1,279**	**$196,672**	**$294,663,833**
Long Term Care													
Class I Nursing Facilities	$386,581,897	$28,352,812	$72,076,695	$5,285	$0	$0	$0	$0	$0	$0	$0	$57,644	$487,074,333
Class II Nursing Facilities	$78,087	$345,366	$1,592,381	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,015,835
Program of All-Inclusive Care for the Elderly	$61,913,944	$4,981,340	$2,345,339	$0	$0	$0	$0	$0	$0	$0	$0	$0	$69,240,623
Subtotal Long Term Care	**$448,573,929**	**$33,679,519**	**$76,014,415**	**$5,285**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$57,644**	**$558,330,791**
Insurance													
Supplemental Medicare Insurance Benefit	$54,965,748	$3,205,285	$28,812,261	$180,219	$0	$0	$0	$0	$0	$0	$0	$15,905,077	$103,068,590
Health Insurance Buy-In Program	$3,244	$7,611	$907,337	$2,920	$0	$0	$0	$10,334	$192	$0	$0	$0	$931,637
Subtotal Insurance	**$54,968,992**	**$3,212,895**	**$29,719,598**	**$183,139**	**$0**	**$0**	**$0**	**$10,334**	**$192**	**$0**	**$0**	**$15,905,077**	**$104,000,227**
Service Management													
Single Entry Points	$11,622,897	$2,068,951	$9,956,430	$2,637	$0	$0	$0	$1,458	$8,329	$0	$41,435	$5,414	$23,707,551
Disease Management	$4,570	$2,655	$23,534	$12,589	$0	$0	$409	$21,785	$3,047	$3,027	$0	$0	$71,616
Prepaid Inpatient Health Plan Administration	$331,989	$116,999	$938,116	$543,252	$170,250	$0	$0	$2,715,378	$208,304	$87,465	$0	$0	$5,111,753
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,959,457**	**$2,188,605**	**$10,918,080**	**$558,478**	**$170,250**	**$0**	**$409**	**$2,738,620**	**$219,680**	**$90,492**	**$41,435**	**$5,414**	**$28,890,920**
Total Services	**$748,801,817**	**$111,815,763**	**$712,311,577**	**$210,930,998**	**$40,160,568**	**$2,231,930**	**$8,717,294**	**$450,138,739**	**$64,995,449**	**$65,786,568**	**$46,734,999**	**$19,321,953**	**$2,481,947,656**
Financing & Supplemental Payments													
Upper Payment Limit Financing	$11,041,603	$915,688	$3,009,973	$913,585	$278,991	$16,794	$0	$1,462,375	$131,005	$136,616	$28,661	$1,636	$17,936,927
Hospital Supplemental Payments	$11,404,874	$9,618,163	$83,046,197	$55,894,199	$10,402,884	$529,770	$0	$87,130,848	$6,757,128	$22,253,436	$25,428,584	$2,655	$312,468,739
Nursing Facility Supplemental Payments	$37,661,309	$2,762,168	$7,021,805	$515	$0	$0	$0	$0	$0	$0	$0	$5,616	$47,451,412
Physician Supplemental Payments	$268,976	$348,764	$2,688,435	$2,925,976	$492,152	$22,686	$0	$5,795,803	$582,269	$978,146	$401,260	$33	$14,504,498
Outstationing Payments	$60,301	$95,018	$825,288	$781,637	$238,736	$14,371	$0	$1,251,371	$112,103	$116,904	$24,526	$0	$3,520,254
Accounting Adjustments	($5,210)	($778)	($4,956)	($1,468)	($279)	($16)	($61)	($3,132)	($452)	($458)	($325)	($134)	($17,268)
Subtotal Financing & Supplemental Payments	**$60,431,853**	**$13,739,022**	**$96,586,742**	**$60,514,444**	**$11,412,484**	**$583,605**	**($61)**	**$95,637,265**	**$7,582,053**	**$23,484,644**	**$25,882,706**	**$9,805**	**$395,864,563**
Grand Total	**$809,233,671**	**$125,554,785**	**$808,898,319**	**$271,445,443**	**$51,573,052**	**$2,815,535**	**$8,717,234**	**$545,776,004**	**$72,577,502**	**$89,271,212**	**$72,617,705**	**$19,331,759**	**$2,877,812,218**

Exhibit M

Cash-based Actuals													
FY 2009-10 Adjusted Totals for June 2010 Payment Delay	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care													
Physician Services & EPSDT	$4,644,233	$6,088,859	$46,749,044	$50,890,397	$8,461,144	$535,323	$0	$100,673,872	$10,102,008	$16,999,107	$6,991,912	$553	$252,136,452
Emergency Transportation	$135,675	$219,816	$1,715,328	$1,071,466	$182,910	$7,555	$0	$1,604,042	$210,924	$189,910	$92,127	$0	$5,429,754
Non-emergency Medical Transportation	$2,250,142	$881,642	$4,609,047	$347,306	$21,342	$608	$0	$976,900	$103,821	$45,337	$1,244	$0	$9,237,390
Dental Services	$815,475	$244,934	$4,352,134	$3,747,235	$786,925	$78,276	$0	$76,650,059	$5,510,341	$370,427	$2,724	$43	$92,558,572
Family Planning	$0	$24	$12,420	$114,135	$43,396	$2,601	$0	$114,009	$30,897	$17,434	$0	$0	$334,916
Health Maintenance Organizations	$6,690,235	$6,808,868	$45,687,847	$17,679,255	$3,528,957	$149,518	$0	$35,072,631	$902,745	$1,131,694	$0	$0	$117,651,750
Inpatient Hospitals	$15,822,984	$11,626,366	$99,034,203	$56,272,985	$6,305,520	$390,748	$0	$85,902,848	$6,206,952	$30,629,066	$39,618,658	($833)	$351,809,498
Outpatient Hospitals	$2,586,214	$4,061,576	$35,876,257	$34,148,589	$10,090,199	$819,720	$0	$54,117,957	$4,860,761	$5,029,450	$1,066,582	$521	$152,657,826
Lab & X-Ray	$564,758	$733,232	$5,613,057	$10,271,962	$1,803,815	$154,214	$0	$6,852,876	$1,693,335	$3,589,272	$152,136	$638	$31,429,294
Durable Medical Equipment	$18,847,335	$4,155,984	$42,281,065	$2,452,124	$694,756	$39,139	$0	$8,456,254	$4,040,219	$185,251	$559	$2,908	$81,155,593
Prescription Drugs	$8,059,382	$14,076,616	$101,424,097	$34,928,739	$7,947,272	$671,944	$618	$46,186,239	$19,361,739	$2,266,055	$0	$462	$234,923,161
Drug Rebate	($3,418,708)	($5,981,643)	($43,107,160)	($14,786,250)	($3,415,420)	($231,831)	($273)	($19,705,779)	($8,241,293)	($966,767)	$0	($204)	($99,855,328)
Rural Health Centers	$42,647	$152,354	$945,902	$1,314,556	$340,052	$30,726	$0	$4,711,474	$418,503	$308,458	$29,366	$142	$8,294,180
Federally Qualified Health Centers	$943,051	$829,861	$6,305,622	$12,037,090	$2,224,505	$238,621	$0	$48,664,174	$2,029,256	$5,276,198	$472,287	$154	$79,020,818
Co-Insurance (Title XVIII-Medicare	$10,164,073	$1,546,536	$7,014,431	($59,373)	$345,444	$12,158	$0	$22,284	$18,450	$24,953	$32	$3,107,054	$22,196,042
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$9,005,795	$0	$0	$0	$0	$0	$9,005,795
Prepaid Inpatient Health Plan Services	$2,375,072	$2,021,423	$17,073,019	$7,910,314	$1,445,249	$183,288	$0	$8,648,317	$2,128,848	$2,918,289	$0	$0	$44,703,819
Other Medical Services	$3,033	$1,762	$15,618	$8,354	$0	$0	$271	$14,457	$2,022	$2,008	$1,457	$158	$49,140
Home Health	$24,453,284	$6,729,768	$113,570,849	$419,291	$92,754	$2,869	$0	$3,798,833	$11,064,772	$50,413	$0	$217,237	$160,400,069
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$94,978,885**	**$54,197,977**	**$489,172,778**	**$218,768,176**	**$40,898,817**	**$3,085,476**	**$9,006,411**	**$462,761,448**	**$60,444,300**	**$68,066,557**	**$48,429,084**	**$3,328,831**	**$1,553,138,739**
Community Based Long Term Care													
HCBS - Elderly, Blind, and Disabled	$103,386,211	$14,626,539	$71,841,260	$8,554	$4,831	$0	$0	$0	$79,147	$0	$0	$149,360	$190,095,902
HCBS - Mental Illness	$3,473,457	$2,391,039	$17,109,979	$80	$0	$0	$0	$0	$23,600	$0	$0	$42,459	$23,040,614
HCBS - Disabled Children	$0	$0	$1,840,542	$0	$0	$0	$0	$0	$471	$0	$0	$0	$1,841,013
HCBS - Persons Living with AIDS	$20,536	$28,470	$549,511	$0	$0	$0	$0	$0	$0	$0	$0	$25	$598,542
HCBS - Consumer Directed Attendant Support	$1,910,755	$270,269	$1,331,531	$161	$0	$0	$0	$0	$1,469	$0	$0	$2,733	$3,516,917
HCBS - Brain Injury	$144,343	$532,868	$10,913,491	$2,859	$2,859	$0	$0	$0	$0	$0	$0	$0	$11,596,421
HCBS - Children with Autism	$0	$0	$1,594,735	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,594,735
HCBS - Pediatric Hospice	$0	$0	$101,725	$0	$0	$0	$0	$0	$485	$0	$0	$0	$102,210
Private Duty Nursing	$1,035,252	$240,541	$15,137,079	$0	$0	$0	$0	$604,720	$6,648,963	$0	$0	$0	$23,666,555
Hospice	$34,017,386	$3,025,452	$6,115,615	$180,778	$23,084	$0	$0	$231,678	$34,952	$0	$1,279	$6,603	$43,636,826
Subtotal Community Based Long Term Care	**$143,987,940**	**$21,115,178**	**$126,535,468**	**$192,432**	**$30,774**	**$0**	**$0**	**$836,398**	**$6,789,088**	**$0**	**$1,279**	**$201,179**	**$299,689,736**
Long Term Care													
Class I Nursing Facilities	$393,028,828	$28,956,277	$73,847,716	$5,285	$0	$0	$0	$0	$0	$0	$0	$62,685	$495,900,792
Class II Nursing Facilities	($38,446)	$264,098	$989,694	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,215,347
Program of All-Inclusive Care for the Elderly	$61,924,560	$4,986,130	$2,345,339	$0	$0	$0	$0	$0	$0	$0	$0	$0	$69,256,028
Subtotal Long Term Care	**$454,914,942**	**$34,206,505**	**$77,182,749**	**$5,285**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$62,685**	**$566,372,167**
Insurance													
Supplemental Medicare Insurance Benefit	$54,965,748	$3,205,285	$28,812,261	$180,219	$0	$0	$0	$0	$0	$0	$0	$15,905,077	$103,068,590
Health Insurance Buy-In Program	$3,552	$8,332	$993,385	$3,197	$0	$0	$0	$11,314	$210	$0	$0	$0	$1,019,989
Subtotal Insurance	**$54,969,300**	**$3,213,617**	**$29,805,646**	**$183,416**	**$0**	**$0**	**$0**	**$11,314**	**$210**	**$0**	**$0**	**$15,905,077**	**$104,088,580**
Service Management													
Single Entry Points	$11,622,897	$2,068,951	$9,956,430	$2,637	$0	$0	$0	$1,458	$8,329	$0	$41,435	$5,414	$23,707,551
Disease Management	$4,570	$2,655	$23,534	$12,589	$0	$0	$409	$21,785	$3,047	$3,027	$0	$0	$71,616
Prepaid Inpatient Health Plan Administration	$331,989	$116,999	$938,116	$543,252	$170,250	$0	$0	$2,715,378	$208,304	$87,465	$0	$0	$5,111,753
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,959,457**	**$2,188,605**	**$10,918,080**	**$558,478**	**$170,250**	**$0**	**$409**	**$2,738,620**	**$219,680**	**$90,492**	**$41,435**	**$5,414**	**$28,890,920**
Total Services	**$760,810,523**	**$114,921,883**	**$733,614,722**	**$219,707,787**	**$41,099,842**	**$3,085,476**	**$9,006,820**	**$466,347,779**	**$67,453,278**	**$68,157,048**	**$48,471,798**	**$19,503,186**	**$2,552,180,141**
Financing & Supplemental Payments													
Upper Payment Limit Financing	$11,041,603	$915,688	$3,009,973	$913,585	$278,991	$16,794	$0	$1,462,375	$131,005	$136,616	$28,661	$1,636	$17,936,927
Hospital Supplemental Payments	$11,404,874	$9,618,163	$83,046,197	$55,894,199	$10,402,884	$529,770	$0	$87,130,848	$6,757,128	$22,253,436	$25,428,584	$2,655	$312,468,739
Nursing Facility Supplemental Payments	$37,661,309	$2,762,168	$7,021,805	$515	$0	$0	$0	$0	$0	$0	$0	$5,616	$47,451,412
Physician Supplemental Payments	$268,976	$348,764	$2,688,435	$2,925,976	$492,152	$22,686	$0	$5,795,803	$582,269	$978,146	$401,260	$33	$14,504,498
Outstationing Payments	$60,301	$95,018	$825,288	$781,637	$238,736	$14,371	$0	$1,251,371	$112,103	$116,904	$24,526	$0	$3,520,254
Accounting Adjustments	($5,210)	($778)	($4,956)	($1,468)	($279)	($16)	($61)	($3,132)	($452)	($458)	($325)	($134)	($17,268)
Subtotal Financing & Supplemental Payments	**$60,431,853**	**$13,739,022**	**$96,586,742**	**$60,514,444**	**$11,412,484**	**$583,605**	**($61)**	**$95,637,265**	**$7,582,053**	**$23,484,644**	**$25,882,706**	**$9,805**	**$395,864,563**
Grand Total	**$821,242,377**	**$128,660,905**	**$830,201,464**	**$280,222,231**	**$52,512,326**	**$3,669,080**	**$9,006,759**	**$561,985,044**	**$75,035,330**	**$91,641,692**	**$74,354,504**	**$19,512,991**	**$2,948,044,704**

Exhibit M

Cash-based Actuals													
FY 2008-09	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care													
Physician Services & EPSDT	$4,994,147	$6,222,450	$45,788,069	$45,929,303	$6,388,849	$0	$0	$89,495,781	$9,896,241	$15,568,366	$8,628,882	$603	$232,912,692
Emergency Transportation	$137,865	$236,302	$1,633,597	$984,736	$129,300	$0	$0	$1,342,177	$176,882	$183,755	$109,310	$157	$4,934,082
Non-emergency Medical Transportation	$2,169,408	$784,497	$4,355,943	$402,309	$0	$0	$0	$809,400	$131,628	$35,042	$791	$0	$8,689,018
Dental Services	$982,210	$236,181	$3,967,399	$3,245,522	$643,081	$0	$0	$61,485,476	$5,488,468	$396,626	$11,462	$0	$76,456,424
Family Planning	$0	$120	$9,036	$115,099	$35,198	$0	$0	$101,028	$34,059	$23,734	$1,150	$0	$319,424
Health Maintenance Organizations	$8,589,196	$7,896,327	$59,131,526	$15,481,484	$2,413,999	$0	$0	$33,428,257	$1,052,528	$1,081,509	$0	$0	$129,074,827
Inpatient Hospitals	$16,801,697	$13,598,479	$98,702,338	$57,489,437	$5,455,282	$0	$0	$84,101,547	$6,535,184	$27,109,511	$46,764,468	$18,694	$356,576,636
Outpatient Hospitals	$3,004,874	$3,827,049	$40,287,696	$35,275,504	$7,081,071	$0	$0	$52,180,563	$5,471,149	$5,159,881	$1,612,752	$1,216	$153,901,754
Lab & X-Ray	$541,036	$700,896	$5,345,769	$9,211,276	$1,364,038	$0	$0	$5,923,803	$1,888,019	$3,098,394	$364,434	$158	$28,437,823
Durable Medical Equipment	$19,191,857	$4,023,304	$40,203,019	$1,972,489	$450,132	$0	$0	$7,113,934	$3,897,828	$147,294	$8,611	$3,345	$77,011,816
Prescription Drugs	$8,113,773	$12,092,935	$104,378,704	$32,051,410	$6,442,536	$0	$1,722	$47,409,911	$21,136,869	$1,959,449	$78,621	$378	$233,666,309
Drug Rebate	($3,188,270)	($4,751,863)	($41,015,133)	($12,594,454)	($2,531,565)	$0	($677)	($18,629,507)	($8,305,636)	($769,957)	($30,894)	($148)	($91,818,104)
Rural Health Centers	$50,160	$147,174	$965,699	$1,145,962	$272,843	$0	$0	$4,193,025	$300,376	$348,898	$34,346	$0	$7,458,484
Federally Qualified Health Centers	$964,422	$691,839	$5,907,249	$10,952,551	$1,637,957	$0	$0	$44,940,460	$2,237,254	$4,162,016	$1,595,266	$0	$73,089,013
Co-Insurance (Title XVIII-Medicare)	$13,247,112	$1,936,238	$8,768,139	($1,273)	$363,789	$0	$0	$31,202	$20,241	$41,983	$1,112	$3,689,845	$28,098,389
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$7,042,030	$0	$0	$0	$0	$0	$7,042,030
Prepaid Inpatient Health Plan Services	$2,208,485	$1,744,095	$12,109,816	$4,331,431	$689,116	$0	$0	$11,378,089	$1,586,101	$1,942,062	$0	$0	$35,989,196
Other Medical Services	$3,147	$1,760	$15,560	$7,453	$0	$0	$212	$13,048	$2,059	$1,783	$1,776	$148	$46,946
Home Health	$24,428,105	$6,617,163	$102,068,348	$446,028	$77,460	$0	$0	$3,328,955	$10,164,895	$25,103	$0	$172,081	$147,328,138
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$102,239,226**	**$56,004,946**	**$492,622,774**	**$206,446,267**	**$30,913,086**	**$0**	**$7,043,287**	**$428,647,150**	**$61,714,145**	**$60,515,451**	**$59,182,087**	**$3,886,476**	**$1,509,214,896**
Community Based Long Term Care													
HCBS - Elderly, Blind, and Disabled	$97,156,797	$13,604,791	$65,434,378	$15,005	$395	$0	$0	$0	$77,857	$0	$0	$192,447	$176,481,671
HCBS - Mental Illness	$3,588,896	$2,137,938	$17,180,010	$0	$1,005	$0	$0	$0	$6,584	$0	$0	$44,433	$22,958,866
HCBS - Disabled Children	$0	$0	$1,747,600	$0	$0	$0	$0	$50	$33	$0	$0	$0	$1,747,683
HCBS - Persons Living with AIDS	$12,764	$32,458	$546,457	$0	$0	$0	$0	$0	$0	$0	$0	$1,066	$592,744
HCBS - Consumer Directed Attendant Support	$2,271,433	$318,067	$1,529,803	$351	$0	$0	$0	$0	$1,820	$0	$0	$4,499	$4,125,973
HCBS - Brain Injury	$159,346	$507,164	$11,361,726	$0	$0	$0	$0	$0	$0	$0	$0	$0	$12,028,236
HCBS - Children with Autism	$0	$0	$1,293,932	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,293,932
HCBS - Pediatric Hospice	$0	$0	$26,940	$0	$0	$0	$0	$0	$2,372	$0	$0	$0	$29,312
Private Duty Nursing	$725,106	$186,844	$14,728,104	$0	$0	$0	$0	$250,793	$5,460,562	$0	$0	$0	$21,351,408
Hospice	$31,767,623	$2,005,681	$5,941,975	$37,529	$7,535	$0	$0	$77,422	$3,390	$2,017	$0	$59,700	$39,902,873
Subtotal Community Based Long Term Care	**$135,681,964**	**$18,792,943**	**$119,790,925**	**$52,885**	**$8,935**	**$0**	**$0**	**$328,265**	**$5,552,618**	**$2,017**	**$0**	**$302,145**	**$280,512,697**
Long Term Care													
Class I Nursing Facilities	$423,682,370	$29,953,087	$77,004,135	$22,194	$0	$0	$0	$0	$0	$0	$0	$256,886	$530,918,672
Class II Nursing Facilities	$0	$335,754	$1,935,960	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,271,714
Program of All-Inclusive Care for the Elderly	$54,470,714	$4,395,937	$2,183,184	$0	$0	$0	$0	$0	$0	$0	$0	$0	$61,049,836
Subtotal Long Term Care	**$478,153,084**	**$34,684,778**	**$81,123,279**	**$22,194**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$256,886**	**$594,240,222**
Insurance													
Supplemental Medicare Insurance Benefit	$49,992,538	$2,915,276	$26,205,375	$163,913	$0	$0	$0	$0	$0	$0	$0	$14,466,011	$93,743,114
Health Insurance Buy-In Program	($177)	$3,200	$917,027	$5,034	$0	$0	$0	$16,561	$0	$500	$0	$0	$942,145
Subtotal Insurance	**$49,992,361**	**$2,918,475**	**$27,122,403**	**$168,948**	**$0**	**$0**	**$0**	**$16,561**	**$0**	**$500**	**$0**	**$14,466,011**	**$94,685,260**
Service Management													
Single Entry Points	$11,356,087	$1,927,170	$9,708,485	$3,228	$0	$0	$0	$1,507	$7,102	$0	$56,818	$6,779	$23,067,175
Disease Management	$201,459	$112,661	$996,159	$477,141	$0	$0	$13,568	$835,312	$131,805	$114,165	$0	$0	$2,882,271
Prepaid Inpatient Health Plan Administration	$352,841	$75,159	$520,646	$530,811	$95,675	$0	$0	$2,101,664	$184,279	$74,059	$0	$0	$3,935,134
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,910,387**	**$2,114,989**	**$11,225,291**	**$1,011,181**	**$95,675**	**$0**	**$13,568**	**$2,938,483**	**$323,187**	**$188,224**	**$56,818**	**$6,779**	**$29,884,581**
Total Services	**$777,977,023**	**$114,516,131**	**$731,884,672**	**$207,701,475**	**$31,017,697**	**$0**	**$7,056,855**	**$431,930,459**	**$67,589,950**	**$60,706,191**	**$59,238,905**	**$18,918,298**	**$2,508,537,655**
Financing & Supplemental Payments													
Upper Payment Limit Financing	$11,596,400	$918,068	$3,187,728	$959,312	$0	$0	$0	$1,418,150	$148,694	$140,234	$43,831	$7,015	$18,419,432
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$10,655	$1,568	$10,023	$2,845	$425	$0	$97	$5,915	$926	$831	$811	$259	$34,355
Subtotal Financing & Supplemental Payments	**$11,607,055**	**$919,637**	**$3,197,752**	**$962,157**	**$425**	**$0**	**$97**	**$1,424,066**	**$149,619**	**$141,065**	**$44,642**	**$7,274**	**$18,453,787**
Grand Total	**$789,584,078**	**$115,435,768**	**$735,082,424**	**$208,663,632**	**$31,018,121**	**$0**	**$7,056,952**	**$433,354,524**	**$67,739,569**	**$60,847,257**	**$59,283,547**	**$18,925,572**	**$2,526,991,443**

Exhibit M

Cash-based Actuals													
FY 2007-08	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care													
Physician Services & EPSDT	$3,469,726	$5,866,568	$39,253,495	$39,870,742	$3,123,248	$0	$0	$71,109,993	$8,011,424	$12,603,872	$7,354,450	$309	$190,663,827
Emergency Transportation	$76,213	$207,485	$1,572,693	$907,188	$74,652	$0	$0	$1,291,389	$163,859	$150,448	$106,578	$0	$4,550,505
Non-emergency Medical Transportation	$1,890,521	$807,146	$3,907,628	$282,264	$7,100	$0	$0	$713,422	$99,207	$24,313	$2,348	$0	$7,733,949
Dental Services	$692,450	$171,089	$3,093,306	$2,560,792	$310,745	$0	$0	$42,256,276	$4,543,616	$250,711	$14,716	$189	$53,893,890
Family Planning	$101	$0	$7,167	$63,821	$19,695	$0	$0	$70,705	$30,651	$8,462	$1,470	$0	$202,073
Health Maintenance Organizations	$9,349,039	$5,367,124	$44,519,944	$12,362,626	$1,532,412	$0	$0	$27,309,963	$873,700	$902,068	$0	$0	$102,216,877
Inpatient Hospitals	$12,490,039	$11,578,942	$87,911,992	$55,261,146	$3,425,569	$0	$0	$77,716,643	$6,608,100	$23,195,257	$42,710,199	$1,406	$320,899,293
Outpatient Hospitals	$2,279,079	$3,626,609	$36,371,235	$29,962,722	$4,019,199	$0	$0	$44,067,264	$4,594,124	$3,998,659	$1,273,061	$243	$130,192,196
Lab & X-Ray	$415,678	$628,260	$4,813,487	$7,519,657	$680,163	$0	$0	$4,844,562	$1,480,894	$2,110,120	$281,245	$175	$22,774,240
Durable Medical Equipment	$19,099,564	$3,724,534	$40,421,276	$1,864,137	$224,468	$0	$0	$6,388,678	$3,963,555	$114,866	$7,053	$7,843	$75,815,972
Prescription Drugs	$6,819,298	$11,618,863	$102,291,859	$29,776,946	$4,304,511	$0	$1,305	$39,162,305	$21,130,262	$1,689,121	$69,578	$90	$216,864,136
Drug Rebate	($1,744,101)	($2,971,636)	($26,162,127)	($7,615,740)	($1,100,920)	$0	($334)	($10,016,136)	($5,404,268)	($432,009)	($17,795)	($23)	($55,465,088)
Rural Health Centers	$33,486	$118,828	$885,721	$988,888	$151,262	$0	$0	$3,411,821	$384,803	$239,581	$28,394	$0	$6,242,784
Federally Qualified Health Centers	$686,433	$672,208	$5,232,210	$9,235,273	$1,057,317	$0	$0	$38,528,501	$2,053,130	$3,358,983	$1,797,419	$0	$62,621,473
Co-Insurance (Title XVIII-Medicare)	$10,666,122	$1,603,558	$7,081,693	$55,556	$150,455	$0	$0	$13,250	$8,349	$30,611	$1,086	$2,896,987	$22,507,668
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$7,088,411	$0	$0	$0	$0	$0	$7,088,411
Prepaid Inpatient Health Plan Services	$2,144,360	$1,683,438	$11,566,837	$3,908,229	$419,271	$0	$0	$10,068,498	$1,601,890	$2,289,781	$0	$0	$33,682,305
Other Medical Services	$2,310	$1,293	$11,593	$5,267	$0	$0	$178	$8,985	$1,584	$1,224	$1,347	$106	$33,888
Home Health	$22,853,620	$6,013,415	$87,841,043	$495,825	$28,573	$0	$0	$3,209,955	$8,809,726	$37,335	$2,426	$423,280	$129,715,198
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,770,690	$0	$0	$3,770,690
Subtotal of Acute Care	**$91,223,938**	**$50,717,725**	**$450,621,054**	**$187,505,340**	**$18,427,719**	**$0**	**$7,089,560**	**$360,156,073**	**$58,954,606**	**$54,344,094**	**$53,633,572**	**$3,330,605**	**$1,336,004,286**
Community Based Long Term Care													
HCBS - Elderly, Blind, and Disabled	$86,813,975	$10,527,340	$43,329,761	$37,677	$210	$0	$0	$0	$13,583	$0	$0	$509,299	$141,231,844
HCBS - Mental Illness	$3,181,676	$1,943,044	$15,184,323	$1,504	$1,005	$0	$0	$0	$9,277	$0	$0	$89,059	$20,409,887
HCBS - Disabled Children	$0	$0	$1,352,728	$0	$0	$0	$0	$973	$147	$0	$0	$0	$1,353,847
HCBS - Persons Living with AIDS	$12,757	$31,627	$549,627	$0	$0	$0	$0	$0	$0	$0	$0	$1,395	$595,406
HCBS - Consumer Directed Attendant Support	$8,673,182	$1,051,738	$4,328,897	$3,764	$0	$0	$0	$0	$1,357	$0	$0	$50,882	$14,109,819
HCBS - Brain Injury	$79,917	$459,639	$10,226,782	$0	$0	$0	$0	$0	$0	$0	$0	$19,249	$10,785,587
HCBS - Children with Autism	$0	$0	$693,081	$0	$0	$0	$0	$2,504	$0	$0	$0	$0	$695,586
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$313,936	$207,166	$13,885,052	$0	$0	$0	$0	$500,847	$4,832,273	$0	$0	$9,988	$19,749,262
Hospice	$25,148,153	$2,134,632	$5,123,646	$70,365	$6,838	$0	$0	$86,351	$0	$0	$0	$240,791	$32,810,776
Subtotal Community Based Long Term Care	**$124,223,595**	**$16,355,185**	**$94,673,897**	**$113,310**	**$8,054**	**$0**	**$0**	**$590,675**	**$4,856,636**	**$0**	**$0**	**$920,662**	**$241,742,014**
Long Term Care													
Class I Nursing Facilities	$389,399,454	$25,395,243	$69,952,848	$6,325	$0	$0	$0	$0	$0	$0	$0	$1,814,628	$486,568,498
Class II Nursing Facilities	$74,970	$191,024	$1,924,394	$0	$0	$0	$0	$0	$0	$0	$0	$45,248	$2,235,636
Program of All-Inclusive Care for the Elderly	$44,272,143	$3,549,809	$1,596,904	$0	$0	$0	$0	$0	$0	$0	$0	$0	$49,418,855
Subtotal Long Term Care	**$433,746,567**	**$29,136,075**	**$73,474,146**	**$6,325**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$1,859,876**	**$538,222,989**
Insurance													
Supplemental Medicare Insurance Benefit	$43,978,504	$2,564,572	$23,052,905	$144,195	$0	$0	$0	$0	$0	$0	$0	$12,725,770	$82,465,946
Health Insurance Buy-In Program	$3,274	$1,762	$877,995	$1,605		$0	$0	$16,916	$1,188	$2,208	$0	$0	$904,947
Subtotal Insurance	**$43,981,778**	**$2,566,334**	**$23,930,899**	**$145,800**	**$0**	**$0**	**$0**	**$16,916**	**$1,188**	**$2,208**	**$0**	**$12,725,770**	**$83,370,893**
Service Management													
Single Entry Points	$10,894,815	$1,743,587	$8,992,484	$2,602	$0	$0	$0	$1,301	$2,602	$0	$0	$119,709	$21,757,100
Disease Management	$165,996	$92,931	$833,085	$378,473	$0	$0	$12,812	$645,653	$113,811	$87,964	$0	$0	$2,330,726
Prepaid Inpatient Health Plan Administration	$366,151	$74,505	$536,817	$430,680	$66,075	$0	$0	$1,873,683	$176,254	$85,306	$0	$0	$3,609,472
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,426,962**	**$1,911,023**	**$10,362,386**	**$811,756**	**$66,075**	**$0**	**$12,812**	**$2,520,636**	**$292,668**	**$173,270**	**$0**	**$119,709**	**$27,697,298**
Total Services	**$704,602,839**	**$100,686,342**	**$653,062,382**	**$188,582,531**	**$18,501,848**	**$0**	**$7,102,372**	**$363,284,302**	**$64,105,098**	**$54,519,572**	**$53,633,572**	**$18,956,623**	**$2,227,037,481**
Financing & Supplemental Payments													
Upper Payment Limit Financing	$7,640,056	$566,098	$2,073,951	$584,574	$0	$0	$0	$859,573	$89,613	$77,998	$24,832	$35,401	$11,952,096
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$33,799	$4,830	$31,327	$9,046	$888	$0	$341	$17,426	$3,075	$2,615	$2,573	$909	$106,828
Subtotal Financing & Supplemental Payments	**$7,673,855**	**$570,928**	**$2,105,277**	**$593,620**	**$888**	**$0**	**$341**	**$877,000**	**$92,688**	**$80,613**	**$27,405**	**$36,310**	**$12,058,924**
Grand Total	**$712,276,694**	**$101,257,270**	**$655,167,660**	**$189,176,151**	**$18,502,735**	**$0**	**$7,102,713**	**$364,161,301**	**$64,197,785**	**$54,600,185**	**$53,660,977**	**$18,992,933**	**$2,239,096,405**

Exhibit M

Cash-based Actuals													
FY 2006-07	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care													
Physician Services & EPSDT	$2,557,590	$4,913,899	$32,157,433	$38,985,126	$1,224,479	$0	$0	$61,863,460	$6,843,560	$9,019,205	$6,665,024	$2,652	$164,232,428
Emergency Transportation	$75,398	$169,825	$1,386,996	$922,395	$33,151	$0	$0	$1,313,302	$139,118	$129,933	$114,504	$0	$4,284,622
Non-emergency Medical Transportation	($18,672)	($8,454)	($25,794)	($1,823)	$0	$0	$0	($4,150)	($1,652)	($176)	($17)	($2)	($60,740)
Dental Services	$662,760	$164,830	$2,924,310	$2,681,114	$152,231	$0	$0	$38,168,661	$4,365,105	$239,992	$8,130	$0	$49,367,133
Family Planning	$0	$0	$464	($1,854)	$8,904	$0	$0	$7,323	$3,119	$422	$55	$0	$18,433
Health Maintenance Organizations	$9,906,026	$5,316,092	$44,014,281	$18,339,469	$832,261	$0	$0	$28,259,688	$667,693	$1,093,523	$0	$0	$108,429,033
Inpatient Hospitals	$12,785,899	$10,333,981	$77,352,935	$59,552,000	$1,558,745	$0	$0	$74,070,764	$5,149,408	$19,508,543	$44,375,127	$0	$304,687,402
Outpatient Hospitals	$1,996,199	$3,500,504	$31,579,126	$30,497,019	$1,404,553	$0	$0	$38,657,701	$3,944,746	$2,972,677	$1,214,531	$217	$115,767,273
Lab & X-Ray	$336,966	$575,229	$4,080,667	$7,613,932	$294,448	$0	($112)	$4,565,655	$1,172,479	$1,552,063	$255,725	$91	$20,447,143
Durable Medical Equipment	$17,788,206	$3,417,083	$34,532,449	$1,944,867	$77,764	$0	$0	$5,382,698	$3,535,980	$114,018	$7,737	$21,364	$66,822,166
Prescription Drugs	$6,520,078	$10,234,109	$88,778,681	$29,066,476	$1,602,085	$0	$1,088	$33,279,711	$19,027,403	$1,277,899	$45,745	$174	$189,833,449
Drug Rebate	($2,014,232)	($3,161,599)	($27,426,192)	($8,979,439)	($494,928)	$0	($336)	($10,281,023)	($5,878,091)	($394,778)	($14,132)	($54)	($58,644,804)
Rural Health Centers	$33,187	$105,329	$792,378	$1,019,191	$68,417	$0	$0	$3,407,281	$221,847	$212,217	$20,555	$0	$5,880,402
Federally Qualified Health Centers	$603,731	$558,662	$4,565,903	$9,985,268	$495,431	$0	$0	$36,599,910	$1,514,903	$2,874,034	$1,762,260	$0	$58,960,102
Co-Insurance (Title XVIII-Medicare	$9,351,692	$1,308,275	$5,742,590	$28,897	$71,544	$0	$0	$6,279	$8,956	$17,869	$0	$2,440,303	$18,976,405
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$5,554,934	$0	$0	$0	$0	$0	$5,554,934
Prepaid Inpatient Health Plan Services	$2,175,087	$1,620,965	$10,503,017	$4,202,795	$138,739	$0	$0	$9,283,867	$1,386,666	$1,974,179	$0	$0	$31,285,316
Other Medical Services	$1,879	$1,007	$8,697	$4,562	$0	$0	$122	$7,155	$1,185	$855	$1,192	$82	$26,736
Home Health	$20,648,369	$5,431,838	$72,782,098	$489,136	$13,061	$0	$0	$2,622,088	$7,357,801	$18,370	$1,011	$283,291	$109,647,063
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$7,849,344	$0	$0	$7,849,344
Subtotal of Acute Care	**$83,410,163**	**$44,481,575**	**$383,750,038**	**$196,349,132**	**$7,480,884**	**$0**	**$5,555,696**	**$327,210,370**	**$49,460,226**	**$48,460,189**	**$54,457,447**	**$2,748,118**	**$1,203,363,838**
Community Based Long Term Care													
HCBS - Elderly, Blind, and Disabled	$77,897,470	$9,019,369	$36,497,817	$37,957	$2,506	$0	$0	$0	$5,953	$0	$0	$211,964	$123,673,036
HCBS - Mental Illness	$2,759,506	$1,696,177	$12,752,277	$4	$2,373	$0	$0	$0	$470	$0	$0	$35,513	$17,246,320
HCBS - Disabled Children	$0	$0	$904,544	$0	$0	$0	$0	$264	$0	$0	$0	$75	$904,883
HCBS - Persons Living with AIDS	$16,836	$17,189	$468,801	$0	$0	$0	$0	$0	$0	$0	$0	$704	$503,530
HCBS - Consumer Directed Attendant Support	$7,923,897	$917,469	$3,712,636	$3,861	$255	$0	$0	$0	$606	$0	$0	$21,561	$12,580,285
HCBS - Brain Injury	$73,747	$313,937	$10,724,693	$151	$0	$0	$0	$0	$0	$0	$0	$0	$11,112,528
HCBS - Children with Autism	$0	$0	$18,801	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,801
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$354,877	$155,949	$12,205,855	$0	$0	$0	$0	$562,535	$3,983,279	$0	$0	$37,261	$17,299,756
Hospice	$23,913,110	$1,986,641	$5,611,231	$46,496	$0	$0	$0	$141,295	$0	$0	$0	$88,575	$31,787,348
Subtotal Community Based Long Term Care	**$112,939,443**	**$14,106,731**	**$82,896,656**	**$88,469**	**$5,134**	**$0**	**$0**	**$704,094**	**$3,990,308**	**$0**	**$0**	**$395,653**	**$215,126,488**
Long Term Care													
Class I Nursing Facilities	$384,275,629	$24,171,304	$68,903,820	$1,596	$0	$0	$0	$0	$0	$0	$0	$951,138	$478,303,487
Class II Nursing Facilities	$106,064	$27,660	$2,100,702	$0	$0	$0	$0	$0	$0	$0	$0	$35,710	$2,270,136
Program of All-Inclusive Care for the Elderly	$37,878,793	$3,182,900	$1,810,588	$0	$0	$0	$0	$0	$0	$0	$0	$0	$42,872,281
Subtotal Long Term Care	**$422,260,486**	**$27,381,864**	**$72,815,110**	**$1,596**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$986,848**	**$523,445,904**
Insurance													
Supplemental Medicare Insurance Benefit	$44,106,993	$2,572,065	$23,120,257	$144,616	$0	$0	$0	$0	$0	$0	$0	$12,762,950	$82,706,881
Health Insurance Buy-In Program	$1,797	$20,389	$704,579	$2,008	$0	$0	$0	$9,795	$651	$3,133	$0	$0	$742,352
Subtotal Insurance	**$44,108,790**	**$2,592,454**	**$23,824,836**	**$146,624**	**$0**	**$0**	**$0**	**$9,795**	**$651**	**$3,133**	**$0**	**$12,762,950**	**$83,449,233**
Service Management													
Single Entry Points	$9,171,616	$1,415,981	$7,352,685	$4,528	$0	$0	$0	$0	$1,132	$0	$0	$56,594	$18,002,536
Disease Management	$31,652	$16,971	$146,541	$76,859	$0	$0	$2,053	$120,548	$19,962	$14,413	$0	$0	$428,999
Prepaid Inpatient Health Plan Administration	$505,046	$102,136	$772,630	$518,429	$1,000	$0	$0	$2,412,273	$223,401	$85,502	$0	$0	$4,620,417
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$9,708,314**	**$1,535,088**	**$8,271,856**	**$599,816**	**$1,000**	**$0**	**$2,053**	**$2,532,821**	**$244,495**	**$99,915**	**$0**	**$56,594**	**$23,051,952**
Total Services	**$672,427,196**	**$90,097,712**	**$571,558,496**	**$197,185,637**	**$7,487,018**	**$0**	**$5,557,749**	**$330,457,080**	**$53,695,680**	**$48,563,237**	**$54,457,447**	**$16,950,163**	**$2,048,437,415**
Financing & Supplemental Payments													
Upper Payment Limit Financing	$8,446,320	$605,079	$2,197,186	$666,891	$0	$0	$0	$845,299	$86,257	$65,001	$26,557	$20,803	$12,959,393
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Financing & Supplemental Payments	**$8,446,320**	**$605,079**	**$2,197,186**	**$666,891**	**$0**	**$0**	**$0**	**$845,299**	**$86,257**	**$65,001**	**$26,557**	**$20,803**	**$12,959,393**
Grand Total	**$680,873,516**	**$90,702,791**	**$573,755,682**	**$197,852,527**	**$7,487,018**	**$0**	**$5,557,749**	**$331,302,380**	**$53,781,937**	**$48,628,238**	**$54,484,004**	**$16,970,966**	**$2,061,396,808**

Exhibit M

Cash-based Actuals													
FY 2005-06	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care													
Physician Services & EPSDT	$3,975,272	$3,688,514	$26,408,980	$36,098,754	$0	$0	$0	$53,028,974	$6,111,311	$8,343,332	$6,611,091	$195	$144,266,423
Emergency Transportation	$84,353	$126,114	$1,133,549	$817,029	$0	$0	$0	$1,140,132	$130,357	$86,656	$93,252	($1)	$3,611,441
Non-emergency Medical Transportation	($3,432)	($1,554)	($4,741)	($335)	$0	$0	$0	($763)	($304)	($32)	($3)	$0	($11,164)
Dental Services	$1,262,181	$236,029	$2,930,118	$3,071,227	$0	$0	$0	$34,885,122	$4,088,844	$217,730	$11,716	$2,547	$46,705,514
Family Planning	($2)	$0	$10,347	$210,459	$0	$0	$0	$106,209	$69,728	$11,612	$765	$1	$409,119
Health Maintenance Organizations	$11,735,631	$9,400,251	$75,960,961	$23,941,548	$0	$0	$0	$32,559,940	$460,293	$718,326	$0	$5,241	$154,782,191
Inpatient Hospitals	$10,886,225	$8,621,491	$71,253,901	$62,945,736	$0	$0	$0	$74,754,190	$4,709,489	$18,737,044	$44,892,047	$1	$296,800,124
Outpatient Hospitals	$3,098,381	$2,915,529	$26,382,059	$28,536,153	$0	$0	$0	$35,812,801	$4,051,514	$2,854,896	$1,562,291	$119	$105,213,743
Lab & X-Ray	$425,283	$446,360	$3,377,104	$7,490,295	$0	$0	$0	$4,504,927	$1,169,897	$1,570,143	$266,156	($128)	$19,250,037
Durable Medical Equipment	$16,326,787	$2,961,537	$29,468,163	$1,671,729	$0	$0	$0	$4,639,863	$3,416,206	$88,577	$10,521	$68,786	$58,652,169
Prescription Drugs	$50,125,835	$12,867,087	$104,466,003	$24,828,668	$0	$0	$2,157	$26,344,076	$17,140,550	$1,101,109	$46,195	$26,145	$236,947,825
Drug Rebate	($16,726,807)	($4,293,700)	($34,859,921)	($8,285,235)	$0	$0	($720)	($8,790,921)	($5,719,738)	($367,436)	($15,415)	($8,724)	($79,068,617)
Rural Health Centers	$32,519	$90,334	$605,016	$864,162	$0	$0	$0	$2,760,432	$214,943	$151,959	$31,966	($1)	$4,751,330
Federally Qualified Health Centers	$641,668	$452,609	$3,870,384	$11,207,906	$0	$0	$0	$39,458,275	$1,483,125	$3,048,685	$1,795,167	($101)	$61,957,718
Co-Insurance (Title XVIII-Medicare	$8,937,877	$1,204,618	$5,757,919	$38,324	$0	$0	$0	$5,379	$7,029	$17,058	$0	$1,954,240	$17,922,444
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$6,808,264	$0	$0	$0	$0	$0	$6,808,264
Prepaid Inpatient Health Plan Services	$3,077,446	$1,637,924	$11,060,481	$4,851,825	$0	$0	$0	$9,484,138	$1,116,719	$1,758,697	$0	$0	$32,987,230
Other Medical Services	$3,822	$1,206	$10,800	$4,420	$0	$0	$61	$5,670	$1,074	$1,445	$1,344	$61	$29,903
Home Health	$18,536,187	$4,997,032	$59,760,483	$402,401	$0	$0	$0	$2,009,317	$6,476,083	$26,958	$0	$18,990	$92,227,451
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,644,540	$0	$0	$2,644,540
Subtotal of Acute Care	**$112,419,226**	**$45,351,381**	**$387,591,606**	**$198,695,066**	**$0**	**$0**	**$6,809,762**	**$312,707,761**	**$44,927,120**	**$41,011,299**	**$55,307,093**	**$2,067,371**	**$1,206,887,685**
Community Based Long Term Care													
HCBS - Elderly, Blind, and Disabled	$66,647,516	$7,757,981	$32,802,759	$37,971	$0	$0	$0	$0	$0	$0	$0	$30,338	$107,276,565
HCBS - Mental Illness	$2,278,956	$1,441,905	$11,259,932	$0	$0	$0	$0	$0	$1,113	$0	$0	$2,267	$14,984,173
HCBS - Disabled Children	($1)	$0	$658,623	$0	$0	$0	$0	$3,201	$0	$0	$0	$0	$661,823
HCBS - Persons Living with AIDS	$16,218	$0	$456,565	$0	$0	$0	$0	$0	$0	$0	$0	$0	$472,783
HCBS - Consumer Directed Attendant Support	$4,916,492	$401,883	$1,919,448	$66	$0	$0	$0	$0	$0	$0	$0	$0	$7,237,889
HCBS - Brain Injury	$12,788	$11,846	$8,788,436	$616	$0	$0	$0	$0	$0	$0	$0	$0	$8,813,686
HCBS - Children with Autism	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$157,164	$405,549	$10,536,627	$0	$0	$0	$0	$397,273	$4,120,147	$0	$0	$0	$15,616,760
Hospice	$21,266,594	$2,111,240	$4,880,020	$111,898	$0	$0	$0	$128,732	$0	$0	$0	$8,603	$28,507,087
Subtotal Community Based Long Term Care	**$95,295,727**	**$12,130,404**	**$71,302,410**	**$150,551**	**$0**	**$0**	**$0**	**$529,206**	**$4,121,260**	**$0**	**$0**	**$41,208**	**$183,570,766**
Long Term Care													
Class I Nursing Facilities	$370,539,529	$22,631,623	$63,039,217	($10,541)	$0	$0	$0	$1,810	$0	$0	$0	$318,690	$456,520,328
Class II Nursing Facilities	$69,154	$0	$1,367,696	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,436,850
Program of All-Inclusive Care for the Elderly	$35,666,638	$2,962,484	$1,841,368	$0	$0	$0	$0	$0	$0	$0	$0	$0	$40,470,490
Subtotal Long Term Care	**$406,275,321**	**$25,594,107**	**$66,248,281**	**($10,541)**	**$0**	**$0**	**$0**	**$1,810**	**$0**	**$0**	**$0**	**$318,690**	**$498,427,668**
Insurance													
Supplemental Medicare Insurance Benefit	$37,744,128	$2,201,019	$19,784,933	$123,754	$0	$0	$0	$0	$0	$0	$0	$10,921,770	$70,775,604
Health Insurance Buy-In Program	$212,695	$18,547	$157,102	$37,769	$0	$0	$0	$63,030	$10,566	$13,231	$8,200	$3,054	$524,194
Subtotal Insurance	**$37,956,823**	**$2,219,566**	**$19,942,035**	**$161,523**	**$0**	**$0**	**$0**	**$63,030**	**$10,566**	**$13,231**	**$8,200**	**$10,924,824**	**$71,299,798**
Service Management													
Single Entry Points	$8,671,602	$1,294,860	$6,568,161	$2,262	$0	$0	$0	$2,262	$0	$0	$0	$7,916	$16,547,063
Disease Management	$38,074	$13,320	$114,902	$52,228	$0	$0	$637	$80,668	$12,989	$9,537	$0	$0	$322,355
Prepaid Inpatient Health Plan Administration	$518,021	$113,193	$895,454	$617,504	$0	$0	$0	$2,912,859	$202,140	$81,570	$0	$0	$5,340,741
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$9,227,697**	**$1,421,373**	**$7,578,517**	**$671,994**	**$0**	**$0**	**$637**	**$2,995,789**	**$215,129**	**$91,107**	**$0**	**$7,916**	**$22,210,159**
Total Services	**$661,174,794**	**$86,716,831**	**$552,662,849**	**$199,668,593**	**$0**	**$0**	**$6,810,399**	**$316,297,596**	**$49,274,075**	**$41,115,637**	**$55,315,293**	**$13,360,009**	**$1,982,396,076**
Financing & Supplemental Payments													
Upper Payment Limit Financing	$9,224,466	$630,714	$2,207,655	$704,247	$0	$0	$0	$884,200	$100,025	$70,482	$38,570	$7,871	$13,868,231
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$0	$0	$1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1
Subtotal Financing & Supplemental Payments	**$9,224,466**	**$630,714**	**$2,207,656**	**$704,247**	**$0**	**$0**	**$0**	**$884,200**	**$100,025**	**$70,482**	**$38,570**	**$7,871**	**$13,868,232**
Grand Total	**$670,399,260**	**$87,347,546**	**$554,870,504**	**$200,372,841**	**$0**	**$0**	**$6,810,399**	**$317,181,796**	**$49,374,100**	**$41,186,119**	**$55,353,863**	**$13,367,880**	**$1,996,264,308**

Exhibit M

Cash-based Actuals													
FY 2004-05	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care													
Physician Services & EPSDT	$3,423,604	$3,193,975	$21,628,805	$32,599,653	$0	$0	$0	$43,820,013	$5,026,864	$8,927,565	$5,498,719	$142	$124,119,339
Emergency Transportation	$154,437	$125,096	$1,062,237	$761,877	$0	$0	$0	$1,030,699	$114,920	$115,808	$108,563	$104	$3,473,741
Non-emergency Medical Transportation	$65,695	$29,745	$90,757	$6,414	$0	$0	$0	$14,601	$5,811	$618	$60	$5	$213,706
Dental Services	$1,138,025	$185,567	$2,573,418	$3,009,041	$0	$0	$0	$29,245,153	$3,562,887	$266,892	$32,867	$0	$40,013,849
Family Planning	$0	$26	$4,351	$97,103	$0	$0	$0	$46,021	$29,939	$7,912	$669	$0	$186,021
Health Maintenance Organizations	$14,841,610	$10,000,351	$80,033,438	$22,355,311	$0	$0	$0	$34,237,510	($91,468)	$713,180	$0	$315	$162,090,246
Inpatient Hospitals	$12,100,223	$8,017,452	$58,771,508	$59,068,158	$0	$0	$0	$70,183,080	$4,604,884	$17,929,034	$35,337,108	$0	$266,011,447
Outpatient Hospitals	$2,308,115	$2,676,602	$22,949,379	$25,028,931	$0	$0	$0	$32,440,056	$3,875,487	$3,256,924	$1,082,574	$49	$93,618,116
Lab & X-Ray	$383,268	$393,747	$2,972,445	$6,616,645	$0	$0	$0	$3,692,266	$1,040,626	$2,080,982	$304,349	$427	$17,484,755
Durable Medical Equipment	$13,866,449	$2,344,377	$24,809,129	$1,387,625	$0	$0	$0	$4,463,726	$3,231,168	$84,778	$15,993	$96,006	$50,299,251
Prescription Drugs	$80,910,411	$14,897,365	$122,641,655	$21,534,152	$0	$0	$0	$24,054,575	$15,406,676	$1,297,940	$79,392	$108,732	$280,930,899
Drug Rebate	($25,860,524)	($3,853,558)	($33,644,073)	($2,532,799)	$0	$0	$0	($2,541,517)	($2,821,952)	($363,610)	($1,803)	($36,838)	($71,656,675)
Rural Health Centers	$49,536	$71,821	$593,992	$806,931	$0	$0	$0	$2,749,051	$172,803	$123,398	$30,392	$471	$4,598,395
Federally Qualified Health Centers	$554,197	$478,212	$3,082,202	$10,107,145	$0	$0	$0	$35,200,815	$1,398,913	$3,824,437	$2,198,858	$786	$56,845,564
Co-Insurance (Title XVIII-Medicare)	$8,401,158	$1,189,659	$5,961,109	$65,701	$0	$0	$0	$3,136	$3,446	$14,758	$0	$1,718,734	$17,357,700
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$2,490,090	$0	$0	$0	$0	$0	$2,490,090
Prepaid Inpatient Health Plan Services	$8,205,532	$3,161,532	$22,924,314	$9,831,589	$0	$0	$0	$18,756,993	$1,883,211	$3,711,132	$0	$0	$68,474,304
Other Medical Services	$3,767	$1,188	$10,643	$4,356	$0	$0	$60	$5,588	$1,058	$1,424	$1,325	$59	$29,468
Home Health	$13,643,727	$3,729,460	$49,395,318	$315,958	$0	$0	$0	$2,142,906	$5,260,733	$34,531	$7,192	$4,787	$74,534,611
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$134,189,229**	**$46,642,619**	**$385,860,624**	**$191,063,789**	**$0**	**$0**	**$2,490,150**	**$299,544,670**	**$42,706,006**	**$42,027,702**	**$44,696,256**	**$1,893,780**	**$1,191,114,826**
Community Based Long Term Care													
HCBS - Elderly, Blind, and Disabled	$63,998,370	$5,231,339	$24,985,616	$857	$0	$0	$0	$0	$0	$0	$0	$0	$94,216,182
HCBS - Mental Illness	$2,003,427	$1,267,654	$9,747,334	$891	$0	$0	$0	$0	$0	$0	$0	$157	$13,019,463
HCBS - Disabled Children	$242,689	$30,421	$195,393	$437	$0	$0	$0	$2,061	$10,913	$7	$0	$5	$481,927
HCBS - Persons Living with AIDS	$14,775	$480	$443,196	$0	$0	$0	$0	$0	$0	$0	$0	$0	$458,451
HCBS - Consumer Directed Attendant Support	$2,977,355	$373,212	$2,397,120	$5,362	$0	$0	$0	$25,291	$133,881	$90	$0	$61	$5,912,371
HCBS - Brain Injury	$5,499	$99,150	$9,119,694	$1,248	$0	$0	$0	$0	$0	$0	$0	$0	$9,225,591
HCBS - Children with Autism	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$119,147	$360,893	$9,569,473	$0	$0	$0	$0	$505,864	$3,516,516	$0	$0	$0	$14,071,893
Hospice	$17,144,015	$1,326,788	$4,807,057	$117,796	$0	$0	$0	$156,717	$4,293	$2,364	$0	$0	$23,559,031
Subtotal Community Based Long Term Care	**$86,505,276**	**$8,689,937**	**$61,264,884**	**$126,591**	**$0**	**$0**	**$0**	**$689,933**	**$3,665,603**	**$2,461**	**$0**	**$224**	**$160,944,908**
Long Term Care													
Class I Nursing Facilities	$342,142,204	$19,699,056	$61,974,535	$56,072	$0	$0	$0	$0	$0	$0	$0	$6,466	$423,878,333
Class II Nursing Facilities	$0	$0	$1,383,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,383,445
Program of All-Inclusive Care for the Elderly	$31,140,652	$2,557,598	$1,461,755	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,160,005
Subtotal Long Term Care	**$373,282,857**	**$22,256,654**	**$64,819,734**	**$56,072**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$6,466**	**$460,421,784**
Insurance													
Supplemental Medicare Insurance Benefit	$31,170,839	$1,817,703	$16,339,309	$102,202	$0	$0	$0	$0	$0	$0	$0	$9,019,700	$58,449,753
Health Insurance Buy-In Program	$246,429	$21,489	$182,018	$43,760	$0	$0	$0	$73,026	$12,242	$15,329	$9,501	$3,538	$607,332
Subtotal Insurance	**$31,417,268**	**$1,839,192**	**$16,521,327**	**$145,961**	**$0**	**$0**	**$0**	**$73,026**	**$12,242**	**$15,329**	**$9,501**	**$9,023,238**	**$59,057,085**
Service Management													
Single Entry Points	$9,077,168	$1,312,201	$6,855,305	$4,865	$0	$0	$0	$1,216	$0	$0	$0	$6,081	$17,256,835
Disease Management	$26,163	$8,253	$73,925	$30,257	$0	$0	$420	$38,813	$7,351	$9,889	$9,202	$408	$204,682
Prepaid Inpatient Health Plan Administration	$373,290	$76,345	$697,995	$487,706	$0	$0	$0	$2,458,050	$114,363	$77,587	$22	$88	$4,285,446
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$9,476,621**	**$1,396,799**	**$7,627,226**	**$522,827**	**$0**	**$0**	**$420**	**$2,498,080**	**$121,714**	**$87,476**	**$9,224**	**$6,576**	**$21,746,963**
Total Services	**$634,871,251**	**$80,825,201**	**$536,093,795**	**$191,915,241**	**$0**	**$0**	**$2,490,571**	**$302,805,710**	**$46,505,565**	**$42,132,968**	**$44,714,981**	**$10,930,284**	**$1,893,285,567**
Financing & Supplemental Payments													
Upper Payment Limit Financing	$18,097,381	$1,175,615	$4,461,893	$1,317,963	$0	$0	$0	$1,704,397	$203,618	$171,118	$56,878	$342	$27,189,205
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$22,384	$2,850	$18,902	$6,767	$0	$0	$88	$10,676	$1,640	$1,486	$1,577	$385	$66,754
Subtotal Financing & Supplemental Payments	**$18,119,765**	**$1,178,464**	**$4,480,795**	**$1,324,730**	**$0**	**$0**	**$88**	**$1,715,073**	**$205,257**	**$172,604**	**$58,455**	**$728**	**$27,255,959**
Grand Total	**$652,991,016**	**$82,003,665**	**$540,574,590**	**$193,239,971**	**$0**	**$0**	**$2,490,659**	**$304,520,783**	**$46,710,822**	**$42,305,572**	**$44,773,436**	**$10,931,012**	**$1,920,541,525**

Cash-based Actuals													
FY 2003-04	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care													
Physician Services & EPSDT	$3,871,515	$3,520,279	$25,923,882	$34,967,666	$0	$0	$0	$23,226,514	$5,500,090	$17,403,246	$8,213,373	$47,103	$122,673,666
Emergency Transportation	$589,405	$218,872	$1,669,140	$782,002	$0	$0	$0	$1,178,072	$149,707	$153,433	$111,945	$0	$4,852,575
Non-emergency Medical Transportation	$806,566	$278,282	$1,243,917	$36,470	$0	$0	$0	$107,240	$143,175	$700	$0	$0	$2,616,352
Dental Services	$2,390,281	$413,398	$5,498,742	$2,990,555	$0	$0	$0	$24,329,953	$3,166,313	$364,666	$31,047	$4,502	$39,189,457
Family Planning	$0	$0	$6,041	$120,575	$0	$0	$0	$32,419	$22,427	$21,222	$1,861	$0	$204,545
Health Maintenance Organizations	$15,369,265	$11,545,880	$99,362,574	$26,008,450	$0	$0	$0	$44,430,797	$545,391	$635,781	$0	$0	$197,898,138
Inpatient Hospitals	$11,297,635	$8,477,930	$60,780,794	$54,483,931	$0	$0	$0	$69,238,974	$5,735,633	$21,617,641	$41,614,823	$0	$273,247,361
Outpatient Hospitals	$2,086,806	$2,521,476	$23,163,401	$22,844,361	$0	$0	$0	$28,358,793	$3,449,321	$5,301,550	$1,321,484	$0	$89,047,191
Lab & X-Ray	$343,381	$364,374	$3,137,799	$5,956,882	$0	$0	$0	$1,691,656	$943,094	$4,523,890	$264,248	$0	$17,225,324
Durable Medical Equipment	$15,032,626	$2,282,023	$25,537,628	$1,166,432	$0	$0	$0	$1,968,676	$3,103,265	$107,680	$13,259	$33,928	$49,245,516
Prescription Drugs	$79,379,246	$13,536,350	$124,035,077	$19,634,829	$0	$0	$0	$12,605,392	$14,335,007	$2,117,560	$86,425	$67,788	$265,797,673
Drug Rebate	($19,302,428)	($2,876,315)	($25,112,109)	($1,890,494)	$0	$0	$0	($1,897,002)	($2,106,320)	($271,400)	($1,346)	($27,496)	($53,484,910)
Rural Health Centers	$26,246	$76,640	$497,819	$772,756	$0	$0	$0	$2,262,303	$163,086	$83,294	$27,166	$0	$3,909,310
Federally Qualified Health Centers	$640,225	$522,098	$4,107,835	$12,142,028	$0	$0	$0	$17,649,180	$1,856,885	$11,045,830	$3,434,383	$434	$51,398,899
Co-Insurance (Title XVIII-Medicare)	$9,322,772	$1,280,424	$6,604,447	$21,924	$0	$0	$0	$2,475	$2,777	$8,276	$0	$1,962,635	$19,205,728
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$2,668,652	$0	$0	$0	$0	$0	$2,668,652
Prepaid Inpatient Health Plan Services	$2,310,425	$922,019	$6,720,440	$2,493,384	$0	$0	$0	$3,674,896	$320,084	$794,356	$0	$0	$17,235,604
Other Medical Services	$12,866	$4,059	$36,353	$14,879	$0	$0	$207	$19,087	$3,615	$4,863	$4,525	$201	$100,654
Home Health	$11,572,193	$3,031,991	$49,085,659	$278,805	$0	$0	$0	$863,860	$4,836,114	$22,643	$5,790	$0	$69,697,057
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$135,749,025**	**$46,119,779**	**$412,299,443**	**$182,825,434**	**$0**	**$0**	**$2,668,859**	**$229,743,284**	**$42,169,663**	**$63,935,230**	**$55,128,983**	**$2,089,094**	**$1,172,728,792**
Community Based Long Term Care													
HCBS - Elderly, Blind, and Disabled	$64,355,491	$5,260,531	$25,125,040	$861	$0	$0	$0	$0	$0	$0	$0	$0	$94,741,923
HCBS - Mental Illness	$2,440,729	$1,455,627	$11,134,445	$0	$0	$0	$0	$0	$145	$0	$0	$0	$15,030,947
HCBS - Disabled Children	$184,675	$20,711	$145,817	$378	$0	$0	$0	$479	$6,830	$0	$0	$0	$358,891
HCBS - Persons Living with AIDS	$16,669	$5,220	$540,329	$0	$0	$0	$0	$0	$0	$0	$0	$0	$562,218
HCBS - Consumer Directed Attendant Support	$1,577,022	$176,863	$1,245,201	$3,231	$0	$0	$0	$4,088	$58,327	$0	$0	$1	$3,064,733
HCBS - Brain Injury	$11,970	$46,893	$8,906,818	$0	$0	$0	$0	$0	$27,116	$0	$0	$0	$8,992,797
HCBS - Children with Autism	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$75,531	$315,738	$9,645,058	$0	$0	$0	$0	$190,788	$2,949,031	$0	$0	$0	$13,176,147
Hospice	$17,064,571	$1,016,913	$4,530,283	$163,150	$0	$0	$0	$18,029	$2,715	$0	$0	$0	$22,795,661
Subtotal Community Based Long Term Care	**$85,726,658**	**$8,298,496**	**$61,272,991**	**$167,620**	**$0**	**$0**	**$0**	**$213,385**	**$3,044,165**	**$0**	**$0**	**$1**	**$158,723,316**
Long Term Care													
Class I Nursing Facilities	$336,650,323	$16,720,841	$62,600,540	$12,286	$0	$0	$0	$0	$0	$0	$0	$27,022	$416,011,012
Class II Nursing Facilities	$0	$0	$1,104,554	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,104,554
Program of All-Inclusive Care for the Elderly	$24,097,092	$1,864,579	$1,067,498	$0	$0	$0	$0	$0	$0	$0	$0	$0	$27,029,169
Subtotal Long Term Care	**$360,747,415**	**$18,585,420**	**$64,772,592**	**$12,286**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$27,022**	**$444,144,736**
Insurance													
Supplemental Medicare Insurance Benefit	$25,391,796	$1,480,703	$13,310,017	$83,254	$0	$0	$0	$0	$0	$0	$0	$7,347,457	$47,613,226
Health Insurance Buy-In Program	$280,042	$24,420	$206,845	$49,728	$0	$0	$0	$82,987	$13,912	$17,420	$10,796	$4,021	$690,172
Subtotal Insurance	**$25,671,838**	**$1,505,123**	**$13,516,862**	**$132,982**	**$0**	**$0**	**$0**	**$82,987**	**$13,912**	**$17,420**	**$10,796**	**$7,351,477**	**$48,303,398**
Service Management													
Single Entry Points	$7,810,601	$1,041,413	$5,676,359	$1,094	$0	$0	$0	$0	$1,094	$0	$0	$0	$14,530,561
Disease Management	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$347,815	$66,518	$562,748	$369,742	$0	$0	$0	$1,829,096	$76,791	$55,410	$0	$0	$3,308,119
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$8,158,415**	**$1,107,932**	**$6,239,107**	**$370,836**	**$0**	**$0**	**$0**	**$1,829,096**	**$77,885**	**$55,410**	**$0**	**$0**	**$17,838,681**
Total Services	**$616,053,351**	**$75,616,749**	**$558,100,995**	**$183,509,158**	**$0**	**$0**	**$2,668,859**	**$231,868,751**	**$45,305,624**	**$64,008,060**	**$55,139,779**	**$9,467,595**	**$1,841,738,922**
Financing & Supplemental Payments													
Upper Payment Limit Financing	$18,054,683	$1,025,615	$4,571,216	$1,218,259	$0	$0	$0	$1,511,523	$183,849	$282,573	$70,435	$1,440	$26,919,593
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$30,679	$3,766	$27,793	$9,138	$0	$0	$133	$11,547	$2,256	$3,188	$2,746	$471	$91,716
Subtotal Financing & Supplemental Payments	**$18,085,361**	**$1,029,381**	**$4,599,009**	**$1,227,397**	**$0**	**$0**	**$133**	**$1,523,070**	**$186,105**	**$285,760**	**$73,181**	**$1,912**	**$27,011,308**
Grand Total	**$634,138,712**	**$76,646,130**	**$562,700,004**	**$184,736,556**	**$0**	**$0**	**$2,668,992**	**$233,391,821**	**$45,491,729**	**$64,293,820**	**$55,212,960**	**$9,469,507**	**$1,868,750,230**

Exhibit N - Expenditure History by Service Category

ACUTE CARE	FY 2010-11	Percent Change from Prior Year	FY 2009-10	Percent Change From Prior Year	FY 2008-09	Percent Change From Prior Year	FY 2007-08	Percent Change From Prior Year	FY 2006-07	Percent Change From Prior Year	FY 2005-06	Percent Change From Prior Year	FY 2004-05	Percent Change From Prior Year	FY 2003-04
Physician Services & EPSDT	$282,592,042	16.33%	$242,929,414	4.30%	$232,912,692	22.16%	$190,663,827	16.09%	$164,232,428	13.84%	$144,266,423	16.23%	$124,119,339	1.18%	$122,673,666
Emergency Transportation	$6,236,250	19.52%	$5,217,633	5.75%	$4,934,082	8.43%	$4,550,505	6.21%	$4,284,622	18.64%	$3,611,441	3.96%	$3,473,741	-28.41%	$4,852,575
Non-Emergency Medical Transportation	$10,469,107	14.65%	$9,131,655	5.09%	$8,689,018	12.35%	$7,733,949	-12832.88%	($60,740)	444.07%	($11,164)	-105.22%	$213,706	-91.83%	$2,616,352
Dental Services	$108,570,692	22.25%	$88,806,857	16.15%	$76,456,424	41.86%	$53,893,890	9.17%	$49,367,133	5.70%	$46,705,514	16.72%	$40,013,849	2.10%	$39,189,457
Family Planning	$441,414	37.10%	$321,975	0.80%	$319,424	58.07%	$202,073	996.27%	$18,433	-95.49%	$409,119	119.93%	$186,021	-9.06%	$204,545
Health Maintenance Organizations	$117,488,456	-0.14%	$117,651,717	-8.85%	$129,074,827	26.28%	$102,216,877	-5.73%	$108,429,033	-29.95%	$154,782,191	-4.51%	$162,090,246	-18.09%	$197,898,138
Inpatient Hospitals	$371,861,948	10.23%	$337,358,448	-5.39%	$356,576,636	11.12%	$320,899,293	5.32%	$304,687,402	2.66%	$296,800,124	11.57%	$266,011,447	-2.65%	$273,247,361
Outpatient Hospitals	$217,492,911	50.04%	$144,956,141	-5.81%	$153,901,754	18.21%	$130,192,196	12.46%	$115,767,273	10.03%	$105,213,743	12.39%	$93,618,116	5.13%	$89,047,191
Lab & X-Ray	$37,862,120	25.59%	$30,148,317	6.01%	$28,437,823	24.87%	$22,774,240	11.38%	$20,447,143	6.22%	$19,250,037	10.10%	$17,484,755	1.51%	$17,225,324
Durable Medical Equipment	$90,627,945	15.78%	$78,272,962	1.64%	$77,011,816	1.58%	$75,815,972	13.46%	$66,822,166	13.93%	$58,652,169	16.61%	$50,299,251	2.14%	$49,245,516
Prescription Drugs	$281,278,949	24.40%	$226,114,086	-3.23%	$233,666,309	7.75%	$216,864,136	14.24%	$189,833,449	-19.88%	$236,947,825	-15.66%	$280,930,899	5.69%	$265,797,673
Drug Rebate	($126,909,710)	27.09%	($99,855,328)	8.75%	($91,818,104)	65.54%	($55,465,088)	-5.42%	($58,644,804)	-25.83%	($79,068,617)	10.34%	($71,656,675)	33.98%	($53,484,910)
Rural Health Centers	$10,188,005	27.45%	$7,993,821	7.18%	$7,458,484	19.47%	$6,242,784	6.16%	$5,880,402	23.76%	$4,751,330	3.33%	$4,598,395	17.63%	$3,909,310
Federally Qualified Health Centers	$90,306,523	18.44%	$76,244,360	4.32%	$73,089,013	16.72%	$62,621,473	6.21%	$58,960,102	-4.84%	$61,957,718	8.99%	$56,845,564	10.60%	$51,398,899
Co-Insurance (Title XVIII-Medicare	$36,387,414	74.50%	$20,852,175	-25.79%	$28,098,389	24.84%	$22,507,668	18.61%	$18,976,405	5.88%	$17,922,444	3.25%	$17,357,700	-9.62%	$19,205,728
Breast and Cervical Cancer Treatment Program	$10,106,643	15.95%	$8,716,269	23.77%	$7,042,030	-0.65%	$7,088,411	27.61%	$5,554,934	-18.41%	$6,808,264	173.41%	$2,490,090	-6.69%	$2,668,652
Prepaid Inpatient Health Plan Services	$50,849,494	13.75%	$44,703,819	24.21%	$35,989,196	6.85%	$33,682,305	7.66%	$31,285,316	-5.16%	$32,987,230	-51.83%	$68,474,304	297.28%	$17,235,604
Other Medical Services	$14,158	-71.19%	$49,140	4.67%	$46,946	38.53%	$33,888	26.75%	$26,736	-10.59%	$29,903	1.48%	$29,468	-70.72%	$100,654
Home Health	$172,633,768	10.35%	$156,448,421	6.19%	$147,328,138	13.58%	$129,715,198	18.30%	$109,647,063	18.89%	$92,227,451	23.74%	$74,534,611	6.94%	$69,697,057
Presumptive Eligibility	$0	0.00%	$0	0.00%	$0	-100.00%	$3,770,690	-51.96%	$7,849,344	196.81%	$2,644,540	0.00%	$0	0.00%	$0
Subtotal of Acute Care	**$1,768,498,130**	**18.21%**	**$1,496,061,883**	**-0.87%**	**$1,509,214,896**	**12.96%**	**$1,336,004,286**	**11.02%**	**$1,203,363,838**	**-0.29%**	**$1,206,887,685**	**1.32%**	**$1,191,114,826**	**1.57%**	**$1,172,728,792**
COMMUNITY BASED LONG TERM CARE															
HCBS - Elderly, Blind, and Disabled	$212,196,143	13.82%	$186,426,075	5.63%	$176,481,671	24.96%	$141,231,844	14.20%	$123,673,036	15.28%	$107,276,565	13.86%	$94,216,182	-0.55%	$94,741,923
HCBS - Mental Illness	$24,946,790	9.99%	$22,681,360	-1.21%	$22,958,866	12.49%	$20,409,887	18.34%	$17,246,320	15.10%	$14,984,173	15.09%	$13,019,463	-13.38%	$15,030,947
HCBS - Disabled Children	$1,965,004	11.44%	$1,763,210	0.89%	$1,747,683	29.09%	$1,353,847	49.62%	$904,883	36.73%	$661,823	37.33%	$481,927	34.28%	$358,891
HCBS - Persons Living with AIDS	$567,535	-2.39%	$581,405	-1.91%	$592,744	-0.45%	$595,406	18.25%	$503,530	6.50%	$472,783	3.13%	$458,451	-18.46%	$562,218
HCBS - Consumer Directed Attendant Support	$2,961,259	-15.80%	$3,516,917	-14.76%	$4,125,973	-70.76%	$14,109,819	12.16%	$12,580,285	73.81%	$7,237,889	22.42%	$5,912,371	92.92%	$3,064,733
HCBS - Brain Injury	$12,297,265	7.10%	$11,482,073	-4.54%	$12,028,236	11.52%	$10,785,587	-2.94%	$11,112,528	26.08%	$8,813,686	-4.46%	$9,225,591	2.59%	$8,992,797
HCBS - Children with Autism	$1,357,612	-13.29%	$1,565,700	21.00%	$1,293,932	86.02%	$695,586	3599.64%	$18,801	0.00%	$0	0.00%	$0	0.00%	$0
HCBS - Pediatric Hospice	$126,702	33.68%	$94,781	223.36%	$29,312	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Private Duty Nursing	$27,761,694	19.50%	$23,230,817	8.80%	$21,351,408	8.11%	$19,749,262	14.16%	$17,299,756	10.78%	$15,616,760	10.98%	$14,071,893	6.80%	$13,176,147
Hospice	$39,862,966	-7.98%	$43,321,496	8.57%	$39,902,873	21.62%	$32,810,776	3.22%	$31,787,348	11.51%	$28,507,087	21.00%	$23,559,031	3.35%	$22,795,661
Subtotal of Community Based Long Term Care	**$324,042,970**	**9.97%**	**$294,663,833**	**5.04%**	**$280,512,697**	**16.04%**	**$241,742,014**	**12.37%**	**$215,126,488**	**17.19%**	**$183,570,766**	**14.06%**	**$160,944,908**	**1.40%**	**$158,723,316**
LONG TERM CARE and INSURANCE															
Class I Nursing Facilities	$508,141,849	4.33%	$487,074,333	-8.26%	$530,918,672	9.11%	$486,568,498	1.73%	$478,303,487	4.77%	$456,520,328	7.70%	$423,878,333	1.89%	$416,011,012
Class II Nursing Facilities	$2,362,706	17.21%	$2,015,835	-11.26%	$2,271,714	1.61%	$2,235,636	-1.52%	$2,270,136	57.99%	$1,436,850	3.86%	$1,383,445	25.25%	$1,104,554
Program of All-Inclusive Care for the Elderly	$84,429,683	21.94%	$69,240,623	13.42%	$61,049,836	23.54%	$49,418,855	15.27%	$42,872,281	5.93%	$40,470,490	15.10%	$35,160,005	30.08%	$27,029,169
Supplemental Medicare Insurance Benefi	$119,543,734	15.98%	$103,068,590	9.95%	$93,743,114	13.67%	$82,465,946	-0.29%	$82,706,881	16.86%	$70,775,604	21.09%	$58,449,753	22.76%	$47,613,226
Health Insurance Buy-In Program	$1,124,996	20.75%	$931,637	-1.12%	$942,145	4.11%	$904,947	21.90%	$742,352	41.62%	$524,194	-13.69%	$607,332	-12.00%	$690,172
Subtotal of Long Term Care and Insurance	**$715,602,968**	**8.04%**	**$662,331,019**	**-3.86%**	**$688,925,481**	**10.83%**	**$621,593,882**	**2.42%**	**$606,895,137**	**6.52%**	**$569,727,466**	**9.67%**	**$519,478,869**	**5.49%**	**$492,448,133**
SERVICE MANAGEMENT															
Single Entry Points	$24,021,660	1.32%	$23,707,551	2.78%	$23,067,175	6.02%	$21,757,100	20.86%	$18,002,536	8.80%	$16,547,063	-4.11%	$17,256,835	18.76%	$14,530,561
Disease Management	$0	-100.00%	$71,616	-97.52%	$2,882,271	23.66%	$2,330,726	443.29%	$428,999	33.08%	$322,355	57.49%	$204,682	0.00%	$0
Prepaid Inpatient Health Plan Administration	$6,475,244	26.67%	$5,111,753	29.90%	$3,935,134	9.02%	$3,609,472	-21.88%	$4,620,417	-13.49%	$5,340,741	24.63%	$4,285,446	29.54%	$3,308,119
Subtotal Service Management	**$31,384,315**	**8.63%**	**$28,890,920**	**-3.32%**	**$29,884,581**	**7.90%**	**$27,697,298**	**20.15%**	**$23,051,952**	**3.79%**	**$22,210,159**	**2.13%**	**$21,746,963**	**21.91%**	**$17,838,681**
Total Services	**$2,839,528,383**	**14.41%**	**$2,481,947,656**	**-1.06%**	**$2,508,537,655**	**12.64%**	**$2,227,037,481**	**8.72%**	**$2,048,437,415**	**3.33%**	**$1,982,396,076**	**4.71%**	**$1,893,285,567**	**2.80%**	**$1,841,738,922**
Financing & Supplemental Payments															
Upper Payment Limit Financing	$16,446,173	-8.31%	$17,936,927	-2.62%	$18,419,432	54.11%	$11,952,096	-7.77%	$12,959,393	-6.55%	$13,868,231	-48.99%	$27,189,205	1.00%	$26,919,593
Hospital Supplemental Payments	$455,348,284	45.73%	$312,468,739	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Nursing Facility Supplemental Payments	$76,315,634	60.83%	$47,451,412	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Physician Supplemental Payments	$2,715,842	-81.28%	$14,504,498	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Outstationing Payments	$5,283,594	50.09%	$3,520,254	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Accounting Adjustments	($10,239)	-40.70%	($17,268)	-150.26%	$34,355	-67.84%	$106,828	0.00%	$0	-100.00%	$1	-100.00%	$66,754	-27.22%	$91,716
Subtotal Financing & Supplemental Payments	**$556,099,288**	**40.48%**	**$395,864,563**	**2045.17%**	**$18,453,787**	**53.03%**	**$12,058,924**	**-6.95%**	**$12,959,393**	**-6.55%**	**$13,868,232**	**-49.12%**	**$27,255,959**	**0.91%**	**$27,011,308**
Grand Total	**$3,395,627,671**	**17.99%**	**$2,877,812,218**	**13.88%**	**$2,526,991,443**	**12.86%**	**$2,239,096,405**	**8.62%**	**$2,061,396,808**	**3.26%**	**$1,996,264,308**	**3.94%**	**$1,920,541,525**	**2.77%**	**$1,868,750,230**

Exhibit N - Expenditure History by Service Category - Delay Adjusted

ACUTE CARE	FY 2010-11 (DA)	Percent Change from Prior Year	FY 2009-10 (DA)	Percent Change From Prior Year	FY 2008-09	Percent Change From Prior Year	FY 2007-08	Percent Change From Prior Year	FY 2006-07	Percent Change From Prior Year	FY 2005-06	Percent Change From Prior Year	FY 2004-05	Percent Change From Prior Year	FY 2003-04
Physician Services & EPSDT	$273,385,005	8.43%	$252,136,452	8.25%	$232,912,692	22.16%	$190,663,827	16.09%	$164,232,428	13.84%	$144,266,423	16.23%	$124,119,339	1.18%	$122,673,666
Emergency Transportation	$6,024,130	10.95%	$5,429,754	10.05%	$4,934,082	8.43%	$4,550,505	6.21%	$4,284,622	18.64%	$3,611,441	3.96%	$3,473,741	-28.41%	$4,852,575
Non-emergency Medical Transportation	$10,363,372	12.19%	$9,237,390	6.31%	$8,689,018	12.35%	$7,733,949	-12832.88%	($60,740)	444.07%	($11,164)	-105.22%	$213,706	-91.83%	$2,616,352
Dental Services	$104,818,977	13.25%	$92,558,572	21.06%	$76,456,424	41.86%	$53,893,890	9.17%	$49,367,133	5.70%	$46,705,514	16.72%	$40,013,849	2.10%	$39,189,457
Family Planning	$428,473	27.93%	$334,916	4.85%	$319,424	58.07%	$202,073	996.27%	$18,433	-95.49%	$409,119	119.93%	$186,021	-9.06%	$204,545
Health Maintenance Organizations	$117,488,424	-0.14%	$117,651,750	-8.85%	$129,074,827	26.28%	$102,216,877	-5.73%	$108,429,033	-29.95%	$154,782,191	-4.51%	$162,090,246	-18.09%	$197,898,138
Inpatient Hospitals	$357,410,898	1.59%	$351,809,498	-1.34%	$356,576,636	11.12%	$320,899,293	5.32%	$304,687,402	2.66%	$296,800,124	11.57%	$266,011,447	-2.65%	$273,247,361
Outpatient Hospitals	$209,791,226	37.43%	$152,657,826	-0.81%	$153,901,754	18.21%	$130,192,196	12.46%	$115,767,273	10.03%	$105,213,743	12.39%	$93,618,116	5.13%	$89,047,191
Lab & X-Ray	$36,581,144	16.39%	$31,429,294	10.52%	$28,437,823	24.87%	$22,774,240	11.38%	$20,447,143	6.22%	$19,250,037	10.10%	$17,484,755	1.51%	$17,225,324
Durable Medical Equipment	$87,745,314	8.12%	$81,155,593	5.38%	$77,011,816	1.58%	$75,815,972	13.46%	$66,822,166	13.93%	$58,652,169	16.61%	$50,299,251	2.14%	$49,245,516
Prescription Drugs	$272,469,874	15.98%	$234,923,161	0.54%	$233,666,309	7.75%	$216,864,136	14.24%	$189,833,449	-19.88%	$236,947,825	-15.66%	$280,930,899	5.69%	$265,797,673
Drug Rebate	($126,909,710)	27.09%	($99,855,328)	8.75%	($91,818,104)	65.54%	($55,465,088)	-5.42%	($58,644,804)	-25.83%	($79,068,617)	10.34%	($71,656,675)	33.98%	($53,484,910)
Rural Health Centers	$9,887,646	19.21%	$8,294,180	11.20%	$7,458,484	19.47%	$6,242,784	6.16%	$5,880,402	23.76%	$4,751,330	3.33%	$4,598,395	17.63%	$3,909,310
Federally Qualified Health Centers	$87,530,065	10.77%	$79,020,818	8.12%	$73,089,013	16.72%	$62,621,473	6.21%	$58,960,102	-4.84%	$61,957,718	8.99%	$56,845,564	10.60%	$51,398,899
Co-Insurance (Title XVIII-Medicare	$35,043,547	57.88%	$22,196,042	-21.01%	$28,098,389	24.84%	$22,507,668	18.61%	$18,976,405	5.88%	$17,922,444	3.25%	$17,357,700	-9.62%	$19,205,728
Breast and Cervical Cancer Treatment Program	$9,817,118	9.01%	$9,005,795	27.89%	$7,042,030	-0.65%	$7,088,411	27.61%	$5,554,934	-18.41%	$6,808,264	173.41%	$2,490,090	-6.69%	$2,668,652
Prepaid Inpatient Health Plan Services	$50,849,494	13.75%	$44,703,819	24.21%	$35,989,196	6.85%	$33,682,305	7.66%	$31,285,316	-5.16%	$32,987,230	-51.83%	$68,474,304	297.28%	$17,235,604
Other Medical Services	$14,158	-71.19%	$49,140	4.67%	$46,946	38.53%	$33,888	26.75%	$26,736	-10.59%	$29,903	1.48%	$29,468	-70.72%	$100,654
Home Health	$168,682,120	5.16%	$160,400,069	8.87%	$147,328,138	13.58%	$129,715,198	18.30%	$109,647,063	18.89%	$92,227,451	23.74%	$74,534,611	6.94%	$69,697,057
Presumptive Eligibility	$0	0.00%	$0	0.00%	$0	-100.00%	$3,770,690	-51.96%	$7,849,344	196.81%	$2,644,540	0.00%	$0	0.00%	$0
Subtotal of Acute Care	**$1,711,421,275**	**10.19%**	**$1,553,138,739**	**2.91%**	**$1,509,214,896**	**12.96%**	**$1,336,004,286**	**11.02%**	**$1,203,363,838**	**-0.29%**	**$1,206,887,685**	**1.32%**	**$1,191,114,826**	**1.57%**	**$1,172,728,792**
COMMUNITY BASED LONG TERM CARE															
HCBS - Elderly, Blind, and Disabled	$208,526,316	9.70%	$190,095,902	7.71%	$176,481,671	24.96%	$141,231,844	14.20%	$123,673,036	15.28%	$107,276,565	13.86%	$94,216,182	-0.55%	$94,741,923
HCBS - Mental Illness	$24,587,535	6.71%	$23,040,614	0.36%	$22,958,866	12.49%	$20,409,887	18.34%	$17,246,320	15.10%	$14,984,173	15.09%	$13,019,463	-13.38%	$15,030,947
HCBS - Disabled Children	$1,887,201	2.51%	$1,841,013	5.34%	$1,747,683	29.09%	$1,353,847	49.62%	$904,883	36.73%	$661,823	37.33%	$481,927	34.28%	$358,891
HCBS - Persons Living with AIDS	$550,397	-8.04%	$598,542	0.98%	$592,744	-0.45%	$595,406	18.25%	$503,530	6.50%	$472,783	3.13%	$458,451	-18.46%	$562,218
HCBS - Consumer Directed Attendant Support	$2,961,259	-15.80%	$3,516,917	-14.76%	$4,125,973	-70.76%	$14,109,819	12.16%	$12,580,285	73.81%	$7,237,889	22.42%	$5,912,371	92.92%	$3,064,733
HCBS - Brain Injury	$12,182,916	5.06%	$11,596,421	-3.59%	$12,028,236	11.52%	$10,785,587	-2.94%	$11,112,528	26.08%	$8,813,686	-4.46%	$9,225,591	2.59%	$8,992,797
HCBS - Children with Autism	$1,328,577	-16.69%	$1,594,735	23.25%	$1,293,932	86.02%	$695,586	3599.64%	$18,801	0.00%	$0	0.00%	$0	0.00%	$0
HCBS - Pediatric Hospice	$119,273	16.69%	$102,210	248.70%	$29,312	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Private Duty Nursing	$27,325,957	15.46%	$23,666,555	10.84%	$21,351,408	8.11%	$19,749,262	14.16%	$17,299,756	10.78%	$15,616,760	10.98%	$14,071,893	6.80%	$13,176,147
Hospice	$39,547,635	-9.37%	$43,636,826	9.36%	$39,902,873	21.62%	$32,810,776	3.22%	$31,787,348	11.51%	$28,507,087	21.00%	$23,559,031	3.35%	$22,795,661
Subtotal of Community Based Long Term Care	**$319,017,067**	**6.45%**	**$299,689,736**	**6.84%**	**$280,512,697**	**16.04%**	**$241,742,014**	**12.37%**	**$215,126,488**	**17.19%**	**$183,570,766**	**14.06%**	**$160,944,908**	**1.40%**	**$158,723,316**
LONG TERM CARE and INSURANCE															
Class I Nursing Facilities	$499,315,391	0.69%	$495,900,792	-6.60%	$530,918,672	9.11%	$486,568,498	1.73%	$478,303,487	4.77%	$456,520,328	7.70%	$423,878,333	1.89%	$416,011,012
Class II Nursing Facilities	$3,163,194	160.27%	$1,215,347	-46.50%	$2,271,714	1.61%	$2,235,636	-1.52%	$2,270,136	57.99%	$1,436,850	3.86%	$1,383,445	25.25%	$1,104,554
Program of All-Inclusive Care for the Elderly	$84,414,277	21.89%	$69,256,028	13.44%	$61,049,836	23.54%	$49,418,855	15.27%	$42,872,281	5.93%	$40,470,490	15.10%	$35,160,005	30.08%	$27,029,169
Supplemental Medicare Insurance Benefit	$119,543,734	15.98%	$103,068,590	9.95%	$93,743,114	13.67%	$82,465,946	-0.29%	$82,706,881	16.86%	$70,775,604	21.09%	$58,449,753	22.76%	$47,613,226
Health Insurance Buy-In Program	$1,036,644	1.63%	$1,019,989	8.26%	$942,145	4.11%	$904,947	21.90%	$742,352	41.62%	$524,194	-13.69%	$607,332	-12.00%	$690,172
Subtotal of Long Term Care and Insurance	**$707,473,240**	**5.52%**	**$670,460,746**	**-2.68%**	**$688,925,481**	**10.83%**	**$621,593,882**	**2.42%**	**$606,895,137**	**6.52%**	**$569,727,466**	**9.67%**	**$519,478,869**	**5.49%**	**$492,448,133**
SERVICE MANAGEMENT															
Single Entry Points	$24,021,660	1.32%	$23,707,551	2.78%	$23,067,175	6.02%	$21,757,100	20.86%	$18,002,536	8.80%	$16,547,063	-4.11%	$17,256,835	18.76%	$14,530,561
Disease Management	$0	-100.00%	$71,616	-97.52%	$2,882,271	23.66%	$2,330,726	443.29%	$428,999	33.08%	$322,355	57.49%	$204,682	0.00%	$0
Prepaid Inpatient Health Plan Administration	$6,475,244	26.67%	$5,111,753	29.90%	$3,935,134	9.02%	$3,609,472	-21.88%	$4,620,417	-13.49%	$5,340,741	24.63%	$4,285,446	29.54%	$3,308,119
Subtotal Service Management	**$31,384,315**	**8.63%**	**$28,890,920**	**-3.32%**	**$29,884,581**	**7.90%**	**$27,697,298**	**20.15%**	**$23,051,952**	**3.79%**	**$22,210,159**	**2.13%**	**$21,746,963**	**21.91%**	**$17,838,681**
Total Services	**$2,769,295,897**	**8.51%**	**$2,552,180,141**	**1.74%**	**$2,508,537,655**	**12.64%**	**$2,227,037,481**	**8.72%**	**$2,048,437,415**	**3.33%**	**$1,982,396,076**	**4.71%**	**$1,893,285,567**	**2.80%**	**$1,841,738,922**
Financing & Supplemental Payments															
Upper Payment Limit Financing	$16,446,173	-8.31%	$17,936,927	-2.62%	$18,419,432	54.11%	$11,952,096	-7.77%	$12,959,393	-6.55%	$13,868,231	-48.99%	$27,189,205	1.00%	$26,919,593
Hospital Supplemental Payments	$455,348,284	45.73%	$312,468,739	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Nursing Facility Supplemental Payments	$76,315,634	60.83%	$47,451,412	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Physician Supplemental Payments	$2,715,842	-81.28%	$14,504,498	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Outstationing Payments	$5,283,594	50.09%	$3,520,254	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Accounting Adjustments	($10,239)	-40.70%	($17,268)	-150.26%	$34,355	-67.84%	$106,828	0.00%	$0	-100.00%	$1	-100.00%	$66,754	-27.22%	$91,716
Subtotal Financing & Supplemental Payments	**$556,099,288**	**40.48%**	**$395,864,563**	**2045.17%**	**$18,453,787**	**53.03%**	**$12,058,924**	**-6.95%**	**$12,959,393**	**-6.55%**	**$13,868,232**	**-49.12%**	**$27,255,959**	**0.91%**	**$27,011,308**
Grand Total	**$3,325,395,185**	**12.80%**	**$2,948,044,704**	**16.66%**	**$2,526,991,443**	**12.86%**	**$2,239,096,405**	**8.62%**	**$2,061,396,808**	**3.26%**	**$1,996,264,308**	**3.94%**	**$1,920,541,525**	**2.77%**	**$1,868,750,230**

"(DA)": "Delay Adjusted" -- indicates actuals have been adjusted for the FY 2009-10 provider payment delay.

Exhibit O
Appropriations and Expenditures

Final FY 2010-11 Funding Splits						
	Total Funds	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
HB 10-1376 FY 2010-11 Long Bill	$3,158,315,617	$814,622,298	$161,444,485	$250,622,514	$3,122,188	$1,928,504,132
SB 11-139 FY 2010-11 Supplemental Bill	$0	($51,000,000)	$0	$51,000,000	$0	$0
SB 11-209 FY 2011-12 Long Bill Add-ons	$237,436,847	($54,936,909)	$117,900,000	$97,223,834	($180,916)	$77,430,838
HB 10-1005 Telemedicine Changes	$123,270	$0	$0	$47,348	$0	$75,922
HB 10-1033 Add Screening, Brief Intervention, and Referral to Treatment to Optional Services	$870,155	$334,227	$0	$0	$0	$535,928
HB 10-1146 Circumstances of Receiving Adult Foster Care & Home Care Allowance	($704,421)	($869,843)	$0	$0	$0	$165,422
HB 10-1378 Health Care Services Fund Moneys FY 2010-11	$0	($12,800,000)	$0	$12,800,000	$0	$0
HB 10-1379 Nursing Facility Rate Reduction	($6,234,689)	($8,211,333)	$0	$5,806,343	$0	($3,829,699)
HB 10-1380 Use of Supplemental Old Age Pension Funds	$0	($4,850,000)	$0	$4,850,000	$0	$0
HB 10-1381 Use of Tobacco Tax Revenue for Health-Related Purposes	$0	($25,691,418)	$0	$21,200,983	$4,490,435	$0
HB 10-1382 Annualization Repeal Delay of Payments	($43,121,235)	($14,679,904)	$0	($2,023,356)	($17,380)	($26,400,595)
SB 10-167 Colorado False Claims Act	($2,390,570)	($918,218)	$0	$0	$0	($1,472,352)
SB 10-169 HB 09-1293 ARRA Funding FY 2010-	$0	($46,329,388)	$0	$46,329,388	$0	$0
Appropriations Totals	$3,344,294,974	$594,669,512	$279,344,485	$487,857,054	$7,414,327	$1,975,009,596
Final Expenditures	$3,395,627,672	$601,033,287	$279,344,485	$518,533,477	$7,414,327	$1,989,302,096
Remaining Balance (Over Expenditure)	**($51,332,698)**	**($6,363,775)**	**$0**	**($30,676,423)**	**$0**	**($14,292,500)**
Totals reflect final COFRS close; they do not include post-closing entries.						

Exhibit O - Final Expenditures for Prior Fiscal Year by Aid Category

FY 2010-11 Final Actuals			
Aid Category	**Caseload**	**Per Capita**	**Total**
Adults 65 and Older (OAP-A)	38,921	$22,561.96	$878,133,965
Disabled Adults 60 to 64 (OAP-B)	7,767	$19,847.03	$154,151,878
Disabled Individuals to 59 (AND/AB)	56,285	$17,114.59	$963,294,603
Categorically Eligible Low-Income Adults (AFDC-A)	60,960	$5,006.11	$305,172,354
Expansion Adults to 60%	20,154	$3,803.18	$76,649,364
Expansion Adults to 100%	27,167	$3,090.16	$83,950,283
Breast & Cervical Cancer Program	531	$18,878.53	$10,024,497
Eligible Children (AFDC-C/BC)	302,410	$2,119.73	$641,028,271
Foster Care	18,393	$4,541.92	$83,539,452
Baby Care Program-Adults	7,868	$12,418.64	$97,709,822
Non-Citizens	3,213	$24,007.65	$77,136,566
Partial Dual Eligibles	17,090	$1,453.28	$24,836,618
TOTAL	**560,759**	**TF**	**$3,395,627,672**
Total Funds include Upper Payment Limit Financing and supplemental payments.		**GF**	$601,033,287
		GFE	$279,344,485
		CF	$518,533,477
		CFE	$7,414,327
		FF	$1,989,302,096

Exhibit O - Comparison of Budget Requests and Appropriations

FY 2008-09 Comparison of Requests and Appropriations										
FY 2008-09	November 1, 2007	February 15, 2008	% Change	FY 2008-09 Long Bill and Special Bills Appropriation	November 3, 2008	February 15, 2009	% Change over Appropriation	FY 2008-09 Final Appropriation	FY 2008-09 Actuals	% Change over Final Appropriation
Acute Care	$1,292,482,914	$1,314,241,262	1.68%	$1,359,212,400	$1,453,999,248	$1,493,902,147	9.91%	$1,457,586,478	$1,509,214,896	3.54%
Community Based Long Term Care	$248,068,802	$245,294,174	-1.12%	$249,024,941	$259,515,815	$273,794,058	9.95%	$276,647,133	$280,512,697	1.40%
Long Term Care	$575,448,073	$567,531,137	-1.38%	$582,520,385	$565,412,808	$604,990,458	3.86%	$605,782,883	$594,240,222	-1.91%
Insurance	$102,177,869	$95,491,972	-6.54%	$95,491,972	$96,235,687	$94,842,913	-0.68%	$95,608,394	$94,685,260	-0.97%
Service Management	$29,347,503	$29,548,058	0.68%	$33,548,058	$33,663,735	$33,764,136	0.64%	$31,315,630	$29,884,581	-4.57%
Financing	$13,265,582	$13,531,089	2.00%	$14,154,163	$16,610,401	$19,263,376	36.10%	$29,429,191	$18,453,787	-37.29%
Total	$2,260,790,743	$2,265,637,692	0.21%	$2,333,951,919	$2,425,437,694	$2,520,557,088	8.00%	$2,496,369,709	$2,526,991,443	1.23%
Class I Nursing Facilities	$514,997,462	$505,518,730	-1.84%	$517,373,050	$505,162,843	$532,841,808	2.99%	$544,726,438	$530,918,672	-2.53%

FY 2009-10 Comparison of Requests and Appropriations										
FY 2009-10	November 3, 2008	February 15, 2009	% Change	FY 2009-10 Long Bill and Special Bills Appropriation	November 2, 2009	February 15, 2010	% Change over Appropriation	FY 2009-10 Final Appropriation	FY 2009-10 Actuals	% Change over Final Appropriation
Acute Care	$1,527,556,326	$1,584,931,164	3.76%	$1,501,855,533	$1,622,263,439	$1,558,561,103	3.78%	$1,552,952,184	$1,571,163,491	1.17%
Community Based Long Term Care	$269,603,995	$293,313,560	8.79%	$281,246,469	$295,457,286	$300,094,070	6.70%	$299,862,085	$299,689,736	-0.06%
Long Term Care	$604,700,067	$644,097,986	6.52%	$602,939,360	$596,411,234	$596,918,714	-1.00%	$610,007,471	$613,823,579	0.63%
Insurance	$102,155,514	$100,407,771	-1.71%	$102,007,071	$99,254,333	$104,853,621	2.79%	$104,062,091	$104,088,580	0.03%
Service Management	$35,158,825	$35,635,941	1.36%	$33,903,391	$29,087,541	$29,826,978	-12.02%	$29,378,461	$28,890,920	-1.66%
Financing	$17,229,193	$19,884,413	15.41%	$348,143,490	$279,891,697	$330,324,799	-5.12%	$332,973,867	$330,388,398	-0.78%
Total	$2,556,403,920	$2,678,270,835	4.77%	$2,870,095,314	$2,922,365,530	$2,920,579,285	1.76%	$2,929,236,159	$2,948,044,704	0.64%
Class I Nursing Facilities	$527,582,647	$564,759,876	7.05%	$529,602,773	$523,401,823	$530,323,834	0.14%	$539,282,492	$543,352,204	0.75%

FY 2010-11 Comparison of Requests and Appropriations										
FY 2010-11	November 3, 2009	February 15, 2010	% Change	FY 2010-11 Long Bill and Special Bills Appropriation	November 1, 2010	February 15, 2011	% Change over Appropriation	FY 2010-11 Final Appropriation	FY 2010-11 Actuals	% Change over Final Appropriation
Acute Care	$1,817,833,344	$1,726,068,473	-5.05%	$1,676,041,654	$1,704,740,814	$1,817,494,423	6.61%	$1,731,337,041	$1,719,420,711	0.69%
Community Based Long Term Care	$316,627,466	$324,965,364	2.63%	$317,177,074	$324,524,665	$338,302,070	4.25%	$318,568,691	$319,017,067	-0.14%
Long Term Care	$647,638,356	$651,246,648	0.56%	$637,084,088	$631,054,441	$0	-100.00%	$658,241,538	$663,208,496	-0.75%
Insurance	$105,641,289	$119,159,548	12.80%	$114,705,505	$120,865,705	$0	-100.00%	$119,052,929	$120,580,378	-1.27%
Service Management	$47,855,679	$49,280,859	2.98%	$32,966,743	$33,560,570	$0	-100.00%	$33,411,741	$31,384,315	6.46%
Financing	$272,640,497	$323,073,599	18.50%	$328,883,062	$481,607,230	$714,831,348	48.43%	$483,683,032	$471,784,218	2.52%
Total	$3,208,236,631	$3,193,794,491	-0.45%	$3,106,858,126	$3,296,353,425	$2,870,627,841	-12.92%	$3,344,294,972	$3,325,395,185	0.57%
Class I Nursing Facilities	$558,617,741	$570,960,660	2.21%	$558,653,333	$551,778,173	$565,885,188	2.56%	$580,097,872	$575,631,025	0.78%

Exhibit O - Comparison of Budget Requests and Appropriations

FY 2011-12 Comparison of Requests and Appropriations										
FY 2011-12	November 1, 2010	February 15, 2011	% Change	FY 2011-12 Long Bill and Special Bills Appropriation	November 1, 2011	February 15, 2012	% Change over Appropriation	FY 2011-12 Final Appropriation	FY 2011-12 Actuals	% Change over Feb.
Acute Care	$1,869,280,623	$1,841,198,096	-1.50%	$1,718,850,632	$1,804,376,597	$1,817,494,423	5.74%			
Community Based Long Term Care	$355,599,322	$344,929,391	-3.00%	$332,818,444	$339,735,624	$338,302,070	1.65%			
Long Term Care	$643,090,480	$661,945,406	2.93%	$592,974,395	$602,704,785	$598,729,747	0.97%			
Insurance	$135,182,109	$130,455,214	-3.50%	$132,376,946	$136,796,432	$114,861,433	-13.23%			
Service Management	$48,099,599	$47,337,900	-1.58%	$55,396,706	$55,222,856	$53,404,975	-3.60%			
Financing	$498,614,128	$515,132,015	3.31%	$515,132,015	$637,431,859	$714,831,348	38.77%			
Total	$3,549,866,261	$3,540,998,022	-0.25%	$3,347,549,138	$3,576,268,153	$3,637,623,996	8.67%			
Class I Nursing Facilities	$551,945,698	$518,406,575	-6.08%	$505,305,001	$515,627,467	$512,062,190	1.34%			

FY 2012-13 Comparison of Requests and Appropriations										
FY 2012-13	November 1, 2011	February 15, 2012	% Change	FY 2012-13 Long Bill and Special Bills Appropriation	November 1, 2012	February 15, 2013	% Change over Appropriation	FY 2012-13 Final Appropriation	FY 2012-13 Actuals	% Change over Feb.
Acute Care	$1,869,280,623	$1,946,571,857	4.13%							
Community Based Long Term Care	$355,599,322	$358,768,860	0.89%							
Long Term Care	$643,090,480	$633,669,852	-1.46%							
Insurance	$135,182,109	$122,479,412	-9.40%							
Service Management	$48,099,599	$63,585,739	32.20%							
Financing	$498,614,128	$754,611,187	51.34%							
Total	$3,549,866,261	$3,879,686,907	9.29%							
Class I Nursing Facilities	$551,945,698	$538,803,358	-2.38%							

Exhibit P - Estimate of FY Expenditures with Prior Year Cash Flow Pattern (For Reference Only - Not the Department's Request)

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 1997-98	$434,352,319	$38,025,425	$330,590,106	$82,516,222	$0	$0	$0	$142,956,889	$22,764,875	$28,964,028	$18,554,312	$6,246,815	$1,104,970,992
FY 1998-99	$463,746,968	$48,533,442	$361,070,568	$71,509,445	$0	$0	$0	$149,648,954	$23,328,439	$31,471,476	$20,738,242	$6,185,875	$1,176,233,410
FY 1999-00	$498,371,676	$54,962,843	$406,908,458	$80,904,393	$0	$0	$0	$169,614,835	$27,483,127	$33,530,293	$29,675,611	$6,968,865	$1,308,420,100
FY 2000-01	$515,213,506	$61,119,754	$450,888,114	$88,758,327	$0	$0	$0	$193,552,834	$30,746,407	$31,503,592	$36,930,022	$7,822,852	$1,416,535,408
FY 2001-02	$571,065,382	$61,284,519	$465,027,758	$104,227,966	$0	$0	$0	$220,555,126	$33,206,413	$33,946,549	$39,372,440	$8,118,537	$1,536,804,691
FY 2002-03	$564,628,021	$64,679,670	$516,439,288	$139,745,425	$0	$0	$1,428,780	$227,992,629	$37,567,968	$42,521,465	$48,734,092	$7,933,536	$1,651,670,874
FY 2003-04	$634,138,712	$76,646,130	$562,700,004	$184,736,556	$0	$0	$2,668,992	$233,391,821	$45,491,729	$64,293,820	$55,212,960	$9,469,507	$1,868,750,230
FY 2004-05	$652,991,016	$82,003,665	$540,574,590	$193,239,971	$0	$0	$2,490,659	$304,520,783	$46,710,822	$42,305,572	$44,773,436	$10,931,012	$1,920,541,525
FY 2005-06	$670,399,260	$87,347,546	$554,870,504	$200,372,841	$0	$0	$6,810,399	$317,181,796	$49,374,100	$41,186,119	$55,353,863	$13,367,880	$1,996,264,308
FY 2006-07	$680,873,516	$90,702,791	$573,755,682	$197,852,527	$7,487,018	$0	$5,557,749	$331,302,380	$53,781,937	$48,628,238	$54,484,004	$16,970,966	$2,061,396,808
FY 2007-08	$712,276,694	$101,257,270	$655,167,660	$189,176,151	$18,502,735	$0	$7,102,713	$364,161,301	$64,197,785	$54,600,185	$53,660,977	$18,992,933	$2,239,096,405
FY 2008-09	$789,584,078	$115,435,768	$735,082,424	$208,663,632	$31,018,121	$0	$7,056,952	$433,354,524	$67,739,569	$60,847,257	$59,283,547	$18,925,572	$2,526,991,443
FY 2009-10	$809,233,671	$125,554,785	$808,898,319	$271,445,443	$51,573,052	$2,815,535	$8,717,234	$545,776,004	$72,577,502	$89,271,212	$72,617,705	$19,331,759	$2,877,812,218
FY 2010-11	$871,980,040	$154,069,643	$964,673,722	$307,637,198	$76,003,282	$83,067,467	$10,106,683	$643,978,787	$84,269,417	$98,059,349	$77,277,933	$24,504,150	$3,395,627,671

Fiscal Year	Expenditures	Percent Change	Dollar Increase/ Decrease	Average Yearly Percent Change From FY 97-98	Percent Change	Three-year Moving Average	Percent Change
FY 1997-98	$1,104,970,992						
FY 1998-99	$1,176,233,410	6.45%	$71,262,418				
FY 1999-00	$1,308,420,100	11.24%	$132,186,690	8.84%			
FY 2000-01	$1,416,535,408	8.26%	$108,115,307	8.65%	-2.19%	8.65%	
FY 2001-02	$1,536,804,691	8.49%	$120,269,284	8.61%	-0.46%	9.33%	7.87%
FY 2002-03	$1,651,670,874	7.47%	$114,866,182	8.38%	-2.64%	8.08%	-13.45%
FY 2003-04	$1,868,750,230	13.14%	$217,079,357	9.18%	9.46%	9.70%	20.14%
FY 2004-05	$1,920,541,525	2.77%	$51,791,295	8.26%	-9.97%	7.80%	-19.65%
FY 2005-06	$1,996,264,308	3.94%	$75,722,783	7.72%	-6.53%	6.62%	-15.10%
FY 2006-07	$2,061,396,808	3.26%	$65,132,500	7.23%	-6.42%	3.33%	-49.76%
FY 2007-08	$2,239,096,405	8.62%	$177,699,597	7.37%	1.93%	5.28%	58.62%
FY 2008-09	$2,526,991,443	12.86%	$287,895,038	7.86%	6.78%	8.25%	56.33%
FY 2009-10	$2,877,812,218	13.88%	$350,820,776	8.37%	6.38%	11.79%	42.93%
FY 2010-11	$3,395,627,671	17.99%	$517,815,452	9.11%	8.85%	14.91%	26.51%
	Official Projection	**Percent Change**	**Dollar Increase/ Decrease**	**Projection Using Most Recent Average Change**	**Percent Change over Official Projection**	**Projection Using Most Recent Three-year Average**	**Percent Change over Premium Workbook Projection**
FY 2011-12 Projection	$3,644,816,560	26.65%	$767,004,342	$3,104,147,227	-14.83%	$3,115,142,628	-14.53%
FY 2012-13 Projection	$4,001,512,858	9.79%	$356,696,298	$3,949,754,249	-1.29%	$4,074,430,303	1.82%
FY 2013-14 Projection	$4,001,512,858	0.00%	$0	$4,365,925,811	9.11%	$4,598,191,222	14.91%
FY 2011-12 Appropriation	$3,459,911,747						
Difference Between FY 2011-12 Projections and FY 2011-12 Appropriation	$184,904,813	5.34%		($355,764,520)	-10.28%	($344,769,119)	-9.96%
Difference Between FY 2012-13 Projections and FY 2011-12 Appropriation	$541,601,111	15.65%		$489,842,502	14.16%	$614,518,556	17.76%
Difference Between FY 2013-14 Projections and FY 2011-12 Appropriation	$541,601,111	15.65%		$906,014,064	26.19%	$1,138,279,475	32.90%

Actuals, Projection, and Appropriation <u>exclude</u> Upper Payment Limit Financing.

Exhibit P - Estimate of FY Expenditures with Prior Year Cash Flow Pattern (For Reference Only - Not the Department's Request)

Fiscal Year	Total Expenditures*	Annual % Change	Total Caseload**	Annual % Change
FY 1997-98	$1,104,970,992		250,098	
FY 1998-99	$1,176,233,410	6.45%	238,594	-4.60%
FY 1999-00	$1,308,420,100	11.24%	237,598	-0.42%
FY 2000-01	$1,416,535,408	8.26%	253,254	6.59%
FY 2001-02	$1,536,804,691	8.49%	275,399	8.74%
FY 2002-03	$1,651,670,874	7.47%	331,800	20.48%
FY 2003-04	$1,868,750,230	13.14%	367,559	10.78%
FY 2004-05	$1,920,541,525	2.77%	406,024	10.46%
FY 2005-06	$1,996,264,308	3.94%	402,218	-0.94%
FY 2006-07	$2,061,396,808	3.26%	392,228	-2.48%
FY 2007-08	$2,239,096,405	8.62%	391,962	-0.07%
FY 2008-09	$2,526,991,443	12.86%	436,812	11.44%
FY 2009-10	$2,948,044,704	16.66%	498,797	14.19%
FY 2010-11	$3,325,395,185	12.80%	560,759	12.42%
FY 2011-12 Projection	$3,644,816,560	9.61%	623,595	11.21%
FY 2012-13 Projection	$4,001,512,858	9.79%	687,473	10.24%
FY 2013-14 Projection	$4,256,817,384	6.38%	739,403	7.55%

*Expenditures are for Medical Services Premiums only. Upper Payment Limit financing and supplemental payments are excluded.

**Caseload does not include retroactivity.

Exhibit P - Estimate of FY Expenditures with Prior Year Cash Flow Pattern (For Reference Only - Not the Department's Request)

Service Category	FY 2011-12 COFRS Actuals (July-December)	FY 2010-11 Cash Flow % (July-December)	FY 2011-12 Year End ROUGH Projection	FY 2011-12 Appropriation	Long Bill Appropriation Minus Cash Flow
ACUTE CARE					
Physician Services & EPSDT	$144,523,823	46.86%	$308,408,192	N/A	N/A
Emergency Transportation	$3,180,526	47.69%	$6,669,468	N/A	N/A
Non-emergency Medical Transportation	$4,914,573	49.54%	$9,921,066	N/A	N/A
Dental Services	$52,917,594	49.06%	$107,870,773	N/A	N/A
Family Planning	$222,493	51.41%	$432,806	N/A	N/A
Health Maintenance Organizations	$64,669,679	47.08%	$137,350,712	N/A	N/A
Inpatient Hospitals	$185,309,587	47.81%	$387,570,665	N/A	N/A
Outpatient Hospitals	$107,781,656	48.81%	$220,817,723	N/A	N/A
Lab & X-Ray	$19,707,309	46.52%	$42,359,268	N/A	N/A
Durable Medical Equipment	$46,557,726	48.82%	$95,362,431	N/A	N/A
Prescription Drugs	$154,980,079	45.70%	$339,149,046	N/A	N/A
Drug Rebate	($69,579,617)	40.28%	($172,723,937)	N/A	N/A
Rural Health Centers	$5,168,413	47.92%	$10,785,605	N/A	N/A
Federally Qualified Health Centers	$48,151,057	47.10%	$102,234,367	N/A	N/A
Co-Insurance (Title XVIII-Medicare)	$12,886,840	27.98%	$46,052,617	N/A	N/A
Breast and Cervical Cancer Treatment Program	$5,377,394	48.12%	$11,173,918	N/A	N/A
Prepaid Inpatient Health Plan Services	$30,303,066	48.50%	$62,481,206	N/A	N/A
Other Medical Services	($11)	26.30%	($42)	N/A	N/A
Home Health	$84,464,004	48.11%	$175,581,227	N/A	N/A
Presumptive Eligibility	$0	0.00%	$0	N/A	N/A
Subtotal of Acute Care	**$901,536,191**	**47.67%**	**$1,891,017,705**	**$1,718,850,632**	**$172,167,073**
COMMUNITY BASED LONG TERM CARE					
HCBS - Elderly, Blind, and Disabled	$112,973,982	49.98%	$226,036,643	N/A	N/A
HCBS - Mental Illness	$12,942,845	51.44%	$25,161,918	N/A	N/A
HCBS - Disabled Children	$1,367,836	49.48%	$2,764,450	N/A	N/A
HCBS - Persons Living with AIDS	$270,094	54.83%	$492,584	N/A	N/A
HCBS - Consumer Directed Attendant Support	$1,804,624	47.47%	$3,801,842	N/A	N/A
HCBS - Brain Injury	$6,504,280	41.14%	$15,810,950	N/A	N/A
HCBS - Children with Autism	$502,938	60.42%	$832,446	N/A	N/A
HCBS - Pediatric Hospice	$103,583	56.64%	$182,888	N/A	N/A
Private Duty Nursing	$15,783,836	47.87%	$32,969,038	N/A	N/A
Hospice	$20,586,160	50.10%	$41,091,927	N/A	N/A
Subtotal of Community Based Long Term Care	**$172,840,178**	**49.62%**	**$348,346,732**	**$332,818,444**	**$15,528,288**
LONG TERM CARE and INSURANCE					
Class I Nursing Facilities	$254,028,843	50.24%	$505,678,484	$505,305,001	$373,483
Class II Nursing Facilities	$791,453	64.94%	$1,218,716	$2,518,879	($1,300,163)
Program for All-Inclusive Care for the Elderly	$40,212,867	45.98%	$87,449,032	$85,150,515	$2,298,517
Subtotal Long Term Care	**$295,033,163**	**49.70%**	**$593,591,144**	**$592,974,395**	**$616,749**
Supplemental Medicare Insurance Benefit	$62,467,332	47.97%	$130,212,467	$130,649,240	($436,773)
Health Insurance Buy-In Program	$593,778	49.35%	$1,203,095	$1,727,706	($524,611)
Subtotal Insurance	**$63,061,110**	**47.99%**	**$131,417,671**	**$132,376,946**	**($959,275)**
Subtotal of Long Term Care and Insurance	**$358,094,273**	**49.41%**	**$724,735,946**	**$725,351,341**	**($615,395)**
SERVICE MANAGEMENT					
Single Entry Points	$12,068,565	49.67%	$24,296,018	$25,399,319	($1,103,301)
Disease Management	$0	0.00%	$0	$500,000	($500,000)
Prepaid Inpatient Health Plan Administration	$8,374,634	43.04%	$19,458,086	$29,497,387	($10,039,301)
Subtotal Service Management	**$20,443,199**	**48.12%**	**$42,486,630**	**$55,396,706**	**($12,910,076)**
Total	**$1,452,913,841**	**48.35%**	**$3,005,187,522**	**$2,832,417,123**	**$172,770,399**

The FY 2011-12 Appropriation amounts include totals from SB 11-209 plus special bills that passed during the 2011 legislative session.

For HCBS - Brain Injury, the cash flow percentage does not include a large transfer that took place in the first half of FY 2010-11.

This is a rough projection utilizing past expenditure patterns as a guide to future expenditures. The Cash Flow Pattern is one forecasting tool used to estimate final expenditures on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medicaid Mental Health Community Programs

Priority Number: S-2A, BA-2

Dept. Approval by: John Bartholomew 2/15/12 Date

OSPB Approval by: 2/15/12 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$276,400,984	($1,594,036)	$277,590,898	$2,726,901	$6,629,698
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$127,777,722	($1,726,244)	$128,194,192	($4,693,763)	($4,150,100)
	GFE	$0	$0	$0	$0	$0
	CF	$10,510,223	$822,147	$10,510,223	$6,226,382	$1,547,417
	RF	$13,544	$25,046	$13,544	$0	$0
	FF	$138,099,495	($714,985)	$138,872,939	$1,194,282	$9,232,381
(3) Medicaid Mental Health Community Programs; Mental Health Capitation Payments	**Total**	$272,492,157	($1,425,963)	$273,682,071	$2,798,213	$6,674,301
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$125,823,308	($1,642,207)	$126,239,778	($4,658,107)	($4,127,798)
	GFE	$0	$0	$0	$0	$0
	CF	$10,510,223	$822,147	$10,510,223	$6,226,382	$1,547,417
	RF	$13,544	$25,046	$13,544	$0	$0
	FF	$136,145,082	($630,949)	$136,918,526	$1,229,938	$9,254,682
(3) Medicaid Mental Health Community Programs; Medicaid Mental Health Fee for Services Payments	**Total**	$3,908,827	($168,073)	$3,908,827	($71,312)	($44,603)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,954,414	($84,037)	$1,954,414	($35,656)	($22,302)
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,954,413	($84,036)	$1,954,413	($35,656)	($22,301)

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**
See Exhibit BB for cash fund splits.

Cash or Federal Fund Name and COFRS Fund Number: Breast and Cervical Cancer Prevention and Treatment Fund (Fund 15D); Hospital Provider Fee Cash Fund (24A). FF: Title XIX.

Reappropriated Funds Source, by Department and Line Item Name: Transfer from the Department of Public Health and Environment, Prevention, Early Detection, and Treatment Fund.

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: None.

Other Information:

Exhibit	Title of Exhibit
Exhibit AA	Calculation of Current Total Long Bill Group Impact
Exhibit BB	Calculation of Fund Splits
Exhibit CC	Medicaid Mental Health Community Programs Summary
Exhibit DD	Medicaid Mental Health Community Programs, Caseload
Exhibit DD	Medicaid Mental Health Community Programs, Mental Health Capitation Payments Per Capita Historical Summary
Exhibit DD	Medicaid Mental Health Community Programs, Expenditures Historical Summary
Exhibit EE	Expenditure Calculations by Eligibility Category
Exhibit EE	Incurred But Not Reported Runout by Fiscal Period
Exhibit EE	Incurred But Not Reported Expenditures by Fiscal Period
Exhibit FF	Medicaid Mental Health Retroactivity Adjustment
Exhibit FF	Medicaid Mental Health Partial Month Adjustment Multiplier
Exhibit GG	Medicaid Mental Health Capitation Rate Trends and Forecasts
Exhibit HH	Forecast Model Comparisons - Final Forecasts
Exhibit HH	Forecast Model Comparisons - Capitation Trend Models
Exhibit II	Recoupment of Payments Made for Clients Found to be Ineligible for Medicaid and Reconciliations for Adults without Dependent Children
Exhibit JJ	Cash Funded Expansion Populations
Exhibit KK	Medicaid Mental Health Fee For Service Forecast
Exhibit LL	Global Reasonableness Test for Medicaid Mental Health Capitation Payments

Exhibit AA - Calculation of Current Total Long Bill Group Impact

FY 2011-12 Mental Health Capitation

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Mental Health Capitation Appropriation						
FY 2011-12 Long Bill Appropriation (SB 11-209)	$272,492,157	$125,823,308	$0	$10,510,223	$13,544	$136,145,082
FY 2011-12 Total Mental Heath Capitation Spending Authority	**$272,492,157**	**$125,823,308**	**$0**	**$10,510,223**	**$13,544**	**$136,145,082**
Projected Total FY 2011-12 Mental Health Capitation Expenditure	**$275,155,770**	**$131,821,371**	**$0**	**$5,764,076**	**$25,046**	**$137,545,277**
Total FY 2011-12 Mental Health Capitation Request	**$2,663,613**	**$5,998,063**	**$0**	**($4,746,147)**	**$11,502**	**$1,400,195**
Percent Change from Spending Authority	0.98%	4.77%	-	-45.16%	84.92%	1.03%
FY 2011-12 Supplemental Request (S-2)	$4,089,576	$7,640,270	$0	($5,568,294)	($13,544)	$2,031,144
FY 2011-12 Current Supplemental Request	**($1,425,963)**	**($1,642,207)**	**$0**	**$822,147**	**$25,046**	**($630,949)**
Percent Change	-0.52%	-1.25%	0.00%	14.26%	100.00%	-0.46%

FY 2011-12 Mental Health Fee-for-Service

FY 2011-12 Mental Health Fee-For-Service Appropriation						
FY 2011-12 Long Bill Appropriation (SB 11-209)	$3,908,827	$1,954,414	$0	$0	$0	$1,954,413
FY 2011-12 Total Mental Heath Fee-For-Service Spending Authority	**$3,908,827**	**$1,954,414**	**$0**	**$0**	**$0**	**$1,954,413**
Projected Total FY 2011-12 Mental Health Fee-for-Service Expenditure	**$3,943,389**	**$1,971,694**	**$0**	**$0**	**$0**	**$1,971,695**
Total FY 2011-12 Mental Health Fee-For-Service Request	**$34,562**	**$17,280**	**$0**	**$0**	**$0**	**$17,282**
Percent Change from Spending Authority	0.88%	0.88%	-	-	-	0.88%
FY 2011-12 Supplemental Request (S-2)	$202,635	$101,317	$0	$0	$0	$101,318
FY 2011-12 Current Supplemental Request	**($168,073)**	**($84,037)**	**$0**	**$0**	**$0**	**($84,036)**
Percent Change	-4.26%	-4.26%	0.00%	0.00%	0.00%	-4.26%

FY 2011-12 Medicaid Mental Health Programs

FY 2011-12 Total Spending Authority	**$276,400,984**	**$127,777,722**	**$0**	**$10,510,223**	**$13,544**	**$138,099,495**
Total Projected FY 2011-12 Expenditures	$279,099,159	$133,793,065	$0	$5,764,076	$25,046	$139,516,972
Total FY 2011-12 Request	**$2,698,175**	**$6,015,343**	**$0**	**($4,746,147)**	**$11,502**	**$1,417,477**
Percent Change from Spending Authority	0.98%	4.71%	-	-45.16%	84.92%	1.03%
FY 2011-12 Supplemental Request (S-2)	$4,292,211	$7,741,587	$0	($5,568,294)	($13,544)	$2,132,462
FY 2011-12 Current Supplemental Request	**($1,594,036)**	**($1,726,244)**	**$0**	**$822,147**	**$25,046**	**($714,985)**
Percent Change	-0.57%	-1.29%	0.00%	14.26%	100.00%	-0.51%

Exhibit AA - Calculation of Current Total Long Bill Group Impact

FY 2012-13 Mental Health Capitation

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Mental Health Capitation Appropriation Plus Special Bills	**$272,492,157**	**$125,823,308**	**$0**	**$10,510,223**	**$13,544**	**$136,145,082**
Bill Annualizations						
SB 11-008 "Medicaid Eligibility for Children'	$1,009,781	$353,423	$0	$0	$0	$656,358
SB 11-250 "Pregnant Women Medicaid Eligibility'	$180,133	$63,047	$0	$0	$0	$117,086
FY 2012-13 Mental Health Capitation Base Amount	**$273,682,071**	**$126,239,778**	**$0**	**$10,510,223**	**$13,544**	**$136,918,526**
Projected Total FY 2012-13 Mental Health Capitation Expenditure	**$312,580,712**	**$142,712,972**	**$0**	**$13,648,932**	**$0**	**$156,218,808**
Total FY 2012-13 Mental Health Capitation Request	**$38,898,641**	**$16,473,194**	**$0**	**$3,138,709**	**($13,544)**	**$19,300,282**
Percent Change from FY 2012-13 Mental Health Capitation Base	14.21%	13.05%	-	29.86%	-100.00%	14.10%
Percent Change from FY 2011-12 Estimated Mental Health Capitation Expenditure	13.60%	8.26%	-	136.79%	0.00%	13.58%
FY 2012-13 Funding Request (R-2)	$36,100,428	$21,131,301	$0	($3,087,673)	($13,544)	$18,070,344
FY 2012-13 Current Budget Amendment	**$2,798,213**	**($4,658,107)**	**$0**	**$6,226,382**	**$0**	**$1,229,938**
Percent Change	0.90%	-3.26%	-	45.62%	0.00%	0.79%

FY 2012-13 Mental Health Fee-for-Service

FY 2011-12 Mental Health Fee-For-Service Appropriation Plus Special Bills	**$3,908,827**	**$1,954,414**	**$0**	**$0**	**$0**	**$1,954,413**
FY 2012-13 Mental Health Fee-For-Service Base Amount	**$3,908,827**	**$1,954,414**	**$0**	**$0**	**$0**	**$1,954,413**
Projected Total FY 2011-12 Mental Health Fee-for-Service Expenditure	**$4,351,395**	**$2,175,697**	**$0**	**$0**	**$0**	**$2,175,698**
Total FY 2012-13 Mental Health Fee-For-Service Request	**$442,568**	**$221,283**	**$0**	**$0**	**$0**	**$221,285**
Percent Change from FY 2012-13 Mental Health Fee-For-Service Base	11.32%	11.32%	-	-	-	11.32%
Percent Change from FY 2011-12 Estimated Mental Health Fee-For-Service Expenditure	10.35%	10.35%	-	-	-	10.35%
FY 2012-13 Funding Request (R-2)	$513,880	$256,939	$0	$0	$0	$256,941
FY 2012-13 Current Budget Amendment	**($71,312)**	**($35,656)**	**$0**	**$0**	**$0**	**($35,656)**
Percent Change	-1.64%	-1.64%	0.00%	0.00%	0.00%	-1.64%

FY 2012-13 Medicaid Mental Health Programs

FY 2012-13 Base Amount	**$277,590,898**	**$128,194,192**	**$0**	**$10,510,223**	**$13,544**	**$138,872,939**
Total Projected FY 2012-13 Expenditure	$316,932,107	$144,888,669	$0	$13,648,932	$0	$158,394,506
Total FY 2012-13 Request	**$39,341,209**	**$16,694,477**	**$0**	**$3,138,709**	**($13,544)**	**$19,521,567**
Percent Change from Spending Authority	14.17%	13.02%	-	29.86%	-100.00%	14.06%
FY 2012-13 Funding Request (R-2)	$36,614,308	$21,388,240	$0	($3,087,673)	($13,544)	$18,327,285
FY 2012-13 Current Budget Amendment	**$2,726,901**	**($4,693,763)**	**$0**	**$6,226,382**	**$0**	**$1,194,282**
Percent Change	0.86%	-3.24%	0.00%	45.62%	0.00%	0.75%

Exhibit AA - Calculation of Current Total Long Bill Group Impact

FY 2013-14 Mental Health Capitation

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Mental Health Capitation Appropriation Plus Special Bills	**$273,682,071**	**$126,239,778**	**$0**	**$10,510,223**	**$13,544**	**$136,918,526**
Bill Annualizations						
SB 11-008 Annualization "Medicaid Eligibility for Children'	$3,218,931	$1,126,626	$0	$0	$0	$2,092,305
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility'	$215,864	$75,552	$0	$0	$0	$140,312
FY 2013-14 Mental Health Capitation Base Amount	**$277,116,866**	**$127,441,956**	**$0**	**$10,510,223**	**$13,544**	**$139,151,143**
Projected Total FY 2013-14 Mental Health Capitation Expenditure	**$350,548,439**	**$155,951,106**	**$0**	**$12,782,988**	**$0**	**$181,814,345**
Total FY 2013-14 Mental Health Capitation Continuation Amount	**$73,431,573**	**$28,509,150**	**$0**	**$2,272,765**	**($13,544)**	**$42,663,202**
Percent Change from FY 2013-14 Mental Health Capitation Base	26.50%	22.37%	-	21.62%	-100.00%	30.66%
Percent Change from FY 2012-13 Estimated Mental Health Capitation Expenditure	12.15%	9.28%	-	-6.34%	0.00%	16.38%
FY 2012-13 Funding Request (R-2)	$66,757,272	$32,636,948	$0	$725,348	($13,544)	$33,408,520
FY 2013-14 Current Budget Amendment	**$6,674,301**	**($4,127,798)**	**$0**	**$1,547,417**	**$0**	**$9,254,682**
Percent Change	1.90%	-2.65%	-	12.11%	0.00%	5.09%

FY 2013-14 Mental Health Fee-for-Service

FY 2012-13 Mental Health Fee-For-Service Appropriation Plus Special Bills	**$3,908,827**	**$1,954,414**	**$0**	**$0**	**$0**	**$1,954,413**
FY 2013-14 Mental Health Fee-For-Service Base Amount	**$3,908,827**	**$1,954,414**	**$0**	**$0**	**$0**	**$1,954,413**
Projected Total FY 2012-13 Mental Health Fee-for-Service Expenditure	**$4,680,035**	**$2,340,017**	**$0**	**$0**	**$0**	**$2,340,018**
Total FY 2013-14 Mental Health Fee-For-Service Continuation Amount	**$771,208**	**$385,603**	**$0**	**$0**	**$0**	**$385,605**
Percent Change from FY 2013-14 Mental Health Fee-For-Service Base	19.73%	19.73%	-	-	-	19.73%
Percent Change from FY 2012-13 Estimated Mental Health Fee-For-Service Expenditure	7.55%	7.55%	-	-	-	7.55%
FY 2012-13 Funding Request (R-2)	$815,811	$407,905	$0	$0	$0	$407,906
FY 2013-14 Current Budget Amendment	**($44,603)**	**($22,302)**	**$0**	**$0**	**$0**	**($22,301)**
Percent Change	-0.95%	-0.95%	0.00%	0.00%	0.00%	-0.95%

FY 2013-14 Medicaid Mental Health Programs

FY 2013-14 Base Amount	**$281,025,693**	**$129,396,370**	**$0**	**$10,510,223**	**$13,544**	**$141,105,556**
Total Projected FY 2013-14 Expenditure	$355,228,474	$158,291,123	$0	$12,782,988	$0	$184,154,363
Total FY 2013-14 Continuation Amount	**$74,202,781**	**$28,894,753**	**$0**	**$2,272,765**	**($13,544)**	**$43,048,807**
Percent Change from Spending Authority	26.40%	22.33%	-	21.62%	-100.00%	30.51%
FY 2012-13 Funding Request (R-2)	$67,573,083	$33,044,853	$0	$725,348	($13,544)	$33,816,426
FY 2013-14 Current Budget Amendment	**$6,629,698**	**($4,150,100)**	**$0**	**$1,547,417**	**$0**	**$9,232,381**
Percent Change	1.87%	-2.62%	0.00%	12.11%	0.00%	5.01%

Exhibit BB - Calculation of Fund Splits

Calculation of Fund Splits - FY 2011-12 Mental Health Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Source of Funding
Mental Health Capitation Base Traditional Clients	$264,857,139	$132,428,569	$0	$0	$132,428,570	50.00%	General Fund
Breast and Cervical Cancer Program Traditional Clients	$117,614	$0	$41,165	$0	$76,449	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
Breast and Cervical Cancer Program Expansion Clients	$50,093	$0	$0	$25,046	$25,047	65.00%	RF: Prevention, Early Detection, and Treatment Fund
HB 09-1293 Hospital Provider Fee Expansion Adults to 100% and Adults without Dependent Children	$11,341,998	$0	$5,670,998	$0	$5,671,000	50.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293 Hospital Provider Fee Buy-In for Disabled Individuals	$103,826	$0	$51,913	$0	$51,913	50.00%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$0	$0	$0	$0	$0	65.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$0	$0	$0	$0	$0	65.00%	General Fund
Estimated FY 2011-12 Capitation Expenditure	**$276,470,670**	**$132,428,569**	**$5,764,076**	**$25,046**	**$138,252,979**		
Date of Death Retractions	($625,337)	($312,668)	$0	$0	($312,669)	50.00%	
Estimated Recoupments	($689,563)	($294,530)	$0	$0	($395,033)	57.29%	
Final Estimated FY 2011-12 Capitation Expenditure	**$275,155,770**	**$131,821,371**	**$5,764,076**	**$25,046**	**$137,545,277**		
Medicaid Mental Health Fee-for-Service Payments	**$3,943,389**	**$1,971,694**	**$0**	**$0**	**$1,971,695**	50.00%	
Final Estimated FY 2011-12 Medicaid Mental Health Community Programs Expenditure	**$279,099,159**	**$133,793,065**	**$5,764,076**	**$25,046**	**$139,516,972**		

Exhibit BB - Calculation of Fund Splits

Calculation of Fund Split - FY 2012-13 Mental Health Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Source of Funding
Mental Health Capitation Base Traditional Clients	$286,841,818	$143,420,909	$0	$0	$143,420,909	50.00%	
Breast and Cervical Cancer Program Traditional and Expansion Clients [(1)]	$195,363	$34,188	$34,189	$0	$126,986	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
HB 09-1293 Hospital Provider Fee Expansion Adults to 100% and Adults without Dependent Children	$21,605,100	$0	$10,802,550	$0	$10,802,550	50.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293 Hospital Provider Fee Buy-In for Disabled Individuals	$4,076,189	$0	$2,038,094	$0	$2,038,095	50.00%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$457,351	$160,073	$0	$0	$297,278	65.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$51,942	$18,180	$0	$0	$33,762	65.00%	General Fund
Estimated FY 2012-13 Capitation Expenditure	**$313,227,763**	**$143,633,350**	**$12,874,833**	**$0**	**$156,719,580**		
Date of Death Retractions	($562,802)	($281,401)	$0	$0	($281,401)	50.00%	
Estimated Recoupments	($1,672,249)	($638,977)	($19,901)	$0	($1,013,371)	60.60%	CF: Hospital Provider Fee Cash Fund
Estimated Adults without Dependent Children Reconciliations	$1,588,000	$0	$794,000	$0	$794,000	50.00%	CF: Hospital Provider Fee Cash Fund
Final Estimated FY 2012-13 Capitation Expenditure	**$312,580,712**	**$142,712,972**	**$13,648,932**	**$0**	**$156,218,808**		
Medicaid Mental Health Fee-for-Service Payments	**$4,351,395**	**$2,175,697**	**$0**	**$0**	**$2,175,698**	50.00%	
Final Estimated FY 2012-13 Medicaid Mental Health Community Programs Expenditure	**$316,932,107**	**$144,888,669**	**$13,648,932**	**$0**	**$158,394,506**		

[1] In the past, 30% of total caseload for the Breast and Cervical Cancer Treatment Program were funded via a transfer from the Department of Public Health and Environment. For FY 2012-13, the Department is changing this allocation so that none of the mental health services for this program are funded with these reappropriated funds; this is due to the fact that there is a cap on the amount of reappropriated funds available to the Department, and it is assumed that starting in FY 2012-13, the full amount of reappropriated funds will be used to fund the physical health services for the Breast and Cervical Cancer Treatment Program expansion clients.

Exhibit BB - Calculation of Fund Splits

Calculation of Fund Split - FY 2013-14 Mental Health Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Source of Funding
Mental Health Capitation Base Traditional Clients	$310,887,900	$155,443,950	$0	$0	$155,443,950	50.00%	
Breast and Cervical Cancer Program Traditional and Expansion Clients	$221,294	$38,726	$38,727	$0	$143,841	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
HB 09-1293 Hospital Provider Fee Expansion Adults to 100% and Adults without Dependent Children	$24,000,890	$0	$6,000,222	$0	$18,000,668	75.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293 Hospital Provider Fee Buy-In for Disabled Individuals	$11,058,620	$0	$5,529,310	$0	$5,529,310	50.00%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$3,047,628	$1,066,670	$0	$0	$1,980,958	65.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$330,431	$115,651	$0	$0	$214,780	65.00%	General Fund
Estimated FY 2013-14 Capitation Expenditure	**$349,546,763**	**$156,664,997**	**$11,568,259**	**$0**	**$181,313,507**		
Date of Death Retractions	($506,522)	($253,261)	$0	$0	($253,261)	50.00%	
Estimated Recoupments	($981,802)	($460,630)	($30,271)	$0	($490,901)	50.00%	CF: Hospital Provider Fee Cash Fund
Estimated Adults without Dependent Children Reconciliations	$2,490,000	$0	$1,245,000	$0	$1,245,000	50.00%	CF: Hospital Provider Fee Cash Fund
Final Estimated FY 2013-14 Capitation Expenditure	**$350,548,439**	**$155,951,106**	**$12,782,988**	**$0**	**$181,814,345**		
Medicaid Mental Health Fee-for-Service Payments	**$4,680,035**	**$2,340,017**	**$0**	**$0**	**$2,340,018**	50.00%	
Final Estimated FY 2013-14 Medicaid Mental Health Community Programs Expenditure	**$355,228,474**	**$158,291,123**	**$12,782,988**	**$0**	**$184,154,363**		

Cash Funds Report									
Cash Fund	**FY 2011-12**			**FY 2012-13**			**FY 2013-14**		
	Spending Authority	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**
Cash Funds									
Hospital Provider Fee Cash Fund	$10,466,206	$5,722,911	($4,743,295)	$10,466,206	$13,614,743	$3,148,537	$10,466,206	$12,744,261	$2,278,055
Breast and Cervical Cancer Prevention and Treatment Fund	$44,017	$41,165	($2,852)	$44,017	$34,189	($9,828)	$44,017	$38,727	($5,290)
Total Cash Funds	**$10,510,223**	**$5,764,076**	**($4,746,147)**	**$10,510,223**	**$13,648,932**	**$3,138,709**	**$10,510,223**	**$12,782,988**	**$2,272,765**
Reappropriated Funds - Transfers from the Department of Public Health and Environment									
(9) Prevention Services Division; (A) Prevention Programs, (3) Chronic Disease and Cancer Prevention Grants Program	$13,544	$25,046	$11,502	$13,544	$0	($13,544)	$13,544	$0	($13,544)
Total Reappropriated Funds	**$13,544**	**$25,046**	**$11,502**	**$13,544**	**$0**	**($13,544)**	**$13,544**	**$0**	**($13,544)**

Exhibit CC - Medicaid Mental Health Community Programs Expenditure Summary

Actuals, Appropriations and Estimates Prior to Recoupments

ITEM	FY 2010-11 Actual		FY 2011-12 Appropriated		FY 2011-12 Estimate		FY 2011-12 Change from Appropriation		FY 2012-13 Estimate		FY 2012-13 Change from FY 2011-12 Estimate		FY 2012-13 Change from FY 2011-12 Appropriation		FY 2013-14 Estimate		FY 2013-14 Change from FY 2012-13 Estimate	
	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure
Mental Health Capitation Payments																		
Adults 65 and Older (OAP-A)	38,921	$6,265,262	39,556	$6,179,742	39,867	$6,561,189	311	$381,447	40,820	$6,734,584	953	$173,395	1,264	$554,842	41,914	$7,122,734	1,094	$388,150
Disabled Individuals Through 64 (AND/AB, OAP-B)	64,052	$112,579,810	70,268	$126,618,910	68,046	$122,289,478	(2,222)	($4,329,432)	73,254	$135,666,988	5,208	$13,377,510	2,986	$9,048,078	79,346	$155,116,170	6,092	$19,449,182
Low Income Adults	116,149	$31,142,656	129,767	$35,925,352	137,227	$38,189,772	7,460	$2,264,420	153,880	$44,169,120	16,653	$5,979,348	24,113	$8,243,768	164,489	$48,887,048	10,609	$4,717,928
Adults without Dependent Children	0	$0	16,400	$0	1,667	$1,491,341	(14,733)	$1,491,341	10,000	$9,443,024	8,333	$7,951,683	(6,400)	$9,443,024	10,000	$10,083,870	0	$640,846
Eligible Children (AFDC-C/BC)	302,410	$57,953,130	316,392	$61,721,658	336,582	$68,496,390	20,190	$6,774,732	367,649	$79,281,853	31,067	$10,785,463	51,257	$17,560,195	399,867	$90,738,535	32,218	$11,456,682
Foster Care	18,393	$43,070,676	18,878	$42,966,292	18,141	$39,274,793	(737)	($3,691,499)	18,159	$37,736,831	18	($1,537,962)	(719)	($5,229,461)	18,264	$37,377,112	105	($359,719)
Breast and Cervical Cancer Program	531	$134,493	595	$164,458	610	$167,707	15	$3,249	679	$195,363	69	$27,656	84	$30,905	743	$221,294	64	$25,931
Sub-total Mental Health Capitation Payments	**540,456**	**$251,146,027**	**591,856**	**$273,576,412**	**602,140**	**$276,470,670**	**10,284**	**$2,894,258**	**664,441**	**$313,227,763**	**62,301**	**$36,757,093**	**72,585**	**$39,651,351**	**714,623**	**$349,546,763**	**50,182**	**$36,319,000**
Recoupments for Prior Years' Payments for Ineligibles		$1,793,362		($1,084,255)		($689,563)		$394,692		($1,672,249)		($982,686)		($587,994)		($981,802)		$690,447
Reconciliations for Adults without Dependent Children		$0		$0		$0		$0		$1,588,000		$1,588,000		$1,588,000		$2,490,000		$902,000
Date of Death Retractions [(1)]		($556,269)		$0		($625,337)		($625,337)		($562,802)		$62,535		($562,802)		($506,522)		$56,280
Total Mental Health Capitation Payments	**540,456**	**$252,939,389**	**591,856**	**$272,492,157**	**602,140**	**$275,155,770**	**10,284**	**$2,663,613**	**664,441**	**$312,580,712**	**62,301**	**$37,424,942**	**72,585**	**$40,088,555**	**714,623**	**$350,548,439**	**652,322**	**$37,967,727**
Incremental Percent Change							**1.74%**	**0.98%**			10.35%	13.60%	12.26%	14.71%			1047.05%	12.15%
Mental Health Fee-for Service-Payments																		
Inpatient Services		$802,447		$810,373		$557,236		($253,137)		$614,891		$57,655		($195,482)		$661,331		$46,440
Outpatient Services		$2,971,816		$3,001,171		$3,245,419		$244,248		$3,581,209		$335,790		$580,038		$3,851,680		$270,471
Physician Services		$96,331		$97,283		$140,734		$43,451		$155,295		$14,561		$58,012		$167,024		$11,729
Total Mental Health Fee-for-Service Payments		**$3,870,594**		**$3,908,827**		**$3,943,389**		**$34,562**		**$4,351,395**		**$408,006**		**$442,568**		**$4,680,035**		**$328,640**
Total Mental Health Community Programs		**$256,809,982**		**$276,400,984**		**$279,099,159**		**$2,698,175**		**$316,932,107**		**$37,832,948**		**$40,531,123**		**$355,228,474**		**$38,296,367**
Incremental Percent Change								0.98%				13.56%		14.66%				12.08%

[1] Date of death retractions are already included in FY 2010-11 actual expenditure figures; the total amount of retractions is presented here for informational purposes.

Exhibit DD - Medicaid Mental Health Community Programs, Caseload

Medicaid Mental Health Community Programs Caseload

Item	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/ BC)	Foster Care	Breast and Cervical Cancer Program	TOTAL MENTAL HEALTH
FY 2005-06 Actuals	36,207	53,897	64,004	-	214,158	16,460	188	384,914
FY 2006-07 Actuals	35,888	54,858	61,031	-	205,390	16,724	228	374,119
% Change from FY 2005-06	-0.88%	1.78%	-4.65%	0.00%	-4.09%	1.60%	21.28%	-2.80%
FY 2007-08 Actuals	36,284	56,079	59,761	-	204,022	17,141	270	373,557
% Change from FY 2006-07	1.10%	2.23%	-2.08%	0.00%	-0.67%	2.49%	18.42%	-0.15%
FY 2008-09 Actuals	37,619	57,802	68,850	-	235,129	18,033	317	417,750
% Change from FY 2007-08	3.68%	3.07%	15.21%	0.00%	15.25%	5.20%	17.41%	11.83%
FY 2009-10 Actuals	38,487	60,313	85,907	-	275,672	18,381	425	479,185
% Change from FY 2008-09	2.31%	4.34%	24.77%	0.00%	17.24%	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,921	64,052	116,149	-	302,410	18,393	531	540,456
% Change from FY 2009-10	1.13%	6.20%	35.20%	0.00%	9.70%	0.07%	24.94%	12.79%
FY 2011-12 Projection	39,867	68,046	137,227	1,667	336,582	18,141	610	602,140
% Change from FY 2010-11	2.43%	6.24%	18.15%	100.00%	11.30%	-1.37%	14.88%	11.41%
FY 2012-13 Projection	40,820	73,254	153,880	10,000	367,649	18,159	679	664,441
% Change from FY 2011-12	2.39%	7.65%	12.14%	499.88%	9.23%	0.10%	11.31%	10.35%
FY 2013-14 Projection	41,914	79,346	164,489	10,000	399,867	18,264	743	714,623
% Change from FY 2012-13	2.68%	8.32%	6.89%	0.00%	8.76%	0.58%	9.43%	7.55%
FY 2011-12 Appropriation	39,556	70,268	129,767	16,400	316,392	18,878	595	591,856
Difference between the FY 2011-12 Appropriation and the FY 2011-12 Projection	311	(2,222)	7,460	(14,733)	20,190	(737)	15	10,284

Expanded Medicaid Caseload for Mental Health Community Programs

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB) [1]	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Baby Care Program-Adults	Adults without Dependent Children	Eligible Children (AFDC-C/ BC)	Foster Care	Breast and Cervical Cancer Program	TOTAL MENTAL HEALTH
FY 2005-06 Actuals	36,207	6,042	47,855	58,885	-	-	5,119	-	214,158	16,460	188	384,914
FY 2006-07 Actuals	35,888	6,059	48,799	50,687	5,162	-	5,182	-	205,390	16,724	228	374,119
% Change from FY 2005-06	-0.88%	0.28%	1.97%	-13.92%	100.00%	0.00%	1.23%	0.00%	-4.09%	1.60%	21.28%	-2.80%
FY 2007-08 Actuals	36,284	6,146	49,933	44,555	8,918	-	6,288	-	204,022	17,141	270	373,557
% Change from FY 2006-07	1.10%	1.44%	2.32%	-12.10%	72.76%	0.00%	21.34%	0.00%	-0.67%	2.49%	18.42%	-0.15%
FY 2008-09 Actuals	37,619	6,447	51,355	49,147	12,727	-	6,976	-	235,129	18,033	317	417,750
% Change from FY 2007-08	3.68%	4.90%	2.85%	10.31%	42.71%	0.00%	10.94%	0.00%	15.25%	5.20%	17.41%	11.83%
FY 2009-10 Actuals	38,487	7,049	53,264	57,661	17,178	3,238	7,830	-	275,672	18,381	425	479,185
% Change from FY 2008-09	2.31%	9.34%	3.72%	17.32%	34.97%	100.00%	12.24%	0.00%	17.24%	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,921	7,767	56,285	60,960	20,154	27,167	7,868	-	302,410	18,393	531	540,456
% Change from FY 2009-10	1.13%	10.19%	5.67%	5.72%	17.32%	739.01%	0.49%	0.00%	9.70%	0.07%	24.94%	12.79%
FY 2011-12 Projection	39,867	8,399	59,647	70,299	24,050	35,406	7,472	1,667	336,582	18,141	610	602,140
% Change from FY 2010-11	2.43%	8.14%	5.97%	15.32%	19.33%	30.33%	-5.03%	100.00%	11.30%	-1.37%	14.88%	11.41%
FY 2012-13 Projection	40,820	8,948	64,306	77,455	26,498	42,381	7,546	10,000	367,649	18,159	679	664,441
% Change from FY 2011-12	2.39%	6.54%	7.81%	10.18%	10.18%	19.70%	0.99%	499.88%	9.23%	0.10%	11.31%	10.35%
FY 2013-14 Projection	41,914	9,491	69,855	81,351	27,831	46,835	8,472	10,000	399,867	18,264	743	714,623
% Change from FY 2012-13	2.68%	6.07%	8.63%	5.03%	5.03%	10.51%	12.27%	0.00%	8.76%	0.58%	9.43%	7.55%
FY 2011-12 Appropriation	39,556	8,098	62,170	64,432	23,628	34,050	7,657	16,400	316,392	18,878	595	591,856
Difference between the FY 2011-12 Appropriation and the FY 2011-12 Projection	311	301	(2,523)	5,867	422	1,356	(185)	(14,733)	20,190	(737)	15	10,284

[1] The caseload for disabled individuals to 59 includes the disabled buy-in population funded by the Hospital Provider Fee Cash Fund. This expansion will take effect in FY 2011-12.

Exhibit DD - Medicaid Mental Health Community Programs, Mental Health Capitation Payments Per Capita Historical Summary

Mental Health Capitation Payments Per Capita History

Item	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/ BC)	Foster Care	Breast and Cervical Cancer Program	TOTAL PER CAPITA
FY 2006-07 Actuals	$163.47	$1,316.67	$209.68	-	$170.95	$3,503.51	$191.14	$493.53
FY 2007-08 Actuals	$159.45	$1,473.28	$243.04	-	$184.13	$3,235.25	$222.88	$524.72
% Change from FY 2006-07	-2.46%	11.89%	15.91%	0.00%	7.71%	-7.66%	16.61%	6.32%
FY 2008-09 Actuals	$163.48	$1,593.93	$247.30	-	$185.92	$3,147.83	$230.52	$516.72
% Change from FY 2007-08	2.53%	8.19%	1.75%	0.00%	0.97%	-2.70%	3.43%	-1.52%
FY 2009-10 Actuals	$148.47	$1,632.73	$247.36	-	$180.47	$2,792.78	$230.48	$472.93
% Change from FY 2008-09	-9.18%	2.43%	0.02%	0.00%	-2.93%	-11.28%	-0.02%	-8.47%
FY 2010-11 Actuals	$160.97	$1,757.63	$268.13	-	$191.64	$2,341.69	$253.28	$464.69
% Change from FY 2009-10	8.42%	7.65%	8.40%	0.00%	6.19%	-16.15%	9.89%	-1.74%
FY 2011-12 Projection	$161.77	$1,790.10	$278.22	$894.63	$203.49	$2,164.19	$273.73	$458.11
% Change from FY 2010-11	0.50%	1.85%	3.76%	100.00%	6.18%	-7.58%	8.07%	-1.42%
FY 2012-13 Projection	$162.51	$1,846.10	$286.97	$944.30	$215.63	$2,077.43	$286.75	$470.57
% Change from FY 2011-12	0.46%	3.13%	3.14%	5.55%	5.97%	-4.01%	4.76%	2.72%
FY 2013-14 Projection	$167.77	$1,950.03	$297.15	$1,008.39	$226.91	$2,045.86	$297.04	$488.43
% Change from FY 2012-13	0.48%	2.49%	3.45%	52.78%	6.08%	-5.80%	6.42%	0.65%

Expanded Medicaid Per Capita Summary for Mental Health Capitation Payments

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Baby Care Program-Adults	Adults without Dependent Children	Eligible Children (AFDC-C/ BC)	Foster Care	Breast and Cervical Cancer Program	TOTAL PER CAPITA
FY 2006-07 Actuals	$163.47	$1,266.28	$1,322.93	$209.42	$199.14	-	$222.77	-	$170.95	$3,503.51	$191.14	$493.53
FY 2007-08 Actuals	$159.45	$1,400.04	$1,482.29	$245.09	$238.32	-	$235.19	-	$184.13	$3,235.25	$222.88	$524.72
% Change from FY 2006-07	-2.46%	10.56%	12.05%	17.03%	19.67%	0.00%	5.58%	0.00%	7.71%	-7.66%	16.61%	6.32%
FY 2008-09 Actuals	$163.48	$1,511.57	$1,604.27	$252.17	$244.48	-	$218.14	-	$185.92	$3,147.83	$230.52	$516.72
% Change from FY 2007-08	2.53%	7.97%	8.23%	2.89%	2.58%	0.00%	-7.25%	0.00%	0.97%	-2.70%	3.43%	-1.52%
FY 2009-10 Actuals	$148.47	$1,537.50	$1,645.34	$253.36	$257.25	$198.60	$201.68	-	$180.47	$2,792.78	$230.48	$472.93
% Change from FY 2008-09	-9.18%	1.72%	2.56%	0.47%	5.22%	100.00%	-7.55%	0.00%	-2.93%	-11.28%	-0.02%	-8.47%
FY 2010-11 Actuals	$160.97	$1,659.68	$1,771.15	$284.94	$218.34	$281.77	$218.28	-	$191.64	$2,341.69	$253.28	$464.69
% Change from FY 2009-10	8.42%	7.95%	7.65%	12.46%	-15.13%	41.88%	8.23%	0.00%	6.19%	-16.15%	9.89%	-1.74%
FY 2011-12 Projection	$161.77	$1,790.10	$1,790.10	$278.22	$278.22	$278.22	$278.22	$894.63	$203.49	$2,164.19	$273.73	$458.11
% Change from FY 2010-11	0.50%	7.86%	1.07%	-2.36%	27.43%	-1.26%	27.46%	100.00%	6.18%	-7.58%	8.07%	-1.42%
FY 2012-13 Projection	$162.51	$1,846.10	$1,846.10	$286.97	$286.97	$286.97	$286.97	$944.30	$215.63	$2,077.43	$286.75	$470.57
% Change from FY 2011-12	0.46%	3.13%	3.13%	3.14%	3.14%	3.14%	3.14%	5.55%	5.97%	-4.01%	4.76%	2.72%
FY 2013-14 Projection	$167.77	$1,950.03	$1,950.03	$297.15	$297.15	$297.15	$297.15	$1,008.39	$226.91	$2,045.86	$297.04	$488.43
% Change from FY 2012-13	3.24%	5.63%	5.63%	3.55%	3.55%	3.55%	3.55%	6.79%	5.23%	-1.52%	3.59%	3.80%

Exhibit DD - Medicaid Mental Health Community Programs, Expenditures Historical Summary

Annual Total Expenditures

Item		Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Breast & Cervical Cancer Program	MENTAL HEALTH TOTAL
FY 2006-07	Capitations	$5,866,615	$72,229,819	$12,797,159	$0	$35,110,732	$58,592,664	$43,579	$184,640,568
	Fee-For-Service								
	Inpatient Services	$18,654	$247,165	$55,477	$0	$46,028	$14,448	$0	$381,772
	Outpatient Services	$8,844	$272,393	$271,742	$0	$306,454	$101,237	$0	$960,670
	Physician Services	$394	$16,272	$2,931	$0	$3,885	$1,943	$0	$25,425
	Sub-Total Fee-For-Service	$27,892	$535,830	$330,150	$0	$356,367	$117,628	$0	$1,367,867
	Total FY 2006-07 Expenditures	**$5,894,507**	**$72,765,649**	**$13,127,309**	**$0**	**$35,467,099**	**$58,710,292**	**$43,579**	**$186,008,435**
FY 2007-08	Capitations	$5,785,556	$82,620,046	$14,524,307	$0	$37,565,608	$55,455,338	$60,178	$196,011,033
	Fee-For-Service								
	Inpatient Services	$7,069	$221,467	$45,469	$0	$93,439	$46,660	$0	$414,104
	Outpatient Services	$12,721	$267,020	$231,300	$0	$282,037	$74,411	$0	$867,489
	Physician Services	$479	$32,552	$9,170	$0	$8,970	$2,972	$0	$54,143
	Sub-Total Fee-For-Service	$20,269	$521,039	$285,939	$0	$384,446	$124,043	$0	$1,335,736
	Total FY 2007-08 Expenditures	**$5,805,825**	**$83,141,085**	**$14,810,246**	**$0**	**$37,950,054**	**$55,579,381**	**$60,178**	**$197,346,769**
	% Change from FY 2006-07	**-1.50%**	**14.26%**	**12.82%**	**0.00%**	**7.00%**	**-5.33%**	**38.09%**	**6.10%**
FY 2008-09	Capitations	$6,149,782	$92,132,599	$17,026,544	$0	$43,714,042	$56,764,896	$73,074	$215,860,937
	Fee-For-Service								
	Inpatient Services	$22,235	$331,864	$107,478	$0	$171,764	$8,913	$0	$642,254
	Outpatient Services	$9,657	$284,108	$300,557	$0	$364,710	$103,091	$0	$1,062,123
	Physician Services	$285	$37,367	$12,386	$0	$13,685	$8,153	$0	$71,876
	Sub-Total Fee-For-Service	$32,177	$653,339	$420,421	$0	$550,159	$120,157	$0	$1,776,253
	Total FY 2008-09 Expenditures	**$6,181,959**	**$92,785,938**	**$17,446,965**	**$0**	**$44,264,201**	**$56,885,053**	**$73,074**	**$217,637,190**
	% Change from FY 2007-08	**6.48%**	**11.60%**	**17.80%**	**0.00%**	**16.64%**	**2.35%**	**21.43%**	**10.28%**
FY 2009-10 [1]	Capitations	$5,714,066	$98,475,008	$21,250,051	$0	$49,749,580	$51,334,158	$97,955	$226,620,818
	Fee-For-Service								
	Inpatient Services	$36,707	$327,355	$24,703	$0	$184,094	$23,702	$0	$596,561
	Outpatient Services	$18,805	$528,618	$623,741	$0	$601,664	$139,423	$0	$1,912,251
	Physician Services	$61	$45,659	$6,543	$0	$22,296	$4,291	$0	$78,850
	Sub-Total Fee-For-Service	$55,573	$901,632	$654,987	$0	$808,054	$167,416	$0	$2,587,662
	Total FY 2009-10 Expenditures	**$5,769,639**	**$99,376,640**	**$21,905,038**	**$0**	**$50,557,634**	**$51,501,574**	**$97,955**	**$229,208,480**
	% Change from FY 2008-09	**-6.67%**	**7.10%**	**25.55%**	**0.00%**	**14.22%**	**-9.46%**	**34.05%**	**5.32%**
FY 2010-11 [1]	Capitations	$6,265,262	$112,579,810	$31,142,656	$0	$57,953,130	$43,070,676	$134,493	$251,146,027
	Fee-For-Service								
	Inpatient Services	$26,281	$462,018	$73,357	$0	$209,493	$31,297	$0	$802,447
	Outpatient Services	$19,668	$838,729	$1,066,059	$0	$843,338	$204,022	$0	$2,971,816
	Physician Services	$44	$53,652	$13,542	$0	$19,019	$10,074	$0	$96,331
	Sub-Total Fee-For-Service	$45,993	$1,354,399	$1,152,958	$0	$1,071,850	$245,393	$0	$3,870,594
	Total FY 2010-11 Expenditures	**$6,311,255**	**$113,934,209**	**$32,295,614**	**$0**	**$59,024,980**	**$43,316,069**	**$134,493**	**$255,016,621**
	% Change from FY 2009-10	**9.39%**	**14.65%**	**47.43%**	**0.00%**	**16.75%**	**-15.89%**	**37.30%**	**11.26%**

[1] FY 2009-10 and FY 2010-11 have been adjusted for one-time recoupments

Exhibit DD - Medicaid Mental Health Community Programs Expenditures Historical Summary

Expanded Annual Total Expenditures

Item		Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Baby Care Program-Adults	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Breast & Cervical Cancer Program	MENTAL HEALTH TOTAL
FY 2006-07	Capitations	$5,866,615	$7,672,363	$64,557,456	$10,614,800	$1,027,979	$0	$1,154,380	$0	$35,110,732	$58,592,664	$43,579	$184,640,568
	Fee-For-Service												
	Inpatient Services	$18,654	$0	$247,165	$42,853	$4,150	$0	$8,474	$0	$46,028	$14,448	$0	$381,772
	Outpatient Services	$8,844	$14,190	$258,203	$247,938	$24,011	$0	($207)	$0	$306,454	$101,237	$0	$960,670
	Physician Services	$394	$380	$15,892	$2,427	$235	$0	$269	$0	$3,885	$1,943	$0	$25,425
	Sub-Total Fee-For-Service	$27,892	$14,570	$521,260	$293,218	$28,396	$0	$8,536	$0	$356,367	$117,628	$0	$1,367,867
	Total FY 2006-07 Expenditures	**$5,894,507**	**$7,686,933**	**$65,078,716**	**$10,908,018**	**$1,056,375**	**$0**	**$1,162,916**	**$0**	**$35,467,099**	**$58,710,292**	**$43,579**	**$186,008,435**
FY 2007-08	Capitations	$5,785,556	$8,604,645	$74,015,401	$10,920,110	$2,125,310	$0	$1,478,887	$0	$37,565,608	$55,455,338	$60,178	$196,011,033
	Fee-For-Service												
	Inpatient Services	$7,069	$13,110	$208,357	$36,603	$8,866	$0	$0	$0	$93,439	$46,660	$0	$414,104
	Outpatient Services	$12,721	$14,262	$252,758	$181,408	$43,943	$0	$5,949	$0	$282,037	$74,411	$0	$867,489
	Physician Services	$479	$2,275	$30,277	$6,235	$1,510	$0	$1,425	$0	$8,970	$2,972	$0	$54,143
	Sub-Total Fee-For-Service	$20,269	$29,647	$491,392	$224,245	$54,320	$0	$7,374	$0	$384,446	$124,043	$0	$1,335,736
	Total FY 2007-08 Expenditures	**$5,805,825**	**$8,634,292**	**$74,506,793**	**$11,144,355**	**$2,179,630**	**$0**	**$1,486,261**	**$0**	**$37,950,054**	**$55,579,381**	**$60,178**	**$197,346,769**
	% Change from FY 2006-07	**-1.50%**	**12.32%**	**14.49%**	**2.17%**	**100.00%**	**0.00%**	**27.80%**	**0.00%**	**7.00%**	**-5.33%**	**38.09%**	**6.10%**
FY 2008-09	Capitations	$6,149,782	$9,745,116	$82,387,483	$12,393,351	$3,111,446	$0	$1,521,747	$0	$43,714,042	$56,764,896	$73,074	$215,860,937
	Fee-For-Service												
	Inpatient Services	$22,235	$9,653	$322,211	$85,371	$22,107	$0	$0	$0	$171,764	$8,913	$0	$642,254
	Outpatient Services	$9,657	$19,613	$264,495	$231,456	$59,937	$0	$9,164	$0	$364,710	$103,091	$0	$1,062,123
	Physician Services	$285	$1,580	$35,787	$8,969	$1,904	$0	$1,513	$0	$13,685	$8,153	$0	$71,876
	Sub-Total Fee-For-Service	$32,177	$30,846	$622,493	$325,796	$83,948	$0	$10,677	$0	$550,159	$120,157	$0	$1,776,253
	Total FY 2008-09 Expenditures	**$6,181,959**	**$9,775,962**	**$83,009,976**	**$12,719,147**	**$3,195,394**	**$0**	**$1,532,424**	**$0**	**$44,264,201**	**$56,885,053**	**$73,074**	**$217,637,190**
	% Change from FY 2007-08	**6.48%**	**13.22%**	**11.41%**	**14.13%**	**46.60%**	**0.00%**	**3.11%**	**0.00%**	**16.64%**	**2.35%**	**21.43%**	**10.28%**
FY 2009-10 [(1)]	Capitations	$5,714,066	$10,837,828	$87,637,180	$14,608,762	$4,419,081	$643,078	$1,579,130	$0	$49,749,580	$51,334,158	$97,955	$226,620,818
	Fee-For-Service												
	Inpatient Services	$36,707	$0	$327,355	$18,244	$5,435	$1,024	$0	$0	$184,094	$23,702	$0	$596,561
	Outpatient Services	$18,805	$35,433	$493,185	$443,259	$132,053	$24,891	$23,538	$0	$601,664	$139,423	$0	$1,912,251
	Physician Services	$61	$631	$45,028	$3,657	$1,090	$205	$1,591	$0	$22,296	$4,291	$0	$78,850
	Sub-Total Fee-For-Service	$55,573	$36,064	$865,568	$465,160	$138,578	$26,120	$25,129	$0	$808,054	$167,416	$0	$2,587,662
	Total FY 2009-10 Expenditures	**$5,769,639**	**$10,873,892**	**$88,502,748**	**$15,073,922**	**$4,557,659**	**$669,198**	**$1,604,259**	**$0**	**$50,557,634**	**$51,501,574**	**$97,955**	**$229,208,480**
	% Change from FY 2008-09	**-6.67%**	**11.23%**	**6.62%**	**18.51%**	**42.63%**	**100.00%**	**4.69%**	**0.00%**	**14.22%**	**-9.46%**	**34.05%**	**5.32%**
FY 2010-11 [(1)]	Capitations	$6,265,262	$12,890,748	$99,689,062	$17,369,817	$4,400,500	$7,654,920	$1,717,419	$0	$57,953,130	$43,070,676	$134,493	$251,146,027
	Fee-For-Service												
	Inpatient Services	$26,281	$0	$462,018	$41,298	$13,654	$18,405	$0	$0	$209,493	$31,297	$0	$802,447
	Outpatient Services	$19,668	$54,047	$784,682	$584,992	$193,410	$260,702	$26,955	$0	$843,338	$204,022	$0	$2,971,816
	Physician Services	$44	$559	$53,093	$6,489	$2,145	$2,892	$2,017	$0	$19,019	$10,074	$0	$96,331
	Sub-Total Fee-For-Service	$45,993	$54,606	$1,299,792	$632,779	$209,209	$281,999	$28,972	$0	$1,071,850	$245,393	$0	$3,870,594
	Total FY 2010-11 Expenditures	**$6,311,255**	**$12,945,354**	**$100,988,854**	**$18,002,596**	**$4,609,709**	**$7,936,919**	**$1,746,391**	**$0**	**$59,024,980**	**$43,316,069**	**$134,493**	**$255,016,621**
	% Change from FY 2009-10	**9.39%**	**19.05%**	**14.11%**	**19.43%**	**1.14%**	**1086.03%**	**8.86%**	**0.00%**	**16.75%**	**-15.89%**	**37.30%**	**11.26%**

[1] FY 2009-10 and FY 2010-11 have been adjusted for one-time recoupments

Exhibit EE - Expenditure Calculations by Eligibility Category

Mental Health Capitation Calculations by Eligibility Category for FY 2011-12

FY 2011-12 Q1 and Q2 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Weighted Capitation Rate	$13.89	$150.13	$23.13	-	$16.47	$185.90	$22.17	
Average Monthly Caseload	39,635	67,241	131,936	0	327,398	18,112	594	584,916
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Costs for FY 2011-12 Q1 and Q2 Capitated Payments	$3,303,113	$60,570,005	$18,313,628	$0	$32,358,524	$20,202,312	$79,019	$134,826,601
Percentage of Claims Paid in Current Period with Current Period Dates of Service[2]	97.88%	93.30%	94.71%	-	96.63%	99.26%	98.71%	
Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,233,229	$56,512,744	$17,344,819	$0	$31,268,478	$20,052,898	$77,999	$128,490,167
Expenditures for Prior Period Dates of Service	$67,262	$3,699,937	$772,828	$0	$962,051	$143,805	$1,189	$5,647,072
Total Expenditures in FY 2011-12 Q1 and Q2	**$3,300,491**	**$60,212,681**	**$18,117,647**	**$0**	**$32,230,529**	**$20,196,703**	**$79,188**	**$134,137,239**

FY 2011-12 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$13.55	$150.86	$23.60	$78.69	$17.55	$174.91	$23.60	
Estimated Monthly Caseload[1]	40,099	68,851	142,518	3,333	345,766	18,170	626	619,363
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2011-12 Q3 and Q4 Capitated Payments	$3,260,049	$62,321,171	$20,180,549	$1,573,643	$36,409,160	$19,068,688	$88,642	$142,901,902
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service[2]	97.89%	93.31%	94.77%	94.77%	96.66%	99.26%	98.74%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,191,262	$58,151,885	$19,125,106	$1,491,341	$35,193,094	$18,927,580	$87,525	$136,167,793
Estimated Expenditures for Prior Period Dates of Service	$69,436	$3,924,912	$947,019	$0	$1,072,767	$150,510	$994	$6,165,638
Total Estimated Expenditures in FY 2011-12 Q3 and Q4	**$3,260,698**	**$62,076,797**	**$20,072,125**	**$1,491,341**	**$36,265,861**	**$19,078,090**	**$88,519**	**$142,333,431**
Total Estimated FY 2011-12 Expenditures	**$6,561,189**	**$122,289,478**	**$38,189,772**	**$1,491,341**	**$68,496,390**	**$39,274,793**	**$167,707**	**$276,470,670**
Estimated Date of Death Retractions	($112,082)	($480,542)	($11,056)	$0	($6,660)	($14,263)	($734)	($625,337)
Total Estimated FY 2011-12 Expenditures Including Date of Death Retractions	**$6,449,107**	**$121,808,936**	**$38,178,716**	**$1,491,341**	**$68,489,730**	**$39,260,530**	**$166,973**	**$275,845,333**
Estimated FY 2011-12 Monthly Caseload	39,867	68,046	137,227	1,667	336,582	18,141	610	602,140
Estimated FY 2011-12 Per Capita Expenditure	**$161.77**	**$1,790.10**	**$278.22**	**$894.63**	**$203.49**	**$2,164.19**	**$273.73**	**$458.11**

[1] This number is based on the projected average monthly caseload for the entire fiscal year, as applied through each month's trended growth in caseload.

[2] Exhibit EE, pages 4 and 5 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

Exhibit EE - Expenditure Calculations by Eligibility Category

Mental Health Capitation Calculations by Eligibility Category for FY 2012-13

FY 2012-13 Q1 and Q2 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$13.55	$150.86	$23.60	$78.69	$17.55	$174.91	$23.60	
Estimated Monthly Caseload[1]	40,571	71,466	150,344	10,000	359,587	18,163	661	650,792
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2012-13 Q1 and Q2 Capitated Payments	$3,298,422	$64,688,165	$21,288,710	$4,721,400	$37,864,511	$19,061,342	$93,598	$151,016,148
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service[2]	97.89%	93.31%	94.77%	94.77%	96.66%	99.26%	98.74%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,228,825	$60,360,527	$20,175,310	$4,474,471	$36,599,836	$18,920,288	$92,419	$143,851,676
Estimated Expenditures for Prior Period Dates of Service	$68,972	$4,097,036	$1,040,134	$69,398	$1,199,458	$143,036	$1,114	$6,619,148
Total Estimated Expenditures in FY 2012-13 Q1 and Q2	**$3,297,797**	**$64,457,563**	**$21,215,444**	**$4,543,869**	**$37,799,294**	**$19,063,324**	**$93,533**	**$150,470,824**

FY 2012-13 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$13.96	$159.39	$24.41	$82.27	$18.46	$171.40	$24.41	
Estimated Monthly Caseload[1]	41,069	75,042	157,416	10,000	375,711	18,155	696	678,089
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2012-13 Q3 and Q4 Capitated Payments	$3,439,939	$71,765,666	$23,055,147	$4,936,200	$41,613,750	$18,670,602	$101,936	$163,583,240
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service[2]	97.89%	93.31%	94.77%	94.77%	96.66%	99.26%	98.74%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,367,356	$66,964,543	$21,849,363	$4,678,037	$40,223,851	$18,532,440	$100,652	$155,716,242
Estimated Expenditures for Prior Period Dates of Service	$69,431	$4,244,882	$1,104,313	$221,118	$1,258,708	$141,067	$1,178	$7,040,697
Total Estimated Expenditures in FY 2012-13 Q3 and Q4	**$3,436,787**	**$71,209,425**	**$22,953,676**	**$4,899,155**	**$41,482,559**	**$18,673,507**	**$101,830**	**$162,756,939**
Total Estimated FY 2012-13 Expenditures	**$6,734,584**	**$135,666,988**	**$44,169,120**	**$9,443,024**	**$79,281,853**	**$37,736,831**	**$195,363**	**$313,227,763**
Estimated Date of Death Retractions	($100,874)	($432,488)	($9,950)	$0	($5,994)	($12,836)	($660)	($562,802)
Total Estimated FY 2012-13 Expenditures Including Date of Death Retractions	**$6,633,710**	**$135,234,500**	**$44,159,170**	**$9,443,024**	**$79,275,859**	**$37,723,995**	**$194,703**	**$312,664,961**
Estimated FY 2012-13 Monthly Caseload	40,820	73,254	153,880	10,000	367,649	18,159	679	664,441
Estimated FY 2012-13 Per Capita Expenditure	**$162.51**	**$1,846.10**	**$286.97**	**$944.30**	**$215.63**	**$2,077.43**	**$286.75**	**$470.57**

[1] This number is based on the projected average monthly caseload for the entire fiscal year, as applied through each month's trended growth in caseload.

[2] Exhibit EE, pages 4 and 5 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

Exhibit EE - Expenditure Calculations by Eligibility Category

Mental Health Capitation Calculations by Eligibility Category for FY 2013-14

FY 2013-14 Q1 and Q2 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$13.96	$159.39	$24.41	$82.27	$18.46	$171.40	$24.41	
Estimated Monthly Caseload[1]	41,619	78,052	162,362	10,000	388,858	18,212	728	699,831
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2013-14 Q1 and Q2 Capitated Payments	$3,486,007	$74,644,250	$23,779,539	$4,936,200	$43,069,912	$18,729,221	$106,623	$168,751,752
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service[2]	97.89%	93.31%	94.77%	94.77%	96.66%	99.26%	98.74%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,412,452	$69,650,550	$22,535,869	$4,678,037	$41,631,377	$18,590,625	$105,280	$160,604,190
Estimated Expenditures for Prior Period Dates of Service	$71,974	$4,578,350	$1,191,299	$256,401	$1,374,527	$138,826	$1,282	$7,612,659
Total Estimated Expenditures in FY 2013-14 Q1 and Q2	**$3,484,426**	**$74,228,900**	**$23,727,168**	**$4,934,438**	**$43,005,904**	**$18,729,451**	**$106,562**	**$168,216,849**

FY 2013-14 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$14.38	$168.42	$25.25	$86.02	$19.43	$169.68	$25.25	
Estimated Monthly Caseload[1]	42,209	80,640	166,616	10,000	410,876	18,316	758	729,415
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2013-14 Q3 and Q4 Capitated Payments	$3,641,793	$81,488,333	$25,242,324	$5,161,200	$47,899,924	$18,647,153	$114,837	$182,195,564
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service[2]	97.89%	93.31%	94.77%	94.77%	96.66%	99.26%	98.74%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,564,951	$76,036,764	$23,922,150	$4,891,269	$46,300,067	$18,509,164	$113,390	$173,337,755
Estimated Expenditures for Prior Period Dates of Service	$73,357	$4,850,506	$1,237,730	$258,163	$1,432,564	$138,497	$1,342	$7,992,159
Total Estimated Expenditures in FY 2013-14 Q3 and Q4	**$3,638,308**	**$80,887,270**	**$25,159,880**	**$5,149,432**	**$47,732,631**	**$18,647,661**	**$114,732**	**$181,329,914**
Total Estimated FY 2013-14 Expenditures	**$7,122,734**	**$155,116,170**	**$48,887,048**	**$10,083,870**	**$90,738,535**	**$37,377,112**	**$221,294**	**$349,546,763**
Estimated Date of Death Retractions	($90,787)	($389,239)	($8,955)	$0	($5,395)	($11,552)	($594)	($506,522)
Total Estimated FY 2013-14 Expenditures Including Date of Death Retractions	**$7,031,947**	**$154,726,931**	**$48,878,093**	**$10,083,870**	**$90,733,140**	**$37,365,560**	**$220,700**	**$349,040,241**
Estimated FY 2013-14 Monthly Caseload	41,914	79,346	164,489	10,000	399,867	18,264	743	714,623
Estimated FY 2013-14 Per Capita Expenditure	**$167.77**	**$1,950.03**	**$297.15**	**$1,008.39**	**$226.91**	**$2,045.86**	**$297.04**	**$488.43**

[1] This number is based on the projected average monthly caseload for the entire fiscal year, as applied through each month's trended growth in caseload.

[2] Exhibit EE, pages 4 and 5 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

Exhibit EE - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Adults 65 and Older (OAP-A)

	Actuals Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	*0.41%*	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	*1.68%*	0.43%	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	*97.88%*	1.68%	0.43%	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	97.89%	1.68%	0.43%	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	97.89%	1.68%	0.43%	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	97.89%	1.68%	0.43%
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	97.89%	1.68%
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	97.89%

Incurred But Not Reported (IBNR) Estimate for Disabled Individuals Through 64 (AND/AB, OAP-B)

	Actuals Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	*2.81%*	0.86%	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	*3.74%*	2.00%	0.86%	-	-	-
Incurred in FY 2011-12 Q1 and Q2	*93.30%*	3.83%	2.00%	0.86%	-	-
Incurred in FY 2011-12 Q3 and Q4	-	93.31%	3.83%	2.00%	0.86%	-
Incurred in FY 2012-13 Q1 and Q2	-	-	93.31%	3.83%	2.00%	0.86%
Incurred in FY 2012-13 Q3 and Q4	-	-	-	93.31%	3.83%	2.00%
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	93.31%	3.83%
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	93.31%

Incurred But Not Reported (IBNR) Estimate for Low Income Adults

	Actuals Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	*0.74%*	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	*3.92%*	0.82%	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	*94.71%*	4.41%	0.82%	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	94.77%	4.41%	0.82%	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	94.77%	4.41%	0.82%	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	94.77%	4.41%	0.82%
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	94.77%	4.41%
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	94.77%

Incurred But Not Reported (IBNR) Estimate for Adults without Dependent Children

	Actuals Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	-	0.82%	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	-	4.41%	0.82%	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	94.77%	4.41%	0.82%	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	94.77%	4.41%	0.82%	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	94.77%	4.41%	0.82%
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	94.77%	4.41%
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	94.77%

Exhibit EE - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Eligible Children (AFDC-C/BC)

	Actuals Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	*0.47%*	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	*2.74%*	0.41%	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	*96.63%*	2.93%	0.41%	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	96.66%	2.93%	0.41%	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	96.66%	2.93%	0.41%	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	96.66%	2.93%	0.41%
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	96.66%	2.93%
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	96.66%

Incurred But Not Reported (IBNR) Estimate for Foster Care

	Actuals Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	*0.17%*	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	*0.50%*	0.17%	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	*99.26%*	0.57%	0.17%	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	99.26%	0.57%	0.17%	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	99.26%	0.57%	0.17%	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	99.26%	0.57%	0.17%
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	99.26%	0.57%
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	99.26%

Incurred But Not Reported (IBNR) Estimate for Breast and Cervical Cancer Program

	Actuals Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	*0.32%*	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	*1.34%*	0.03%	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	*98.71%*	1.23%	0.03%	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	98.74%	1.23%	0.03%	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	98.74%	1.23%	0.03%	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	98.74%	1.23%	0.03%
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	98.74%	1.23%
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	98.74%

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Adults 65 and Older (OAP-A)

	Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	$12,622	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	$54,640	$13,944	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	$3,233,229	$55,492	$14,203	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	$3,191,262	$54,769	$14,018	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	$3,228,825	$55,413	$14,183	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	$3,367,356	$57,791	$14,792
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	$3,412,452	$58,565
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	$3,564,951
Total Paid in Current Period	$3,233,229	$3,191,262	$3,228,825	$3,367,356	$3,412,452	$3,564,951
Total IBNR Amount	$67,262	$69,436	$68,972	$69,431	$71,974	$73,357
Total Paid for All Incurred Dates	$3,300,491	$3,260,698	$3,297,797	$3,436,787	$3,484,426	$3,638,308

Incurred But Not Reported (IBNR) Estimate for Disabled Individuals Through 64 (AND/AB, OAP-B)

	Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	$1,531,873	$445,233	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	$2,168,064	$1,159,848	$498,735	-	-	-
Incurred in FY 2011-12 Q1 and Q2	$56,512,744	$2,319,831	$1,211,400	$520,902	-	-
Incurred in FY 2011-12 Q3 and Q4	-	$58,151,885	$2,386,901	$1,246,423	$535,962	-
Incurred in FY 2012-13 Q1 and Q2	-	-	$60,360,527	$2,477,557	$1,293,763	$556,318
Incurred in FY 2012-13 Q3 and Q4	-	-	-	$66,964,543	$2,748,625	$1,435,313
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	$69,650,550	$2,858,875
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	$76,036,764
Total Paid in Current Period	$56,512,744	$58,151,885	$60,360,527	$66,964,543	$69,650,550	$76,036,764
Total IBNR Amount	$3,699,937	$3,924,912	$4,097,036	$4,244,882	$4,578,350	$4,850,506
Total Paid for All Incurred Dates	$60,212,681	$62,076,797	$64,457,563	$71,209,425	$74,228,900	$80,887,270

Incurred But Not Reported (IBNR) Estimate for Low Income Adults

	Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	$106,329	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	$666,499	$139,388	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	$17,344,819	$807,631	$150,172	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	$19,125,106	$889,962	$165,481	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	$20,175,310	$938,832	$174,567	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	$21,849,363	$1,016,732	$189,052
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	$22,535,869	$1,048,678
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	$23,922,150
Total Paid in Current Period	$17,344,819	$19,125,106	$20,175,310	$21,849,363	$22,535,869	$23,922,150
Total IBNR Amount	$772,828	$947,019	$1,040,134	$1,104,313	$1,191,299	$1,237,730
Total Paid for All Incurred Dates	$18,117,647	$20,072,125	$21,215,444	$22,953,676	$23,727,168	$25,159,880

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Adults without Dependent Children

	Paid in FY 2011-12 Q1 and	Paid in FY 2011-12 Q3 and	Paid in FY 2012-13 Q1 and	Paid in FY 2012-13 Q3 and	Paid in FY 2013-14 Q1 and	Paid in FY 2013-14 Q3 and
Incurred in all other previous periods	$0	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	$0	$0	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	$0	$0	$0	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	$1,491,341	$69,398	$12,904	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	$4,474,471	$208,214	$38,715	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	$4,678,037	$217,686	$40,477
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	$4,678,037	$217,686
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	$4,891,269
Total Paid in Current Period	$0	$1,491,341	$4,474,471	$4,678,037	$4,678,037	$4,891,269
Total IBNR Amount	$0	$0	$69,398	$221,118	$256,401	$258,163
Total Paid for All Incurred Dates	$0	$1,491,341	$4,543,869	$4,899,155	$4,934,438	$5,149,432

Incurred But Not Reported (IBNR) Estimate for Eligible Children (AFDC-C/BC)

	Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	$128,366	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	$833,685	$124,662	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	$31,268,478	$948,105	$132,670	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	$35,193,094	$1,066,788	$149,278	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	$36,599,836	$1,109,430	$155,244	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	$40,223,851	$1,219,283	$170,616
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	$41,631,377	$1,261,948
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	$46,300,067
Total Paid in Current Period	$31,268,478	$35,193,094	$36,599,836	$40,223,851	$41,631,377	$46,300,067
Total IBNR Amount	$962,051	$1,072,767	$1,199,458	$1,258,708	$1,374,527	$1,432,564
Total Paid for All Incurred Dates	$32,230,529	$36,265,861	$37,799,294	$41,482,559	$43,005,904	$47,732,631

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Foster Care

	Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	$40,418	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	$103,387	$35,357	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	$20,052,898	$115,153	$34,344	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	$18,927,580	$108,692	$32,417	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	$18,920,288	$108,650	$32,404	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	$18,532,440	$106,422	$31,740
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	$18,590,625	$106,757
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	$18,509,164
Total Paid in Current Period	$20,052,898	$18,927,580	$18,920,288	$18,532,440	$18,590,625	$18,509,164
Total IBNR Amount	$143,805	$150,510	$143,036	$141,067	$138,826	$138,497
Total Paid for All Incurred Dates	$20,196,703	$19,078,090	$19,063,324	$18,673,507	$18,729,451	$18,647,661

Incurred But Not Reported (IBNR) Estimate for Breast and Cervical Cancer Program

	Paid in FY 2011-12 Q1 and Q2	Paid in FY 2011-12 Q3 and Q4	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4
Incurred in all other previous periods	$198	-	-	-	-	-
Incurred in FY 2010-11 Q3 and Q4	$991	$22	-	-	-	-
Incurred in FY 2011-12 Q1 and Q2	$77,999	$972	$24	-	-	-
Incurred in FY 2011-12 Q3 and Q4	-	$87,525	$1,090	$27	-	-
Incurred in FY 2012-13 Q1 and Q2	-	-	$92,419	$1,151	$28	-
Incurred in FY 2012-13 Q3 and Q4	-	-	-	$100,652	$1,254	$31
Incurred in FY 2013-14 Q1 and Q2	-	-	-	-	$105,280	$1,311
Incurred in FY 2013-14 Q3 and Q4	-	-	-	-	-	$113,390
Total Paid in Current Period	$77,999	$87,525	$92,419	$100,652	$105,280	$113,390
Total IBNR Amount	$1,189	$994	$1,114	$1,178	$1,282	$1,342
Total Paid for All Incurred Dates	$79,188	$88,519	$93,533	$101,830	$106,562	$114,732

Exhibit FF - Medicaid Mental Health Retroactivity Adjustment

Fiscal Year		Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [1]	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care
FY 2006-07	Average Monthly Claims	36,562	59,698	71,961	-	228,302	17,244
	Average Caseload	35,888	54,858	61,031	-	205,390	16,724
	Claims as a Percentage of Caseload	101.88%	108.82%	117.91%	-	111.16%	103.11%
FY 2007-08	Average Monthly Claims	36,863	60,694	69,316	-	225,108	17,797
	Average Caseload	36,284	56,079	59,761	-	204,022	17,141
	Claims as a Percentage of Caseload	101.59%	108.23%	115.99%	-	110.34%	103.83%
FY 2008-09	Average Monthly Claims	37,848	62,224	77,172	-	251,382	18,587
	Average Caseload	37,619	57,802	68,850	-	235,129	18,033
	Claims as a Percentage of Caseload	100.61%	107.65%	112.09%	-	106.91%	103.07%
FY 2009-10	Average Monthly Claims	38,645	65,336	94,476	-	290,845	18,839
	Average Caseload	38,487	60,313	85,907	-	275,672	18,381
	Claims as a Percentage of Caseload	100.41%	108.33%	109.97%	-	105.50%	102.49%
FY 2010-11	Estimated Average Monthly Claims	38,873	68,064	126,568	-	322,354	18,774
	Average Caseload	38,921	64,052	116,149	-	302,410	18,393
	Claims as a Percentage of Caseload	99.88%	106.26%	108.97%	-	106.60%	102.07%
Weighted Average Claims as a Percentage of Caseload [2]		100.41%	108.33%	109.97%	-	105.50%	102.49%
Retroactivity Adjustment Factor		0.41%	8.33%	9.97%	-	5.50%	2.49%

[1] Breast and Cervical Cancer Program participants share a capitation rate with the Adult population, and comprise less than 1% of that total population. As such, a separate analysis was not performed.

[2] The retroactivity adjustment captures the difference in total claims paid versus caseload due to retroactive eligibility. After analyzing the data and historical trends, the Department determined that the most recent year with adequate runout, which in this request is FY 2009-10, most accurately represents the relationship between average monthly claims and average caseload for all eligibility categories.

Exhibit FF - Medicaid Mental Health Partial Month Adjustment Multiplier

Fiscal Year		Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [1]	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care
FY 2006-07	Weighted Claims-Based Rate	$13.38	$105.59	$14.95	-	$12.80	$280.10
	Weighted Capitation Rate	$13.46	$106.01	$14.96	-	$12.85	$282.90
	Claims as a Percentage of Capitation	99.44%	99.61%	99.95%	-	99.58%	99.01%
FY 2007-08	Weighted Claims-Based Rate	$13.07	$113.59	$17.48	-	$13.87	$260.01
	Weighted Capitation Rate	$13.15	$114.03	$17.51	-	$13.94	$262.46
	Claims as a Percentage of Capitation	99.35%	99.61%	99.84%	-	99.49%	99.07%
FY 2008-09	Weighted Claims-Based Rate	$13.49	$122.69	$18.40	-	$14.47	$253.55
	Weighted Capitation Rate [2]	$13.57	$123.19	$18.47	-	$14.57	$255.40
	Claims as a Percentage of Capitation	99.42%	99.60%	99.63%	-	99.34%	99.28%
FY 2009-10	Weighted Claims-Based Rate	$13.21	$127.20	$18.74	-	$14.21	$225.87
	Weighted Capitation Rate [2]	$13.29	$127.70	$18.82	-	$14.29	$227.45
	Claims as a Percentage of Capitation	99.40%	99.61%	99.56%	-	99.44%	99.30%
FY 2010-11	Weighted Claims-Based Rate	$13.51	$136.44	$20.56	-	$15.10	$191.25
	Weighted Capitation Rate [2]	$13.59	$136.95	$20.64	-	$15.19	$192.53
	Claims as a Percentage of Capitation	99.39%	99.63%	99.63%	-	99.44%	99.33%
Average Claims as a Percentage of Capitation [3]		99.40%	99.61%	99.56%	-	99.44%	99.30%
Partial Month Adjustment Multiplier		-0.60%	-0.39%	-0.44%	-	-0.56%	-0.70%

[1] Breast and Cervical Cancer Program participants share a capitation rate with the Adult population, and comprise less than 1% of that total population. As such, a separate analysis was not performed

[2] The Department has adjusted the rates paid to the BHOs in the last three fiscal years due to budget actions. The numbers provided, here, reflects the actual paid rates and therefore do not match the numbers in Exhibit GG, which demonstrate the trend on the actuarial point estimates.

[3] The partial month adjustment captures the difference in the amount paid per claim versus the capitation rate due to paying an adjusted rate for clients enrolled for only part of a month. After analyzing the data and historical trends, the Department determined that the most recent year with adequate runout, which in this request is FY 2009-10, most accurately represents the relationship between the claims-based rate and the capitation rate for all eligibility categories.

Exhibit GG - Medicaid Mental Health Capitation Rate Trends and Forecasts

Capitation Rate Trends

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [1]	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Weighted Mental Health Total [2]
FY 2006-07 Actuals	**$13.46**	**$106.01**	**$14.96**	-	**$12.85**	**$282.90**	**$38.99**
FY 2007-08 Actuals	**$13.15**	**$114.03**	**$17.51**	-	**$13.94**	**$262.46**	**$40.88**
% Change from FY 2006-07	-2.30%	7.57%	17.05%	-	8.48%	-7.23%	4.84%
FY 2008-09 Actuals [3]	**$13.37**	**$121.30**	**$18.18**	-	**$14.34**	**$251.87**	**$39.96**
% Change from FY 2007-08	1.67%	6.38%	3.83%	-	2.87%	-4.03%	-2.24%
FY 2009-10 Actuals [3]	**$13.40**	**$131.64**	**$19.33**	-	**$14.71**	**$220.67**	**$38.08**
% Change from FY 2008-09	0.22%	8.52%	6.33%	-	2.58%	-12.39%	-4.72%
FY 2010-11 Actuals [3]	**$13.80**	**$139.09**	**$20.94**	-	**$15.41**	**$195.38**	**$37.29**
% Change from FY 2009-10	2.99%	5.66%	8.33%	-	4.76%	-11.46%	-2.07%
FY 2011-12 Q1 and Q2 Known Rate	$14.18	$141.59	$21.77	$0.00	$15.89	$186.86	$36.87
% Change from FY 2010-11	2.75%	1.80%	3.96%	-	3.11%	-4.36%	-1.12%
FY 2011-12 Q3 and Q4 Known Rate	$13.58	$139.80	$21.55	$71.87	$16.73	$171.87	$35.99
% Change from FY 2011-12 Q1 and Q2	-4.23%	-1.26%	-1.01%	-	5.29%	-8.02%	-2.38%
% Change from FY 2010-11	-1.59%	0.51%	2.91%	-	8.57%	-12.03%	-3.48%
FY 2011-12 Known Weighted Average Rate [4]	**$13.88**	**$140.68**	**$21.66**	**$71.87**	**$16.32**	**$179.35**	**$36.42**
% Change from FY 2010-11	0.58%	1.14%	3.44%	-	5.91%	-8.20%	-2.33%
FY 2012-13 Q1 and Q2 Known Rate	$13.58	$139.80	$21.55	$71.87	$16.73	$171.87	$35.80
% Change from FY 2011-12 Q3 and Q4 Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.52%
% Change from FY 2011-12 Average Rate	-2.16%	-0.63%	-0.51%	0.00%	2.51%	-4.17%	-1.69%
FY 2012-13 Q3 and Q4 Estimated Rate	$13.99	$147.71	$22.29	$75.14	$17.60	$168.42	$37.21
% Change from FY 2012-13 Q1 and Q2 Rate	3.02%	5.66%	3.43%	4.55%	5.20%	-2.01%	3.93%
% Change from FY 2012-13 Average Rate	0.79%	5.00%	2.91%	4.55%	7.84%	-6.09%	2.17%
FY 2012-13 Estimated Weighted Average Rate [4]	**$13.79**	**$143.85**	**$21.93**	**$73.51**	**$17.17**	**$170.15**	**$36.52**
% Change from FY 2011-12 Average Rate	-0.65%	2.25%	1.25%	2.28%	5.21%	-5.13%	0.27%
FY 2013-14 Q1 and Q2 Estimated Rate	$13.99	$147.71	$22.29	$75.14	$17.60	$168.42	$37.21
% Change from FY 2012-13 Q3 and Q4 Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% Change from FY 2012-13 Average Rate	1.45%	2.68%	1.64%	2.22%	2.50%	-1.02%	1.89%
FY 2013-14 Q3 and Q4 Estimated Rate	$14.41	$156.07	$23.06	$78.56	$18.52	$166.73	$38.84
% Change from FY 2013-14 Q1 and Q2 Rate	3.00%	5.66%	3.45%	4.55%	5.23%	-1.00%	4.37%
% Change from FY 2013-14 Average Rate	4.50%	8.49%	5.15%	6.87%	7.86%	-2.01%	6.35%
FY 2013-14 Estimated Weighted Average Rate [4]	**$14.20**	**$151.96**	**$22.68**	**$76.85**	**$18.07**	**$167.57**	**$37.88**
% Change from FY 2012-13 Average Rate	2.97%	5.64%	3.42%	4.54%	5.24%	-1.52%	3.72%

[1] Breast and Cervical Cancer Program participants share a capitation rate with the remainder of the Adult population, and comprise less than 1% of that total population. As such, a separate analysis was not performe

[2] The Weighted Mental Health Total is the weighted capitation rate distributed by Behavioral Health Organization (BHO) across each eligibility category based on the total number of claims processed (i.e. Elderly clients age 65 and over make up a percentage of all client claims, and each BHO services some subset of the total number of claims for Elderly clients).

[3] The Department has adjusted the rates paid to the BHOs in the last three fiscal years due to budget actions. The numbers provided, here, reflects the actuarial point estimates prior to budget actions and therefore do not match the numbers in Exhibit FF, which demonstrate the actual paid rates to the BHOs.

[4] The weighted rate is derived by distributing the individual rates across the estimated proportion of caseload seen under the respective half years the two rates are in effec

Exhibit HH - Forecast Model Comparisons - Final Forecasts

Adjustment Factors for Forecasted Rates

Model	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [1]	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care
FY 2011-12 Estimated Q1/Q2 Rate						
Weighted Capitation Point Estimate (Known)	***$14.18***	***$141.59***	***$21.77***	**-**	***$15.89***	***$186.86***
FY 2011-12 Final Paid Q1/Q2 Rate [2]	***$13.89***	***$150.13***	***$23.13***	**-**	***$16.47***	***$185.90***
FY 2011-12 Estimated Q3/Q4 Rate						
Weighted Capitation Point Estimate (Known)	**$13.58**	**$139.80**	**$21.55**	**$71.87**	**$16.73**	**$171.87**
Retroactivity Adjustment Multiplier (Exhibit FF)	0.41%	8.33%	9.97%	9.97%	5.50%	2.49%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.60%	-0.39%	-0.44%	-0.44%	-0.56%	-0.70%
Final Adjustment Factor [3]	**-0.19%**	**7.91%**	**9.49%**	**9.49%**	**4.91%**	**1.77%**
FY 2011-12 Final Estimated Q3/Q4 Rate	**$13.55**	**$150.86**	**$23.60**	**$78.69**	**$17.55**	**$174.91**
FY 2012-13 Estimated Q1/Q2 Rate [4]						
Weighted Capitation Point Estimate (Known)	**$13.58**	**$139.80**	**$21.55**	**$71.87**	**$16.73**	**$171.87**
Retroactivity Adjustment Multiplier (Exhibit FF)	0.41%	8.33%	9.97%	9.97%	5.50%	2.49%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.60%	-0.39%	-0.44%	-0.44%	-0.56%	-0.70%
Final Adjustment Factor [3]	**-0.19%**	**7.91%**	**9.49%**	**9.49%**	**4.91%**	**1.77%**
FY 2012-13 Final Estimated Q1/Q2 Rate	**$13.55**	**$150.86**	**$23.60**	**$78.69**	**$17.55**	**$174.91**
FY 2012-13 Estimated Q3/Q4 Rate						
Weighted Capitation Point Estimate	**$13.99**	**$147.71**	**$22.29**	**$75.14**	**$17.60**	**$168.42**
Retroactivity Adjustment Multiplier (Exhibit FF)	0.41%	8.33%	9.97%	9.97%	5.50%	2.49%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.60%	-0.39%	-0.44%	-0.44%	-0.56%	-0.70%
Final Adjustment Factor [3]	**-0.19%**	**7.91%**	**9.49%**	**9.49%**	**4.91%**	**1.77%**
FY 2012-13 Final Estimated Q3/Q4 Rate	**$13.96**	**$159.39**	**$24.41**	**$82.27**	**$18.46**	**$171.40**

[1] Breast and Cervical Cancer Program participants share a capitation rate with the remainder of the Adult population, and comprise less than 1% of that total population. As such, a forecast for BCCP program eligibles was not performed.

[2] The number presented, here, reflects the final outcome of payment of partial capitations and the estimate of full IBNR based on that component of IBNR runout that has been completed. Because the IBNR component is estimated, this final figure is estimated and may change in future exhibits.

[3] The final adjustment factor is derived by adding 1 to each individual adjustment, multiplying the result, and subtracting 1 from the product.

[4] The rate set for Q3 and Q4 of FY 2011-12 will be the same rate in effect for Q1 and Q2 of FY 2012-13.

Exhibit HH - Forecast Model Comparisons - Final Forecasts

Adjustment Factors for Forecasted Rates

Model	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [1]	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care
FY 2013-14 Estimated Q1/Q2 Rate [3]						
Weighted Capitation Point Estimate	**$13.99**	**$147.71**	**$22.29**	**$75.14**	**$17.60**	**$168.42**
Retroactivity Adjustment Multiplier (Exhibit FF)	0.41%	8.33%	9.97%	9.97%	5.50%	2.49%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.60%	-0.39%	-0.44%	-0.44%	-0.56%	-0.70%
Final Adjustment Factor [2]	**-0.19%**	**7.91%**	**9.49%**	**9.49%**	**4.91%**	**1.77%**
FY 2013-14 Final Estimated Q3/Q4 Rate	**$13.96**	**$159.39**	**$24.41**	**$82.27**	**$18.46**	**$171.40**
FY 2013-14 Estimated Q3/Q4 Rate						
Weighted Capitation Point Estimate	**$14.41**	**$156.07**	**$23.06**	**$78.56**	**$18.52**	**$166.73**
Retroactivity Adjustment Multiplier (Exhibit FF)	0.41%	8.33%	9.97%	9.97%	5.50%	2.49%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.60%	-0.39%	-0.44%	-0.44%	-0.56%	-0.70%
Final Adjustment Factor [2]	**-0.19%**	**7.91%**	**9.49%**	**9.49%**	**4.91%**	**1.77%**
FY 2013-14 Final Estimated Q3/Q4 Rate	**$14.38**	**$168.42**	**$25.25**	**$86.02**	**$19.43**	**$169.68**

[1] Breast and Cervical Cancer Program participants share a capitation rate with the remainder of the Adult population, and comprise less than 1% of that total population. As such, a forecast for BCCP program eligibles was not performed.

[2] The final adjustment factor is derived by adding 1 to each individual adjustment, multiplying the result, and subtracting 1 from the product.

[3] The rate set for Q3 and Q4 of FY 2012-13 will be the same rate in effect for Q1 and Q2 of FY 2013-14.

Exhibit HH - Forecast Model Comparisons - Capitation Trend Models

Capitation Rate Forecast Model for FY 2011-12 Q3 and Q4

Model	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [1]	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care
FY 2010-11 Actual Rate	$13.80	$139.09	$20.94	-	$15.41	$195.38
FY 2011-12 Q1 and Q2 Weighted Average Rate	$14.18	$141.59	$21.77	-	$15.89	$186.86
FY 2011-12 Q3 and Q4 Weighted Average Rate	$13.58	$139.80	$21.55	$71.87	$16.73	$171.87
FY 2011-12 Full Year Average Rate	$13.88	$140.68	$21.66	$71.87	$16.32	$179.35
FY 2012-13 Q1 and Q2 Weighted Average Rate	$13.58	$139.80	$21.55	$71.87	$16.73	$171.87
Recent Growth Rates						
% Growth from FY 2010-11 to FY 2011-12 Rate	0.58%	1.14%	**3.44%**	-	5.91%	-8.20%
% Growth from CY 2011 to CY 2012 Rate	-4.23%	-1.26%	-1.01%	-	5.29%	**-8.02%**
Selected Trend Models						
Average Growth Model	$14.58	$157.98	$26.21	-	$17.60	$159.08
% Difference from FY 2012-13 Q1 and Q2 Rate	7.36%	13.00%	21.62%	-	**5.20%**	-7.44%
% Difference from FY 2011-12 Full Year Average Rate	5.04%	12.30%	21.01%	-	7.84%	-11.30%
Two Period Moving Average Model	$14.10	$139.97	$21.05	-	$15.00	$202.87
% Difference from FY 2012-13 Q1 and Q2 Rate	3.83%	0.12%	-2.32%	-	-10.34%	18.04%
% Difference from FY 2011-12 Full Year Average Rate	1.59%	-0.50%	-2.82%	-	-8.09%	13.11%
Exponential Growth Model	$16.84	$167.82	$30.07	-	$17.91	$216.74
% Difference from FY 2012-13 Q1 and Q2 Rate	24.01%	20.04%	39.54%	-	7.05%	26.11%
% Difference from FY 2011-12 Full Year Average Rate	21.33%	19.29%	38.83%	-	9.74%	20.85%
Linear Growth Model	$16.28	$162.84	$25.85	-	$17.04	$217.69
% Difference from FY 2012-13 Q1 and Q2 Rate	19.88%	16.48%	19.95%	-	1.85%	26.66%
% Difference from FY 2011-12 Full Year Average Rate	17.29%	15.75%	19.34%	-	4.41%	21.38%
CY 2013 Forecast Minimum	$14.10	$139.97	$21.05	-	$15.00	$159.08
CY 2013 Forecast Maximum	$16.84	$167.82	$30.07	-	$17.91	$217.69
% change from CY 2012 Rate to Selected CY 2013 Capitation Rate [2]	2.99%	5.66%	3.44%	4.55%	5.20%	-2.01%
CY 2013 Forecast Point Estimate	**$13.99**	**$147.71**	**$22.29**	**$75.14**	**$17.60**	**$168.42**
% change from CY 2013 Rate to Selected CY 2014 Capitation Rate [2]	2.99%	5.66%	3.44%	4.55%	5.20%	-1.00%
CY 2014 Forecast Point Estimate	**$14.41**	**$156.07**	**$23.06**	**$78.56**	**$18.52**	**$166.73**

[1] Breast and Cervical Cancer Program participants share a capitation rate with the remainder of the Adult population, and comprise less than 1% of that total population. As such, a forecast for BCCP program eligibles was not performed.

(2) Percentage selected to modify capitation rates for CY 2013: Where applicable, percentage selections have been bolded for clarification.	Adults 65 and Older (OAP-A)	Rate change from FY 2009-10 to FY 2010-11	Adults without Dependent Children	Average of trends selected for Disabled Individuals Through 64 (AND/AB, OAP-B) and Low Income Adults
	Disabled Individuals Through 64 (AND/AB, OAP-B)	Rate change from FY 2009-10 to FY 2010-11	Eligible Children (AFDC-C/BC)	Average growth model
	Low Income Adults	Rate change from FY 2010-11 to FY 2011-12	Foster Care	One-fourth of rate change from CY 2011 to CY 2012

(2) Percentage selected to modify capitation rates for CY 2014: Where applicable, percentage selections have been bolded for clarification.	Adults 65 and Older (OAP-A)	Rate change from FY 2009-10 to FY 2010-11	Adults without Dependent Children	Average of trends selected for Disabled Individuals Through 64 (AND/AB, OAP-B) and Low Income Adults
	Disabled Individuals Through 64 (AND/AB, OAP-B)	Rate change from FY 2009-10 to FY 2010-11	Eligible Children (AFDC-C/BC)	Average growth model
	Low Income Adults	Rate change from FY 2010-11 to FY 2011-12	Foster Care	One-eighth of rate change from CY 2011 to CY 2012

Exhibit II - Recoupments and Reconciliations

Total Recoupment of Payments Made for Clients Found to be Ineligible by Fiscal Year

	FY 2009-10 Actuals	FY 2010-11 Actuals	FY 2011-12 Estimate	FY 2012-13 Estimate	FY 2013-14 Estimate
Recoupments for FY 2005-06, FY 2006-07, and FY 2007-08 Ineligibles	($3,252,765)	$0	$0	$0	$0
Recoupment for FY 2004-05 Ineligibles	$0	($1,793,362)	$0	$0	$0
Recoupment for FY 2008-09 Ineligibles	$0	$0	($689,563)	$0	$0
Estimated Recoupment for FY 2009-10 Ineligibles [(1)]	$0	$0	$0	*($790,998)*	$0
Estimated Recoupment for FY 2010-11 Ineligibles [(1)]	$0	$0	$0	*($881,251)*	$0
Estimated Recoupment for FY 2011-12 Ineligibles [(1)]	$0	$0	$0	$0	*($981,802)*
Net Impact of Estimated Recoupments	($3,252,765)	($1,793,362)	($689,563)	($1,672,249)	($981,802)

[1] Estimated recoupments for FY 2009-10, FY 2010-11, and FY 2011-12 ineligibles are based on the recoupment made for FY 2008-09 ineligibles, which is the most recently reconciled year. The Department trended future recoupments for each fiscal year's ineligibles by that fiscal year's caseload growth as it is anticipated that more will be recouped as the magnitude of the base expenditure increases over time.

Recoupment Fund Splits

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Recoupments in FY 2009-10	($3,252,765)	($1,626,382)	$0	$0	($1,626,383)
Recoupments in FY 2010-11	($1,793,362)	($896,681)	$0	$0	($896,681)
Recoupments in FY 2011-12 [(1)]	($689,563)	($294,530)	$0	$0	($395,033)
Estimated Recoupments in FY 2012-13 [(2)]	($1,672,249)	($638,977)	($19,901)	$0	($1,013,371)
Estimated Recoupments in FY 2013-14	($981,802)	($460,630)	($30,271)	$0	($490,901)

[1] Fund splits for recoupments for FY 2008-09 ineligibles account for differing levels of federal match over the course of that fiscal year due to the American Reinvestment and Recovery Act; in FY 2008-09, three months of expenses were matched at the standard 50%, six months were matched at 58.78%, and three months were matched at 61.59%.

[2] Fund splits for recoupments for FY 2009-10 ineligibles account for a federal match of 61.59% over the course of that fiscal year due to the American Reinvestment and Recovery Act. Fund splits for recoupments for FY 2010-11 ineligibles account for an average federal match of 59.71% over the course of that fiscal year due to the American Reinvestment and Recovery Act.

Exhibit II - Recoupments and Reconciliations

Total Reconciliations for Adults without Dependent Children by Fiscal Year [(1)]

	FY 2009-10 Actuals	FY 2010-11 Actuals	FY 2011-12 Estimate	FY 2012-13 Estimate	FY 2013-14 Estimate
Estimated Reconciliation for FY 2011-12	$0	$0	$0	*$397,000*	$0
Estimated Reconciliation for FY 2012-13	$0	$0	$0	*$1,191,000*	*$1,245,000*
Estimated Reconciliation for FY 2013-14	$0	$0	$0	$0	*$1,245,000*
Net Impact of Estimated Reconciliations	$0	$0	$0	$1,588,000	$2,490,000

[1] The Department assumes that it will reconcile a portion of the true costs of the Adults without Dependent Children population with the BHOs every half year.

Reconciliation Fund Splits

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Estimated Reconciliations in FY 2012-13	$1,588,000	$0	$794,000	$0	$794,000
Estimated Reconciliations in FY 2013-14	$2,490,000	$0	$1,245,000	$0	$1,245,000

Exhibit JJ - Expansion Populations [1]

FY 2011-12 Calculation

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Prevention, Early Detection, and Treatment Fund:								
Health Care Expansion Breast and Cervical Cancer Treatment Program Clients	183	$273.73	$50,093	$0	$0	$25,046	$25,047	50.00%
Hospital Provider Fee Cash Fund:								
Expansion Adults to 100%	35,406	$278.22	$9,850,657	$0	$4,925,328	$0	$4,925,329	50.00%
Adults without Dependent Children	1,667	$894.63	$1,491,341	$0	$745,670	$0	$745,671	50.00%
Buy-In for Disabled Individuals	58	$1,790.10	$103,826	$0	$51,913	$0	$51,913	50.00%
Total from Hospital Provider Fee Fund [1]	-	-	**$11,445,824**	**$0**	**$5,722,911**	**$0**	**$5,722,913**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Eligible Children: Family Medical Program	0	$203.49	$0	$0	$0	$0	$0	65.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Baby Care Program-Adults	0	$278.22	$0	$0	$0	$0	$0	65.00%

FY 2012-13 Calculation

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
Expansion Adults to 100%	42,381	$286.97	$12,162,076	$0	$6,081,038	$0	$6,081,038	50.00%
Adults without Dependent Children	10,000	$944.30	$9,443,024	$0	$4,721,512	$0	$4,721,512	50.00%
Buy-In for Disabled Individuals	2,208	$1,846.10	$4,076,189	$0	$2,038,094	$0	$2,038,095	50.00%
Total from Hospital Provider Fee Fund [2]	-	-	**$25,681,289**	**$0**	**$12,840,644**	**$0**	**$12,840,645**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Eligible Children: Family Medical Program	2,121	$215.63	$457,351	$160,073	$0	$0	$297,278	65.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Baby Care Program-Adults	181	$286.97	$51,942	$18,180	$0	$0	$33,762	65.00%

[1] The Department's allocation methodology is described in the Expansion Populations section of this Budget Request.

[2] This amount does not include payments from the Hospital Provider Fee for reconciliations; the total amount estimated to be paid out of the Hospital Provider Fee in FY 2012-13 is $13,614,743.

Exhibit JJ - Expansion Populations [1]

FY 2013-14 Calculation

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate [3]**
Hospital Provider Fee Cash Fund:								
Expansion Adults to 100%	46,835	$297.15	$13,917,020	$0	$3,479,255	$0	$10,437,765	75.00%
Adults without Dependent Children	10,000	$1,008.39	$10,083,870	$0	$2,520,967	$0	$7,562,903	75.00%
Buy-In for Disabled Individuals	5,671	$1,950.03	$11,058,620	$0	$5,529,310	$0	$5,529,310	50.00%
Total from Hospital Provider Fee Fund [2]	**-**	**-**	**$35,059,510**	**$0**	**$11,529,532**	**$0**	**$23,529,978**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Eligible Children: Family Medical Program	13,431	$226.91	$3,047,628	$1,066,670	$0	$0	$1,980,958	65.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Baby Care Program-Adults	1,112	$297.15	$330,431	$115,651	$0	$0	$214,780	65.00%

[1] The Department's allocation methodology is described in the Expansion Populations section of this Budget Request.

[2] This amount does not include payments from the Hospital Provider Fee for reconciliations; the total amount estimated to be paid out of the Hospital Provider Fee in FY 2013-14 is $12,744,261.

[3] The Department will receive 100% FFP for the Expansion Adults to 100% and Adults without Dependent Children populations beginning in January 2014 due to the passage of the Affordable Care Act. The average FFP over FY 2013-14 is 75%.

Exhibit KK - Medicaid Mental Health Fee-For-Service Forecast

FY 2011-12 Calculation

Components	FY 2010-11 Actual	FY 2010-11 Adjustment for Payment Delay Payback [1]	FY 2010-11 Total Expenditure Excluding Payment Delay Payback	FY 2011-12 Appropriation	FY 2011-12 Year-to-Date Actual [2]	Estimated Change in Total Mental Health Caseload			FY 2011-12 Estimate	FY 2011-12 Change from Appropriation
						FY 2010-11 Q1 and Q2 Average Monthly Caseload	FY 2010-11 Q3 and Q4 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$802,447	$35,153	$767,294	$810,373	$270,649	584,916	619,363	5.89%	$557,236	($253,137)
Outpatient Services	$2,971,816	$99,718	$2,872,098	$3,001,171	$1,576,294	584,916	619,363	5.89%	$3,245,419	$244,248
Physician Services	$96,331	$1,693	$94,638	$97,283	$68,354	584,916	619,363	5.89%	$140,734	$43,451
Total After Prior Year Adjustments	**$3,870,594**	**$136,564**	**$3,734,030**	**$3,908,827**	**$1,915,297**				**$3,943,389**	**$34,562**

[1] In order to forecast from a 52-week base, the FY 2010-11 actual paid amounts are adjusted for the two-week payment delay that occurred in June 2010 and were paid in July 2010.

[2] Year-to-date actual is adjusted for transfers that took place in the first week of January for claims paid in December.

FY 2012-13 Calculation

Components	FY 2011-12 Estimate	Estimated Change in Total Mental Health Caseload			FY 2012-13 Estimate	FY 2012-13 Change from FY 2011-12 Estimate
		FY 2011-12 Forecasted Average Monthly Caseload	FY 2012-13 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$557,236	602,140	664,441	10.35%	$614,891	$57,655
Outpatient Services	$3,245,419	602,140	664,441	10.35%	$3,581,209	$335,790
Physician Services	$140,734	602,140	664,441	10.35%	$155,295	$14,561
Total After Prior Year Adjustments	**$3,943,389**				**$4,351,395**	**$408,006**

FY 2013-14 Calculation

Components	FY 2012-13 Estimate	Estimated Change in Total Mental Health Caseload			FY 2013-14 Estimate	FY 2013-14 Change from FY 2012-13 Estimate
		FY 2012-13 Forecasted Average Monthly Caseload	FY 2013-14 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$614,891	664,441	714,623	7.55%	$661,331	$46,440
Outpatient Services	$3,581,209	664,441	714,623	7.55%	$3,851,680	$270,471
Physician Services	$155,295	664,441	714,623	7.55%	$167,024	$11,729
Total After Prior Year Adjustments	**$4,351,395**				**$4,680,035**	**$328,640**

Exhibit KK - Medicaid Mental Health Fee-For-Service Forecast					
Medicaid Mental Health Fee-for-Service Fund Splits					
	Total Funds	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Total Estimated FY 2011-12 Fee-for-Service Expenditure	$3,943,389	$1,971,694	$0	$0	$1,971,695
Total Estimated FY 2012-13 Fee-for-Service Expenditure	$4,351,395	$2,175,697	$0	$0	$2,175,698
Total Estimated FY 2013-14 Fee-for-Service Expenditure	$4,680,035	$2,340,017	$0	$0	$2,340,018

Exhibit LL - Global Reasonableness Test for Medicaid Mental Health Capitation Payments [(1)]

	Actual/Estimated Expenditures	Percent Change	Dollar Increase/ Decrease	Two-year Rolling Average	Percent Change Two-year Average	Three-year Rolling Average	Percent Change Three-year Average
FY 2006-07 Actual	$184,640,568	N/A	N/A	N/A	N/A	N/A	N/A
FY 2007-08 Actual	$196,011,033	6.16%	$11,370,465	$190,325,801	N/A	N/A	N/A
FY 2008-09 Actual	$215,860,937	10.13%	$19,849,904	$205,935,985	8.20%	$198,837,513	N/A
FY 2009-10 Actual	$226,620,818	4.98%	$10,759,881	$221,240,878	7.43%	$212,830,929	7.04%
FY 2010-11 Actual	$251,146,027	10.82%	$24,525,209	$238,883,423	7.97%	$231,209,261	8.64%
FY 2011-12 Appropriation vs. FY 2010-11 Actual	$272,492,157	8.50%	$21,346,130	$261,819,092	9.60%	$250,086,334	8.16%
FY 2011-12 Estimate vs. FY 2010-11 Actual	$275,155,770	9.56%	$24,009,743	$263,150,899	10.16%	$250,974,205	8.55%
FY 2011-12 Estimate vs. Appropriation	$275,155,770	0.98%	$2,663,613	$263,150,899	0.51%	$250,974,205	0.36%
FY 2012-13 Estimate vs. FY 2011-12 Appropriation	$312,580,712	14.71%	$40,088,555	$292,536,435	11.73%	$270,564,562	8.19%
FY 2012-13 Estimate vs. FY 2011-12 Estimate	$312,580,712	13.60%	$37,424,942	$293,868,241	11.67%	$279,627,503	11.42%
FY 2013-14 Estimate vs. FY 2011-12 Appropriation	$350,548,439	28.65%	$78,056,282	$311,520,298	18.98%	$311,873,769	24.71%
FY 2013-14 Estimate vs. FY 2012-13 Estimate	$350,548,439	12.15%	$37,967,727	$331,564,576	12.83%	$312,761,640	11.85%

[1] This analysis compares the percent change between Mental Health Capitation Payments Reported in Exhibit DD. Other Medicaid Mental Health Payments have been excluded.

Department of Health Care Policy and Financing
Medical Services Premiums
and
Medicaid Mental Health Community Programs

FY 2011-12, FY 2012-13, and FY 2013-14 Budget Request

February 15, 2012

(2) MEDICAL SERVICES PREMIUMS

I. BACKGROUND

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, the disabled, adults, and children. The Medicaid budget is constructed based on projected numbers of persons who will be eligible (caseload) and projected average costs per person/eligible (per capita cost). This Budget Request is a projection of services that entitled individuals will utilize during the year. The first section of the Medical Services Premiums Budget Narrative describes the Medicaid caseload projection. The second section describes the development of the per capita cost, the application of per capita caseload and bottom-line adjustments. A series of exhibits in this Budget Request support the Narrative.

Several key points should be made evident before further discussion. These change-producing issues cause this line item to be complicated to project. They are summarized as follows:

1. In June 2010, the Department was directed, by the Governor's Office of State Planning and Budgeting and the State Controller, to withhold payments to Medicaid providers for the final two weeks of FY 2009-10. The Department subsequently released payments in the first week of July 2010. As a result of the payment delay, actuals for FY 2009-10 are understated when compared to prior fiscal years. Further, this creates difficulties from a forecasting perspective, as cash-based actuals do not reflect similar periods.

   To account for the delayed payments, the Department has taken the following steps:

   - Additional pages showing the effect of the delay are included in Exhibit C, Exhibit M, and Exhibit N.
   - In all cases, the Department's forecasts are based on the delay-adjusted cash-based actuals. As a result, the Department consistently forecasts a 52-week period in Exhibits F, G, H, and I.

2. The Department's request includes a number of references to various budget reduction items and early supplemental budget reductions. Effective July 1, 2009, September 1, 2009, December 1, 2009, July 1, 2010 and again on July 1, 2011, the Department implemented various reductions to reduce its budget in order to meet the revenue shortages being predicted by the various revenue forecasts and to bring the State into compliance with its balanced budget requirement. In response, the Department began a process of identifying possible targets for reduction, engaging stakeholders regarding those possibilities, and submitting various budget change requests to reduce funding.

3. The Department's request identifies, and in some cases amends, the fiscal impact of these reductions through a series of bottom line impacts. Bottom line impacts can be found by service category (e.g. Acute Care, Community Based Long Term Care, Long Term Care, Insurance, etc.) in the respective sections of this request. Those bottom line impacts include the identification number of the originally submitted request, so that the bottom line impact in the current year may be traced to that originally submitted budget change request document. Additionally, the annualization of a particular reduction's fiscal impact will be found in the out-year bottom line impacts.

4. The Department has made substantial adjustments to estimates from the fiscal note for HB 09-1293, the Health Care Affordability Act of 2009, based on actual provider cost information, and actual experience related to expansion populations. The Department incorporates these adjustments in various places in the request, notably Exhibit F and Exhibit J

5. The Department's request also incorporates estimates for revised eligibility requirements and new expansion populations which gain eligibility as a result of HB 09-1293. This includes the implementation of the Disabled Buy-In program and expansion of eligibility to Adults without Dependent Children in FY 2011-12. These expansions increase Medicaid caseload, and are discussed further in Sections II and III of this narrative.

6. The Department's request incorporates the expected expenditure and savings from the implementation of the Accountable Care Collaborative (ACC) program. Savings from the ACC program are incorporated in Exhibit F, while expenditure for administration and case management are included in Exhibit I.

7. The Department's request includes a forecast for FY 2011-12, FY 2012-13 and FY 2013-14. Because previous requests included only forecasts for the current and request years, additional exhibits and changes in formatting to accommodate the additional year are present throughout.

8. Previously "Expansion Adults" encompassed populations funded through multiple cash fund sources. However, effective with this request, the eligibility category has been bifurcated. "Expansion Adults to 60%" and "Expansion Adults to 100%" are now separate eligibility types. As a result, the calculations in Exhibit F which calculated the aggregate per capita growth for all expansion adults is no longer included as part of the Department's request.

9. Due to changes in how the Department is appropriated funds from the Health Care Expansion Fund, adjustments for Expansion Adults to 60% are no longer made at the service category level. This is reflected in both exhibits A and J.

10. The Department has added a new calculation for its Money Follows the Person grant program, known as Colorado Choice Transitions, to exhibit G. Please see the narrative for Exhibit G, and section V, for additional information.

The Department's exhibits for Medical Services Premiums remain largely the same as previous Budget Requests. Minor differences are noted in the description of each exhibit and/or program in sections IV and V.

II. MEDICAID CASELOAD

The Medicaid caseload analysis, including assumptions and calculations, are included in a separate section of this Request.

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

Once caseload is forecasted, the next step in the process is to forecast per capita costs. Per capita costs contain price, utilization, and Special Bill impacts. Inherent in the per capita cost is the differential "risk" of each eligibility category. The concept of "risk" can be roughly described as follows: due to the differences in health status (age, pre-existing condition, etc.), generally healthy clients are less costly to serve (lower "risk") than clients with severe acute or chronic medical needs requiring medical intervention (higher "risk"). For example, on average, a categorically eligible low-income child is substantially less costly to serve than a disabled person each year. Because Medicaid caseload is growing and receding at differing rates by individual eligibility categories, it is essential to determine the anticipated cost per capita for all types of eligibility categories that will be served. In very broad terms and for most services, the rate of change that was experienced across actual expenditure reference periods is applied to the future in order to estimate the premiums that will be needed for current and request years. To that base, adjustments are made due to policy items or environmental changes (e.g., Change Requests and new legislation).

A detailed discussion of how the projection was prepared for this budget request follows.

Rationale for Grouping Services for Projection Purposes

The Medical Services Premiums calculations are grouped into like kinds of services and similar calculation considerations. Actual collection of data for expenditures is very detailed, but for purposes of preparing projections, premium calculations are clustered into several groupings. This is done to improve the reasonableness of the projections that result from the calculations. The objective is to cluster services that have like characteristics (e.g., community based long-term care services) or which demonstrate a high degree of relationship (e.g., the impact of health maintenance organization service utilization on inpatient hospital, outpatient, physician services, etc.). Adversely, the approach of projecting the budget by individual service category and applying historic rates generates a materially higher forecast.

Following are the service groupings used in computing the projections or summarizing individual service calculations in this Budget Request.

Acute Care:

- Physician Services and the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
- Emergency Transportation
- Non-emergency Medical Transportation
- Dental Services
- Family Planning
- Health Maintenance Organizations
- Inpatient Hospitals
- Outpatient Hospitals
- Lab & X-Ray
- Durable Medical Equipment
- Prescription Drugs
- Drug Rebate
- Rural Health Centers
- Federally Qualified Health Centers
- Co-Insurance (Title XVIII-Medicare)
- Breast and Cervical Cancer Treatment Program
- Prepaid Inpatient Health Plan Services
- Other Medical Services
- Home Health
- Presumptive Eligibility

Community Based Long Term Care:

- Home and Community Based Services: Elderly, Blind and Disabled
- Home and Community Based Services: Mental Illness
- Home and Community Based Services: Disabled Children
- Home and Community Based Services: Persons Living with AIDS
- Home and Community Based Services: Brain Injury
- Home and Community Based Services: Children with Autism
- Home and Community Based Services: Pediatric Hospice
- Private Duty Nursing
- Hospice

Long Term Care:

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-inclusive Care for the Elderly

Insurance:

- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management:

- Single Entry Points
- Disease Management
- Prepaid Inpatient Health Plan Administration

Financing:

- Hospital Provider Fee Financed Programs and Populations
- Department Recoveries
- Upper Payment Limit Financing
- Outstationing Payments
- Other Supplemental Payments

Note that for services in the Long Term Care, Insurance, and Service Management categories and Financing, separate forecasts are performed. Only Acute Care and Community Based Long Term Care are forecast as a group.

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

EXHIBIT A - CALCULATION OF TOTAL REQUEST AND FUND SPLITS

Summary of Request

For the current year, the Department sums total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department.[1] The total spending authority is compared to the total projected estimated current year expenditures from page EA-4. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the current year.

For the request year, the Department starts with the prior year's appropriation including special bills, and adds in any required annualizations. This total is the Base Amount for the request year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-5. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year.

For the out year, the Department starts with the prior year's appropriation including special bills, and adds in any required annualizations. This total is the Base Amount for the out year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-6. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the out year.

Totals for the base request on this page correspond with Columns 2, 4, and 5 on the Schedule 13, where appropriate.

Federal Medical Assistance Percentages

The Department's standard federal medical assistance percentage (FMAP) is 50%. The FMAP for Medicaid is recomputed by the Federal Funds Information Service each year and is based on a statewide per capita earnings formula that is set in federal law.

The FMAP was impacted by the American Recovery and Reinvestment Act of 2009 (ARRA). One provision of ARRA was an enhanced FMAP for specified Medicaid programs; the effective period of this enhanced rate was originally October 1, 2008 through December 31, 2010. However, federal legislation (HR 1586) extended the effective period of ARRA to June 30, 2011. The enhanced

[1] For FY 2010-11, the Department's totals on this page differ from the actual spending authority due to the inclusion of the budget balancing items submitted and implemented (labeled with priority numbers beginning with "ES"). Page EA-3 shows the actual total spending authority. Annualizations of budget balancing items are included in the FY 2011-12 base request.

FMAP from ARRA beyond December 31, 2010 underwent a staged phase out. Additional relief was available for states which experience increased unemployment; there were three defined tiers of the rate of increased unemployment percentage with respective increases to the enhanced FMAP. ARRA included a 'hold harmless period'; if the FMAP for any calendar quarter from January 1, 2009 and ending before July 1, 2010 was less than the FMAP for the preceding quarter, the higher percent continued to be in effect for each subsequent calendar year ending before July 1, 2010. Below is a table detailing the Department's FMAP for FY 2008-09 through FY 2011-12. ARRA continues to be a relevant component of the Department's request as certified public expenditure receives the enhanced FMAP associated with the period of time during which the expenditure was initially included. This specifically impacts upper payment limit financing. See Exhibit K for additional details.

FMAP Rate		Effective Period	Fiscal Year Quarters
50.00%	Pre-ARRA	Through September 2008	Through first quarter of FY 2008-09
58.78%	Enhanced rate per ARRA	October 2008 through March 2009	Second and third quarters of FY 2008-09
61.59%	Enhanced rate per ARRA	April 2009 through December 2010	FY 2009-10, First and second quarters of FY 2010-11
58.77%	First stage of ARRA phase out	January 2011 through March 2011	Third quarter of FY 2010-11
56.88%	Final stage of ARRA phase out	April 2011 through June 2011	Fourth quarter of FY 2010-11
50.00%	Post-ARRA	July 2011 forward	First quarter of FY 2011-12 forward

The resulting FMAP for FY 2010-11 was a weighted average of the multiple FMAPs available during the fiscal year, totaling 59.71%.

Calculation of Fund Splits

These pages take the total estimated expenditure by service group and calculate the required source of funding for each. For each service category, the federal medical assistance percentage (FMAP) is listed on the right-hand side of the table. The FMAP calculations reflect the participation rate information provided from the federal Centers for Medicare and Medicaid Services, as reported through the Federal Register, or as specified in federal law and/or regulation.

In order to calculate appropriate fund splits, the Department selectively breaks out the large service groups (e.g. Acute Care) by programs which are funded with either a different state source or a different federal medical assistance percentage rate. The majority

of programs in Medical Services Premiums are paid with 50% General Fund and 50% federal funds. However, the following programs are paid for using different funding mechanisms:

- Breast and Cervical Cancer Program: This program receives a 65% federal financial participation rate. To determine state funding, the population is separated into two groups: traditional clients, and expansion clients. Traditional clients, who gained eligibility through SB 01S2-012, have funding sources specified in statute, at 25.5-5-308 (9), C.R.S. (2009). For FY 2011-12, 100% of state funding for traditional clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. For FY 2012-13 and FY 2013-14, 50% of state funding for traditional clients comes from the Breast and Cervical Prevention and Treatment Fund and 50% comes from the General Fund. Expansion clients, who gained eligibility through additional screenings funded in HB 05-1262, receive state funding through the Prevention, Early Detection, and Treatment fund, which is administered by the Department of Public Health and Environment. Please see Exhibit F for calculations.

- Family Planning: The Department receives a 90% federal medical assistance percentage available for all documented family planning expenditures. This includes those services that are rendered through health maintenance organizations. Please see Exhibit F for calculations. This line also included reappropriated funds from the Department of Public Health and Environment to fund the state share of a family planning waiver program; see section V for additional details.

- Home Health Telemedicine Services: In HB 10-1005, the Department received authority to use gifts, grants, and donations to fund home health telemedicine services. The Department has been informed by CMS that these funds are not eligible for a federal match. Therefore, the Department assumes that the grant funding will be used as state only funds, and that the remainder of the expenditure will be funded with General Fund and federal funds. See section V for additional details.

- Indian Health Services: The federal financial participation rate for this program is 100%. The total is a rough estimate based on the Department's most recent two years of paid expenditure.

- Affordable Care Act Drug Rebate Offset: The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. As a result, this provision of the ACA is intended to be budget neutral to the state. Drug rebates are recorded as an offset to total fund expenditure in Acute Care (exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in exhibit A, as the increased drug rebate will offset total federal funds expenditure.

- SB 11-008: "Aligning Medicaid Eligibility for Children": This bill specifies that the income eligibility criteria for Medicaid that applies to children aged 5 and under and pregnant women shall also apply to children between the ages of 6 and 19. On or after September 1, 2011, children under the age of 19 and pregnant women will be eligible for Medicaid if their family income is less than 133 percent of the federal poverty level (FPL). The Department assumes that the FMAP for clients these clients will remain at the same level it would have had the clients enrolled in the Children's Basic Health Plan instead of Medicaid, or 65%. The Department estimates that the provisions of this bill will not be implemented until FY 2012-13 due to needed federal approval and system changes.

- SB 11-250: "Eligibility for Pregnant Women in Medicaid": This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133 percent to 185 percent of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to transition from the Children's Basic Health Plan (CBHP) to Medicaid. As with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients. The Department estimates that the provisions of this bill will not be implemented until FY 2012-13 due to needed federal approval and system changes.

- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act): Provisions of federal healthcare reform require Medicaid agencies to compensate primary care physician services at a level equal to Medicare reimbursement. The difference in rates between July 1, 2009 and January 1, 2013 will be paid for by the federal government through an enhanced federal medical assistance percentage (FMAP) of 100%. Additional details are provided in sections IV and V.

- Nursing Facility Supplemental Payments: HB 08-1114 and SB 09-263 directed the Department to implement a new methodology for calculating nursing facility reimbursement rates, introduced a cap on General Fund growth for core components of the reimbursement rate, and authorized the Department to collect a provider fee from nursing facilities statewide. Any growth in the portion of the per diem reimbursement rate for core components beyond the General Fund cap is paid from the Nursing Facility Provider Fee cash fund, as are all supplemental payments. Please refer to Exhibit H for calculations and additional details.

- Tobacco Tax Funded Disease Management: The Department annually receives funding from the Department of Public Health and Environment for the operation of disease management programs that address cancer, heart disease, lung disease and the risk factors associated therewith. The funding for these programs is a constant $2,000,000 allocation of tobacco tax cash funds from the Prevention, Early Detection, and Treatment Fund overseen by the Department of Public Health and Environment. For FY 2011-12 and FY 2012-13, the Department is requesting to use a portion of the funding for the adult medical home pilot program;

see Exhibit I for further details. In accordance with SB 08-118 - Money Transfer for Medicaid Programs, FY 2012-13 is the last year in which this transfer will occur.

- Children with Autism Waiver Services: This program provides case management and behavioral therapy services to 75 children living with autism. The available funding is a fixed allocation of Tobacco Master Settlement Funds equal to $1,000,000 per year; the Department receives funding through the Colorado Autism Treatment Fund. Clients are limited to a cap of $25,000 in waiver services. The Department estimates the funding need from the Colorado Autism Treatment Fund at 85% of the cap for each of the 75 clients, plus $163,500 in administration paid to the Community Centered Boards to serve as the single entry point agency for services and as the care planning agency for eligible children.

- Disabled Buy-in: Funds for this population come from three sources: Hospital Provider Fee, premiums paid by clients, and federal funds. While the program will receive federal match on the Hospital Provider Fee contribution, the premiums paid by clients are not eligible. Premium estimates and additional calculation of fund splits can be found in Exhibit J.

- Adults Without Dependent Children: This population is anticipated to begin participation in Medicaid in FY 2011-12. The population is funded with a combination of federal funds and Hospital Provider Fee. Calculations and information regarding this population can be found in Exhibit J.

- Physician Supplemental Payments: The Department draws a federal financial match on uncompensated expenditures by Denver Health Medical Center on physician and other non-physician practitioner professional services. The state share of funding is through certification of public expenditure.

- Expansion Adults to 100% Adjustment: HB 09-1293, the Health Care Affordability Act of 2009, authorizes the Department to collect hospital provider fees for the purpose of obtaining federal financial participation for the state's medical assistance programs and using the combined funds to: 1) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program; 2) increase the number of persons covered by public medical assistance; and 3) pay the administrative costs to the Department in implementing and administering the program. These adjustments allocate Hospital Provider Fee to each applicable service categories. See Exhibit J for additional information and detailed calculations.

- Supplemental Medicare Insurance Benefit: Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive a 100% federal financial participation rate. In aggregate, the Department estimates that approximately 80% of the total will receive federal financial participation, while 20% will be provided with state-only funding.

- Coordinated Care for People with Disabilities Program: The coordinated care for people with disabilities pilot program, as authorized by SB 06-128, allows the Department to pay per member per month administration fees to a nonprofit organization which operates a system that is a client-centered, comprehensive, integrated approach to primary, acute, and long-term care designed to reduce the incidences of emergency room visits, hospitalizations, secondary disabilities, and institutionalizations. The state funding for this program comes from the Coordinated Care for People with Disabilities Fund, which was created by SB 06-128 and is generated by interest earned in the Breast and Cervical Cancer Prevention and Treatment Fund.

- Upper Payment Limit Financing: The Upper Payment Limit financing offset to General Fund is a bottom-line adjustment to total expenditures. This is further described in Exhibit K.

- Denver Health Outstationing: Federal funds are drawn to reimburse Denver Health federally qualified health centers for the federal share of their actual expenditures in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund. The FY 2011-12 and FY 2012-13, and FY 2013-14 totals are based on the total amount Denver Health Medical Center was able to certify in FY 2010-11 inflated annually by four percent.

- Department Recoveries Adjustment: Department Recoveries used to offset General Fund are incorporated as a bottom-line adjustment to total expenditure. Further detail is available in exhibit L.

- Cash Funds Financing: This item includes the impact of legislation which reduces General Fund expenditure through cash fund transfers. Please refer to Section V for more detailed information on the legislation which authorized the transfers. The table below shows the impact, by cash fund for FY 2011-12, FY 2012-13, and FY 2013-14

Cash Funds	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**
Tobacco Tax Cash Fund (SB 11-210)	$2,230,500	$2,230,500	$2,230,500
Prevention, Early Detection, and Treatment Fund (SB 11-211)	$11,955,055	$0	$0
Hospital Provider Fee Cash Fund(SB 11-212)	$50,000,000	$25,000,000	$0
Primary Care Fund (SB 11-219)	$15,775,670	$0	$0
Tobacco Education Program Fund (SB 11-219)	$17,758,594	$0	$0
Old Age Pension Adult Transfer (10-1380)	$3,000,000	$0	$0
Total	$100,719,819	$27,230,500	$2,230,500

In addition, the Department's appropriation includes a $5,036,351 transfer of reappropriated funds for FY 2011-12 from the Prevention, Early Detection and Treatment fund. This amount is reduced to $1,750,000 in FY 2012-13 and $0 in FY 2013-14. Of this amount, $1,750,000 in FY 2011-12 and a like amount in FY 2012-13 is funding associated with the Department's Disease Management program and is funded through the Department of Public Health and Environment's Prevention Programs line. $3,286,351 is a one-time transfer for medical services funded through CDPHE's Health Disparities Program line as provided for by SB 11-211.

- Health Care Expansion Fund Transfer Adjustment: In previous years, the Department received an appropriation from the Health Care Expansion Fund to cover the costs of programs funded with tobacco tax revenues. However, beginning in FY 2011-12, the Health Care Expansion Fund is insolvent and no longer covers the cost of the programs. The balance in the Health Care Expansion Fund is appropriated to the Department to offset the costs of these programs. In the Department's calculations in this exhibit, this transfer appears as a General Fund offset because the costs of the programs are included as General Fund in the calculations at the top of the exhibit.

- Old Age Pension Adult Transfer Adjustment: In FY 2011-12, the Department is appropriated $3,000,000 from the Supplemental OAP Health and Medical Care Fund to offset General Fund.

The Department's request no longer includes an adjustment for "Prenatal Costs for Optional Legal Immigrants". In FY 2008-09, prenatal services were provided as a state-only option and therefore required to be funded through 100% General Fund with the exception that delivery costs qualify for the standard 50% federal financial participation rate. However, effective July 1, 2010, the Department granted full eligibility to clients enrolled in its prenatal state-only program who meet all eligibility criteria except citizenship status; this allows the Department to receive federal financial participation for these clients without enrolling any new populations. This change was made possible due to new provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Because the Department is now receiving a 50% federal match on these services, the Department no longer needs to separate out prenatal expenditure.

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1995-96 through FY 2013-14. Adjustments for HB 09-1293 funded populations such as Disabled Buy-In and Adults Without Dependent Children, and children and women that gain eligibility through SB 11-08 and SB 11-250 are shown on page EB-2. Totals unadjusted for special populations are shown on EB-3

Pages EB-4 and EB-5 provide historical monthly caseload without retroactivity for each of the eligibility types for FY 2006-07 through FY 2010-11.

A description of the forecasting methodology for Medicaid caseload is located in a separate section of this request.

EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS

Medical Services Premiums per capita costs history (through FY 2010-11) and projections are included for historical reference and comparison. The Department provides two separate tables. On page EC-1, the Department provides the per capita cost history based on the cash-based actuals (i.e. the actual expenditure paid in the fiscal year). On page EC-2, the Department providers the per capita cost history adjusted for the FY 2009-10 payment delay; that is, the claims which were delayed at the end of FY 2009-10 (and paid in FY 2010-11) are included in the FY 2009-10 totals.

For FY 2002-03 through FY 2008-09, expenditures for the Prenatal State-Only program are included in the Non-Citizens aid category. These expenditures are included in the Baby Care Program – Adults aid category for FY 2009-10 and forward.

EXHIBIT D - CASH FUNDS REPORT

This exhibit displays spending authority, total request, and incremental request for each source of cash funds in the Medical Services Premiums line item. This information is a summary of the information presented on Exhibit A. In addition, for the current year, total spending authority is broken out between the Long Bill and other special bills; this information is used to calculate the revised letternote amount on the Schedule 13. The Department also provides the specific requested changes to special bill appropriation clauses, when appropriate.

EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

Summary of Total Requested Expenditure by Service Group

This exhibit is a summary of the requests by service group and by eligibility category for the current year, request year, and out year. It aggregates information from the calculations contained in exhibits F, G, H, and I, along with presenting totals for populations without specific exhibits (Disabled Buy-In and Adults without Dependent Children), financing and supplemental payments, and caseload information.

Comparison of Request to Long Bill Appropriation and Special Bills

This exhibit contains a detailed summary of the Department's Budget Request, by service category. In addition, this exhibit directly compares the Department's Budget Request to the Department's Long Bill plus Special Bills appropriation as well as compares the current request to the Department's most recent prior requests for Medical Services Premiums. The Department has isolated

individual components of the appropriation based on information provided by the Joint Budget Committee during Figure Setting and subsequent actions, including additional information provided by Joint Budget Committee staff. This exhibit includes all bottom-line impacts and financing, but does not break the request down by eligibility type or funding source. Totals on this portion of the exhibit match the totals on Exhibit A, and the Schedule 13.

EXHIBIT F – ACUTE CARE

Calculation of Acute Care Expenditure

Acute Care services expenditure is calculated in a series of steps. At the top of page EF-1, historical expenditures and the annual percent changes are provided. Historical expenditure has been restated with this request to reflect a redistribution of Prepaid Inpatient Health Plan expenditure among eligibility types. Historical per capita costs and the annual percent changes are also provided. The first step of the calculation is to select a historical per capita percent change rate, if possible, to trend the last actual per capita to the next year. Finally, bottom-line adjustments are made for legislation and other impacts not included in historical trends. Total expenditure after bottom-line adjustments is divided by the projected caseload to obtain a final per capita cost for the current year. To calculate the request year expenditure, the same methodology is applied to the projected request year per capita, including a per capita trend factor and bottom-line impacts. The total estimated expenditure for Acute Care is added to total estimated expenditure in other service groups and bottom-line impacts to generate the total request for Medical Services Premiums.

Calculation of Per Capita Percent Change

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2002-03 through FY 2010-11. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EF-2, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in the three most recent historical years. Typically, the same percentage selected to modify current year per capita costs were used to modify the request year per capita costs, although the Department makes adjustments to the selected trend where necessary. In light of changes resulting from the Medicare Modernization Act of 2003, trends that incorporate historical data from FY 2005-06 or earlier have been omitted for the following eligibility types: 'Adults 65 and Older', 'Disabled Adults 60 to 64', and 'Disabled Individuals to 59'. For these categories, pharmaceutical expenditure was drastically reduced in FY 2006-07 for these eligibility types resulting in artificially deflated trends.

Percentages selected to modify per capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, per capita trend factors must not take into account changes in caseload, or

changes that have been accounted for as bottom-line adjustments. Because the eligibility categories differ in eligibility requirements, demographics, and utilization, different trends are used for each eligibility category.

The table below describes the trend selections for FY 2011-12, FY 2012-13, and FY 2013-14. In some cases, though not all, the Department has held the trend constant between the three years. On Exhibit F, the selected trend factors have been bolded for clarification. As described in the Department's caseload narrative, populations which are sensitive to economic conditions are growing at substantial rates. Historically, rapid caseload growth leads to per capita declines, due to several factors. First, clients may not receive services immediately upon receiving eligibility; there is typically a lag between when eligibility is determined to when clients receive services and when those services are billed. For this reason, under cash accounting, where services are accounted for in the period where the claim is paid, expenditure growth will typically lag caseload growth, causing a per capita decline. Additionally, new caseload for economically sensitive populations may previously have had health insurance, and may generally be healthier than populations who have not had access to care. These clients may require fewer services, further lowering the overall per capita cost.

The selected trend factors for FY 2011-12, FY 2012-13, and FY 2013-14, with the rationale for selection, are as follows:

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Adults 65 and Older (OAP-A)	-1.15% The per capita growth from FY 2003-04 to FY 2004-05	0.70% One half the per capita growth from FY 2009-10 to FY 2010-11	0.70% One half the per capita growth from FY 2009-10 to FY 2010-11	While primary cost drivers in FY 2010-11 saw low to modest levels of growth, a portion of this growth is attributed to a one-time level shift in expenditure associated with restating third party liability recoveries as revenue instead of as a direct offset to expenditure. Half year expenditure support this conclusion and indicates a mild decline in per capita expenditure in FY 2011-12. The Department has selected a trend that captures the underlying stability in the per capita growth pattern for this population for FY 2012-13 and FY 2013-14.
Disabled Adults 60 to 64 (OAP-B)	2.06% The average per capita growth from FY 2007-08 through FY 2009-10	2.06% The average per capita growth from FY 2007-08 through FY 2009-10	2.06% The average per capita growth from FY 2007-08 through FY 2009-10	This eligibility type displayed growth despite rate reductions and other bottom line impacts which put downward pressure on per capita growth. The Department anticipates continued per capita growth over the next three years similar to what was experienced between FY 2009-10 and FY 2010-11.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Disabled Individuals to 59 (AND/AB)	2.38% The per capita growth from FY 2009-10 to FY 2010-11	2.38% The per capita growth from FY 2009-10 to FY 2010-11	2.38% The per capita growth from FY 2009-10 to FY 2010-11	Similar to OAP-B, this eligibility category experienced modest growth in FY 2010-11. Primary cost drivers for this eligibility type (Physician, Inpatient Hospital, Outpatient Hospital, Pharmacy, and Home Health) increased by approximately 4% in per capita expenditure in the last fiscal year. With a strong history of growth, the Department expects this trend to continue and has selected a trend that reflects the most recent year's expenditure patterns.
Categorically Eligible Low-Income Adults (AFDC-A)	-0.41% The average per capita growth from FY 2007-08 through FY 2009-10	-0.41% One half the FY 2011-12 per capita growth rate	-0.41% One half the FY 2011-12 per capita growth rate	With high growth in caseload, per capita figures have declined in the last two years. Caseload is anticipated to continue to grow aggressively over the next three years. However, most recent expenditure data indicates the rate of decline has slowed dramatically. The Department has selected a trend that accounts for the recent stabilization of per capita growth for this population.
Expansion Adults to 60%	2.18%	2.18%	2.18%	This population is showing signs of reaching maturity as per capita growth is beginning to slow. While FY 2010-11 growth was still aggressive, the Department anticipates the rate of growth to continue to decrease in FY 2011-12 as the per capita costs get closer to that of other non disabled adults in Medicaid. The trend selected for this population allows for a modest amount of continued growth over the next three years.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Expansion Adults to 100%	12.73%	5.92%	0.75%	The Department assumes that the per capita cost of this population will quickly reach the same level as Expansion Adults to 60%. Early experience with this population indicates a high per capita cost compared to the early experience of Expansion Adults to 60%; this reflects that many clients in this aid category were transitioned from other aid categories at the beginning of the program. For FY 2011-12, the selected trend is the percent change required to bring the per capita costs to 90% of the per capita costs of expansion adults to 60%The trends for the request year and out year are set at levels that allow the per capita cost of Expansion Adults to 100% to continue to converge to the Expansion Adults to 60% per capita cost.
Breast & Cervical Cancer Program (Page EF-7)	-1.08%	-1.08%	-1.08%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program Per Capita Detail and Fund Splits" for a description of this trend factor.
Eligible Children (AFDC-C/ BCKC-C)	-1.02% One half the per capita growth from FY 2009-10 to FY 2010-11	-1.02% One half the per capita growth from FY 2009-10 to FY 2010-11	-1.02% One half the per capita growth from FY 2009-10 to FY 2010-11	Growth in per capita costs have been decreasing over the last three fiscal years. However, the magnitude of the most recent years decrease includes factors such as rate cuts, efficiency measures and increases in caseload. Continued strong caseload growth indicates continuation of decline in per capita.
Foster Care	1.97% One half the average per capita growth from FY 2007-08 through FY 2010-11	1.97% One half the average per capita growth from FY 2007-08 through FY 2010-11	1.97% One half the average per capita growth from FY 2007-08 through FY 2010-11	Historically, this eligibility category has had significant variation in per capita growth from year to year; on average, growth is moderate to strongly positive. FY 2010-11 growth reflected this trend of moderate positive growth. The Department expects FY 2011-12 growth to follow this trend.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	Justification
Baby Care Program - Adults (BCKC-A)	1.22% One half the average per capita growth from FY 2006-07 through FY 2009-10	1.22% One half the average per capita growth from FY 2006-07 through FY 2009-10	1.22% One half the average per capita growth from FY 2006-07 through FY 2009-10	Recent history for this populations shows virtually no per capita growth; this is true even after the inclusion of the former prenatal state-only population in FY 2009-10, which added roughly $6.5 million in expenditure. As such, the Department selected a conservative growth factor for this population.
Non-Citizens	14.60% The average per capita growth from FY 2005-06 through FY 2008-09	7.30% One half the FY 2011-12 trend	7.30% One half the FY 2011-12 trend	The Department has selected a per capita trend for these clients that reflects the most recent years aggressive per capita growth while maintaining consideration for the volatile history of the population.
Partial Dual Eligibles	10.74%	5.37% One half the FY 2011-12 trend	5.37% One half the FY 2011-12 trend	This population consistently experiences a strong growth in per capita expenditure growth from the first part of the year to the second. This is primarily due to coinsurance maximums resetting January 1st each year. Given the level of expenditure in the first half of FY 2011-12, the Department has selected a trend that allows for the level of expected growth in the second half of the year. For the out years, the trend is halved, still allowing for continued growth in per capita expenditure.

Legislative Impacts and Bottom-line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. These impacts are described briefly below, and in detail in section V, Additional Calculation Considerations:

- BRI-1 (FY 2011-12), Client Overutilization, expanded the Department's Client Over Utilization Program (COUP). The program reduced expenditure by identifying clients that over utilize ER, pharmaceutical, or physician services and assisting them in managing their care in a more cost effective manner.
- BRI-5 (FY 2011-12), State Maximum Allowable Cost Expansion, expands the list of drugs reimbursed under the State Maximum Allowable Cost (SMAC) pricing methodology. Savings results as drugs reimbursed under this methodology typically have lower levels of reimbursement than other pricing methodologies.
- BRI-5 (FY 2011-12), Reduce Rates for Diabetes Supplies, reduced reimbursement for diabetic test strips. Prices were reduced to reflect the current median market price for the product, $18.00 per box of 50.
- BRI-5 (FY 2011-12), Reduce Payment for Uncomplicated C-Sections, set reimbursement for uncomplicated c-sections equal to the rate paid for complicated vaginal deliveries.
- BRI-5 (FY 2011-12), Reduce Payments for Renal Dialysis, reduced the amount paid for inpatient renal dialysis from 185 percent of cost to 100 percent of cost. The Department agreed to reduce payment to 129.42 percent rather than 100 percent after negotiations with affected providers.
- BRI-5 (FY 2011-12), Deny Payment of Hospital Readmissions within 48 hours, stopped payment to hospitals for clients readmitted to the same hospital within 48 hours of the original discharge for a condition related to the original admission.
- BRI-5 (FY 2011-12), Prior Authorize Certain Radiology, requires prior authorization for MRI, CT, PET, and SPECT scans in the outpatient setting except in the case of emergency.
- BRI-5 (FY 2011-12), Limit Acute Home Health Services, requires enforcement of the Department's policy to require prior authorization for acute home health services beyond 60 days.
- BRI-5 (FY 2011-12), HMO Impact to Rates, accounts for the impact to HMO rates that results when fee-for-service rates are reduced.
- BA-9 (FY 2011-12), 0.75% Provider Rate Reduction, reduced reimbursement for most acute care services by 0.75%. The Department's original request was for a 0.50% rate reduction.
- BA-9 (FY 2011-12), Expand the Accountable Care Collaborative (ACC), increased the volume of clients to be enrolled in the ACC in FY 2011-12.
- BA-9 (FY 2011-12), Limit Fluoride Application Benefit, restricts the fluoride application benefit to three applications per year.
- BA-9 (FY 2011-12), Limit Dental Prophylaxis Benefit, limits the routine dental cleaning benefit to two per year.
- BA-9 (FY 2011-12), Eliminate Reimbursement for Oral Hygiene Instruction, terminated the oral hygiene instruction benefit.
- BA-9 (FY 2011-12), Limit Number of Physical and Occupational Therapy Units for Adults, limited the number of units of therapy an adult can receive to 48 per year regardless of prior authorization.
- BA-9 (FY 2011-12), Home Health Billing Changes, requires providers to utilize a brief visit billing code for services that should require only a brief home health visit.

- Estimated Impact of Increasing PACE Enrollment – accounts for the Department's initiative to increase enrollment of new PACE providers. The Department anticipates that this increased enrollment will cause a shift in expenditure from the Acute Care and Community Based Long Term Care service groups to the PACE service category.
- Eliminate Circumcision Benefit – as part of budget balancing measures for FY 2011-12, the Joint Budget Committee eliminated the circumcision benefit of the Medicaid program.
- Wound Therapy DME Reduction – as part of budget balancing measures for FY 2011-12, the General Assembly specified in footnote 11a of the Long Bill that their intent was that the Department should reduce reimbursement for negative pressure wound to $88.50 per day. The Department complied with the footnote.
- SB 11-177: "Sunset of Pregnancy Prevention Program", provides for the continuation and expansion of the Department's teen pregnancy and dropout prevention program. Through the program, teens receive vocational, health and educational counseling.
- Managed Care Organization Reconciliations account for recoupment payments that the Department will receive from ,managed care organizations in FY 2011-12. The Department does not know when future reconciliations will occur and therefore annualized the full amount of the payments out in FY 2012-13. The Department will include reconciliations in future requests as the payment timelines are known.
- BRI-1 (FY 2010-11), Prevention and Benefits for Enhanced Value (P-BEV) and BA-12 (FY 2010-11) Evidence Guided Utilization Review (EGUR), increased utilization review funding in order to provide an evidence guided utilization review program. Savings is expected as a result of increased utilization reviews. In addition, the Department is able to expand a set of dental procedures to be performed by dental hygienists, and improve non-emergency medical transportation policies.
- BRI-2 (FY 2010-11), Coordinated Payment and Payment Reform, implements proposed steps toward payment coordination and payment reform. Payment coordination is characterized by streamlined payment processes, enhanced recovery efforts and proactive integration of care. The payment reform component supports performance-based payment structures which incentivize desired outcomes.
- BRI-6 (FY 2010-11), Medicaid Program Reductions - Limitation on Incontinence Products - this request reduces Medicaid physical health provider rates by 1% (effective July 1, 2010) and imposes restrictions on certain durable medical equipment.
- S-6 (FY 2010-11), Accountable Care Collaborative – the Accountable Care Collaborative is a client/family-centered, outcomes-focused system of care that affordably maximizes the health, functioning and self-sufficiency of members. This bottom line impact reflects the estimated savings the Department expects as a result of the program.
- BA-16 (FY 2010-11), Implementation of Family Planning Waiver transfers funds from the Department of Public Health and Environment (DPHE) to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. Transferring this funding to the Department will allow for an enhanced federal financial participation rate of 90% to fund family planning services for uninsured, low-income Coloradans who would otherwise be receiving services funded by the unmatched General Fund dollars currently appropriated to the Department of Public Health and Environment.

- Increased Drug Rebates due to the Affordable Care Act: The minimum level of drug rebates collected from manufactures by Medicaid agencies increased. The Department estimates the impact of this change in Exhibit F.
- HB 10-1005, Home Health Care – Telemedicine Changes, clarifies and enhances the Department's ability to reimburse for telemedicine services. Payment for telemedicine services comes from the newly created Home Health Telemedicine Cash Fund for FY 2011-12.
- HB 10-1033, Add Screening, Brief Intervention and Referral to Treatment to Optional Services, adds screening, brief intervention, and referral for treatment for substance abuse to the list of optional services covered by Medicaid.
- SB 10-167, Colorado False Claims Act, has four components. The first component increases enrollment in the Health Insurance Buy-in (HIBI) program. Beginning in April, 2011, 1,500 new enrollees will be added incrementally to the HIBI program. The second component of SB 10-167 is an automated prepayment review of claims. This system will produce savings by identifying coding errors prior to reimbursement of claims. The third components is a systems change that allows for coordination of the Department's pharmacy benefit with other payers. The final component of SB 10-167 is the addition of an internal auditor. The auditor will identify clients currently enrolled in Colorado Medicaid that are eligible to enroll in the Medicaid programs of other states.
- BA-33 (FY 2009-10), Prior Authorization of Anti-convulsant Drugs, adds anti-convulsant pharmaceuticals to prior authorization requirements and/or the preferred drug list for non-seizure uses of anti-convulsants in coordination with the BRI-1, Pharmacy Efficiencies (see below).
- BRI-1 (FY 2009-10), Pharmacy Efficiencies, reduces expenditure as a result of implementing an automated prior authorization system and changing the reimbursement rates of drugs using a state maximum allowable cost structure. Automating prior authorizations increases efficiency in managing current prior authorizations while decreasing the administrative burden on providers. The automated process makes it easier for providers to submit requests, in turn making it easier and faster for clients to obtain drugs with prior authorization restrictions. Increased Drug Rebates due to the Affordable Care Act – the estimated impact of increased pharmacy rebates the Department will receive as a direct result of the implementation of the Affordable Care Act.
- BRI-2 (FY 2009-10), Oxygen Restriction, reduced expenditure on Oxygen by an estimated 2% by bringing on an FTE to evaluate billing practices and assessing national best practices. As a result of this action, restrictions were put in place in FY 2010-11. Figures listed in exhibit F represent an annualization of savings from this initiative.
- ACA 4107 Smoking Cessation Counseling for Pregnant Women – Section 4107 of the Affordable Care acts requires states to implement a program offering pharmacotherapy and smoking cessation counseling to pregnant women. The requirement does not receive additional funding to support it. Currently, the Department offers coverage for tobacco cessation pharmacotherapy to all Medicaid clients but does not have coverage for counseling. In implementing a counseling benefit the Department has restricted services by allowing a maximum of 5 counseling sessions up to 10 minutes and 3 counseling sessions of more than 10 minutes. The Department opened billing codes to implement the program in January 2012.

Initiatives that impact FY 2012-13 or FY 2013-14 only:

- Implementation of SB 10-117: "Over the Counter Medications" accounts for savings incurred through the implementation of SB 10-117. This bill allows pharmacists to directly prescribe certain over the counter medication to Medicaid clients without prior authorization or a prescription from the client's primary care physician. The Department anticipates initial implementation by July 1, 2012.
- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act) accounts for the increase in primary care physician rates as mandated by federal health care reform legislation. This is effective January 1, 2013.
- Colorado Choice Transitions: this adjustment accounts for increased home health service expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. Additional detail can be found in exhibit G.
- In its previous request, the Department included an adjustment for its approved 1331 supplemental request to not apply the BA-9 0.75% rate reduction to pharmacies. The funding for that request was included in the Department's FY 2011-12 supplemental bill. To prevent double-counting, the Department has removed the impact from that request from this calculation.

Breast and Cervical Cancer Program Per Capita Detail and Fund Splits

In 2001, the General Assembly passed SB 01S2-012, which established a breast and cervical cancer treatment program in the Department. In 2005, the General Assembly passed HB 05-1262, which provided additional funding to the Department of Public Health and Environment to increase the number of cancer screenings. HB 05-1262 also provided additional funding to the Department to pay for increased caseload as a result of increased screenings. The Department cannot identify which clients in the Breast and Cervical Cancer Treatment Program come into the program solely because of the increased screenings. In the Department's February 15, 2006 Budget Request, the Department stated that the Department of Public Health and Environment is funding approximately 30% of all screening with Amendment 35 funds. The Department suggested that the same allocation could be used for the treatment program. During Figure Setting, the Joint Budget Committee approved the Department's allocation plan (Figure Setting, March 13, 2006, page 104). Therefore, 30% of the total Breast and Cervical Cancer Treatment patients are allocated as Prevention, Early Detection and Treatment Fund patients and the other 70% of the total Breast and Cervical Cancer Treatment patients are considered "traditional" clients.

Per Capita Cost

In the Department's November 1, 2006 Budget Request, the Department observed that the expenditure and per capita costs in FY 2005-06 grew at an unexpected rate. The Department has investigated the issues involved, and determined that the total expenditure in FY 2005-06 contained a large amount of retroactive transactions, which caused the expenditure for FY 2005-06 to appear overstated. The residual effects of this experience continue, as the affected caseload is very small and changes to total expenditure, therefore, have a large impact on per capita calculations. Per capita expenditure has grown from year-to-year by as much as 26.55% and has been reduced by as much as -32.73%.

For this reason, the Department has been using only the most recent months of expenditure history to forecast per capita for this program. In the past few years, however, program caseload has grown at a steep rate, resulting in substantial decreases in per capita expenditures. The Department assumes that the decline in the per capita expenditures is a temporary product of the increasing caseload, and that as the new clients incur costs, the per capita rate will begin to slow down in its decline. In the past twelve months, the per capita expenditure has decreased more slowly than in previous periods, indicating that the negative growth is beginning to moderate. For the current and request years, the Department analyzed per capita data since April 2007, when there were enough clients in the program for a robust time-series analysis. The Department regressed rolling average per capita expenditure on caseload, monthly dummy variables, and a time trend, producing a model that explained much of the variation in the per capita expenditures with an R-squared of 0.9972. The Department calculated the average of the percent changes of the predicted values produced by the regression model for the current year and annualized the average for a full-year effect. The resulting trend factor is -1.08%. The Department kept this trend constant for the request and out years – the regression model produces much larger negative trends for those years, but as discussed above, the Department believes that per capita expenditure will not continue to decline as quickly as it has in the past. The trend factor for each year is applied to the base per capita on page EF-4.

Fund Splits

The second half of this exhibit calculates the portion of Breast and Cervical Cancer Program expenditure that will be allocated to the Prevention, Early Detection, and Treatment Fund, and the amount allocated to the Breast and Cervical Cancer Prevention and Treatment Program Fund.

Per 25.5-5-308 (9) (d) and (e), C.R.S. (2011), enacted in HB 08-1373, state funding for "traditional" Medicaid Breast and Cervical Program clients comes, in part, from the Breast and Cervical Cancer Prevention and Treatment Fund. According to the original legislation, beginning in FY 2009-10 and into the future, state funding would be split: 50% from General Fund and 50% from the Breast and Cervical Cancer Prevention and Treatment Fund.

SB 09-262 revised the statute, requiring that in FY 2009-10 through FY 2011-12, 100% of state funding for these clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. Beginning FY 2012-13, state funding will be split with 50% coming from the General Fund and 50% from the Breast and Cervical Cancer Prevention and Treatment Fund. Per 24-22-117 (2) (d) (II), C.R.S. (2011), state funding for clients who have gained eligibility due to the Health Care Expansion Breast and Cervical Cancer Program comes from the Prevention, Early Detection, and Treatment Fund. Using the allocation methodology described above, 70% of clients are funded through the Breast and Cervical Cancer Prevention and Treatment Fund, while the remaining 30% of clients are funded through the Prevention, Early Detection, and Treatment Fund. All Breast and Cervical Cancer Program expenditures have a 65% federal match rate.

The Department is requesting a change to the allocation of traditional and expansion clients in FY 2012-13 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program is $1,215,340. On a go-forward basis, the Department will continue to limit the amount paid from this fund source for this program to this amount. Any expenditure beyond this amount will be allocated to the Breast and Cervical Cancer Prevention and Treatment Fund and the General Fund, in accordance with statute.

All Breast and Cervical Cancer Program expenditures have a 65% federal medical assistance percentage.

Antipsychotic Drugs

Antipsychotic drugs were moved from the Department's premiums line to the Department of Human Services for FY 2001-02. For FY 2003-04, the General Assembly removed antipsychotic drugs from the Department of Human Services' portion of the budget and located those costs within the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group, within the Pharmaceutical Drug service category. Exhibit F, page EF-8 through EF-9, shows annual costs by aid category and per capita cost in two versions: with and without the estimated impact of drug rebate. The rebate calculation excludes supplemental rebates, as antipsychotic drugs are not including on the Department's preferred drug list. The Department has eliminated the projection of expenditure in this area due to the elimination of the informational only line-item in Long Bill group (3), effective with HB 08-1375.

Federal Funds Only Pharmacy Rebates

The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. Drug rebates are recorded as an offset to total funds expenditure in Acute Care (Exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after

the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure. In this exhibit, the Department estimates the incremental amount of rebates that are federal funds only. Estimates are based on FY 2010-11 and two quarters of FY 2011-12 data.

Family Planning - Calculation of Enhanced Federal Match

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must be able to uniquely identify these services. The services are provided both through fee-for-service, and beginning in late FY 2001-02 the Department was able to identify those family planning services provided by health maintenance organizations. Therefore, the State receives the enhanced match on all family planning services provided to Medicaid clients. Totals listed on page EF-10 are taken directly from the Department's reporting to the Centers for Medicare and Medicaid Services for enhanced federal funds.

As of FY 2005-06, the Department no longer has any contingency-fee based contracts to calculate the managed care portion of the enhanced family planning match rate. This calculation is now done by the Department. Additionally, historically, calculations for fee-for-service and health maintenance organizations were done independently. However, due to changes in the Department's managed care program, the totals were combined beginning in FY 2008-09, and a single combined estimate is now produced. In FY 2009-10 the Department submitted a managed care claiming methodology proposal to the Center for Medicare and Medicaid Services (CMS). The Department did not claim managed care family planning until the methodology was approved in FY 2010-11. As a result, managed care claims for the stagnant period were realized in FY 2010-11 through a large, but temporary, increase in managed care expenditure.

The total estimate for FY 2011-12 and the out-years are based on a linear regression analysis of FY 2000-01 to FY 2010-11. The Department trended FY 2010-11 expenditure forward using the percent change between the forecasted estimates, 5.99%. This trend was carried forward and the addition of SB 11-177 "Sunset Teen Pregnancy and Dropout Program" were added separately.

Due to recent expenditure increases beginning in FY 2009-10, the Department controlled for a level shift in expenditure in the regression model. The Department believes this level shift is a result of the Departments considered effort to educate providers as to which services are billable as family planning services. Research by the Department had indicated that only a fraction of allowable services were being appropriately billed.

In FY 2010-11 the Department submitted BA-16 "Implementation of Family Planning Waiver" which was to add $1,903,500 in FY 2012-13 to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. The state share

of the funding was to be transferred from the Department of Public Health and Environment (DPHE) to the Department as reappropriated funds. However, after further discussion between the two agencies, the Department has removed its application for federal waiver approval. Populations that would have been served under the waiver would be eligible by July 2014 for services either through Medicaid or through a subsidized plan under the Colorado Health Benefit Exchange. In addition, system changes necessary to implement the program would be delayed due to federally mandated changes that could not be done concurrently with the changes necessary to implement the family planning waiver. The Department has removed all impacts of the family planning waiver from this request.

SB 11-177 "Sunset Teen Pregnancy and Dropout Program" adds $19,763 local funds, annualizing to $40,869 in FY 2012-13 and $69,819 in FY 2013-14 to operate and expand the program. This estimate varies from the projection the Department submitted in the November request for several reasons. First, the Montrose County Department of Health and Human Services had to discontinue the program as a result of limited budget funding available. In addition, the Department is currently working with the Center for Medicare and Medicaid Services to assure an appropriate payment methodology for the services. The Department currently anticipates a proper payment methodology would be established by July 2012. With such approval the Department would move forward expanding the program.

Indian Health Service

In 1976, the Indian Health Care Improvement Act (PL 94-437) was passed with the goal of improving the health status of American Indians and Alaskan Natives and encouraging tribes to participate as much as possible in the management of their health services. The law specified that the payments for inpatient and outpatient services and emergency transportation for Medicaid clients who are Indians with a legal tribe affiliation receive 100% federal financial participation. The Indian Health Service is the federal agency within the Department of Health and Human Services that provides services to American Indians and Alaskan Natives directly through its hospitals, health centers, and health stations, as well as indirectly by coordinating with tribe-administered health care facilities.

The Department uses historical expenditure to estimate total expenditure for services to these clients for the current and request years, all of which is federally funded. Expenditure was very low in the first six months of the current year; an inpatient facility in New Mexico that normally serves a few Colorado Medicaid clients has not had any Colorado Medicaid clients need services this year. In FY 2007-08 through FY 2010-11, an average of 50.72% of the total annual expenditure was paid in the first six months of the year (please see table below). The Department assumes that expenditure this year will follow that pattern and estimates total expenditure as the year-to-date expenditure divided by 50.72%. In the request and out years, the Department anticipates enrolling several new facilities into the Indian Health Service program. The Department chose the average growth from FY 2008-09 to FY 2010-11, or 17.82%, to trend expenditure for FY 2012-13 and FY 2013-14.

Indian Health Service Cash Flow Analysis		
	Percentage of Total Expenditure Complete in First Half of the Year	Percentage of Total Expenditure Complete in Second Half of the Year
FY 2006-07	52.90%	47.10%
FY 2007-08	33.62%	66.38%
FY 2008-09	56.90%	43.10%
FY 2009-10	56.07%	43.93%
FY 2010-11	61.49%	38.51%
Average of FY 2007-08 through FY 2010-11	**50.72%**	**49.28%**

Prior Year Expenditure

As an additional reasonableness check, this section presents last fiscal year's actual and per capita expenditure by six month intervals. Year-to-date average caseload for this exhibit has been taken from Exhibit B of this request. The change in per capita by six month period can be quickly compared, and the prior year's per capita costs may be referenced with page EF-1 and 2 of this request.

EXHIBIT G - COMMUNITY BASED LONG TERM CARE

The increased emphasis on utilizing community based services has served to keep the census in Class I nursing facilities relatively flat. In FY 1981-82, with the implementation of the first wave of Home and Community Based Service (HCBS) waivers, Class I nursing facility census was over 12,500 clients. Almost immediately, the census dropped to just over 10,000 clients. The HCBS census generally remained in this range though FY 2002-03. However, since that time, HCBS utilization has risen sharply; in FY 2010-11, the Department paid HCBS claims for an average of 19,847 clients per month.

In response to budget balancing in FY 2002-03, rules were passed by the Medical Services Board to improve utilization management, which resulted in a reduction of per capita spending. Among these changes, the Department clarified the requirements necessary to meet the level of care required to qualify for nursing facility care or Home and Community Based Services. In addition, a requirement was added that in order to be eligible for long term home health, a client 18 years and over had to meet the need for that level of care. Although home health costs are in the Acute Care portion of the Premiums calculation, long term home health costs do correlate to community based long term care costs. High cost clients in the community were reviewed by Single Entry Points and transitioned to less expensive alternatives if their care plans and services did not assure that all services being provided were required. The

assessment, which was a functional assessment to determine whether a client meets the long term care level of care, was redone with the help of providers, Single Entry Points, and clients. Responsibilities were shifted to ensure that Single Entry Points are the primary entities through which clients access long term care. Additionally, responsibilities required Single Entry Points to have tools and the authority to act as gatekeepers for long term care benefits. Federal requirements were more completely enforced, ensuring that clients regularly receive Home and Community Based Services waiver services in order to retain eligibility for the waiver.

HB 05-1243 extended the option of receiving home and community-based services (HCBS) through the Consumer-Directed care service model to all Medicaid recipients who are enrolled in a home and community-based services waiver for which the Department has federal waiver authority. The bill specifies that an eligible person shall not be required to disenroll from the person's current home and community-based services waiver in order to receive services through the Consumer-Directed care service model. Additionally, the bill specifies that certain professional licensing requirements do not apply to a person who is directly employed by an individual participating in the Consumer-Directed care service model and who is acting within the scope and course of such employment. The restrictions that apply to this professional licensure exclusion and the circumstances under which the exclusion does not apply are noted in the bill. A consumer of attendant support is allowed to have an authorized representative who has the judgment and ability to assist the consumer in acquiring and using services under the program.

In 2005, the Centers for Medicare and Medicaid Services completely revised the home and community-based services waiver application forms, requiring additional components that needed to be researched and addressed by the Department prior to submission. This caused a substantial extension to the timeframe required for the implementation of this bill. Approval by the Centers for Medicare and Medicaid Services for the implementation of Consumer Directed Care for the Elderly, Blind, and Disabled waiver and the Mental Illness waiver was granted in mid-2007. Services became available to clients in January 2008. The Department has incorporated the estimated costs and savings of this program in the base trends for Community-Based Long Term Care.

Calculation of Community Based Long Term Care Expenditure

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2002-03 through FY 2010-11. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EG-2, the Department has provided a list of historic trends. Included are 2-year, 3-year, 4-year, and 5-year trends, ending in FY 2008-09, FY 2009-10, and FY 2010-11.

Percentages selected to modify per capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, per capita trend factors must not take into account changes in caseload, or

changes that have been accounted for as bottom-line adjustments. Because the eligibility categories differ in eligibility requirements, demographics, and utilization, different trends are used for each eligibility category.

The selected per capita trend factors for FY 2011-12, FY 2012-13 and FY 2013-14, with the rationale for selection, are below. In all cases, the Department has kept the trend for the out year the same as the request year.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 and FY 2013-14 Trend Selection	Justification
Adults 65 and Older (OAP-A)	2.36% FY 2008-09 through FY 2010-11	2.36% FY 2008-09 through FY 2010-11	The FY 2011-12 trend is based on the current expenditure and prior-year cash flow. The primary drivers in this eligibility category are expenditure for Elderly, Blind and Disabled waiver and Hospice clients. The growth rate of expenditure for these services has slowed substantially beginning in FY 2007-08. With a strong history of growth, the Department expects this trend to continue and has selected a trend that reflects the most recent year's expenditure patterns, 2.36% for three years of expenditure.
Disabled Adults 60 to 64 (OAP-B)	5.63% Average of FY 2007-08 through FY 2010-11	2.82% Half the FY 2011-12 Trend	Per capita growth has slowed significantly from FY 2009-10 to FY 2010-11. However, half year growth has indicates that expenditure is slow at much lower rate than the Department had previously anticipated. As a result, the trend was increased from the R-1 request to 5.63% for the remainder of the fiscal year. The out year trends were reduced to half of the FY 2011-12 trend to reflect the stabling of growth the Department expects.
Disabled Individuals to 59 (AND/AB)	2.51% Half the Average of FY 2009-10 through FY 2010-11	2.51% Half the average of FY 2009-10 through FY 2010-11	Significant drivers of expenditure in this aid category are the Elderly, Blind and Disabled waiver, Mental Illness waiver and Private Duty Nursing service categories. Growth for these categories over the past four years has been high and positive averaging 14.85%. The FY 2011-12 trend is half the average of FY 2009-10 through FY 2010-11 per capita growth rate. This rate was reduced from the R-1 request to reflect slowing in per capita growth rates as the Department anticipates programmatic changes to slow rapid per capita growth for these clients, as indicated by half year actual expenditure.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 and FY 2013-14 Trend Selection	Justification
Categorically Eligible Low-Income Adults (AFDC-A)	-57.48% FY 2008-09 change in per capita costs	-1.16% Average of FY 2008-09 through FY 2009-10 overall per capita	Clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to be some expenditure in waiver services. This is due to clients incurring costs before their aid category changes to AND/AB. The Department selected a trend to reflect actual half year expenditure for these clients. The out year trend factor is based on the average overall CBLTC change in per capita spending between FY 2008-09 through FY 2009-10.
Expansion Adults to 60%	-45.00%	4.12% FY 2008-09 total growth in per capita costs	Similar to the low-income adults category, clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to be a relatively small level of expenditure in waiver services. The Department selected a trend in the current year to reflect anticipated expenditure levels based on half year actuals. In the out years the Department trended using the average growth in total per capita for FY 2008-09.
Expansion Adults to 100%	70.00%	5.00% Total average of FY 2006-07 through FY 2010-11	Similar to the low-income adults category, clients in this eligibility category are not generally eligible for community based long term care benefits except hospice care, although there tends to be a relatively small level of expenditure in waiver services. The Department selected a trend in the current year to reflect anticipated expenditure levels based on half year actuals. In the out years the Department trended using the average growth in total per capita for FY 2008-09.
Breast & Cervical Cancer Program	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.

Aid Category	FY 2011-12 Trend Selection	FY 2012-13 and FY 2013-14 Trend Selection	Justification
Eligible Children (AFDC-C/ BCKC-C)	2.75% Average of FY 2007-08 through FY 2010-11	1.38% Half the Average of FY 2007-08 through FY 2010-11	Eligible Children only receive private duty nursing and hospice care. Because a very small number of clients receive services, per capita trends are skewed by changes in caseload, and are unreliable. The Department chose a trend of 2.75% for FY 2011-12 and half that trend for FY 2012-13 and FY 2013-14. This trend appears to be on track with half year expenditure and was not changed from the R-1.
Foster Care	10.11% Average of FY 2005-06 through FY 2009-10	5.06% Half the FY 2011-12 trend	Per capita growth rates is this aid category have been high for the past three years. However, given that half year expenditure was lower than anticipated, the Department has reduced the trend from the R-1 to 10.11%. For the out years the Department took half of the FY 2011-12 trend to reflect stabilizing growth.
Baby Care Program - Adults (BCKC-A)	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Non-Citizens	0.00%	0.00%	Clients in this eligibility category are not eligible for community based long term care benefits.
Partial Dual Eligibles	100.00%	-25.00% (FY 2012-13), 0.00% (FY 2013-14)	Clients in this eligibility category are not eligible for community based long term care benefits. In some cases, however, clients who are eligible for these services are incorrectly being assigned to this aid category. This began in January 2007, and appears to be abating. However, based on expenditure to date, the Department has selected a trend to reflect an increase in expenditure for this category. For the out years the Department chose trends to reflect a decrease in expenditure for FY 2012-13 and a trend to reflect leveling off in FY 2013-14.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the Request for Community Based Long Term Care:

- BRI-5: Medicaid Reductions - Cap CDASS Wage Rates: Impose a cap on the wage rate a client enrolled in the CDASS program is allowed to pay attendants based on current rates for similar services in the HCBS EBD waiver. The Department has delayed implementation of this proposal to March 2012.
- BA-9: Medicaid Reductions - 0.50% Rate Reduction: Reduce long-term care providers by 0.5%, effective July 1, 2011.
- BA-9: Medicaid Reductions - Clients Moved from Nursing Home: The Department intended to use grant funds from the Money Follows the Person award to provide additional transitional services to move clients from nursing facilities to Community Based Long Term Care. The Department was unable to transition these clients due to receiving significantly less grant funds than anticipated. The clients specified in this initiative would have been moved earlier than the actual Money Follow the Person program began using administrative funding provided by the grant. Since the Department did not receive enough administrative funding to move clients early, this initiative could not be implemented.
- Estimated Impact of PACE Enrollment: The Department has reduced its projection under the assumption that increased enrollment in new PACE providers will cause a shift in expenditure from the CBLTC group to the PACE service category. The Department's calculations are contained in Section V of this part of the line item description.
- Annualization of FY 2010-11 BRI-2: Coordinated Payment and Payment Reform: This request, estimated to be implemented July 2010, requested a reduction in totals funds as a result of savings generated by payment coordination and payment reform. An initiative directed at Home and Community Based Services waivers will initiate research into the potential of applying an outcomes-based approach to the payment of claims for waiver services. The timeline for implementation of this program was slowed and was reflected appropriately in the FY 2011-12 request.
- Annualization of FY 2010-11 BRI-6: Medicaid Program Reductions; included a 1% reduction to Medicaid physical health provider rates effective July 1, 2010.
- Annualization of FY 2009-10 ES-2: HCBS Waiver Transportation Limitations: This request included a cap on the amount of non-medical transportation a client enrolled in a home and community based services waiver program can receive per week. Clients are limited to 2 roundtrips per week, with the exception of trips to adult day programs, which are not subject to the cap. The implementation of this program had been delayed to FY 2011-12 to allow time for necessary rule changes or waiver amendments. Savings derived from the limitation were shifted to FY 2011-12.
- HB 10-1146 State Funded Public Assistance Programs: This bill clarifies that persons currently receiving both Home Care Allowance program and Medicaid Home and Community Based Services benefits will now be limited to receiving Medicaid

HCBS benefits only. In addition, the Department of Human Services is given the authority to contract with single entry point (SEP) agencies for the Home Care Allowances (HCA) and Adult Foster Care (AFC) programs as of July 1, 2010. While the Department anticipated an increase in HCBS enrollment as a result of this bill, implementation of the project has been delayed. DHS has assumed responsibility for payment to SEPs for enrollment of clients into the HCA program but system changes necessary to move clients into solely HCBS waivers delayed implementation to FY 2011-12. Therefore, the cost estimate to CBLTC for this bill has been shifted to FY 2011-12.

- HB 09-1047 "Alternative Therapies for Clients with Spinal Cord Injuries" – HB 09-1047 enabled the Department to create a pilot program centered on alternative therapies for clients with spinal cord injuries. Services include massage, acupuncture and chiropractic care. The Department anticipates approval of the waiver and implementation to be delayed to July 2012.
- Colorado Choice Transitions: The Department was awarded Money Follows the Person federal grant monies to implement a program designed to transition clients from nursing facilities into community based services. The program will begin enrolling clients in July 2012.

Colorado Choice Transitions

The Department was awarded the Money Follows the Person federal grant designed to help clients currently residing in nursing facilities to transition into Community Based Long Term Care. The grant allows the Department to provide transitional services to ease the movement from nursing facility to the community and provides an enhanced federal match to those services, existing HCBS waiver services and home health services. The grant is designed to offer clients enhanced services for one year after transitioning from a nursing home to allow them to adapt to the community setting. Savings from the enhanced match are required to be used to improve the long term care service system as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services. The Department anticipates transitioning will begin in July 2012 and the Department will transition 90 clients in the first year of the program and 100 each year following until the end of the 5 year grant.

The Colorado Choice Transitions exhibit illustrates the total cost of the program by delineating the 2 types of services the Department will offer through the program, demonstration (new services offered through the program) and qualified services (existing waiver services and home health). These costs are reflected in exhibits F and G, Community Based Long Term Care as a bottom line impact. The exhibit then reports the savings anticipated from transitioning clients from nursing facilities which is reflected in exhibit H, Class I Nursing Facilities as a bottom line impact. Following the net impact of the program, the Department reports on the rebalancing funds the Department anticipates earning. Rebalancing funds are calculated as 25% of total expenditure and are 100% federal funds.

The Department anticipates the program enrollment will begin in July 2012 and approximately 100 clients will transition per calendar year. The Department estimates the total impact to Medical Services Premiums to be a reduction of $224,911 total funds in in FY 2012-13, and a reduction of $637,405 in FY 2013-14. These figures do not include any expenditure from the rebalancing fund.

Prior Year Expenditure

As an additional reasonableness check, the Department has split FY 2010-11 actual expenditure into two half-year increments to analyze the changing rates of expenditure over time.

EXHIBIT H - LONG TERM CARE AND INSURANCE SERVICES

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

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-Inclusive Care for the Elderly (PACE)
- Supplemental Medicare Insurance Benefits
- Health Insurance Buy-In

Summary of Long Term Care and Insurance Request

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

Class I Nursing Facilities

Class I nursing facility costs are essentially a function of the application and interpretation of rate reimbursement methodology specified in detail in State statutes, the utilization of the services by Medicaid clients, and the impact of the effect of cost offsets such as estate and income trust recoveries. The traditional strategy for estimating the cost of these services is to predict 1) the costs driven by the estimated Medicaid reimbursement methodology (the weighted average per diem allowable Medicaid rate and the estimated average patient payment), 2) the estimated utilization by clients (patient days without hospital backup and out of state placement), and 3) the estimated cost offsets from refunds and recoveries and the expected adjustments due to legislative impacts.

Overall, patient days have declined since FY 1999-00, although caseload in the Department's Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories has increased by approximately 20.8% (through the FY 2009-10 total) since FY 1999-00. This is due to efforts by the Department to place clients in Home and Community Based Services (HCBS), and in the Department's Program for All-Inclusive Care for the Elderly (PACE). Recent history indicates this trend is changing and the Department no longer anticipates a continued decline in patient days.

Patient payment is primarily a function of client income. As clients receive cost-of-living adjustments in their supplemental security income, their patient payment has increased accordingly.

HB 08-1114 directed the Department to change the existing method of reimbursing Class I Nursing Facilities. In addition, the legislation authorized a new quality assurance fee to be collected by the Department from certain Class I Nursing Facilities, including facilities which do not serve Medicaid clients. The fee can be used for administrative costs related to assessing the fee and to limit growth of General Fund expenditures to 3% annually. The Department received federal approval of both the nursing facility fee and the new rate reimbursement method from the federal Centers for Medicare and Medicaid Services (CMS) on March 26, 2009, effective retroactive to July 1, 2008.

The new reimbursement methodology was further amended by SB 09-263, which specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period, adjusted the cap on General Fund growth, specified conditions for supplemental payments, created an upper limit on the nursing facility provider fee, replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate, included a hold harmless provision for administration and general services under certain circumstances, and made changes to the method of implementing pay-for-performance payments. The Department received federal approval of the changes to the reimbursement methodology in December 2009, effective retroactive to July 1, 2009.

HB 10-1324 imposed a 1.5% reduction to FY 2009-10 rates, effective March 1, 2010. HB 10-1379 imposed a 2.5% reduction to FY 2010-11 rates, effective July 1, 2010. The effect of the rate reductions is not cumulative; that is, the total reduction in FY 2010-11 is 2.5%. The rate is restored to the full level effective July 1, 2011. HB 10-1379 also reduced the maximum General Fund growth of the core per diem rate to 1.9% for FY 2010-11, increasing to 3% in FY 2011-12 and subsequent years.

SB 11-125 reprioritized the components of nursing facility supplemental payments made from the Nursing Facility Provider Fee as well as increased the maximum allowable fee per non Medicare day. These changes, however, had no impact on the General Fund portion of nursing facility rates. SB 11-215 continued the 1.5% rate reduction of HB 10-1324 into FY 2011-12 effective July 1, 2011. The additional 1.0% rate decrease from HB 10-1379 expired at the end of FY 2010-11.

For complete information regarding specific calculations, the footnotes in pages EH-6 through EH-9 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[2]:

[2] For clarity, FY 2011-12 is used as an example. The estimates for FY 2012-13 and FY 2013-14 are based on the estimate for FY 2011-12, and follows the same methodology.

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2011-12.
- Using historic claims data from the MMIS, the Department calculates the estimated patient payment for claims that will be incurred in FY 2011-12. The difference between the estimated per diem rate for core components and the estimated patient payment, is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2011-12 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2011-12.
- The product of the estimated Medicaid reimbursement per day for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2011-12.
- Of the estimated total reimbursement for claims incurred in FY 2011-12, only a portion of those claims will be paid in FY 2011-12. The remainder is assumed to be paid in FY 2012-13. The Department estimates that 92.47% of claims incurred in FY 2011-12 will also be paid during FY 2011-12. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2010-11.
- During FY 2010-11, the Department will also pay for some claims incurred during FY 2010-11 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2010-11 to calculate an estimate of outstanding claims to be paid in FY 2011-12.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2011-12 prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in footnotes 5 through 9.
- Legislative impacts are added as bottom-line adjustments. For FY 2011-12, this includes run out from HB 10-1324, which introduced a 1.5% rate reduction effective March 1, 2009 and Additionally, HB 10-1379 introduced an additional 1% rate reduction effective July, 1 2010. SB 11-215, which continued the HB 10-1324 rate reduction into FY 2011-12, is also included.
- Once the "non-rate" factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2011-12 expenditure.

For FY 2012-13 and FY 2013-14, the same methodology is applied, taking into account the estimate for FY 2011-12.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional

Calculation Considerations. The following impacts have been included in the FY 2011-12, FY 2012-13, and FY 2013-14 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom line adjustments for FY 2011-12 through FY 2013-14. Please refer to Footnote 6 on page EH-8 for more detail.
- Prior to FY 2010-11 the Department reduced expenditure by the amount received in estate and income trust recoveries. The Department will no longer be including these recoveries as an offset to expenditure. See the narrative section for Exhibit L for further detail.
- The Department recovers funds from in-house audits of nursing facilities; the estimated amount of recoveries is included as a bottom line impact for FY 2011-12, FY 2012-13, and FY 2013-14. FY 2010-11 BRI-2: Coordinated Payment and Payment Reform increased the number of Department auditors resulting in additional audits of nursing facilities. This bottom line impact has been incorporated into the forecast of overpayment recoveries. Footnote 7 on page EH-9 contains additional detail about these recoveries.
- HB 10-1324 resulted in a rate reduction to Class I nursing facilities of 1.5% effective March 1, 2010 and continuing through June 30, 2011. Due to a portion of claims for FY 2010-11 not being paid in the fiscal year in which they are incurred, the fiscal impact of this bill extends into FY 2011-12. Footnote 9 on page EH-9 contains additional detail regarding the fiscal impact of this bill.
- HB 10-1379 resulted in a rate reduction to Class I nursing facilities of an additional 1% above HB 10-1324 reductions effective July 1, 2010 and continuing through June 30, 2011. Due to a portion of claims for FY 2010-11 not being paid in the fiscal year in which they are incurred, the fiscal impact of this bill extends into FY 2011-12. Additionally, this bill reduced the maximum allowable general fund growth cap to 1.9%. The general fund growth cap reduction is not included in the bottom line impacts as it is incorporated into the base calculation of the core component rate. To include it as a bottom line reduction would double count the impact. Additional detail regarding the fiscal impact of the rate reduction can be found in Footnote 9 on page EH-9.
- SB 11-125 reprioritized the components of nursing facility supplemental payments. Growth beyond the General Fund cap now has the lowest priority. Quality incentives and acuity adjustments now take higher priority. Additionally, the maximum allowable fee per non Medicare day increased to $12.00 per day plus inflation with this legislation. As a result, the Nursing Facility Provider Fee will be able to fully fund quality/performance incentives and acuity based adjustments, but will be unable to fully fund growth beyond the General Fund cap. The Department estimates that approximately 68% of growth beyond the General Fund cap will be supported by the provider fee.
- SB 11-215 continued the 1.5% rate cut of HB 10-1324, effective July 1, 2012.
- The Colorado Choice Transitions adjustment accounts for the reduction in class I nursing facility expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. Additional detail can be found in exhibit G.

Incurred But Not Reported Adjustments

As part of the estimates for the allowable per diem rate, patient payment, and patient days, the Department utilizes the most recent four years of incurred claims to calculate estimates for the current year and the request year. However, because not all claims which have been incurred have been reported, the Department must adjust the incurred data for the expected incidence of claims which will be paid in the future for prior dates of service. Without such an adjustment, the claims data would appear to drop off at the end of the year, erroneously introducing a negative trend into the estimate.

The Department uses an extensive model which examines past claims by month of service and month of payment to estimate the amount of claims which will be paid in the future. This is known as an "Incurred But Not Reported" (IBNR) adjustment. The IBNR adjustments analyze the prior pattern of expenditure (specifically, the lag between the time past claims were incurred and when they were paid), and applies that pattern to the data. This enables the Department to use its most recent data, where there is a significant volume of claims which have yet to be paid.

Separate IBNR adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department's estimate of claims paid in the current year for current year dates of service, particularly footnotes 4 and 5 of Exhibit H, page EH-4. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2010-11 which will be paid in FY 2011-12, and the percentage of claims incurred in FY 2011-12 which will be paid in FY 2011-12 and subsequent years. The Department applies the same factor to the FY 2012-13 and FY 2013-14 estimates.

The Department uses the IBNR adjustment calculation for the November 2011 Budget Request, using paid claims data through April 2011. For reference, the following table lists IBNR factors calculated over the previous four Change Requests and compares them with the current IBNR factor. There is a slight increase in the factors over time, suggesting that there is a decreasing lag time between the date of service and the payment of a typical claim.

Date of Change Request:	**IBNR Factor:**
November 2006	91.54%
February 2007	91.82%
November 2007	91.78%
February 2008	91.94%
November 2008	92.75%

Date of Change Request:	IBNR Factor:
February 2009, November 2009, February 2010	92.27%
November 2010	92.89%
February 2011	92.46%
November 2011	92.30%
February 2012	92.47%

Patient Days Forecast Model

To forecast patient days, the Department selected a seasonal, auto-regressive model with a linear trend. This model was selected because the data exhibits monthly seasonality and follow a trend over time. In addition, the value in a given month is partially a function of the value in the previous month; this is represented by an auto-regressive term in the forecasting model.

The Department presents two sets of statistical results supporting the selection of this forecasting model. First, the F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. Second, the stationarity of the model needs to be tested to determine the validity of the forecasts. A non-stationary time series cannot be forecast without additional manipulation to the data. The Department tested for stationarity by performing a Dickey-Fuller unit root test. In this test, the first difference of the values predicted by the forecast model are a function of an auto-regressive term and a linear trend term. The resulting regression coefficient of the lagged term is the calculated d-statistic. This is compared again the Durbin-Watson d-statistic upper and lower bounds. If the absolute value of the calculated statistic is lower than the lower bound value, there is evidence of serial autocorrelation, and the model cannot be assumed stationary. If the absolute value of the calculated statistic is higher than the upper bound value, then there is no evidence of serial autocorrelation, and the model can be assumed stationary. If the value of the calculated statistic lies between the upper and lower bounds, then the evidence is inconclusive.

Testing the Overall Predictive Ability of the Model

The F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. This test indicates how well the components of the model together generate valid forecasts. With a p-value of 0.0000, the patient days model is statistically significant at the 99% confidence level.

Testing the Stationarity of the Model

The second set of statistics test the stationarity of the models. This is important, because if a model is not stationary, it cannot be used to predict values for time periods outside of the period represented by the actual data. The Department tested stationarity by performing a Dickey-Fuller unit root test. Theoretically, this test checks to see if the predictive components defined in the forecasting

model are actually generating random predictions even though the overall model is statistically significant. With any model, a portion of the predicted value will be random. So, while having a random element in the model is not in itself a problem; stationarity issues result from a model in which the components assumed to be generating defined results are actually generating random results.

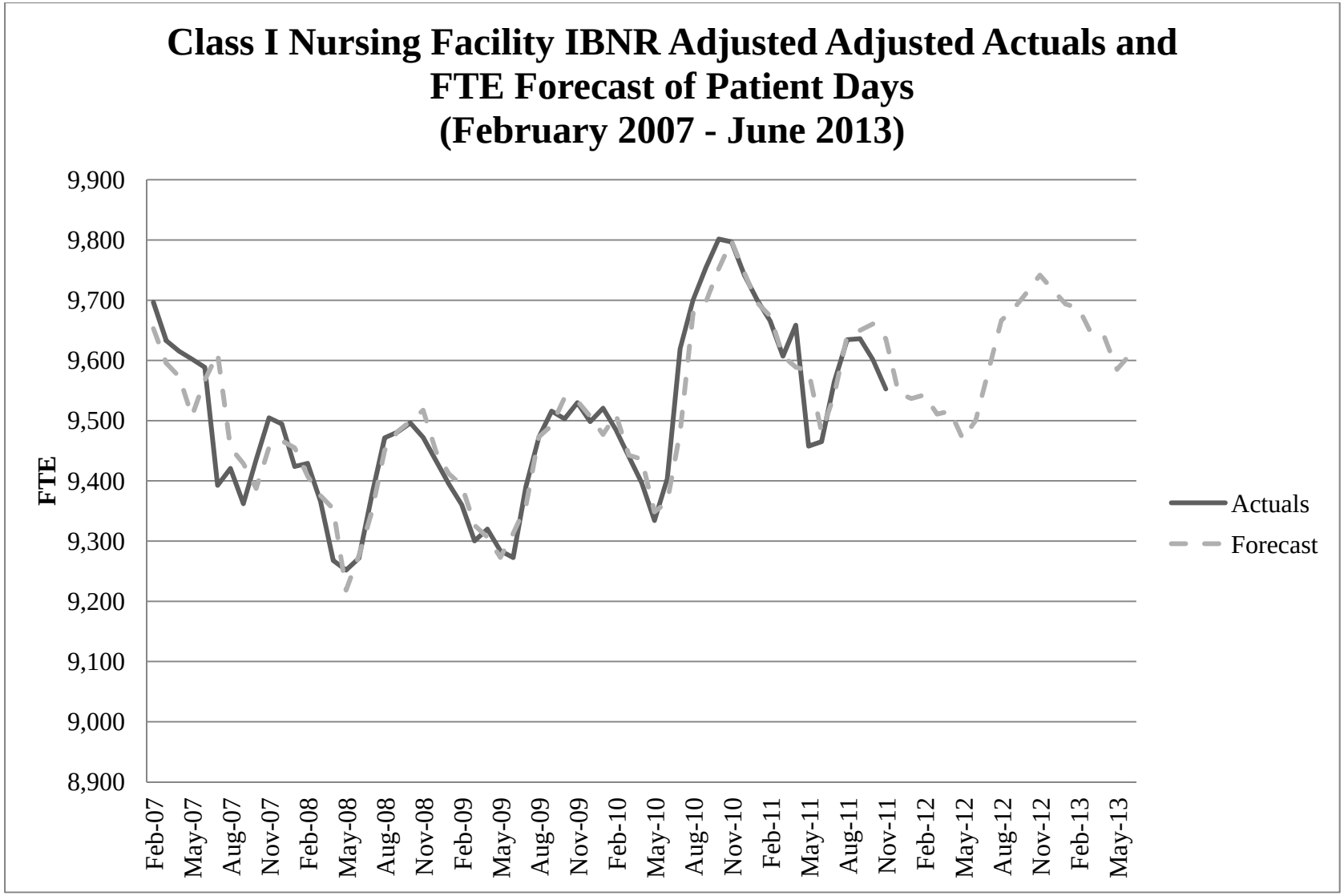
Technically, the test is performed by creating a model where the first difference (the current month minus the previous month's value) of each value predicted by the forecast model is a function of an auto-regressive term and a linear trend term. The corresponding coefficient from this regression can used to test for a unit root. The Department utilized statistical analysis software to test for a unit root in the FTE series. The result is summarized in the following table:

Augmented Dickey-Fuller Unit Root Test of Stationarity		
	T-Statistic	**P-Value**
Augmented Dickey-Fuller Test Statistic	**-3.287**	**0.0789**
Conclusion: Reject that null hypothesis that there is a unit root at the 93 percent confidence level. An auto-regressive model can be used with this series.		

Forecasting Patient Days

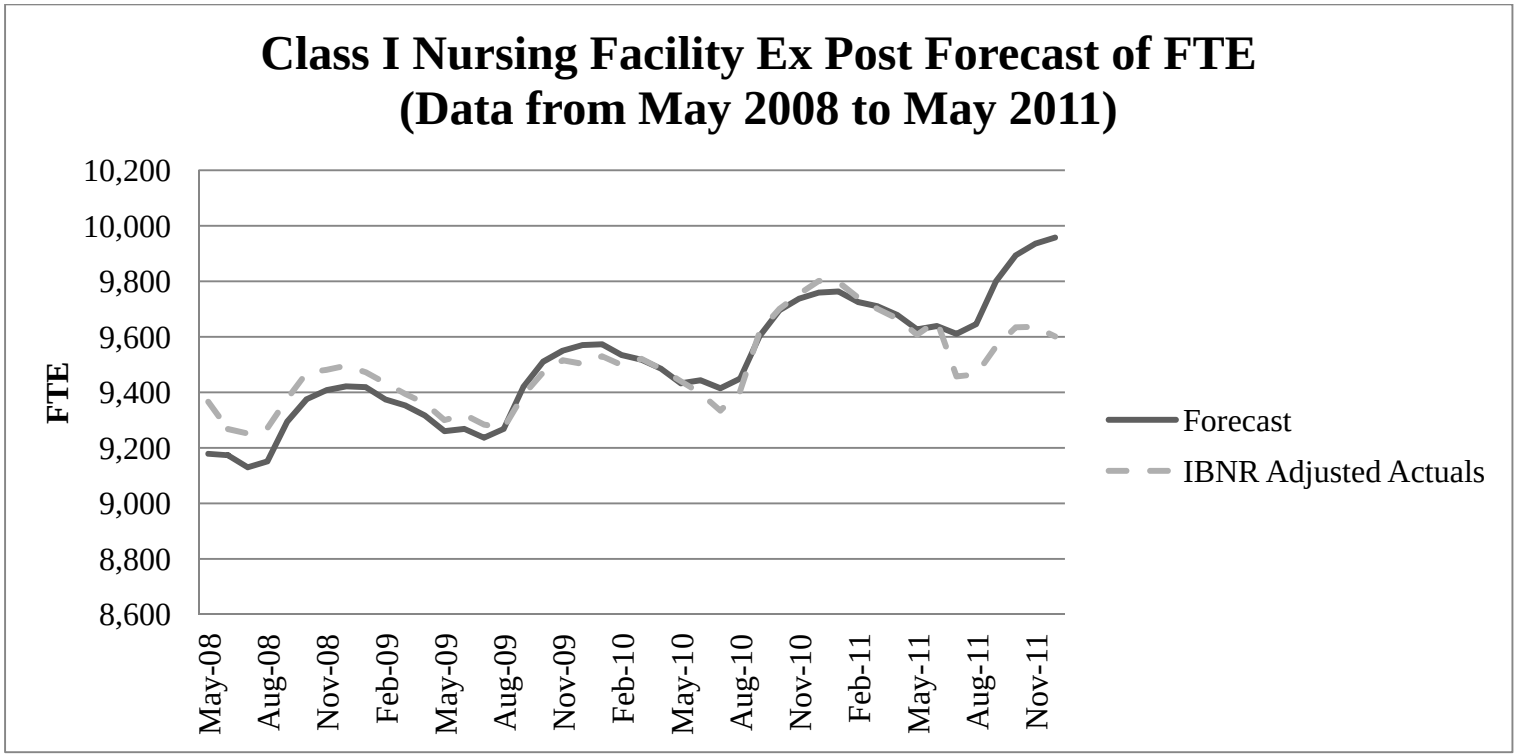
Since the number of monthly patient days is influenced by the number of days in each month, the data needs to be normalized before trending calculations are executed. The total number of days in each month is divided by the number of days in the month to create the number of FTEs, full time equivalent days. Trending is done using the FTEs, and then the total patient days are calculated by multiplying the FTE figures by the number of days in each month.

Historically, the Department's efforts toward increasing utilization of home and community based services have resulted in downward pressure on the class one nursing facility days trend. However, in face of an aging population and ever increasing demand for long term care services, the most recent years have displayed a return to marginal annual growth in patient days.


Class I Nursing Facility IBNR Adjusted Adjusted Actuals and FTE Forecast of Patient Days (February 2007 - June 2013)
FTE
9,900
9,800
9,700
9,600
9,500
9,400
9,300
9,200
9,100
9,000
8,900
Feb-07
May-07
Aug-07
Nov-07
Feb-08
May-08
Aug-08
Nov-08
Feb-09
May-09
Aug-09
Nov-09
Feb-10
May-10
Aug-10
Nov-10
Feb-11
May-11
Aug-11
Nov-11
Feb-12
May-12
Aug-12
Nov-12
Feb-13
May-13
Actuals
Forecast

Ex Post/In-sample Forecasts

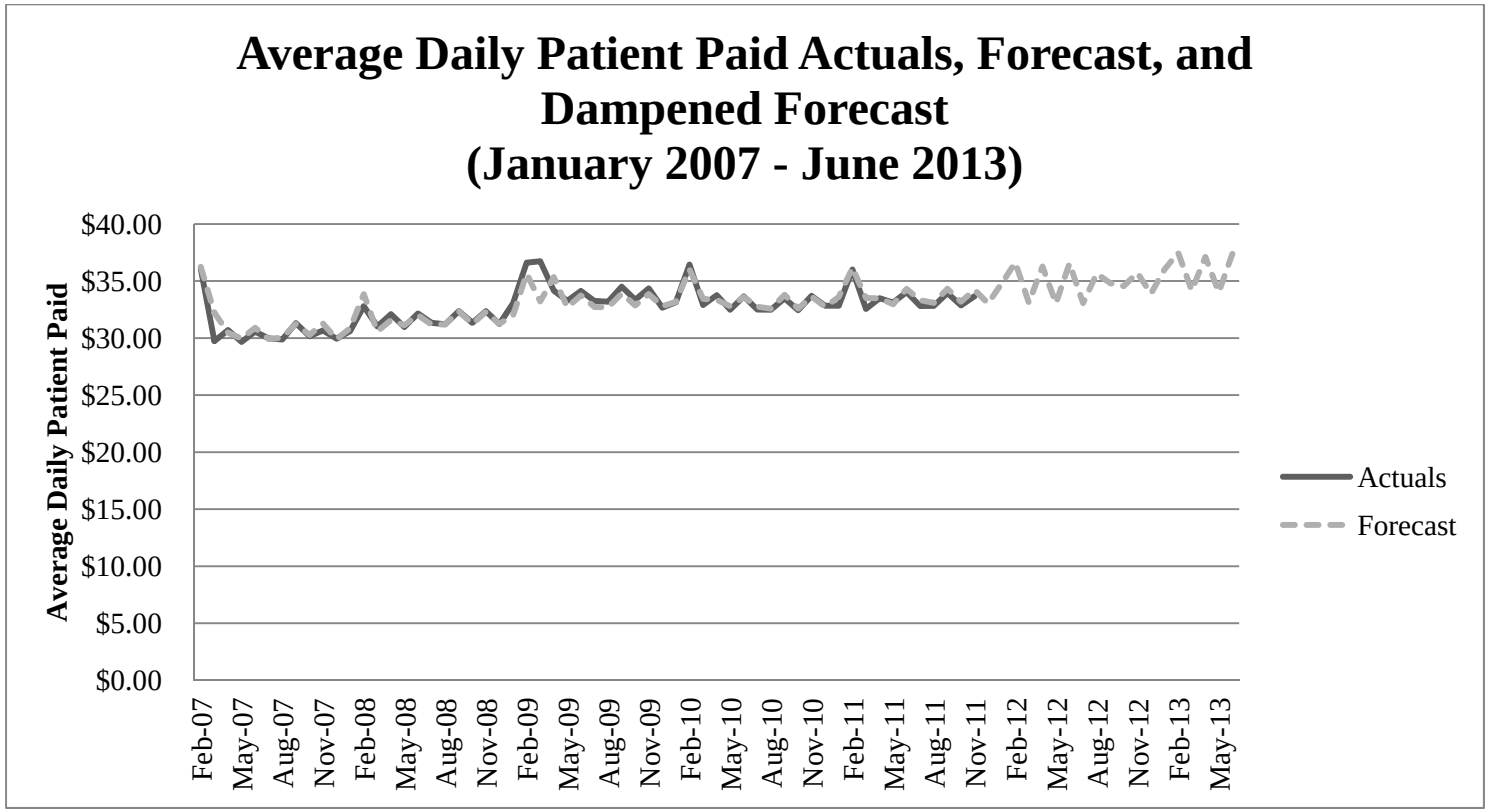
As an additional test of the reasonableness and robustness of the forecasts, the Department calculated in-sample forecasts (using the data from May 2008 through May 2011) and compared the results to actual data reported for June 2011 through November 2011.



It is of note that Ex Post Forecast model significant over estimates FTE in the forecast period from June 2011 to November 2011. This is the direct result of higher than average patient days in the period directly proceeding the forecast period. While FY 2010-11 had higher than levels of patient days than the underlying historical trend would predict, actuals from the first half of FY 2011-12 indicate a reversion to the underlying trend of marginal growth over time. By incorporating more data, the Department mitigates the effect of the higher than average patient days in FY 2010-11.

Patient Payment Forecast Model

As with the days forecast, the Department utilizes a seasonally adjusted autoregressive model to forecast patient payment. Inclusion of historical data from the period prior to November 2008 results in a linear trend that greater than would be anticipated given the most recent data. Consequently, the Department has dampened the forecasted values by approximately 1%.



Testing the Stationarity of the Model

To test the stationarity of the patient paid series, the Augmented Dickey-Fuller Unit Root Test of Stationarity is again used. The series is stationary.

Augmented Dickey-Fuller Unit Root Test of Stationarity		
	T-Statistic	**P-Value**
Augmented Dickey-Fuller Test Statistic	**-5.36**	**0.0002**
Conclusion: Reject that null hypothesis that there is a unit root at the 99 percent confidence level. An auto-regressive model can be used with this series.		

Testing the Overall Predictive Ability of the Model

Again utilizing the F-statistic, an analysis of the model's overall statistical significance can be done. Like the patient days model, the patient payment model also has a p-value of 0.0000, and is statistically significant at the 99% confidence level. R-squared for the model is 0.976 suggesting that 97.6% of the variation in this series can be explained by the linear trend.

Nursing Facility Rate Methodology Changes

The following is a timeline of changes to Class I Nursing Facility policy:

FY 1997-98 8% Health Care Cap and 6% Administrative Cap Implemented
FY 1998-99 No change
FY 1999-00 8% Health Care Cap temporarily removed and Case Mix Cap Implemented
FY 2000-01 No change
FY 2001-02 8% Health Care Cap permanently removed and Quality of Care Incentive Program / Resident Centered Quality Improvement Program discontinued
FY 2002-03 Administrative Incentive Allowance removed for three months then reinstated
FY 2004-05 8% Health Care Cap reinstated
FY 2005-06 No change
FY 2006-07 8% Health Care Cap removed for facilities with an average annual Medicaid resident census that exceeds 64% of the number of actual residents in that facility for that same period. Established a rate floor of 85% of the statewide average rate, or 110% of the facility's current year rate, whichever is lower (SB 06-131). Provisions from SB 06-131 are applicable for FY 2006-07 only.
FY 2007-08 Established the Nursing Facility Grant Rate Program (HB 07-1183). Providers affected by the end of provisions implemented in SB 06-131 are given additional funding to mitigate the impact of the end of the rate floor.
FY 2008-09 New methodology introduced for calculating nursing facility reimbursement rates (HB 08-1114): the 8% Health Care and 6% Administrative and General caps are removed, and an Administrative and General price is set based on 105%

of the median cost for all facilities. Add-on rates are implemented for performance and for facilities with residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. The Department is authorized to collect a provider fee from nursing facilities statewide.

FY 2009-10 The new methodology established in HB 08-1114 was further amended by SB 09-263 which: specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period; adjusted the cap on General Fund growth; specified conditions for supplemental payments; created a maximum for the nursing facility provider fee; replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate; included a hold harmless provision for administration and general services under certain circumstances; and, made changes to the method of implementing pay-for-performance payments. HB 10-1324 implemented a 1.5% rate reduction to the core rate components effective March 1, 2010 through June 30, 2010.

FY 2010-11 HB 10-1379 implemented a 2.5% rate reduction to the core rate components effective July 1, 2010 through June 30, 2011. This bill also reduced the maximum general funds portion of the core per diem rate to 1.9% growth for FY 2010-11.

FY 2011-12 SB 11-125 increased the level of the provider fee to $12.00 per non Medicare day plus annual inflation. Additionally the bill reprioritized the hierarchy for the components of nursing facility supplemental payments. Growth beyond the General Fund cap is prioritized last under the new hierarchy.

FY 2011-12 SB 11-215 extended the 1.5% rate reduction from the prior year. The rate reduction expires July 1, 2012.

Department Forecast Methodology Change

With the Department's November 2011 request, the forecast methodology has been altered to increase the predictive capability of the model while aligning the components of the forecast with the rate setting methodology in statute. To generate the nursing facility forecast using the previous methodology, claims that were 100 percent patient paid were excluded from the data set. This was done to prevent patient days with no associated Medicaid payment from inflating forecasted expenditure when multiplied by the effective per diem. As current legislation allows the aggregate statewide average per diem net of patient payment to grow by a fixed amount annually, claims that have 100 percent patient payment impact the next year's rate. To more accurately forecast the per diem rates, the revised forecast methodology, claims with 100 percent patient payment are included in the data set. This has several noticeable effects; both patient payment and days increase when these claims are included in the data set. Restated historical values can be found in the footnotes section of Exhibit H.

This methodology allows for a more accurate forecast of the statewide aggregate per diem net of patient payments. Additionally, with this methodology, patient payment and patient days more accurate reflect what were actually paid or incurred.

Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category

For comparison purposes to other service categories, this exhibit lists prior year expenditure along with the projected expenditure from page EH-2. Estimated totals by aid category are split proportionally to the most recent year of actual expenditure. Additionally, the Department calculates per capita costs for each year. Supplemental payments made to Class I nursing facilities through the Nursing Facility Provider Fee program are not included in total expenditure.

Totals for each aid category are used to calculated total expenditure by aid category in Exhibit E, and total per capita by aid category in Exhibit C.

Class II Nursing Facilities

This service category is for specialized private nursing facility care for developmentally disabled clients, which was the focus of the Department of Human Services' initiative to deinstitutionalize these clients by placing them in appropriate care settings. The deinstitutionalization strategy was completed in April of FY 1997-98. Beginning in FY 1998-99, the service category was limited to one facility. There are no plans to eliminate this facility as it essentially functions more like a group home than an institutional facility. At the end of FY 2005-06, the provider increased its enrollment from 16 clients to 20 clients. During FY 2006-07, the census at this facility has remained constant**.** Additionally, this facility received an annual cost-based rate adjustment, similar to Class I nursing facilities. As a result, this service category has experienced expenditure growth that differs sharply from any recent year. FY 2009-10 enrollment rates were slightly lower than in the previous year. The facility averaged between 18 and 19 clients. However, for FY 2010-11 and FY 2011-12 there the Department anticipates enrollment will return to the 20 client enrollment level. The estimated growth rate for FY 2011-12 reflects changes in per diem rates based on audited cost reports from CY 2010. The estimated growth rate for FY 2012-13 is based on anticipated changed in per diem reimbursement using information from unaudited cost reports for CY 2011. Because all clients are paid the same rate regardless of aid category, it is anticipated that change in expenditure per aid category will only change if enrollment varies by aid category. However, total expenditure would still remain the same; therefore, differences between aid categories are less relevant.

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

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older (OAP-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB). PACE rates are adjusted once per year, generally on January 1 of each year.

Effective with the November 1, 2007 Budget Request, the Department has substantially revised the methodology used to calculate the projections for PACE expenditure. In prior years, the Department performed a per capita-based estimate, similar to the Acute Care and Community Based Long Term Care projections. However, enrollment trends in PACE are different from the overall Medicaid population. Therefore, the standard per capita measure is unreliable, in that it does not reflect the true cost of serving a client enrolled in PACE.

HB 08-1374 removed the requirement that the Department reimburse PACE providers at 95% of the equivalent fee-for-service cost, effective July 1, 2008. The Department now pays providers the lesser of the 100% rate or the federal upper payment limit.

To better forecast expenditure, the Department began providing two new metrics in FY 2008-09: average monthly enrollment, and average cost per enrollee. The average monthly enrollment is based on the number of distinct clients for whom capitations were paid to PACE providers in each fiscal year, as determined by claims information from the Medicaid Management Information System. The average cost per enrollee is the total expenditure divided by the average monthly enrollment for each fiscal year.

The FY 2011-12 projection for PACE is computed in several parts: First, the Department estimates the growth in the average enrollment at PACE providers using a linear regression model for each eligibility category. This projection is then added to the exhibit to calculate total expenditure. Second, the Department estimates the growth in the average cost per enrollee, and applies the selected trend factor to the FY 2010-11 average cost per enrollee. The estimated cost per enrollee and estimated enrollment are multiplied to calculate the estimated FY 2011-12 base expenditure. The Department then adjusts for any bottom-line impacts not incorporated in the trend (described below). The sum of the base expenditure and the bottom-line adjustments is the estimated FY 2011-12 total expenditure. FY 2012-13 and FY 2013-14 expenditure is calculated in the same fashion.

To estimate the average increase in cost per enrollee in FY 2011-12, the Department selected the estimated growth rate between PACE rates from FY 2010-11 to FY 2011-12. Because the PACE program is capitated, the Department believes the best estimate for cost per enrollee is based on the actual rate that will be paid. For FY 2011-12 the Department selected the estimated growth rate in PACE rates for Total Longterm Care (TLC), the Department's largest PACE provider for all eligibility categories, Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to age 59 aid categories. For FY 2012-13 and FY 2013-14 the Department took the average growth rate in TLC PACE rates from FY 2008-09 to FY 2010-11.

In recent years, the Department has added a number of new PACE providers. Senior CommUnity Care of Colorado (Volunteers of America), a new provider, began serving clients on August 1, 2008, in Montrose and Delta counties. The organization originally planned to open a third facility in Grand Junction in Spring 2010, however this plan is on hold. Rocky Mountain Health Care began serving clients on December 1, 2008, in El Paso County. Total Longterm Care, the Department's oldest PACE organization, opened a

facility in late 2009 to serve clients in Pueblo. The organization also expanded its current facility in Thornton in 2010 and is looking to expand into Larimer and Weld county in 2012.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V of this narrative. For FY 2011-12, FY 2012-13 and FY 2013-14 no bottom line adjustments have been added. However, in FY 2010-11 a reconciliation was paid to PACE providers for rates which were paid below the true cost of providing the services due to erroneous patient payment reporting. This was a onetime payment the Department accounted for through a bottom line impact. To account for this payment the Department subtracted it out when calculating per capita and per enrollee costs and trended costs forward using the adjusted amounts.

Supplemental Medicare Insurance Benefit (SMIB)

The Supplemental Medicare Insurance Benefit (SMIB) consists of two parts: Medicare Part A, the insurance premium for hospital care and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients have both Medicaid and Medicare coverage) or Partial Dual Eligibles receive payment for Medicare Part B, and in some cases, Medicare Part A. The Partial Dual Eligibles aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility group only.[3] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types, and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

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

[3] Most Medicare beneficiaries do not make a Part A payment, because they have contributed to Medicare for 40 or more quarters during their working life. The Department only subsidizes Part A payments for Qualified Medicare Beneficiaries who do not meet the 40 quarter requirement.

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients, and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:[4]

History of Medicare Premiums

Calendar Year	Part A	% Change	Part B	% Change
2003	$316.00	-	$58.70	-
2004	$343.00	8.54%	$66.60	13.46%
2005	$375.00	9.33%	$78.20	17.42%
2006	$393.00	4.80%	$88.50	13.17%
2007	$410.00	4.33%	$93.50	5.65%
2008	$423.00	3.17%	$96.40	3.10%
2009	$443.00	4.73%	$96.40	0.00%
2010	$461.00	4.06%	$110.50	14.63%
2011	$450.00	-2.39%	$115.40	4.43%
2012	$451.00	0.22%	$99.90	-13.43%

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

During FY 2007-08, the Department made its July 2007 payment for Medicare premiums several days late. As a result, Medicare automatically deducted the balance from the Department's Medicaid grant. As a result, from the perspective of Medicare, the Department effectively double-paid July, and the difference became a credit against the September total. As a result, the total expenditure for this line does not reflect payment for one month, because the federal funds Medicare received directly from the Medicaid grant did not pass through the state's accounting system. Therefore, in order to accurately project expenditure, the Department used the actual Medicare invoice totals for FY 2007-08 instead of the actual expenditure for FY 2007-08. This ensures that the projection base is not understated, which would lead to a material under-projection in the forecast.

[4] Premium information taken from the Centers for Medicare and Medicaid Services, http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment|PremiumCostInfo#TabTop

To forecast FY 2011-12, the Department inflates the actual expenditure from the second half of FY 2010-11 by the increase caseload from FY 2010-11 to FY 2011-12. This generates the anticipated expenditure for the first half of FY 2011-12 as there will be no increases to Medicare premiums during this period. Expenditure for the second half of FY 2011-12 is calculated by inflating the estimated first half of the year's expenditure by the anticipated decrease in Medicare premiums effective January 1, 2012 or -13.43%. This decrease in premiums is based on the change in premiums from CY 2011 to CY 2012 as reported by CMS. The total estimated expenditure for FY 2011-12 is the sum of the first half actual expenditures and the second half estimated expenditures. The Department's February forecast deviates significantly from the November forecast to the unforeseen decrease in Medicare Part B premiums. The decrease represents the first in over a decade.

To forecast FY 2012-13, the Department first inflates the estimated expenditure from the second half of FY 2011-12 by the estimated caseload trend for FY 2012-13 as reported in exhibit B. This figure represents the approximate expenditure for the first half of FY 2012-13. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2012-13 is the sum of the first half and second half estimates. The Department does not anticipate a decrease in Part B premiums for a second year in a row. Consequently, the Department has selected a positive premiums trend for CY 2013 and CY 2014 of 6.49% which is equal to the average percentage change in Part B premiums since CY 2004.

The forecast of FY 2013-14 expenditure utilizes the same methodology as the forecast of FY 2012-13.

Health Insurance Buy-In (HIBI)

The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost effective. This is known as the Health Insurance Buy-In (HIBI) program, permitted under 25.5-4-210, C.R.S. (2009). In recent years, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. In particular, during FY 2005-06, due to the implementation of the Medicare Modernization Act, many of the health plans that were previously cost effective became ineffective, since the costs of those health plans included a drug benefit. This caused a significant decrease in HIBI expenditure and enrollment in FY 2005-06. Additionally, the Department found that, with rare exceptions, it was no longer cost effective to purchase commercial insurance for clients in the Adults 65 and Older (OAP-A) aid category. Instead, the majority of expenditure was shifted to Disabled Individuals to 59 (AND/AB), for clients who do not qualify for the Medicare Part D benefit.

In FY 2006-07, the Department experienced significant growth in the program, although the cause appears to be related to administrative changes rather than other factors. For example, a single outside agency has referred approximately 50 new clients to the Department for enrollment in the program. Additionally, during FY 2006-07, the Department examined and upgraded the existing

process to determine client eligibility for the program. This change enabled the Department to process clients more efficiently, resulting in an increase in caseload.

Contrary to previous budget submissions where the Department examined per capita growth trends to forecast the HIBI budget, for FY 2011-12 through FY 2013-14 the Department examined total expenditure trends to estimate expenditure. The Department believes this methodology to be more accurate as per capita growth has fluctuated significantly historically because HIBI enrollment does not bear a direct relationship to Medicaid caseload. The Department selected 3.27%, the FY 2010-11 expenditure growth rate for AND/AB clients to trend expenditure in FY 2011-12 for the Disabled Adults 60 to 64 (OAP-B), Disabled Individuals to 59 (AND/AB), Eligible Children, Categorically Eligible Low-Income Adults (AFDC-A), and Baby Care Program Adults aid categories. All FY 2011-12 trend selections were held constant for FY 2012-13 and FY 2013-14.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2011-12, FY 2012-13 and FY 2013-14 calculations for the Health Insurance Buy-In Program:

- SB 10-167 Medicaid Efficiency and Colorado False Claims Act impacts the HIBI program in FY 2010-11 by requesting the purchase of private health insurance coverage through the Health Insurance Buy-In Program for an additional 1,500 eligible clients to create cost savings for the state. Savings as a result of SB 10-167 are captured in the Acute Care exhibit. The Department has adjusted costs associated with this bill by changing the payment methodology for the contractor from a contingency fee to a per member per month payment. In addition, adjustments were made to reflect additional premium payments that would be made as the number of clients utilizing the program increases. The estimate was also adjusted for delays in the implementation timeline and enrollment capabilities of the contractor. Please see section V for a complete description of the bill and changes.

EXHIBIT I – SERVICE MANAGEMENT

This service group includes administrative-like contract services within the Medical Services Premiums budget. The group is comprised of Single Entry Point agencies, disease management, and administrative fees for prepaid inpatient health plans.

Summary of Service Management

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

Single Entry Points

Single Entry Point (SEP) agencies were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. The single entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients in order to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients, pursuant to 25.5-6-105, C.R.S. (2009). A single entry point agency is an agency in a local community through which persons eighteen years or older, who are in need of long-term care services, can access needed long-term care services.

The single entry point agency is required to serve clients of publicly funded long-term care programs including nursing facility care, Home and Community Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons living with acquired immune deficiency syndrome, HCBS for persons with brain injury, HCBS for persons with mental illness, long-term home health care, home care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965.

The major functions of single entry point agencies include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and maintaining fiscal accountability. Single entry point agencies also serve as the utilization review coordinator for all community based long term care services.

Single entry point agencies are paid a case management fee for each client admitted into a community based service program. Single entry point agencies also receive payment for services provided in connection with the development and management of long term home health prior authorization requests, for work associated with client appeals and for utilization review services related to home and community based services and nursing facilities.

On November 1, 2002, the Department submitted a report for Footnote 52 of HB 02-1420, describing the payment methodology for single entry point agencies. However, recently it has come to light that the process described in the footnote report is not being used. Instead, individual single entry point agency contract amounts are determined using data from each single entry point agency's previous year's history of client and activity counts. At the end of the contract year the actual client and activity counts are reconciled against the projected client and activity counts. This process results in either funds owed to single entry point agencies for services delivered in excess of funds received, or funds owed to the Department for payments made in excess of services delivered. The Department then issues a reconciliation statement to collect for overpayment or adjusts for underpayment up to the amount allocated.

This payment methodology, combined with close Department oversight, encourages single entry point agencies to enroll only those clients who are appropriate for community based services.

Annual financial audits are conducted by the Department to verify expenditures were made according to the contract scope of work and that to assure single entry point agency compliance with general accounting principles and federal Office of Management and Budget (OMB) circulars. If the audit identifies misused funds, the amount misused is collected through a recovery order.

SB 04-206 directed the Department to implement a pediatric hospice program; the impact of this legislation is fully annualized in the budget request. Entry into the program must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add a pediatric hospice effective January 1, 2008.

Also fully annualized in the budget request is the impact of HB 05-1243, which allowed the Department to add consumer directed care to home and community based waiver services. These services must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services to add consumer directed care to the Elderly, Blind, and Disabled waiver and the Mental Illness waiver in 2007; the Department began to provide these services effective January 1, 2008.

Effective with the November 1, 2007 Budget Request, the Department has revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, single entry points are generally paid a fixed fee for each year, although this amount may be adjusted based on actual experience. In recent years, the number of clients processed by single entry points has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, single entry points would be required to serve an increasing population with the same funding.

Therefore, the Department's request includes an increase to single entry point contracts. The requested increase is based on the expected increase in Home and Community Based Services (HCBS) utilization, as determined by average monthly paid enrollment in the Department's HCBS programs. These figures do not reflect the actual enrollment in HCBS programs, nor do they reflect actual single entry point caseload; rather, they are based on the number of clients for whom the Department has paid a related claim during each fiscal year. This figure is therefore consistent with the cash accounting basis of Medical Services Premiums. The Department believes that growth in paid enrollment is a good proxy for growth in single entry point caseload.

In FY 2010-11 the Department began reporting cost per HCBS waiver utilizer to provide additional information about SEP expenditure and to use in trending expenditure forward.

For FY 2011-12, the Department's projection uses the total base contracts amount, which is the current amount allocated to single entry points in the FY 2010-11 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during

Figure Setting), and adds legislative impacts (see below). For FY 2012-13, the Department estimates the increase in HCBS utilization based on the average percent change in average monthly paid enrollment from FY 2007-08 through FY 2010-11 for the Adults 65 and Older. For Disabled Adults 60 to 64 the Department used the year to date growth rate in paid HCBS utilization. For the Disabled Individuals to 59 aid category the Department trended HCBS paid enrollment using the average percent change in average monthly paid enrollment from FY 2006-07 through FY 2010-11 . The overall HCBS utilization growth rate from FY 2006-07 to FY 2010-11 was selected to trend expenditure for the remaining aid categories; Categorically Eligible Low-Income Adults, Eligible Children, Foster Care, Non-Citizen, and Partial Dual Eligibles. The estimated FY 2011-12 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 2012-13 and FY 2013-14 expenditure.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department does not anticipate any new changes that impact expenditure for SEPs from FY 2011-12 through FY 2013-14.

Disease Management

Beginning in July 2002 the Department implemented several targeted disease management pilot programs, as permitted by HB 02-1003. Specifically, the Department was authorized "to address over- or under-utilization or the inappropriate use of services or prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease or combination of diseases" (25.5-5-316, C.R.S. (2009)). Initially, pilot programs were funded solely by pharmaceutical companies; the programs began and ended at different times between July 2002 and December 2004.

During the pilot program, the Department initiated seven disease management programs to identify the most appropriate strategies to contain rising health care costs, improve access to services and improve the quality of care for the fee-for-service Medicaid clients. The targeted disease conditions included high-risk infants, clients with asthma, clients with diabetes, clients with schizophrenia, female clients with breast and cervical cancer, and clients with chronic obstructive pulmonary disease. Additionally, the Care Management Organization pilot was established to coordinate all of the disease management programs and to establish a means for additional fee-for-service clients to obtain intensive case management or health counseling.

The pilot programs revolved around three key managed care principles: appropriate and timely access to health care services, evaluation and support for adherence to appropriate medical regimens/treatments and provision of nationally recommended practice guidelines for each chronic disease. The pilot programs enabled the Department to obtain actual Colorado Medicaid disease management data and experience to be utilized for future program development.

As a result of the pilot programs, the Department entered into permanent contracts with two disease management companies for two health conditions: clients with asthma, and clients with diabetes. In order to provide appropriate management to achieve cost-savings, reducing hospitalizations and emergency room visits, the Department contracted with Alere Medical Incorporated for clients with asthma, and with McKesson Health Solutions for clients with diabetes. Over time, the Department has added and changed contracts as appropriate to ensure that Medicaid clients continue to receive quality care.

At the start of FY 2008-09, the Department had five disease management contracts covering specific conditions. Those conditions were: asthma; congestive heart failure (CHF); chronic obstructive pulmonary disease (COPD); high risk obstetrics; and weight management. The Department also employed a contractor to do more general disease management via telemedicine. The Department's funding for these contracts was a combination of General Fund, Prevention Early Detection and Treatment Fund, and federal funds. Certain restrictions, specified in section 24-22-117 (2) (d) (IV.5), C.R.S. (2009), limit the use of Prevention Early Detection and Treatment Fund. Therefore, the Department separated the amount of base funding (contracts financed with General Fund) and the amount of expansion funding (contracts financed with Prevention Early Detection and Treatment Fund) in order to ensure that its request reflects the correct amount from each funding source. For FY 2008-09 only, this separation was reflected as a bottom-line impact.

The Department's disease management contractors operated on a fixed budget (specified in the contract), and client enrollment could not exceed a fixed number of clients that the Department has determined shall be managed on that budget. Contractors accepted new clients only up to the enrollee limit as specified in the contract.

Effective June 30, 2009, the Department discontinued the five specific Disease Management programs. The remaining funds were used toward services related to the treatment of the health conditions specified in 24-22-117(2)(d)(V), C.R.S. (2011) (further described in exhibit A). The Department's telemedicine program has two months of expenditures encumbered for FY 2009-10; the encumbered amount of $63,488 is included in the FY 2009-10 request. The Department did not renew the telemedicine contract when it expired on September 30, 2009.

In the estimate of expenditure for FY 2011-12, the Department's appropriation includes $500,000 total funds to continue its Adult Medical Home pilot program. Although currently funded through the Department's Health Resources and Services Administration (HRSA) grant, the state share for this program would be paid for from the Prevention, Early Detection, and Treatment funds described above.

FY 2012-13 remains at the same level as FY 2011-12. However, in FY 2013-14, the statutory authorization for this funding expires. Expenditure in the out year and any year following is expected to be zero.

Prepaid Inpatient Health Plan Administration

Prepaid inpatient health plans (formerly known as Administrative Service Organizations) are an alternative to traditional health maintenance organizations. They offer the case management and care coordination services of a health maintenance organization for a fixed fee. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. The Department began using this type of organization to deliver health care to Medicaid clients during FY 2003-04. In FY 2005-06, the Department ended its contract with Management Team Solutions. Since then, the Department contracted with only one prepaid inpatient health plan, Rocky Mountain Health Plans, until FY 2009-10. The Department contracted with three additional prepaid inpatient health plans in FY 2009-10. These include: Colorado Access and Kaiser Foundation Health Plan, which are jointly part of the Colorado Regional Integrated Care Collaborative (CRICC); and Colorado Alliance & Health Independence (CAHI). In FY 2010-11, the Department implemented the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Care Collaborative Organizations (RCCOs), the Primary Care Providers (PCPs), and the Statewide Data Analytic Contractor (SDAC) are administrative fees that are incorporated in the prepaid inpatient health plan exhibit.

Prepaid inpatient health plans receive a fixed amount administrative fee per client. Exhibit EI-6 depicts the administrative fee expenditures for the Department's current contractors, including estimated cost avoidance payments for Rocky Mountain Health Plans. The service costs for these organizations are included in Acute Care and Community Based Long Term Care. In the current request, the Department forecasts enrollment and costs for each program separately.

Rocky Mountain Health Plans

Because the administrative fees remain the same in FY 2011-12 and FY 2012-13, the Department uses actual enrollment to forecast expenditure in FY 2011-12 and FY 2012-13 for Rocky Mountain Health Plan. In prior budget requests, enrollment for Rocky Mountain Health Plan was forecasted by eligibility group; for this request, enrollment is forecasted in aggregate for each provider, as it is based more on the provider's ability to expand to new clients than on the growth in caseload by eligibility group. The administrative fees paid to the providers are the same regardless of the eligibility category of the clients served.

To forecast enrollment in Rocky Mountain Health Plan for the current and request years, the Department assumes that the provider will be concentrating the majority of its resources to enroll new clients into the ACC and its network as a RCCO instead of into its Health Plan. Therefore, the Department estimates that the only growth into the Health Plan in FY 2011-12 will be the base trend from the December 2011 level. In FY 2012-13 and FY 2013-14, the Department assumes that there will be no enrollment growth in the Health Plan.

In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plan. During FY 2007-08, the Department and Rocky Mountain Health Plan were unable to come to an agreement on the correct amount of cost avoidance for the contract year FY 2005-06, and no payment was made. At that time, the Department anticipated that it may make a combined payment for FY 2005-06 and FY 2006-07 in FY 2008-09 with existing funding. In addition, the Department anticipated making a single contracted payment in FY 2009-10 for services rendered in FY 2007-08. However, since that time, federal Centers for Medicare and Medicaid Services (CMS) directed the Department to cease making any cost avoidance payments until all historical encounter data for prepaid inpatient health plan claims is integrated into the Medicaid Management Information System (MMIS). The Department has completed all CMS requirements pertaining to Rocky Mountain Health Plan and anticipates making a cost avoidance payment to Rocky Mountain Health Plan for services rendered in FY 2009-10 in the latter half of FY 2011-12. Rocky Mountain Health Plan and the Department agreed with the methodology used to calculate the payment and will use it as the standard methodology for all future payments. They also agreed that no cost avoidance payments will be made for fiscal years prior to FY 2009-10, as they were not able to compromise on the correct amount to be paid. In addition to the FY 2009-10 payment, the Department will also make a cost avoidance payment in FY 2011-12 for services rendered in FY 2010-11. For all subsequent fiscal years, the Department will make one cost avoidance payment for the year prior to it.

The Department included the cost avoidance amount for FY 2009-10 services as a bottom line impact for FY 2011-12 and multiplied it by two, which takes into account the need to pay an additional cost avoidance payment in that fiscal year for FY 2010-11 services. For the FY 2012-13 and FY 2013-14 fiscal years, the Department assumed that the cost avoidance payments would be similar in magnitude to the calculated payment for FY 2009-10 and carried that amount forward for both fiscal years. The final payments will differ from the budgeted amount, as the Department will calculate the actual amount of cost avoidance, which may be higher or lower than the estimated levels.

Colorado Regional Integrated Care Collaborative Programs (Colorado Access and Kaiser Foundation Health Plan)

The Colorado Regional Integrated Care Collaborative (CRICC) is part of a larger national collaborative sponsored by the Center for Health Care Strategies (CHCS). This program aims to better serve Medicaid clients with the highest needs and costs by coordinating physical, mental health, and substance abuse services. The Colorado Access contract for CRICC was altered from a risk-based, capitated program to an Administrative Services Organization (ASO) after the provider informed the Department that the risk-based model would no longer be sustainable. The Department and the provider negotiated an alternative that would allow for continuity of services while altering the reimbursement structure to a more sustainable model. This transition occurred on April 1, 2010. Expenditure for administrative fees to Access as an ASO is accounted for in the prepaid inpatient health plan exhibit. The contract for Colorado Access in the CRICC program expired on June 30, 2011, at which time all of the clients in the program were disenrolled. A study on the effectiveness of the program is being completed by MDRC, a nonprofit, nonpartisan policy research organization. The

study will analyze the program in terms of quality of care, utilization, and expenditure. MDRC's evaluation of Colorado Access will be completed and available to the Department in 2012.

Kaiser Foundation Health Plan began enrolling clients for CRICC in August of 2009. The claims for Kaiser are not paid for through the MMIS; therefore, there is no information in the system on the number of enrolled clients by month as there is for Colorado Access. To forecast future enrollment, the Department averaged the expected capped enrollment by month for the current and request years. The Department estimates that enrollment will remain around the current level until the end of the program. At the end of FY 2010-11, the Department had not yet paid for the last four months of administrative fees incurred in that fiscal year, and as a result, the payments for these months were made in FY 2011-12. The payments are now caught up to the point where the lag time between month of service and month paid is only one month. For this reason, it is assumed that the Department will make payments to Kaiser for fifteen months of case management fees in FY 2011-12, including four from FY 2010-11 plus eleven from FY 2011-12. Kaiser will continue to serve CRICC clients until June 30, 2012, when its part of the pilot program will end. Due to the lag in payments, it is expected that there will be one additional payment to be made in FY 2012-13. MDRC is currently studying the effectiveness of the program at Kaiser, and will complete the evaluation for the Department at the beginning of 2013.

Colorado Alliance & Health Independence (CAHI)

Colorado Alliance & Health Independence (CAHI) was authorized in SB 06-128 as a new, integrated approach to care for people with disabilities up to age 64, designed to provide a network of services that are high-quality and cost effective. It is funded through the Coordinated Care for People with Disabilities Program. The pilot program was launched on January 1, 2010. The claims for CAHI are now paid for through the MMIS, allowing the Department to forecast enrollment based on actual clients served by month. The enrollment forecasts for FY 2011-12 and FY 2012-13 were based on the Department's estimate of when periods of passive enrollment would take place and how many clients the provider would be allowed to enroll, as well as its brief historical experience of how many clients were enrolled from January 2010 to December 2011. The payments to CAHI were lagged by one month at the end of FY 2010-11. The Department assumes that there will be a one-month lag in payment at the end of FY 2011-12, resulting in payments of twelve months in that fiscal year, including one from FY 2010-11 plus eleven from FY 2011-12. Similarly, it is assumed that the Department will make payments for twelve months in FY 2012-13 (one from FY 2011-12 plus eleven from FY 2012-13) and FY 2013-14.

Accountable Care Collaborative (ACC)

The Accountable Care Collaborative (ACC) is a Department initiative requested originally in FY 2009-10 DI-6, "Medicaid Value Based Care Coordination Initiative" and revised in FY 2010-11 S-6/BA-5, "Accountable Care Collaborative." The Department enrolled the first clients into the program in May 2011, and enrollment increased to 60,000 by December 2011. The Department

anticipates that enrollment will expand to 123,000 clients by April 2012, which was requested in FY 2011-12 BA-9, "Medicaid Budget Balancing Reductions." The cost savings estimated for this program are included in acute care; please see Exhibit F and Section V for more information on its impact to acute care. The monthly management fees are estimated in the prepaid inpatient health plan exhibit. The fees in FY 2011-12 include $2,700,000 paid to the SDAC, $12.00 PMPM paid to the RCCOs, $3.00 PMPM paid to the primary care providers for each client who has been enrolled with them for at least a month, and a $2.00 monthly incentive payment divided between the providers and the RCCOs. The fees in FY 2012-13 are the same, except the SDAC costs will increase to $3,000,000. In FY 2011-12, the SDAC will not have as much data to analyze as the ACC is still ramping up; by FY 2012-13, however, the SDAC will have a full year's data to analyze and will be assisting the Department in integrating more information to evaluate the program. The contract will increase by $300,000 in that year, and the Department anticipates that it will remain at that level for future years. In the current and request year, the Department assumes that the full $2.00 incentive will be paid out to the RCCOs and PCMPs for each of their members. This is the case for the current year, but starting in FY 2012-13, the incentive payment will only be paid out if the providers meet certain predetermined benchmarks; the total PMPM for the program may be less if providers are not meeting their benchmarks. The Department will analyze this in FY 2012-13 and may request a lower PMPM depending on the average percentage of the incentive payments paid to providers. The FY 2013-14 estimate incorporates the same PMPM amounts and enrollment levels as FY 2012-13.

Legislative Impacts and Bottom- Line Adjustments

To account for programmatic changes which are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans, as detailed above.

EXHIBIT J - HOSPITAL PROVIDER FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

These exhibits summarize the source of funding for Health Care Affordability Act of 2009 cash funded expansion populations. These estimates are incorporated into the Calculation of Fund Splits in Exhibit A. Information regarding Tobacco Tax funds has been removed from this exhibit with the Department's November 1, 2011 request as Tobacco Tax funding is now appropriated to the Department at a fixed value that is independent of the actual caseload or per capita costs associated with clients that would have otherwise been funded by Tobacco Tax.

Hospital Provider Fee Fund

HB 09-1293 established this fund, which provides for the costs of the following expansion populations that impact the Medical Services Premiums budget:

Expansion Adults to 100%

While the Health Care Expansion Fund originally provided funding for parents of children enrolled in Medicaid from approximately 29% to at least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund extends eligibility to parents from 61% to 100% of the federal poverty level. This expansion population receives the standard Medicaid benefits. Eligibility for this population under Medicaid was effective May 1, 2010.

The Department assumes that the medical and mental health per capita costs for this expansion group will be the same as those for the Medicaid Expansion Adults to 60% FPL. Per capita cost estimates for this population have been updated to reflect the most recent projection of per capita costs for the Expansion Adults population.

For caseload estimates and methodology, please see the Section II of this narrative.

Adults without Dependent Children

This expansion allows Adults without Dependent Children to be eligible for Medicaid benefits. Eligibility for this population is scheduled for May 2012. The Department is pursuing a Section 1115 Demonstration Waiver in order to implement the population. The Department submitted the Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) in December 2011, and rules were approved by the State Medical Services Board (MSB) in January 2012.

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the economic statistics of disabled and uninsured Colorado residents. The data showed that there were 143,191 uninsured Adults without Dependent Children in Colorado in 2009, 49,511 of which were in the 0-10% FPL bracket. This data, along with a cost analysis, led the Department to conclude that it must initially cap enrollment for this expansion at 10,000.

The Department assumes the per capita costs for this population will be a blend of the historical per capitas trended forward for the Low-Income Adults from 29% to 60% of the FPL and the Disabled Individuals to 59 (AND/AB). The experiences from other states and a literature review on this population confirm this assumption. As the Department is only implementing up to 10% FPL, the Department assumes that these clients will be the most high-need clients, with a lot of pent-up demand. With these assumptions, the Department assumed a blended per capita with 25% resembling the Low-Income Adults from 29% to 60% of the FPL, with the other

75% resembling the Disabled Individuals to 59 (AND/AB) population. These proportions were applied to the per capitas for the Low-Income Adults and the Disabled Individuals to 59 calculated by the Department's contractor using the historical data of both populations. To allow for potentially higher than anticipated costs with the rollout of a new population, the Department is requesting additional funding beyond the amount indicated in the per capita estimates. If expenditure falls short of the requested amount, all funds will remain in the hospital provider fee cash fund.

Medicaid Buy-in Fund

This fund is administered by the Department to collect buy-in premiums and support expenditures for the Buy-in for Individuals with Disabilities expansion population, as authorized by HB 09-1293.

Buy-in for Individuals with Disabilities

This expansion allows for disabled individuals with income up to 450% of the federal poverty level to purchase Medicaid benefits. Eligibility for the working adults with disabilities is scheduled for March 1, 2012, with eligibility to children with disabilities expected to follow four to six months later. The Department does not have an implementation timeframe for non-working adults with disabilities at this time. The Department submitted a state plan amendment to CMS in January 2012 , and rules were approved by the Medical Services Board (MSB) by in January 2012.

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the economic statistics of disabled and uninsured Colorado residents. The Department first excluded individuals who, due to income, would either already be eligible for Medicaid or who would be required to pay the full cost of their services under federal regulations. As there is always some portion of a given population that is eligible but not enrolled for a given program, the Department assumed penetration rates depending on FPL bracket and adult/child category. The Department assumed that children would have a higher penetration rate than adults, and also that the penetration rate would vary by FPL group due to interactions with other programs. Furthermore, while the Department acknowledges that as individuals' incomes increase they may be more likely to obtain their own insurance, the Department learned many may buy into the program to receive "wraparound" benefits, where they would receive benefits not available through their own plan.

The Department assumes that the Medical Services Premiums for the Disabled Buy-In program will be comparable to those for the current Medicaid Disabled Individuals to 59 (AND/AB). The Department assumes that the Mental Health per capita for the Buy-In program would be equivalent to that for Medicaid Disabled Individuals to 59, and the Medical Services Premiums per capita is adjusted based on the following assumptions:

- The Department assumes that most clients in the Buy-In program will have lower utilization of many Home and Community Based Services (HCBS) waivers and other Long Term Care services. The Department assumes that few individuals with the ability to work would meet the level of care for either a waiver or nursing facility. In addition, clients that are working are more likely to have access to employer-sponsored insurance, which would be utilized to the maximum of the offered benefits before Medicaid services are utilized. In addition, the Department also assumes that 75% of the adult population would be dual-eligible for Medicare, which will decrease the costs to the Medicaid program as Medicare will pay for most of the utilized services. Buy-in participants will also be eligible for Consumer Directed Attendant Support Services (CDASS) through either the Department's HCBS waivers or the existing state plan option, and the Department assumes 10% of the population will use these services. Overall, the Medicaid Disabled Individuals to 59 Acute Care per capita has been adjusted based on all of the above factors, some of which act to increase and some of which act to decrease the per capita. These adjustments were applied to the total per capita rather than at the service category level.

Hospital Provider Fee Supplemental Payments

Hospital payments are increased for Medicaid hospital services through a total of thirteen supplemental payments, eleven of which are paid out of Medical Services Premiums directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, CICP and DSH payments, and targeted payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to ensure access to hospital services for Medicaid and CICP clients.

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

The Upper Payment Limit financing methodology accomplishes the following:

- Increases the Medicaid payment up to the federally allowable percentage for all public government owned or operated home health agencies, outpatient hospitals, and nursing facilities without an increase in General Fund.
- Maximizes the use of federal funds available to the State under the Medicare upper payment limit through the use of certification of public expenditures.
- Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditures.

The basic calculation for Upper Payment Limit financing incorporates the difference between Medicare and Medicaid reimbursement amounts, with slight adjustments made to account for different types of services and facilities. Because actual Medicare and Medicaid reimbursement amounts are not yet known for the current fiscal year, prior year's data for discharges, claims, and charges are incorporated into the current year calculation.

Funds received through the Upper Payment Limit for home health services and nursing facilities are used to offset General Fund expenditures. These offsets started in FY 2001-02. While nursing facilities account for the larger portion of Upper Payment Limit funding, home health has expenditures that are relatively small by comparison, and will experience little impact related to changes in reimbursement rates.

In FY 2005-06, the Department only certified expenditure for a half year due to a federal audit requiring the Department to certify expenditure on a calendar year basis. During Figure Setting in March 2006, the Department's FY 2006-07 Base Reduction Item 2 (November 15, 2005) was approved; starting in FY 2006-07, the Department will record exactly the certified amount as Cash Funds Exempt.

During FY 2007-08, the Department was informed by the Centers for Medicare and Medicaid Services (CMS) that it would no longer be permitted to certify public expenditure for nursing facilities. However, in FY 2008-09, CMS and the Department came to an agreement which allowed for a certification process as long as it included a reconciliation process to provider cost. Therefore, the Department has included expenditure for certification of public nursing facility expenditure. Where applicable, the Department's estimates will be adjusted for any reconciliation performed.

In prior fiscal years, the Department was able to utilize UPL financing for outpatient hospital services as well. However, FY 2010-11 was the last year the Department was able to certify public expenditure for Outpatient Hospital services. This was due to HB 09-1293, which allowed the Department to use other state funds to draw federal funds to the upper payment limit.

EXHIBIT L – DEPARTMENT RECOVERIES

This exhibit displays the Department's forecast for estate recoveries, trust recoveries, and tort/casualty recoveries. Prior to FY 2010-11, these recoveries were utilized as an offset to expenditure in Medical Services Premiums. In compliance with State Fiscal Rule 6-6, the Department now reports the recovery types listed above as revenue.

In addition to anticipated recovery revenue, Exhibit L also shows the anticipated contingency fee to be paid to contractors for recovery efforts. The Department's revised forecast for the activity reflects changes to contingency fee paid to the contractor as the contract was reprocured in FY 2011-12. Total revenue used to offset General Fund and federal funds, as shown in Exhibit A, is the sum of all recoveries less contingency fee paid to contractors.

Recoveries made for dates of service under periods where the state received an enhanced federal match are given the same federal match as was applicable when the services were rendered. The Department previously assumed a larger percentage of recoveries would fall under periods of enhanced federal match. However, the most recent expenditure data indicates that a smaller percentage of

recoveries are from periods with enhanced federal match. Consequently, the Department has revised assumptions regarding federal match on recoveries accordingly.

EXHIBIT M – CASH-BASED ACTUALS

Actual final expenditure data by service category for the past eleven years are included for historical purpose and comparison. This history is built around cash-based accounting, with a 12 month period for each fiscal year, based on paid date. This exhibit displays the estimated distribution of final service category expenditures by aid category from the estimated final expenditures by service categories. This is a necessary step because expenditures in the Colorado Financial Reporting System (COFRS) are not allocated to eligibility categories. The basis for this allocation is data obtained from the Department's Medicaid Management Information System. This data provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community Based Long Term Care, Long Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management.

This exhibit also includes six-month cash-based actuals for July 2011 through December 2011.

Effective with the November 1, 2007 Budget Request, the Department has made several labeling changes to this exhibit:

Service Group	**Old Title**	**New Title**
Acute Care	Administrative Service Organizations - Services	Prepaid Inpatient Health Plan Services
Community Based Long Term Care	Home and Community Based Services - Case Management	HCBS - Elderly, Blind, and Disabled
Community Based Long Term Care	Home and Community Based Services - Mentally Ill	HCBS - Mental Illness
Community Based Long Term Care	Home and Community Based Services-Children	HCBS - Disabled Children
Community Based Long Term Care	Home and Community Based Services - People Living with AIDS	HCBS - Persons Living with AIDS
Community Based Long Term Care	Consumer Directed Attendant Support	HCBS - Consumer Directed Attendant Support

Service Group	Old Title	New Title
Community Based Long Term Care	Brain Injury	HCBS - Brain Injury
Service Management	Administrative Service Organizations Administrative Fee	Prepaid Inpatient Health Plan Administration

Effective with the February 15, 2008 Budget Request, the Department has restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 2006-07. The Department has adjusted the allocation to exclude categories that did not utilize this service category. The total amount in aggregate remains the same.

Effective with the November 3, 2008 Budget Request, the Department has restated actuals for Single Entry Points from, by using HCBS utilization rates as opposed to total expenditure in Community Based Long Term Care and Long Term Care service categories.

Effective with the November 1, 2010 Budget Request, the Department has provided 3 pages for FY 2009-10 expenditure: cash-based actuals, the total amount delayed in FY 2009-10 as a result of a mandated payment delay, and the estimated FY 2009-10 expenditure adjusted for the payment delay.

Effective with the November 1, 2011 Budget Request, the Department has made numerous changes to this exhibit:

- The Department has restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 2002-03 forward. The Department has altered the methodology for distributing expenditure between eligibility types to more accurately reflect expenditure actually incurred in the service category.
- The Department has separated Expansion Adults into Expansion Adults to 60% and Expansion Adults to 100%.
- The Department has included totals for financing categories in Medical Services Premiums. As a result, this exhibit now matches the totals shown in other places in the budget, notably the Schedule 3.
- The Department has removed historical totals prior to FY 2002-03. These pages remain available on the Department's website, and upon request.

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2002-03 through FY 2010-11 final actual expenditures are included in this Budget Request for historical purpose and comparison.

Effective with the November 1, 2010 Budget Request, the Department has included a second version of this exhibit which adjusts for the payment delays imposed in FY 2009-10.

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

This exhibit displays the FY 2010-11 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2010-11 appropriation, and the per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

Additionally, this exhibit compares the Department's Budget Requests by broad service category to the Department's Long Bill and special bills appropriations, for FY 2008-09, FY 2009-10, FY 2010-11, and FY 2011-12 in the chronological order of the requests/appropriations. Shaded areas indicate that the Request or appropriation has not yet taken place.

The Department has adjusted totals in Exhibit O to capture the effect of audit adjustments that occurred since the Department's November 1, 2012 request.

EXHIBIT P – GLOBAL REASONABLENESS

This exhibit displays several global reasonableness tests as a comparison to the projection in this Budget Request. In addition, on page EP-3, this exhibit displays the FY 2011-12 year-to-date expenditures through September 2011 and the cash flow pattern of actual expenditures for the first quarter of FY 2011-12 to determine a rough estimate of FY 2011-12 expenditures, with certain exceptions. This exhibit is a rough projection utilizing past expenditure patterns as a guide to future expenditures. The Cash Flow Pattern is one forecasting tool used to estimate final expenditures on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

In places where the Department does not expect the prior year cash flow pattern to be relevant to the current year, the Department has made adjustments based on knowledge of current program trends. Exceptions to the cash flow pattern are noted in footnotes on page EP-3.

EXHIBIT Q – CASELOAD GRAPHS

This exhibit is described in the Caseload Narrative.

V. ADDITIONAL CALCULATION CONSIDERATIONS

Several bills passed during prior legislative sessions affect the Department's Request for Medical Services Premiums. Additionally, the Department has added several bottom-line impacts for factors which are not reflected in historical trends. This section details the adjustments the Department has made to the Request for Medical Services Premiums.

New Legislation and Impacts from FY 2011-12 Budget Cycle Requests

This section describes the impact from legislation passed during the 2011 legislative session, and also includes impacts from the Department's FY 2011-12 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

SB 11-209 – FY 2011-12 Long Bill

The FY 2011-12 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2011 Legislative Session which impact the Medical Services Premiums budget request. Except where noted, the Department uses the appropriated value as the bottom-line impact. All figures listed are total funds.

- *Client Overutilization Program Expansion (BRI-1):* Increase enrollment by 200 clients in the Client Overutilization Program (COUP) by paying providers an incentive payment to participate and changing some of the criteria in the MMIS to allow a broader range of providers to participate as lock-in providers. This program generates savings by decreasing excessive use of medical services and thereby reducing the expenditure for medically unnecessary claims. The program criteria primarily target the abuse of prescription medication, but also include inappropriate use of emergency room and/or physician services. The expansion has been delayed due to a delay in the required system changes. The Department has been able to expand to more clients in the current year through outreach efforts, but will not reach 200 clients by June 2012 as anticipated. However, as the program expanded to more clients prior to the assumed March 2012 implementation date, the Department believes that it will reach the acute care savings of $136,000. The Department projects that it will expand to 200 clients by January 2013 through more outreach efforts by its utilization management vendor and by completing the system change that will broaden the pool of providers who can participate. The savings were reduced in FY 2012-13 by one-fourth as a result of the delay for annualized savings of $823,650. It is uncertain at this time when the Department will be able to make incentive payments through the MMIS, as that change has not yet been prioritized. The Department will continue to evaluate whether this payment is necessary to maintain at least 200 clients in the program.

- *Medicaid Reductions (BRI-5):* This budget reduction item included a series of initiatives that were proposed to reduce Medicaid expenditure and meeting budget balancing goals. The initiatives imposed a combination of rate adjustments to realign incentives, service restrictions, and financial efficiencies, as listed below.

  - Pharmacy State Maximum Allowable Cost Expansion: Add more drugs to be placed on the SMAC list, reducing expenditure by $1,833,334 in FY 2011-12 and annualized in FY 2012-13 to an additional reduction of $166,666.
  - Reduce Rates for Specific Diabetes Supplies: Reduce payment for blood glucose/reagent strips from $31.80 per box of 50 strips to the current median market price of $18.00. This rate cut reduces expenditure by $842,728 in FY 2011-12 and an additional $150,066 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
  - Reduce Payments for Uncomplicated Cesarean Section Deliveries: Reduce the amount paid for uncomplicated cesarean section deliveries to the amount paid for complicated vaginal deliveries, which reduces expenditure by $6,276,004 in FY 2011-12 and an additional $811,545 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
  - Reduce Payments for Inpatient Renal Dialysis: Reduce the amount paid for inpatient renal dialysis from 185% of cost to 100% of cost. The Department agreed to reduce payment to 129.42% rather than 100% after negotiations with affected providers. This results in a reduction of $1,418,733 in FY 2011-12 and an additional $183,455 in FY 2012-13. The request amount also includes an adjustment to account for cash accounting.
  - Deny Hospital Readmissions within 48 Hours: Cease making a separate payment to hospitals for clients who are readmitted within 48 hours to the same hospital for a related condition, reducing expenditure by $2,475,418 in FY 2011-12 and an additional $320,094 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
  - Prior Authorize Specific Radiology Services at Outpatient Hospitals: Require prior authorization in outpatient hospitals for MRIs, CT scans, PET scans and SPECT scans, except for in emergency situations. This policy reduces expenditure by $672,136 in FY 2011-12 and an additional $3,720,409 in FY 2012-13. It is on track to be implemented in April 2012.
  - Normalize Consumer Directed Attendant Support Services Wage Rates: Impose a cap on the wage rate a client enrolled in the CDASS program is allowed to pay attendants based on current rates for similar services in the HCBS EBD waiver. This results in a reduction of $473,564 in FY 2011-12 and an additional reduction of $1,204,144 in FY 2012-13 to community based long term care. The request amount was adjusted for a delay in the implementation date from July 2011 to March 2011, and it includes an adjustment to account for cash accounting.
  - Enforce Existing Limitations on Acute Home Health Services: Enforce requirement that prior authorization is needed for acute home health services beyond 60 days, reducing expenditure by $1,131,555 in FY 2011-12 and an additional $286,551 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
  - Reduction to Managed Care Organization: Incorporate the reductions to Medicaid fee-for-service in the rates paid to the Department's managed care organization, resulting in a reduction of $1,906,233 in FY 2011-12 and an additional reduction

of $81,968 in FY 2012-13. The Department has adjusted its request to account for initiatives that were not appropriated and will therefore not affect the rates paid to the managed care organization.

- *Medicaid Budget Balancing Reductions (BA-9):* In this budget amendment, the Department proposed to reduce Medicaid expenditure through a series of initiatives, including: an expansion of the Accountable Care Collaborative, deinstitutionalization efforts through the Department's "Money Follows the Person" federal grant, and a combination of service limitations and rate reductions.

  - Expand the Accountable Care Collaborative: Enroll 63,000 additional clients in the ACC by November 2011, for a total program enrollment of 123,000. Please see the section below on the Accountable Care Collaborative for a more detailed explanation of the program and the costs and savings estimated it.
  - Money Follows the Person Deinstitutionalization Efforts: Use grant funds to provide additional transitional services to move clients from nursing facilities to Community Based Long Term Care. The Department was unable to transition these clients due to receiving significant less grant funds than anticipated. The clients specified in this initiative would be moved earlier than the actual Money Follow the Person program began using administrative funding provided by the grant. Since the Department did not receive enough administrative funding to move clients early, this initiative could not be implemented.
  - Limit Fluoride Application Benefit: Limit fluoride application benefit to a maximum of three applications per year, reducing expenditure by $30,982 in FY 2011-12 and an additional $6,101 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
  - Limit Dental Prophylaxis Benefit: Restrict dental prophylaxis (routine dental cleaning) to two procedures per fiscal year, reducing expenditure by $161,936 in FY 2011-12 and an additional $31,892 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
  - Eliminate Reimbursement for Oral Hygiene Instruction: Eliminate reimbursement for oral hygiene instruction. This results in a reduction of $4,241,026 in FY 2011-12 and an additional $835,251 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
  - Limit Number of Physical and Occupational Therapy Units for Adults: Limit number of physical and occupational therapy units that adults can receive to 48 total units of service per year, regardless of prior authorization. Implementation of this has been delayed from July 2011 until March 2012 as the Department is awaiting feedback from a new utilization management contractor to appropriately implement the proposal. The Department adjusted its request accordingly; for FY 2011-12, expenditure is reduced by $154,227 and for FY 2012-13, it is reduced by an additional $400,840. The request amount also includes an adjustment to account for cash accounting.

- Require Specific Billing for Certain Home Health Visits: Require home health providers to specifically bill codes for brief visits in circumstances in which only a short visit is required, reducing expenditure by $2,511,443 in FY 2011-12 and an additional $636,809 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Provider Rate Reduction: Reduce acute care physical health provider rates by 0.75% and community based long-term care providers by 0.5%, effective July 1, 2011. This results in a $12,092,847 reduction in FY 2011-12 and an additional $2,904,019 in FY 2012-13 to Acute Care, and a $1,561,829 reduction in FY 2011-12 and an additional $361,468 in FY 2012-13 to Community Based Long Term Care.

The following table shows the original request amount, FY 2011-12 appropriation, and FY 2012-13 R-1 request amount for each of the FY 2011-12 impacts requested in BRI-5 and BA-9, as detailed above:

FY 2011-12 BRI-5 and BA-9 Request to Appropriation Comparison					
Initiative	Department Priority	Original Request Amount	FY 2011-12 Appropriation	FY 2012-13 R-1 Request Amount	FY 2012-13 S-1 Request Amount
State Allowable Cost Expansion	BRI-5	($1,833,333)	($1,833,334)	($1,833,334)	($1,833,334)
Reduce Rates for Diabetes Supplies	BRI-5	($842,727)	($919,340)	($842,728)	($842,728)
Reduce Payment for Uncomplicated C-Section	BRI-5	($6,276,004)	($6,846,550)	($6,276,004)	($6,276,004)
Reduce Payments for Renal Dialysis	BRI-5	($2,169,701)	($2,366,947)	($1,418,733)	($1,418,733)
Deny Payment of Hospital Readmissions 48 hrs	BRI-5	($2,475,418)	($2,700,456)	($2,475,418)	($2,475,418)
Prior Authorize Certain Radiology	BRI-5	($672,136)	($672,136)	($672,136)	($672,136)
Cap CDASS Wage Rates	BRI-5	($1,420,692)	($1,549,846)	($1,065,519)	($473,564)
Limit Acute Home Health Services	BRI-5	($1,131,555)	($1,234,424)	($1,131,555)	($1,131,555)
HMO Impact to Rates	BRI-5	($2,945,547)	($2,707,680)	($1,906,233)	($1,906,233)
Estimated ACC Net Savings	BA-9	($9,537,806)	($4,768,903)	($2,753,663)	($734,598)
Clients Moved from Nursing Home	BA-9	($624,975)	($625,704)	$0	$0
Limit Fluoride Application Benefit	BA-9	($29,898)	($33,798)	($30,982)	($30,982)
Limit Dental Prophylaxis Benefit	BA-9	($156,274)	($176,658)	($161,936)	($161,936)
Limit Oral Hygiene Instruction	BA-9	($4,092,739)	($4,626,574)	($4,241,026)	($4,241,026)

FY 2011-12 BRI-5 and BA-9 Request to Appropriation Comparison					
Initiative	Department Priority	Original Request Amount	FY 2011-12 Appropriation	FY 2012-13 R-1 Request Amount	FY 2012-13 S-1 Request Amount
Limit Physical and Occupational Therapy	BA-9	($446,504)	($504,744)	($347,012)	($154,227)
Home Health Billing Changes	BA-9	($2,423,629)	($2,739,756)	($2,511,443)	($2,511,443)
0.75% Acute Care Provider Rate Reduction	BA-9	($8,261,265)	($11,711,574)	($12,092,847)	($12,092,847)
0.5% CBLTC Provider Rate Reduction	BA-9	($1,507,220)	($2,260,830)	($1,561,829)	($1,561,829)
Total		($46,847,423)	($48,279,254)	($41,322,398)	($38,518,593)

In cases where savings estimates have been reduced due to implementation delays, the Department accounts for the full impact in FY 2012-13.

SB 11-209 also included the following reductions that were not part of the Department's original requests:

- *Wound Therapy Code Reduction:* Reduce payment for negative pressure wound therapy to $88.50 per day, reducing expenditure by $100,000 in FY 2011-12.
- *Elimination of Circumcision Benefit:* Eliminate circumcision as a covered benefit. This results in a reduction of $373,000 in FY 2011-12.

SB 11-008 – Concerning Medicaid Eligibility for Children

This bill specifies that the income eligibility criteria for Medicaid that applies to children aged 5 and under and pregnant women shall also apply to children between the ages of 6 and 19. On or after September 1, 2011, children under the age of 19 and pregnant women will be eligible for Medicaid if their family income is less than 133 percent of the federal poverty level (FPL). The Department assumes that the federal match for clients these clients will remain at the same level it would have had the clients enrolled in the Children's Basic Health Plan instead of Medicaid, or 65%. The impact of this bill will not be seen until FY 2012-13 due to needed system changes.

Fiscal Year	Caseload	Total Fund Expenditure
FY 2012-13	2,121	$3,294,614
FY 2013-14	13,431	$20,766,966

SB 11-125 – Concerning Nursing Home Fees and Order of Payments

This bill alters the hierarchy of the supplemental payment components funded by the Nursing Facility Provider Fee and increases the maximum allowable fee assessed to nursing facilities.

Nursing facility rates are cost-based. However, the General Fund portion of a nursing facility's rate is limited by statute regardless of the amount of growth seen. Facilities are compensated for cost growth beyond the General Fund cap though supplemental payments from the Nursing Facility Cash Fund. On the aggregate level, nursing facilities typically see approximately 4.25% growth in costs each fiscal year.

As quality and performance incentives were previously funded after growth beyond the General Fund Cap and the provider fee was unable to fully fund all components of the supplemental payments, these quality and performance components were not always funded. Under this statute, quality and performance incentives take priority over growth beyond the General Fund cap. As a result, the provider fee is able to fully fund quality and performance incentives, but can no longer fully fund growth beyond the General Fund cap. The Department estimates that the provider fee is able to fund approximately 68% of growth beyond the General Fund cap in FY 2011-12.

SB 11-177 – Concerning Pregnancy and Dropout Prevention

SB 11-177 extended the sunset deadline and expanded the Teen Pregnancy and Dropout Prevention program for Medicaid clients. In FY 2010-11 the Department offers teen pregnancy prevention services to at-risk teenagers through two providers: Hilltop Community Resources, Incorporated (Hilltop) and the Montrose County Department of Health and Human Services (Montrose). This program provides services such as group and individual counseling, vocational, health and educational guidance, science-based instruction concerning human sexuality and home visits. In FY 2008-09, Hilltop served approximately 150 teens at a cost of $98,776 total funds. Montrose served approximately 140 teens at a cost of $125,453 total funds in FY 2008-09. The program receives a 90% federal financial participation match rate which is drawn through local funds paid to the Department.

Through this bill the Department is able to hire a FTE to administer this program which was historically absorbed by other Departmental resources. The Department believes the increased administration will allow the program to expand to addition providers at a rate of two to three new providers per year. The Department assumes the cost of the FTE will be offset in Acute Care through avoided births.

In FY 2011-12 the Department anticipates receiving $19,763 local funds, annualizing to $40,869 in FY 2012-13 and $69,819 in FY 2013-14 to operate and expand the program. This estimate varies from the projection the Department submitted in the November request for a few reasons. First, the Montrose County Department of Health and Human Services had to discontinue the program as a result of limited budget funding available. In addition, the Department is currently working with the Center for Medicare and Medicaid Services to assure appropriate payment methodology for the services. The Department anticipates a proper payment methodology would be established by July 2012. With such approval the Department would move forward expanding the program.

SB 11-210 – Concerning the Phase Out of Supplemental Old Age Pension Health Fund

As part of the Joint Budget Committee's budget balancing package, this bill allows for an annual transfer of $2,230,500 from the Health Care Expansion Fund to be used as a General Fund offset for services in the Medical Service Premiums line beginning FY 2011-12. This statute eliminates the additional step of transferring funds from tobacco tax to the OAP fund and then appropriating funds from the OAP fund to the MSP line. The fiscal impact of this bill is accounted for in Exhibit A.

SB 11-211 – Concerning Tobacco Revenues Offsetting Medical Services

Also part of the JBC budget balancing package, this bill allows for the use of $33,000,000 in tobacco tax funds for services in the Medical Services Premiums line. Of this amount, $17,758,594 is from the Tobacco Education Program Fund, $11,955,055 is from the Prevention, Early Detection, and Treatment fund, and $3,286,351 is reappropriated funds from the Department of Public Health and Environment. The fiscal impact of this bill is accounted for in Exhibit A.

SB 11-212 – Concerning the Use of Provider Fee to Offset Medicaid Expenditure

This bill authorizes the Department to utilize $50,000,000 in Hospital Provider Fee funds as a direct offset to General Fund expenditure for services in the Medical Services Premiums line in FY 2011-12 and $25,000,000 in FY 2012-13.

SB 11-215 – Concerning the 2011 Nursing Facility Rate Reduction

Effective July 1, 2011, SB 11-215 continues the 1.5% reduction to class I nursing facility reimbursement from HB 10-1324 which expired on June 30, 2011. The total fiscal impact of this bill will depend on the number of patient days incurred in FY 2011-12. Exhibit H of the Department's request contains detailed calculations for the fiscal impact of this bill.

SB 11-219 – Concerning 2011 Transfers for Health Care Services

This bill authorizes the Department to use $15,775,670 in funds from the Primary Care fund as offset to General Fund expenditure in the Medical Services Premiums line. The fiscal impact of this bill is accounted for in Exhibit A.

SB 11-250 – Concerning Eligibility for Pregnant Women

This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133 percent to 185 percent of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to transition from the Children's Basic Health Plan (CBHP) to Medicaid. As with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients and that the first fiscal impact within the Medical Services Premiums line will occur in FY 2012-13 due to necessary systems changes.

Fiscal Year	Caseload	Total Fund Expenditure
FY 2012-13	181	$1,506,373
FY 2013-14	1,112	$9,440,092

Federal Legislation

Section 1202 of the Health Care and Education Reconciliation Act – Primary Care Physician Rates to 100% of Medicare

Section 1202 of the Health Care and Education Reconciliation Act (part of the Affordable Care Act) states that for calendar years 2013 and 2014, states must provide for payment for primary care services at a rate not less than 100% of the Medicare rate. The difference in rates between July 1, 2009 and January 1, 2013 will be paid for by the federal government through an enhanced federal medical assistance percentage (FMAP). The increased FMAP rate will apply to certain primary care services, including evaluation and management and immunizations, performed by physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine.

The Department estimates that the difference in rates between July 1, 2009 and January 1, 2013 will generate an estimated $4,950,838 total funds in FY 2012-13 and $12,872,971 total funds in FY 2013-14, all of which will be 100% federally funded. In addition, the Department will need to increase physician rates from the level at which they are currently set to the rates that were effective on July

1, 2009; this gap represents rate cuts that were taken since July 1, 2009 due to budget reduction measures. The Department estimates that increasing rates to the July 1, 2009 level will increase expenditure by $1,347,828 in FY 2012-13 and $3,234,787 in FY 2013-14. These amounts will be matched by the federal government at the standard FMAP rates.

Section 4107 of the Affordable Care Act – Providing Smoking Cessation Counseling for Pregnant Women

Section 4107 of the Affordable Care acts requires states to implement a program offering pharmacotherapy and smoking cessation counseling to pregnant women. The requirement does not receive additional funding to support it. Currently, the Department offers coverage for tobacco cessation pharmacotherapy to all Medicaid clients but does not have coverage for counseling. In implementing a counseling benefit the Department has restricted services by allowing a maximum of 5 counseling sessions up to 10 minutes and 3 counseling sessions of more than 10 minutes. The Department opened billing codes to implement the program in January 2012.

The Department estimates this initiative will have a net savings of $46,357 in FY 2012-13 annualizing to $142,333 savings in FY 2013-14. By reducing the smoking rate of pregnant mothers, the Department anticipates savings through a reduction to low birth rate births (attributed to smoking mothers) which tend to be more costly than a normal birth.

Colorado Choice Transitions (Money Follows the Person Grant)

The Department was awarded the Money Follows the Person federal grant designed to help clients currently residing in nursing facilities to transition into Community Based Long Term Care. The grant allows the Department to provide transitional services to ease the movement from nursing facility to the community and provides an enhanced federal match to those services, existing HCBS waiver services and home health services. Savings from the enhanced match are required to be used to improve the long term care service system as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services. The grant is designed to offer clients enhanced services for one year after transitioning from a nursing home to allow them to adapt to the community setting. The Department anticipates transitioning will begin in July 2012 and the Department will transition 90 clients in the first year of the program and 100 each year following until the end of the 5 year grant.

Prior Year Legislation, Impacts from Previous Budget Cycles, and Other Adjustments

This section describes the impact from legislation passed during the 2009 and 2010 legislative sessions, and also includes impacts from the Department's budget cycle requests prior to FY 2011-12. Information from budget requests has been updated to be consistent with any approval granted by the legislature. Please note that the descriptions in this section only discuss those portions of approved initiatives which have an impact in this budget request. The budget requests, or portions of budget requests, from prior cycles which have been implemented and do not require further adjustment in this request (such as a bottom line impact) are not

discussed in this narrative. For information on the Department's complete requests, please consult the narrative for prior years, or the original requests.

HB 10-1376 – FY 2010-11 Long Bill

The FY 2010-11 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2010 Legislative Session which impact the Medical Services Premiums budget request. Except where noted, the Department uses the appropriated value as the bottom-line impact. All figures listed are total funds. Budget actions listed in this section are from the FY 2010-11 budget cycle.

- *Evidence Guided Utilization Review (EGUR) (BA-12) and Prevention and Benefits for Enhanced Value (P-BEV) (BRI-1):* This Budget Reduction Item increases FY 2010-11 expenditure by an estimated $282,653, with an additional $481,092 in FY 2011-12, in order to provide increased utilization review funding in order to create an evidence guided utilization review program. Savings is expected as a result of increased utilization reviews. In addition, the Department is able to expand a set of dental procedures including fluoride treatment, and improve non-emergency medical transportation policies. Delayed implementation has shifted anticipated Medical Services Premiums savings from FY 2010-11 to FY 2011-12. The Department estimates FY 2011-12 savings to be $764,595 total funds. The revised implementation date for this initiative was November 1, 2011 when the Department began paying a new utilization management contractor.

- *Implementation of Family Planning Waiver (BA-16):* This funding was to be used to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. Transferring this funding to the Department would allow for an enhanced federal financial participation rate of 90% to fund family planning services for uninsured, low-income Coloradans who would otherwise be receiving services funded by the unmatched General Fund dollars currently appropriated to the Department of Public Health and Environment. However, after further discussion between the two agencies, the Department has removed its application. Populations that would have been served under the waiver would be eligible by July 2014 for services either through Medicaid or through a subsidized plan under the Colorado Health Benefit Exchange. In addition, system changes necessary to implement the program would be delayed due to federally mandated changes that could not be done concurrently with the changes necessary to implement the family planning waiver. Therefore, the Department has removed the estimate from the request.

- *Coordinated Payment and Payment Reform (BRI-2):* This budget reduction item reduces expenditure in FY 2011-12 and FY 2012-13 for both Acute Care Services and Community Based Long Term Care Services. The table below demonstrates these reductions by service category.

This budget reduction item implements proposed steps toward payment coordination and payment reform. This request included four proposed initiatives which work in tandem to serve the goal of lowering the cost of providing medical services to Medicaid clients while improving health outcomes and access to care. The initiatives aim to consolidate payment and billing processes, expand audits conducted by the Nursing Facilities Section, initiate a pilot audit of a Community Mental Health Center, and increase enrollment of Medicare-eligible clients into Medicare. In addition, the Department is targeting three payment rate reform initiatives. The first, directed at Home and Community Based Services waivers will initiate research into the potential of applying an outcomes-based approach to the payment of claims for waiver services. A similar approach will be taken to investigate the potential to apply outcomes-based approach to the payment of physician payment rates. The third initiative targeted at changing the methodology of Federally Qualified Health Centers (FQHCs) payments aims to investigate the feasibility of creating an outcomes-based performance payment for FQHCs. Savings in FY 2011-12 and FY 2012-13 are associated with the enrollment of Medicare eligible clients in Medicare. The Department has enlisted the services of a contractor to perform outreach to clients and to assist clients with the Medicare application project. The Department has revised savings estimates based on lower per capita savings assumptions and lower than anticipated initiative participation rates as well as a adjustments for partial delays in implementation.

FY 2010-11 BRI -2 Coordinated Payment and Payment Reform Request			
Service Category	**FY 2011-12 Estimate (November 2011 Request)**	**FY 2011-12 Estimate (February 2012 Request)**	**FY 2012-13 Estimate Annualization Values (February 2012 Request)**
Acute Care	($5,060,838)	($1,555,000)	($275,000)
Community Based Long Term Care	($616,405)	($310,000)	($55,000)
Total	**($5,122,243)**	**($1,866,000)**	**($330,000)**

- *Medicaid Program Reductions (BRI-6):* This budget reduction item imposes restrictions on certain durable medical equipment and reduces Medicaid physical health provider rates by 1%.

    - Limitation on Incontinence Products: The Department would impose a 210-unit limit on incontinence products (down from the current limit of 240) Implemented in FY 2010-11, this Budget Reduction Item is expected to reduce Acute Care services expenditure by an additional $125,098 in FY 2011-12.

  - 1% Rate Reduction: As part of this request, the Department proposes to reduce rates paid to Medicaid physical health fee-for-service and managed care providers by 1% effective July 1, 2010. These reductions are annualized in FY 2011-12 to additional reductions of $2,698,858 for Acute Care services, $441,287 for CBLTC services, $130,355 for PACE expenditures, and $33,712 for Single Entry Points.

- *Accountable Care Collaborative (S-6, BA-5):* The Department was appropriated an overall reduction in expenditure of $514,730 in FY 2010-11, annualizing to $10,268,779 in FY 2011-12 in order to provide Medicaid clients, regardless of age or health status, a coordinated delivery system beginning in FY 2010-11. For this request, the Department limited enrollment to 60,000 clients with the anticipation of enrolling more clients as the program becomes established. Please see the section below on the Accountable Care Collaborative for a more detailed explanation of the program and the costs and savings estimated it.

HB 10-1005 - Concerning Home Health Care through Telemedicine Pursuant to the "Colorado Medical Assistance Act"

HB 10-1005 alters the provision of home health telemedicine services established in SB 07-196. This bill asserts that telemedicine services are now eligible for Medicaid reimbursement, reimbursement rates are no longer required to be budget-neutral, reductions in travel costs by home health care and home and community-based service providers are no longer required to be considered when setting reimbursement rates, and incorrect references to the way reimbursement payments are made are removed.

Additionally, payments of telemedicine reimbursements are contingent upon the receipt of gifts, grants, and donations in the newly created Home Health Telemedicine Cash Fund for FY 2011-12 and FY 2012-13. The bill increases Department expenditure $130,240 in FY 2011-12, with an additional $182,336 in FY 2012-13.

As of December 2010 the Department has received donations to implement the telemedicine program. However, after review by the Centers for Medicare and Medicaid Services the donated funds will not receive a federal match. Within this bill the Department is given authority to request General Fund to continue operating the program after donated funds are completely utilized. The Department believes this authority grants the Department an exemption from requirements in HB 10-1178 which prohibits agencies from requesting General Fund to continue grant and donated fund programs.

The Department anticipates client enrollment will begin in February 2012 as program implementation has been delayed due to rule change requirements and completion of the documented quote for the vendor.

HB 10-1033 - Concerning the Addition of Screening, Brief Intervention, and Referral to Treatment to Optional Services

In 2006, the Governor's Office, and Departments of Human Services and Public Health and Environment were awarded a five-year $2.8 million dollar grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), to implement a Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative in Colorado for clients 12 and older. The initiative teaches health care providers to use the ASSIST tool to conduct screenings for substance and tobacco use; provide brief interventions to persons with positive screening results; and make referrals for more extensive treatment where appropriate. The SBIRT protocol is currently being used in 12 clinics and hospitals in 9 Colorado counties statewide. This bill adds screening, brief intervention, and referral for treatment for substance abuse to the list of optional services covered by Medicaid. The bill is was estimated to increase Department expenditure $870,155 in FY 2010-11, annualizing to $1,230,285 in FY 2011-12. Billing codes for SBIRT services opened in December 2010 completing the implementation of the program.

HB 10-1379 – Concerning a Reduction in the General Fund Portion of the Per Diem Rates Paid to Nursing Facilities for the 2010-11 Fiscal Year

HB 10-1379 initiated a Nursing Facilities rate reduction of 1%, in addition to the rate reduction of HB 10-1324 for the period of July 1, 2010 to June 30, 2011. The rate reductions apply to all days incurred under the effective periods of each bill. Due to issues related with claims run out, the Department has also estimated an FY 2011-12 impact. See Exhibit H, footnote 9 for further details.

HB 10-1380 – Concerning the Use of Moneys in the Supplemental Old Age Pension Health And Medical Care Fund to Pay for Services Received by Certain Persons in the State Medicaid Program

HB 10-1380, recommended by the Joint Budget Committee as part of its budget package for FY 2010-11, 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 $3,000,000 in FY 2011-12. The provisions of the bill are repealed on July 1, 2012.

SB 10-167 - Concerning Increased Efficiency in the Administration of the "Colorado Medical Assistance Act", and, in Connection Therewith, Creating the "Colorado Medicaid False Claims Act"

This bill creates efficiencies in the Department by creating the Colorado Medicaid False Claims Act, as described below, The bill originally reduced Department expenditure $2,390,570 in FY 2010-11, annualizing to $3,699,827 in FY 2011-12 by requiring the Department to implement a number of initiatives. While the Department has been able to partially implement the components of SB

10-167, full implementation is not anticipated until spring of 2012. Consequently, a portion of the savings originally anticipated in FY 2010-11 has been shifted to FY 2011-12 and FY 2012-13. The initiatives are as follows::

National Correct Coding Initiative

With this initiative, the MMIS is enhanced to perform prepayment review of claims. The system checks for medically unlikely billing code pairs and medically unlikely unit quantities. Due the magnitude of changes required to the MMIS as well as issues in rate structures that need to occur for the coding edits to be effective, there have been delays in the implementation of this component of SB 10-167. In FY 2010-11 the Department manually implemented approximately 200 of the highest utilized coding pairs (out of over three million in total) to achieve savings despite delays in implementation. The FY 2011-12 NCCI impact, $12,500, reflects both delays in implementation and savings achieved through the manual implementing codes in FY 2010-11.

Rx Coordination of Benefits

The Rx Coordination of benefits program implements system changes that allow the Department to perform prepayment review of pharmacy claims to determine whether another party should be primary payer for the claim. A delay in system change implementation has resulted in a shift of savings from FY 2011-12 to FY 2012-13. Estimated savings for FY 2012-13 total $351,262 with a like amount in FY 2013-14. Revised implementation is scheduled for July 1, 2012.

Colorado Medicaid False Claims Act:

Anyone who knowingly submits a false claim or intends to defraud the state or a political subdivision is liable for up to three times the amount of damages, the costs of civil action, and a civil penalty of between $5,000 and $10,000. Persons ineligible to receive state funds and who report to the Attorney General within 30 days of receiving such funds may be liable for two times the amount of damages and no civil penalty, provided certain conditions are met. The bill specifies certain investigative, notification, and court procedures for false claims and requires the Attorney General to prepare an annual report for certain legislative committees.

Enhanced Internal Audits

Appoint an internal auditor and to ensure that duplicate benefits are not being paid by other states to clients enrolled in DHCPF programs through creating access to the Public Assistance Reporting Information System (PARIS) which will allow the Department to identify and eliminate clients receiving medical services premiums in other states.

Health Insurance Buy-In Program Expansion

Purchase private health insurance coverage through the Health Insurance Buy-In Program for an additional 1,500 eligible clients to create cost savings for the state by enrolling clients into individual insurance plans where enrollment is deemed cost effective. This initiative has been delayed to implement in April 2012 to allow for contract execution. The Department has identified a vendor and is

in the process of completing the contract to begin enrollment in April 2012. The vendor anticipates 90 clients will be enrolled per month until the maximum of 2,000 clients is reached.

In addition to adjusting savings estimates for implementation delays in the HIBI expansion, the Department has revised both cost and savings estimates to better reflect the impact the Department anticipates with the increased enrollment in this program. First, the Department changed the payment methodology from a contingency based payment plan to PMPM payment. The Department believes this methodology better allows the Department to reimburse for managing payments to clients' primary insurance agencies. In addition, the Department adjusted the monthly savings based on FY 2010-11 per capita costs. Finally the Department added costs associated with premium reimbursement to the estimated cost of the bill. This captures the additional costs to the Department for increased enrollment in the HIBI program. The following table illustrated the full impact of SB 10-167 on the HIBI program for FY 2011-12 through FY 2012-13.

FY 2011-12 and FY 2012-13 Total HIBI Impact from SB 10-167		
Item	**FY 2011-12**	**FY 2012-13**
Provider Payment	$54,725	$369,325
Premiums Payment	$115,183	$2,073,287
Savings (Realized in Acute Care)	($244,599)	($3,340,516)
Total Impact	**($74,691)**	**($897,904)**

SB 10-117 – Concerning Over the Counter Medication for Medicaid Clients

SB 10-117 allows pharmacists to directly prescribe certain medications, as approved by the Department, to Medicaid clients. By including only drugs that, when access is increased, reduce the likelihood of more expensive exacerbation of conditions, savings can be achieved. Avoided ER visits, physician office visits to obtain prescriptions for over-the-counter drugs (as is current policy for over-the-counter drug coverage under Medicaid), and avoided births are the primary vectors of savings. Through an extensive stakeholder outreach process, the Department has developed a list of medications that is anticipated to generate savings.

Emergency contraceptives generate the most significant amount of savings as the costs associated with birth are nontrivial. The Department's analysis excludes first year of life costs and thus represents a conservative estimate of savings.

Because of the significant health consequences associated with smoking, expenditure on nicotine replacement therapies have been shown to reduce health care expenditure as quickly as one year post investment. Returns continue to increase over time. While there is an initial increase in expenditure associated with covering nicotine replacement therapy under the provisions of SB 10-117, the Department anticipates short term returns on investment. Further, the increase in expenditure is completely offset by savings achieved by other drugs in the program.

Over the counter medications such as fever reducers are likely to reduce the utilization of emergency/urgent care services when easily accessible. While the Department has not estimated the savings associated with avoided emergency/urgent care service utilization, the Department believes that as the estimated costs are sufficiently low, costs are offset by savings from other drugs on the list, and there are likely cost savings, that inclusion of these drugs on the list are appropriate.

The Department anticipates full implementation by July 1, 2012. The Department will continue to evaluate the list of medications to determine any needed changes or additional opportunities for savings.

Benefit Type	FY 2012-13	FY 2013-14
Emergency Contraceptive	($186,215)	($193,966)
Nicotine Replacement	$28,585	($332)
Children's Over the Counter Medications	$7,876	$10,018
Total	**($149,754)**	**($184,280)**

Estimated Impact of Increasing PACE Enrollment

As described in the narrative for Exhibits F and H, the Department is currently in the process of adding several new Program of All-Inclusive Care for the Elderly (PACE) providers to the Medicaid program. Like other risk-based managed care organizations (including the Department's health maintenance organizations and behavioral health organizations), the monthly payment to the provider covers all services provided by the provider – the in instance of a PACE provider, the payment covers acute care and long term care. While the Department does not adjust its request for each additional client enrolled in PACE – enrollments in existing providers are considered part of the base trend – the addition of new providers will cause an expenditure shift from fee-for-service categories to the PACE service category.

The impact to Acute Care and Community Based Long Term Care is not "dollar-for-dollar." The PACE program is designed to keep clients who have high community-based long term care needs out of nursing facilities. The clients who move into the PACE program

typically are those clients whose needs are no longer met by an HCBS program. Thus, clients are moving from a lower-cost option (HCBS) to a higher-cost option (PACE). However, the Department still anticipates that the move is at least budget neutral in the long-term; clients who do not move to a PACE program will typically require nursing facility coverage, which is more expensive than PACE coverage.

The impact to acute care and CBLTC is calculated as the percentage of the PACE cost-per-enrollee attributable to those services (based on the actuarially-certified capitation rates), adjusted for the cash-flow issues related to transitioning a client from fee-for-service to managed care under cash accounting. The cash-flow impact is calculated as $1/12^{th}$ of the total enrollment impact, and distributed proportionally to the acute care and HCBS reductions.

Estimated Savings due to PACE Enrollments				
FY 2011-12	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Total**
Acute Care	($478,357)	($477,194)	($362,831)	($1,318,382)
CBLTC	($712,245)	($174,874)	($97,387)	($984,506)
Total	**($1,190,602)**	**($652,068)**	**($460,218)**	**($2,302,888)**
FY 2012-13	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Total**
Acute Care	($485,389)	($484,208)	($368,164)	($1,337,761)
CBLTC	($722,715)	($177,445)	($98,820)	($998,980)
Total	**($1,208,104)**	**($661,653)**	**($466,984)**	**($2,336,741)**
FY 2013-14	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Total**
Acute Care	($492,523)	($491,327)	($373,576)	($1,357,426)
CBLTC	($733,339)	($180,053)	($100,273)	($1,013,665)
Total	**($1,225,862)**	**($671,380)**	**($473,849)**	**($2,371,091)**

Managed Care Organization Reconciliations

This impact accounts for recoupment payments that the Department will receive from Denver Health Medicaid Choice and Colorado Access in FY 2011-12. The recoupment payments include overpayments for clients who were later determined to have third party liability at the time of payment, as well as the amount paid for fee-for-service claims for HMO-covered services on behalf of clients who were later determined to be enrolled in the HMO at the time of service. The Department does not know when future reconciliations will occur and therefore annualized the full amount of the payments out in FY 2012-13. The Department will include reconciliations in future requests as the payment timelines are known.

Colorado Choice Transitions

The Department was awarded the Money Follows the Person federal grant designed to help clients currently residing in nursing facilities to transition into Community Based Long Term Care. The grant allows the Department to provide transitional services to ease the movement from nursing facility to the community and provides an enhanced federal match to those services, existing HCBS waiver services a client might use and home health services. Savings from the enhanced match are required to be used to improve the long term care service system as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services.

The Department anticipates program enrollment will begin in July 2012 and approximately 100 clients will transition per calendar year. The Department estimates a reduction in expenditure of $224,911 in FY 2012-13, annualizing to savings of $637,405 in FY 2013-14.

HB 09-1047 – Concerning a program for providing additional therapies to certain persons with disabilities who are eligible to receive Medicaid

HB 09-1047 enabled the Department to create a pilot program centered on alternative therapies for clients with spinal cord injuries. Services are to include massage, acupuncture and chiropractic care. Programmatic design and budgeting constraints delayed timely implementation of this bill. However, in June 2011 the Department applied to CMS for 1915 (c) waiver authority to run the pilot program. The Department originally anticipated, should the waiver be approved, implementation would occur in January 2012 and serve approximately 60 eligible clients. However, waiver approval has not been granted as of January 2012. The Department anticipates approval and implementation to be delayed to July 2012.

The Department estimates increased costs of $187,440 to Community Based Long Term Care in FY 2012-13, annualizing to savings of $14,305 in FY 2013-14. The Department estimates a decrease in utilization of alternative therapy services over time because the need for more intensive therapy tends to happen when first beginning services.

FY 2009-10 BA-33: Prior Authorization of Anti-Convulsants

Anticonvulsants can be used to treat a variety of conditions. By ensuring this drug class is used only for the treatment of organically originating conditions, expenditure is reduced. This initiative, originally scheduled for implementation in FY 2009-10, required the auto prior authorization system to be in place prior to implementation. Previous savings estimates were adjusted to account for implementation delays. While the system is now in place, savings estimates have been further adjusted to account for the likely reduced savings potential stemming from the fact that many of the drugs are now available in a generic form. The Department now estimates FY 2011-12 savings of $180,000 with an additional $60,000 in FY 2012-13. See FY 2009-10 BRI-1 below for additional information regarding the auto PA.

FY 2009-10 BRI-1 Pharmacy Technical and Pricing Efficiencies

This budget reduction item reduced FY 2009-10 expenditure by an estimated $1,022,887, with an expected additional $1,848,763 reduction in FY 2010-11, as the result of an automated prior authorization system for pharmacy claims as well as through changing the reimbursement rates for drugs using a state maximum allowable cost structure. The Department has adjusted savings estimates to reflect a delay in the implementation of the automated prior authorization system. The system came online in October 2011. While the auto PA is now operational, programming needs to be completed to fully implement the initiative. The Department estimates a fiscal impact in FY 2011-12 of $405,770 and an annualization of $1,217,310 in FY 2012-13.

FY 2009-10 ES-2, Medicaid Program Reductions

This request reduces expenditure through a combination of rate reductions, service restrictions, elimination of certain programs, increased cost-sharing, and financial efficiencies. Included in the request are three initiatives which have an annualized impact in this request:

- Non-Medical Transportation Cap: the Department imposed a cap on the amount of non-medical transportation a client enrolled in a home and community based services waiver program can receive per week. Clients are limited to two roundtrips per week. Trips to adult day programs are not to be subject to the cap included limitations on the HCBS waiver transportation benefit. The program was delayed due to necessary system changes and rule changes. The Department anticipates system changes to be

complete in FY 2011-12, however, the Single Entry Point agencies have been aware of and compliant with the rule change. Therefore the Department believes it will realize savings in Community Based Long Term Care in FY 2011-12.

Accountable Care Collaborative

The Accountable Care Collaborative (ACC) was originally requested in FY 2010-11 budget request S-6, BA-5 as a pilot program of 60,000 clients and expanded in FY 2011-12 budget request BA-9 to 123,000 clients. The program is designed to improve clients' health and reduce costs. Clients in the ACC receive the regular Medicaid benefit package, and the Department makes additional payments to doctors and care coordination organizations to help manage clients care. The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds them accountable for health outcomes. The program began in the spring of 2011 with enrollment expected to reach 123,000 Medicaid clients statewide in FY 2011-12. The central goals of the program are to improve health outcomes through a coordinated, client-centered system, and to control costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources.

The key components of the ACC are the Regional Care Collaborative Organizations, the Primary Care Medical Providers, and the Statewide Data and Analytics Contractor, which are outlined below.

The Regional Care Collaborative Organizations (RCCOs) are regional entities that provide for the coordination and integration of care within the ACC framework and are contracted with the Department through competitive procurement. There are seven RCCOs, which provide the following services:

- Medical management, particularly for medically and behaviorally complex clients, to ensure they get the right care, at the right time and in the right setting;
- Care-coordination among providers and with other services such as behavioral health, long-term care, sngle entry point (SEP) programs, and other government social services such as food, transportation and nutrition; and
- Provider support such as assistance with care-coordination, referrals, clinical performance and practice improvement and redesign.

Primary Care Medical Providers (PCMPs) are contracted with RCCOs and act as “health homes” for ACC members. As a health home, the PCMP provides comprehensive primary care and coordinates and manages a client’s health needs across specialties and along the continuum of care.

The Statewide Data and Analytics Contractor (SDAC) builds and implements the ACC data repository, creates reports using advanced health care analytics, hosts and maintains a web portal, provides a continuous feedback loop of critical information, fosters accountability and ongoing improvement among RCCOs and providers, and identifies data-driven opportunities to improve care and outcomes. The SDAC is paid through a fixed-price contract.

Medicaid clients that are enrolled in the ACC are assigned to a RCCO based on the client's county of residence, and are linked with a PCMP via existing claims data that shows a relationship between the client and the provider, if those data are available. The RCCO and the PCMP are both paid a per member per month (PMPM) amount and are responsible for providing enhanced care coordination services, improving health outcomes, and reducing unnecessary costs.

The Department estimates the PMPM costs for the RCCOs and PCMPs, as well as the fixed-price contract for the SDAC, in Exhibit I. The Department estimates the savings that will accrue as a result of the program in Exhibit F. The current savings estimate for the initial phase of 60,000 clients deviates from the appropriated amount as the estimated date of full enrollment to 60,000 clients was delayed from November to December 2011. In addition, the originally assumed eligibility mix of clients varied from the eligibility mix of clients that were actually enrolled in the program. The Department has adjusted cost and savings estimates for the initial phase of 60,000 clients to account for the delayed enrollment and for actual enrolled eligibility types. Similarly, the Department adjusted cost and savings estimates for the expansion phase of 63,000 clients due to an estimated delay in full enrollment from January to April 2012, as well as for the current information regarding the eligibility mix of enrolled clients. The chart below illustrates the difference between the appropriated amounts and the Department's requests by service category for the current year. Note that the request amounts represent the total estimated impact; the savings include the estimated amount saved in FY 2010-11 due to the program, as requested in FY 2011-12 S-1, "Request for Medical Services Premiums," plus the annualized amount estimated in the current request.

Accountable Care Collaborative FY 2011-12 Appropriation to Request Comparison			
Pilot Phase of 60,000 Clients (Requested in FY 2010-11 S-6, BA-5)			
Service Category	**FY 2011-12 Appropriated Amount**	**FY 2011-12 S-1 Request November 1, 2011**	**FY 2012-13 S-1A Request February 15, 2012**
Estimated Administration Payments (PIHP Admin)	$13,009,140	$11,822,246	$12,934,476
Estimated Savings (Acute Care)	($23,277,919)	($20,085,549)	($14,426,782)
Total Net Impact	**($10,268,779)**	**($8,263,303)**	**($1,492,306)**
Expansion Phase of 63,000 Clients (Requested in FY 2011-12 BA-9)			
Service Category	**FY 2011-12 Appropriated Amount**	**FY 2011-12 S-1 Request November 1, 2011**	**FY 2012-13 S-1A Request February 15, 2012**
Estimated Administration Payments (PIHP Admin)	$8,298,555	$7,497,000	$5,455,164
Estimated Savings (Acute Care)	($13,067,458)	($10,250,663)	($6,189,762)
Total Net Impact	**($4,768,903)**	**($2,753,663)**	**($734,598)**

The costs and savings will increase in FY 2012-13 as the Department anticipates that the program will maintain full enrollment of 123,000 clients for the fiscal year. The chart below illustrates the estimated administration payments and savings for the current, request, and out years.

Accountable Care Collaborative Cost and Savings Estimates by Fiscal Year				
	Service Category	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**
Initial Phase of 60,000 Clients	Estimated Administration Payments (PIHP Admin)	$12,934,476	$15,240,000	$15,240,000
	Estimated Savings (Acute Care)	($14,426,782)	($17,440,452)	($17,440,452)
	Total Net Impact	**($1,492,306)**	**($2,200,452)**	**($2,200,452)**
Expansion Phase of 63,000 Clients	Estimated Administration Payments (PIHP Admin)	$5,455,164	$12,852,000	$12,852,000
	Estimated Savings (Acute Care)	($6,189,762)	($15,594,660)	($15,594,660)
	Total Net Impact	**($734,598)**	**($2,742,660)**	**($2,742,660)**
Total Costs and Savings for the Accountable Care Collaborative	Estimated Administration Payments (PIHP Admin)	$18,389,640	$28,092,000	$28,092,000
	Estimated Savings (Acute Care)	($20,616,544)	($33,035,112)	($33,035,112)
	Total Net Impact	**($2,226,904)**	**($4,943,112)**	**($4,943,112)**

(3) MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS

The following is a description of the budget projection for the Medicaid Mental Health Community Programs.

History and Background Information

In 1993, under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act, the Centers for Medicare and Medicaid Services granted the State waivers that allowed the State to implement a pilot managed care mental health program. The pilot program operated until 1995. In 1995, SB 95-078 directed the Department and the Department of Human Services to implement a statewide capitated mental health managed care program. In 1997, SB 97-005 authorized the Department to provide mental health services through a managed care program.

The structure of managed care has changed over time. In 1995, implementation of the Medicaid Mental Health Capitation Program in fifty-one counties of the State was complete, with the remaining twelve counties added in 1998. A sixty-fourth county was added when Broomfield became a county in November 2001. Through a competitive bid process, eight mental health assessment and service agencies were awarded contracts to be service providers in the program. Again through competitive procurement, the Department reduced the number of regions from eight to five and awarded managed care contracts to five behavioral health organizations effective January 1, 2005. The five behavioral health organizations were reprocured through a competitive bid process effective July 1, 2009. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

Each behavioral health organization is responsible for providing or arranging medically necessary mental health services to Medicaid-eligible adults 65 and older, disabled individuals through 64, low income adults, adults without dependent children, eligible children, foster care children, and Breast and Cervical Cancer Program adults enrolled with a behavioral health organization. Services provided by those organizations include, but are not limited to, inpatient hospitalization, psychiatric care, rehabilitation and outpatient care; clinic services, case management, medication management and physician care; and non-hospital residential care as it pertains to mental health. The capitation program also includes alternatives to institutionalization. The Department is required to make monthly capitation payments to contracted behavioral health organizations for services for each eligible Medicaid recipient. Payments vary across each behavioral health organization, as well as each eligibility category.

Since the inception of the Medicaid Mental Health Community Programs, the Department has been responsible for oversight and contracting with the managed care organizations. The budget projections, day-to-day operations and administration of the program were the responsibility of the Department of Human Services. In 2004, the administration and programmatic duties were transferred

from the Department of Human Services to the Department. These duties include budget projections and accounting for the program, site reviews of the institutions, and contract negotiations. The transfer resulted in a new Long Bill group for the Department in the FY 2004-05 Long Bill (HB 04-1422). Subsequently, SB 05-112 transferred: (1) the Mental Health Administration appropriation for Personal Services, Operating Expenses, and External Quality Review Organization Mental Health from Medicaid Mental Health Community Programs – Program Administration to the Executive Director's Office Long Bill group, (2) Single Entry Point case management services from Medicaid Mental Health Fee-for-Service Payments to Medical Services Premiums, and (3) services for the developmentally disabled from the Colorado Department of Human Services for People with Disabilities – Community Services and Regional Centers to Non-Emergency Medical Transportation, Medical Services Premiums, and Mental Health Fee-for-Service appropriations within the Department. As a result, only the Medicaid Mental Health Community Programs expenditures are addressed in this section.

The recent history of the Medicaid Mental Health Community Programs is summarized as follows:

- HB 02-1420 also provided funding for three alternative programs in the Medicaid Mental Health Community Programs: Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program. Each of these programs was the result of reductions in institutional care. Contracting through mental health assessment and service agencies, community mental health centers offered to provide services through managed care at a much lower cost. Initially part of the Mental Health Capitation Payments line, separate appropriations were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-On (SB 05-209). Funding for Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program was incorporated into the capitation base during the request for proposal process for contracts effective January 1, 2005. Due to this new contractual provision with behavioral health organizations, separate appropriations were no longer needed as of FY 2005-06.

- In FY 2002-03, budget reductions were implemented and capitation payments were reduced significantly for FY 2002-03 through FY 2003-04. This led to a reduction of services provided by the behavioral health organizations. Increasing caseload for Medicaid Mental Health Community Programs and incorporating funding for alternative programs to inpatient hospitalization tempered the effect reductions had on the capitation budget.

- Due to a temporary federal change, the Medicaid federal financial participation match was enhanced for the last quarter of FY 2002-03 and the entire FY 2003-04 to 52.95% (up from 50%), while the State's share was reduced to 47.05%. The federal financial participation match rate returned to 50% for FY 2004-05.

- SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medical Services Premiums and the Medicaid-funded services in the Department of Human Services' budget. This resulted in a one-time savings of approximately $70 million in Medical Services Premiums and $7 million in the Department of Human Services' Medicaid-funded services during FY 2002-03. With cash-based accounting, all expenditures became based on the date of payment, regardless of when the date of service occurred, thus eliminating the six-month accounts payable period maintained under accrual-based accounting. Ideally, all prior expenditure history for mental health services would have been rebuilt on a cash basis for historical comparison purposes, using both the Colorado Financial Reporting System and the Medicaid Management Information System data. However, the Department's prospective per capita budget methodology did not require the use of historical data prior to FY 2002-03.

- SB 03-282 gave the Department and the Department of Human Services' Medicaid-funded programs a one-time appropriation of $1,000,000 in FY 2003-04, wherein $500,000 was from the Tobacco Litigation Settlement Cash Fund pursuant to section 24-75-1104, C.R.S. (2005) and the remaining $500,000 was from federal funds for mental health capitation and performance incentive awards.

- Within the appropriation for Medicaid Mental Health Community Programs, the FY 2004-05 Long Bill (HB 04-1422) provided funding for the Mental Health Institute Rate Refinance Adjustment. This funding was necessary because in 2001 it was discovered that the capitation-based payment for Medicaid clients did not cover bed costs at mental health institutes. Separate appropriations for the Mental Health Institutional Rate Refinance Adjustment were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-on (SB 05-209). New contracts with behavioral health organizations effective January 1, 2005 began fully covering the negotiated bed cost at the mental health institutes in new capitation rates via payments withheld from behavioral health organizations and made directly to the Mental Health Institute. Therefore, a separate appropriation for the Mental Health Institute Rate Refinance Adjustment was no longer needed as of FY 2005-06.

- HB 04-1422 reorganized the Medicaid Mental Health Community Programs Long Bill group into the following sections:

    1. Mental Health Capitation Payments, which included Capitation Base Payments, Mental Health Services for Breast and Cervical Cancer Patients, Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo and the Mental Health Institute at Fort Logan and Alternatives to the Fort Logan Aftercare Program. SB 05-209 consolidated these line items into one Mental Health Capitation Payments line item in FY 2005-06.

    2. Other Medicaid Mental Health Payments, which included Medicaid Mental Health Fee-for-Service Payments, Child Placement Agency and Anti-Psychotic Pharmaceuticals. Child Placement Agency and Anti-Psychotic Pharmaceuticals were listed under Other Medicaid Mental Health Payments for informational purposes only. Detailed explanations of the Child Placement

Agency and Anti-Psychotic Pharmaceuticals programs and appropriations can be found in the Department of Human Services Child Welfare section and the Department's Medical Services Premiums section, respectively. SB 05-209 did not change these line items. However, in November 2004, the Department received an order from the Centers for Medicare and Medicaid Services to cease making Child Placement Agency payments since they were considered supplemental payments outside the scope of the existing waiver. Payments were discontinued in December and the line item has been removed from the Department budget.

- HB 05-1262, known as the Tobacco Tax bill, established two funds that provide capitated mental health benefits to an increasing population of Medicaid clients. Increased caseload funded by the Health Care Expansion Fund, administered by the Department, and the Prevention, Early Detection and Treatment Fund, administered by the Department of Public Health and Environment, are included in both the current year and the out-year requests and are elaborated below.

- The Joint Budget Committee approved the Department's September 20, 2006 1331 Supplemental Request to transfer funding from the Department of Human Services to the Department. This transfer allowed for the inclusion of the Goebel enhanced services in the Medicaid Mental Health Capitation rates and eliminated the need to classify and track them separately.

  The Goebel Lawsuit Settlement line item was created in FY 2003-04 to fund specialized and enhanced mental health services for approximately 1,600 Medicaid and non-Medicaid clients with mental illness in northwest Denver. The Goebel lawsuit claimed that residents of northwest Denver with chronic mental illness were being denied services. The FY 2003-04 Supplemental Bill (HB 04-1320) established the Goebel Lawsuit Settlement as a separate line item in the Department's Department of Human Services Medicaid-Funded Programs Long Bill group and paid it separately from Medicaid Mental Health Community Programs payments.

  On March 31, 2006, the Goebel lawsuit was dismissed. After consultation with the Department's contracted actuary and review of the Goebel-specific encounter and eligibility data, it was determined that an actuarially certified payment would become part of the Mental Health Capitation Payments line item. An adjustment was made for the inclusion and it began being included in the FY 2006-07 capitations.

- SB 07-002 and SB 08-099 expanded Medicaid eligibility for foster care children up to age 21.

- HB 08-1320 designated Cash Funds Exempt as cash funds and Reappropriated Funds, in effect moving the Health Care Expansion Fund from Cash Funds Exempt to cash funds, and clearly distinguishing transfers from the Department of Human Services to the Department as Reappropriated Funds.

- HB 08-1373 continued and extended the Breast and Cervical Cancer Treatment Program to July 1, 2014. The bill designates funding sources for the program: a) for FY 2008-09, 100% of the State costs for the Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund; b) for FY 2009-10 through FY 2013-14, 50% of State costs for the Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund and 50% shall be from the General Fund.

- SB 09-262 shifted state funding for the Breast and Cervical Cancer Program from 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund to 100% Breast and Cervical Cancer Prevention and Treatment Fund, effective until FY 2011-12. Beginning FY 2012-13, state funding for the Breast and Cervical Cancer Program will be shifted to 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund.

- Effective January 1, 2009, the Department issued, and the Behavioral Health Organizations (BHOs) actuarially certified, a new set of rates above the actuarial midpoint of the rate setting range. Rates are set using a combination of historical rate experience and recent encounter data. Under direction from the Centers for Medicare and Medicaid Services, the Department has gradually put more weight on the encounter data PMPM. FY 2005-06 was the first year of rate setting that used a combination of historical rate experience and recent encounter data. These capitation rates were calculated using 5% encounter data and 95% of the historical rate experience. During the rate setting process resulting in the January 2009 rates, the Department altered the weight to 35% encounter and 65% historical. However, the Department found that the estimated service expenditures were generally valued at an amount less than expected, relative to the BHO's audited financial statements. The Department believes that there are two primary reasons for this discrepancy. First, the non-traditional, federally waivered (b)(3) service data was newly included in the FY 2006-07 encounter data used for rate setting and appeared to not be completely reported. Additionally, inconsistencies in coding and accounting practices cause some difficulties in the encounter pricing methodology. To offset the discrepancy the Department paid its mental health rates at 3% above the actuarial midpoint. See description of Exhibit GG for additional information.

- HB 09-1293, the "Colorado Health Care Affordability Act" provided health care coverage for more than 100,000 uninsured Coloradans. The bill was implemented in April 2010 when the Department began collecting the hospital provider fee. Mental health services were subsequently expanded to parents up to 100% of the federal poverty line using the Hospital Provider Fee cash fund to cover the additional expenses. Mental health services will be expanded further in FY 2011-12 to adults without dependent children and disabled individuals with income up to 450% of the federal poverty level. For more detail, please see Exhibit J in Medical Services Premiums.

- The June 22, 2009 General Revenue forecast indicated that additional General Fund cuts would be necessary in FY 2009-10. On August 24, 2009, the Department released a series of early supplemental requests (ES), which affected the Department's mental health programs in the following ways:

1. As a part of FY 2010-11 ES-2 "Medicaid Program Reductions" the Department reduced the reimbursement rate for the mental health capitation program by 2.5%, effective September 1, 2009, and accounted for the recoupment of net overpayments on prior years' mental health capitation payments.

2. As a part of NP-ES-5 "Close Beds at the Mental Health Institutes" the Department of Human Services proposed that specific beds at the mental health institutes be closed as of January 1, 2010. These bed closures impacted the Department by immediately making those displaced from the mental health institutes clients of the capitated mental health program. While treated at the institutes, Department of Human Services funding preempted Medicaid payment, with Medicaid being the "payer of last resort." Displacing these clients allowed them to be eligible to receive Medicaid funded benefits and increased expenditure for mental health services.

- Effective January 1, 2010, the Department calculated a new set of mental health rates and set them below the actuarial midpoint. Three of the Behavioral Health Organizations (BHOs) were paid 2.5% below the actuarially set midpoint of the new set of rates. Two of the contracted Behavioral Health Organizations (BHOs) were unable to actuarially certify that they could operate at the new payment schedule. In January 2010, the Joint Budget Committee voted to appropriate funds to continue paying these two BHOs at the previously set rates (the rates from the last rate setting process, with the 2.5% cut from September 2009). These rates remained in effect through CY 2010. See the description of Exhibit GG for additional information.

- Effective January 1, 2011, the Department calculated a new set of mental health rates for calendar year 2011. The new rates implicitly included the 2.5% reductions taken by the BHOs as the rate cuts were part of the historical and encounter data used in the rate-setting methodology. In addition, the rates were set at 1.71% below the point estimate rates in order to achieve an appropriated savings of $2,170,355. The Department worked with the BHOs in order to ensure that they were able to certify the rates and continue to provide quality services to their clients, even while their rates were being reduced. The result of that negotiation process was to begin a series of rate reforms, the first of which was to include a new component in the rate called a "case rate" adjustment that was applied to the CY 2011 rates. The case rate is the BHO statewide average cost by diagnosis category. The case rate allows the Department to comply with CMS's direction by increasing the weight of the encounter data in the rate-setting process. The BHOs can accept the increased weight of encounter data because the case rate allows for any savings achieved to be spread across the entire system, rather than directly reducing the rate of the BHO responsible for generating savings. Incorporating the case rate serves to better align the rate-setting process with the Department's goals by incentivizing the BHOs to be more efficient without sacrificing the quality of the care provided to their clients.

- The Department requested to continue to apply the 1.71% reduction to the BHO rates in the current and request years in FY 2011-12 BRI-5 "Medicaid Reductions." The reduction was appropriated in the FY 2011-12 Long Bill.

- The FY 2011-12 Long Bill transferred $616,044 from the Division of Youth Corrections appropriation, which is administered by the Department of Human Services, to the appropriation for Medicaid Mental Health Community Programs to fund mental health services provided to children living at the Ridge View Youth Services Center. In FY 2009-10, the Ridge View Youth Services Center in the Denver-Aurora area was granted a change of license to be classified as an unlocked, non-secure, community residential facility. The new type of license allowed Ridge View to be considered a community facility in which residents may qualify for Medicaid. Each resident at Ridgeview is viewed by Medicaid as being a low-income family of one, since the residents generally have no independent income. Thus, the residents at Ridgeview qualify under the same category of eligibility as foster care children. Prior to FY 2011-12, the expenditure for mental health services provided to Ridge View clients was transferred from the appropriation for Medicaid Mental Health Community Programs and into the appropriation for the Division of Youth Corrections. Its appropriation was transferred to the mental health long bill line to streamline the process and avoid manually transferring expenditure. Since the Ridge View clients have been incorporated in the caseload data since FY 2009-10, the Department assumes that the impact of these clients on mental health expenditures will be captured in the caseload forecasts and does not need to be added as a bottom line impact to Exhibit BB.

- SB 11-008, "Aligning Medicaid Eligibility for Children," will expand Medicaid eligibility from 100% to up to 133% of the federal poverty line for children ages 7 to 18. The bill shifts impacted children from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for the Children's Basic Health Plan. SB 11-250, "Eligibility for Pregnant Women in Medicaid," will expand Medicaid eligibility from 133% to 185% of the federal poverty line for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate.

Program Administration

In FY 2005-06, SB 05-112 transferred all of Medicaid Mental Health Community Programs - Program Administration expenditures into the Executive Director's Office Long Bill group, and is reflected in the lines for Personal Services, Operating Expenses, and Mental Health External Quality Review Organization. The current year and out-year requests for Program Administration are included in the Executive Director's Office Long Bill group.

Medicaid Anti-Psychotic Pharmaceuticals

Prior to FY 2008-09, as part of the Long Bill, estimated expenditures for anti-psychotic pharmaceuticals were appropriated to this Long Bill group as Cash Funds Exempt. This was an informational-only line item: the costs for these drugs were and are paid in the

Department's Medical Services Premiums Long Bill group, and no actual transfer took place. Because there was no corresponding decrease to the Medical Services Premiums Long Bill group, this double counted the funding for these drugs.

In its November 1, 2007 Budget Request, the Department officially requested the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item and subsequently received approval. The Department continues to report expenditure for anti-psychotics in its Budget Request (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan).

(A) MENTAL HEALTH CAPITATION PAYMENTS

The Mental Health Capitation Payments line item reflects the appropriation that funds Medicaid mental health services throughout Colorado through managed care providers contracted by the Department. As a result of competitive procurement, five behavioral health organizations were awarded contracts with updated capitation rates and services effective January 1, 2005. Payments for Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program were separate payments prior to FY 2005-06, and incorporated into the Mental Health Capitation Payments line item in FY 2005-06. Effective July 1, 2009, the five behavioral health organizations were reprocured through a competitive bid process. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

The behavioral health organizations are responsible for providing or arranging all medically necessary mental health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category. Amounts are prorated for partial months of service and retroactive eligibility is covered. Payments vary across behavioral health organizations, as well as eligibility categories.

The Medicaid populations that are eligible for mental health services covered by capitation rates are combined into seven categories, as indicated below. Partial dual eligible clients and non-citizens are ineligible for Medicaid mental health services.

The eligible Medicaid mental health populations are:

- Adults 65 and Older (OAP-A)
- Disabled Individuals Through 64 (AND/AB, OAP-B)
- Low Income Adults
- Adults without Dependent Children
- Eligible Children (AFDC-C/BC)

- Foster Care
- Breast and Cervical Cancer Prevention and Treatment Program

Analysis of Historical Expenditure Allocations across Eligibility Categories

At the beginning of a contract cycle, behavioral health organization capitation rates were entered in the Medicaid Management Information System. Monthly payments were paid based on eligibility categories. The Medicaid Management Information System provided detailed expenditures by behavioral health organization and eligibility category but did not include offline transactions and accounting adjustments. The only source that included all actual expenditure activity is the Colorado Financial Reporting System. The drawback was the Colorado Financial Reporting System provided total expenditures, but not by eligibility category. The exception was the Breast and Cervical Cancer Treatment Program eligibility category, which was reported separately in the Colorado Financial Reporting System. Since an allocation had to be calculated to determine the amount of actual expenditures across the other eligibility categories, a ratio was calculated for each eligibility category by dividing the Medicaid Management Information System eligibility category expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) by the total Medicaid Management Information System expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category). The ratio for each category was multiplied by the total expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) from the Colorado Financial Reporting System. This calculation estimated actual Colorado Financial Reporting System expenditures across each eligibility category. Variance between the two systems was less than 0.1%.

Description of Transition to New Methodology

Member month methodology was used prior to 2005 when the administration of Medicaid Mental Health Community Programs was transferred from the Department of Human Services to the Department. Historical expenditures were divided by the capitation rates for the region served by each mental health assessment and service agency (now known as behavioral health organizations) to estimate the number of member months for which capitation payments were made. Mental health caseload growth rates were applied to these member months to calculate projected member months. Member months were multiplied by the capitation rates for the upcoming year to determine the projected capitation base payments. The problem with this system was that member months, which reflected the impact of retroactive payments, were not equivalent to the Medicaid caseloads used in Medical Services Premiums, which did not include retroactivity. This methodology was used until February 15, 2005.

From February 2005 until the present Request, the Department had been transitioning towards a per capita methodology. Previous year actual amounts were trended forward by eligibility category, generating an estimated per capita. Prior to this Request, the Joint Budget Committee had asked the Department to explore the possibility of projecting budgets by behavioral health organization as well as by eligibility category. The Department has determined that such a projection is not yet possible due to the following: a) the recent

(FY 2005-06) consolidation of eight mental health assessment and service agencies into five behavioral health organizations, b) the disproportionate impact of Goebel driven expenditures into one behavioral health organization's capitation rate, and c) the volatile nature of specific capitation rates as compared to the overall trend of capitation rate increases within respective eligibility categories. However, the Department will continue to explore this methodology as new data becomes available.

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per capita rates, the Department moved to a capitation trend forecast model for the FY 2008-09 Estimate and FY 2009-10 Request. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends directly, rather than through a per capita methodology, future expenditures are forecasted directly through the primary cost drivers: the actuarially agreed upon capitation rate and caseload. By tying forecasts directly to capitation rates, the methodology may provide more accurate estimates of expenditures by eligibility category, rather than simply in aggregate, as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to behavioral health organizations.

Additionally, the Department has incorporated an incurred but not reported methodology similar to other portions of this Request submitted by the Department (e.g. Nursing Facilities; see Section E, Exhibit H). The Department is adjusting its request to capture the reality that some mental health claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

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

EXHIBIT AA - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

Effective with the November 2, 2009 Budget Request, in this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from Exhibit BB. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

Exhibit AA now presents a concise summary of spending authority affecting the Medicaid Mental Health Programs. In previous budget requests, the Department presented historical expenditure and caseload figures in graphical form. This information can be found in table form in Exhibit DD (see below).

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

EXHIBIT BB - CALCULATION OF FUND SPLITS

Exhibit BB details fund splits for all Mental Health Community Programs budget lines for the current fiscal year Supplemental and the out-year Budget Request. For all of the capitation payments except the Breast and Cervical Cancer Program, the funding is 50% state funds and 50% federal funds. Payments for clients in the Breast and Cervical Cancer Program receive a 65% federal match rate and are described separately, below. Capitation expenditures are split between traditional clients and expansion clients funded from Hospital Provider Fee funds. Finally, the recoupments from prior years for mental health capitation overpayments, retractions for capitations paid for clients later determined to be deceased, and estimated reconciliations for the adults without dependent children population are also presented (see Exhibit II for recoupment calculations).

In the capitation base for both years, most clients are paid for with 50% General Fund and 50% federal funds. Expansion clients funded through HB 09-1293 receive state share funding from the Hospital Provider Fee Cash Fund. These clients also receive a 50% federal match.

Medicaid Mental Health Fee-for-Service Payments also receive 50% General Fund and 50% federal funds. The sum of the capitations and the fee-for-service payments comprise the Department's request.

Mental Health Services for Breast and Cervical Cancer Program Adults

SB 01S2-012 created the Breast and Cervical Cancer Prevention and Treatment Program. SB 05-209 and HB 08-1373 incorporated funding for the Breast and Cervical Cancer patients into the appropriation for Medicaid Mental Health Community Programs Capitation Payments, effective with the FY 2005-06 budget. Mental health care for clients in the Breast and Cervical Cancer Program is managed through the capitation contracts with the behavioral health organizations. Therefore, the budget is based on the mental health caseload that includes the Breast and Cervical Cancer Program eligibility category. For this reason, they are shown as a separate eligibility category where appropriate.

Annual designations of General Fund contributions to program costs are specified in sections 25.5-5-308(8), (9), and (10) C.R.S. (2011). Exhibit BB details funds splits for the Mental Health Community Programs Capitations line. The funding for the clients already enrolled in the program, called "traditional clients," is 35% cash funds from the Breast and Cervical Cancer Prevention and

Treatment Fund and 65% federal funds in FY 2011-12. Starting in FY 2012-13, the funding is 17.5% General Fund, 17.5% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund, and 65% federal funds. In addition, the Department received funding from the Tobacco Tax Bill (HB 05-1262) to enroll more clients in the Breast and Cervical Cancer Program. These clients, called the "expansion clients," are funded by the Prevention, Early Detection and Treatment Fund administered by the Department of Public Health and Environment and the Tobacco Tax Bill (see the explanation below and Exhibit JJ, which shows all Tobacco Tax impacts, for a full explanation). The funding for the expansion clients was 35% reappropriated funds and 65% federal funds.

The Department is requesting a change to the allocation of traditional and expansion clients in FY 2012-13 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program is $1,215,340. The Department is requesting $1,215,340 in reappropriated funds for Breast and Cervical Cancer Program expansion clients in request S-1, "Request for Medical Services Premiums." As this is the total balance of available reappropriated funds, the Department is requesting to fund all Breast and Cervical Cancer Program clients in the Medicaid Mental Health Community Programs Long Bill group with the Breast and Cervical Cancer Prevention and Treatment Fund and General Fund.

Mental Health Services for Hospital Provider Fee Expansion Clients

HB 09-1293 established a funding mechanism for a series of expansion clients. The first set of expansion clients that are funded through the bill was parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these clients are funded through the Hospital Provider Fee Cash Fund. These clients are assumed to be similar to other adult clients, and expenditure for these clients are therefore calculated using the same per capita rate as other adult clients (see exhibit JJ). Starting in FY 2011-12, additional expansion populations will also receive funding through the Hospital Provider Fee Cash Fund. These include disabled individuals with income limits up to 450% of the federal poverty line and adults without dependent children, both of which will receive services through the BHOs as part of their benefit package. The disabled individuals with income limits up to 450% are assumed to be similar to other disabled clients, and expenditure for these clients are therefore calculated using the same per capita rate as other disabled clients (see exhibit JJ). For the adults without dependent children, the BHOs will be reimbursed at a separate capitation rate than other eligibility categories. The Department estimated expenditure for this population using preliminary assumptions about the rate that will be set for adults without dependent children and the reconciliation method that will be used to ensure that the Department adequately pays the BHOs to serve this new population. See exhibits EE, GG, II, and JJ for more detailed explanations of these assumptions.

Mental Health Services for Expansion Populations in SB 11-008 and SB 11-250

SB 11-008, "Aligning Medicaid Eligibility for Children," extends Medicaid eligibility to up to 133% of the federal poverty line for all children under the age of 19. Formerly, the eligibility limit for children ages 7 to 18 was 100%, and it was 133% for children 6 and under. The bill shifts impacted children from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for the Children's Basic Health Plan.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extends Medicaid eligibility from 133% to 185% of the federal poverty line for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate.

EXHIBIT CC - MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS SUMMARY

Exhibit CC presents a summary of mental health caseload and capitation expenditures itemized by eligibility category as well as a summary of the rest of the Mental Health Community Programs. The net capitation payments include the impacts of actions with perpetual effect, such as the decrease in payment rates by 1.7%, as well as caseload driven impacts such as the various recoupments and retractions for clients determined to be ineligible. Exhibit EE illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT DD - MENTAL HEALTH CASELOAD, PER CAPITA, AND EXPENDITURE HISTORY

Exhibit DD contains the caseload, per capita, and expenditure history for each of the eleven eligibility categories. Each of the tables that comprise Exhibit DD is described below.

Medicaid Mental Health Community Programs Caseload

Medicaid Mental Health Community Programs caseload is displayed in two tables. The first table shows total caseload for the combined disabled categories as well as the combined adult categories. The second table displays caseload by all mental health eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The mental health caseload excludes the caseload for partial dual eligible clients and non-citizens and ties to the caseload presented in the Request for Medical Services Premiums, Section E, exhibit B. Please see the

Medicaid Caseload section of the Medical Services Premiums narrative for further discussion of Medicaid caseload projections. The caseload numbers are used in numerous exhibits throughout the Medicaid Mental Health Community Programs Exhibits and narrative.

Medicaid Mental Health Community Programs Per Capita Historical Summary

As with caseload, Medicaid Mental Health Community Programs per capita is displayed in two tables. The first table sets forth total per capita for the combined disabled categories as well as the combined adult categories. The second table displays per capita by all mental health eligibility categories. However, since the actual per capita from the first table is the same for both disabled categories, and the four adult categories have a single per capita, the true per capita is shown in those categories and will not mathematically be the same as dividing each individual category expenditure by the caseload. Figures for fiscal years up to the present fiscal year are actual per capitas, while the current fiscal year and the request year per capitas are estimates.

Medicaid Mental Health Community Programs Expenditures Historical Summary

The history of expenditures includes combined category and expanded category tables as well as total expenditures for both capitation and fee-for-service expenditures. For fee-for-service expenditure, service categories are listed separately.

Actual expenditures are only available from the Colorado Financial Reporting System. Expenditures by eligibility category, other than the Breast and Cervical Cancer Treatment Program, are not available from the Colorado Financial Reporting System. The Medicaid Management Information System does provide expenditures by eligibility category, but does not include offline transactions and accounting adjustments. The two systems typically have minor discrepancies in reported expenditure, often due to accounting adjustments made to the Colorado Financial Reporting System as fiscal periods close. Because the variance is minor, data from the Medicaid Management Information System can be used to distribute total expenditures from the Colorado Financial Reporting System across eligibility categories.

A ratio is calculated for each eligibility category by dividing the Medicaid Management Information System eligibility category expenditures by the total Medicaid Management Information System expenditures. The ratio is multiplied by the total expenditures from the Colorado Financial Reporting System. This calculation estimates actual Colorado Financial Reporting System expenditures across each eligibility category. The Breast and Cervical Cancer Treatment Program expenditures are carved out of both totals before the calculations are done, since this is the only category that does not need to be estimated. Once the overall expenditures by eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category.

EXHIBIT EE - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

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

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

The forecasted capitation rate is derived from exhibits FF through HH, and will be presented in more detail, below. The caseload is the same as presented in Medicaid Medical Services Premiums, Section E, Exhibit B (excepting partial dual eligible clients and non-citizens, as discussed, above).

The Department has broken down the current fiscal year and the request year into two components: a first and second quarter estimate (Q1 and Q2) and a third and fourth quarter estimate (Q3 and Q4). This accounts for the fact that the Department makes rate adjustments on a calendar year basis. As such, the Q1 and Q2 capitation rate is known and is the point estimate rate from the previous two quarters (the first two quarters of the calendar year). For the Department's November requests, the current year's Q1 and Q2 rates are known and the remaining rates are estimated. In the February supplemental, the rates for the current year and the first half of the request year are known and only the final two quarters of the request year are estimated. By the time February numbers are presented, the Department has completed its most recent rate setting process, adding to the known set of data. As presented in Exhibit EE, the estimated capitation rate is multiplied by the monthly caseload and then multiplied by the number of months the rate will be in effect.

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown starting on page EE-3.

After calculating total expenditure, the anticipated date-of-death retractions for each fiscal year are estimated and added to total expenditure. The Department began an aggressive retraction of payments for deceased clients in FY 2009-10; this activity resulted in retraction of payments originally made between FY 2004-05 and FY 2008-09 and reduced prior period dates of service expenditure. The Department is continuing to identify these claims and retracts payments twice a year. For the current year, the retractions are estimated as a 10% reduction in the total amount retracted in the previous year. For the request year, the retractions are estimated as a

10% reduction in the estimated amount that will be retracted in the current year. The retractions are expected to decline as there is a smaller pool of historical clients from which to retract and current processes of identification become more effective.

Incurred but not Reported Estimates

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

The Department examined historical data from the last five fiscal years, and determined that the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Pages F.EE-4 through F.EE-5 presents the percentage of claims paid in a six month period that come from that same period and those which come from previous periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

Historically, for each eligibility category except disabled individuals through 64, over 99% of incurred claims are paid by the end of the fiscal year in which the claims were incurred. For the disabled individuals, it takes a full eighteen months for 99% of claims to be paid. This is likely due to the relative difficulty in determining and documenting disability as opposed to criteria such as age or income. Hence, a larger percentage of claims from previous periods exist for this category of clients.

It is of note that beginning November 1, 2009, the Department instituted a policy of denying retroactive capitation claims that are from a period beyond 18 months prior to the payment month. For those clients with retroactive claims beyond 18 months who are found to have received services, the Department will reimburse the BHOs through a fee-for-service payment. Since capitations are calculated to pay for actual services delivered by spreading that cost to caseload regardless of whether services are received, the net effect of eliminating cap payments and reimbursing for services may be cost neutral. The Department will monitor this policy change, and should there be any expenditure fluctuations, the Department will seek to adjust through future budget requests.

The Department assumes that the adults without dependent children population will follow a similar IBNR trend as low income adults and applied the percentage of claims paid in a six month period for low income adults to the calculation for adults without dependent children expenditure. The rate for the adults without dependent children is also adjusted in Exhibit HH by the same retroactivity and partial month adjustments as are applied to low income adults. In future requests, the Department will use actual cost data available for this new population to determine the true, population-specific IBNR factor and rate adjustments that should be applied.

On pages F.EE-6 through F.EE-8, the Department calculates the estimated outstanding expenditure from claims remaining from previous period by aid category. The sums are then carried forward to the calculations on pages F.EE-1, F.EE-2, and F.EE-3.

Actuarially Certified Capitation Rates

Capitated rates for the behavioral health organizations are required to be actuarially certified and approved by the Centers for Medicare and Medicaid Services, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit EE. The methodology for determining the forecasted capitation rate is the subject of Exhibits FF through HH.

EXHIBIT FF - MEDICAID MENTAL HEALTH RETROACTIVITY ADJUSTMENT AND PARTIAL MONTH ADJUSTMENT MULTIPLIER

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

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

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last five years of claims and caseload data. Page F.FF-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The relatively steady percentage values across each respective eligibility category suggest that the ratio is indeed systemic (as created by retroactivity) rather than a unique circumstance. The Department analyzed the data, however, and has determined that the amount of retroactivity in the claims incurred each period is

steadily changing over time and has trended downward for all eligibility categories except for disabled individuals. For this reason, the Department assumes that the most recent period with adequate time for run-out of claims is the best representation of how much retroactivity will affect the claims-to-caseload ratio in the current and request years.

Partial Month Adjustment Multiplier

To derive the partial month adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last five years of data were examined. Prior to FY 2006-07, capitation rates were radically adjusted to capture systemic changes including, but not limited to, shifting to the Department the bulk of Medicaid program responsibility from the Department of Human Services, the consolidation to five behavioral health organizations from eight, and program and financing adjustments resulting from the Goebel lawsuit. Due to these adjustments, the volatility of capitation rates prior to FY 2006-07 would not be a quality indicator of any future comparisons to claims paid.

As presented on page F.FF-2, for each eligibility category, the weighted average claims-based rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was compared to the weighted capitation rate (similarly weighted). Then, the claims-based rate as a percentage of the capitation rate was calculated, providing a simple comparison of any trend in claims-based rates as compared to capitation rates. The percentages are similar across years, indicating that the claims-based trends are matching capitation trends. The Department analyzed the data, however, and has determined that the amount of partial months paid each period is steadily changing over time within each eligibility category. For this reason, the Department assumes that the most recent period with adequate time for runout of claims is the best representation of how much partial month payments will affect the claims-based rate in the current and request years.

EXHIBIT GG - MEDICAID MENTAL HEALTH CAPITATION RATE TRENDS AND FORECASTS

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e. the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was examined. Exhibit GG presents historical data as well as the forecasted weighted rates.

Beginning in January of 2009, the Department switched its rate setting cycle form a state fiscal year cycle to a calendar year cycle. Capitation rates are now effective from January 1 through December 31. Therefore, the Department now presents its forecasted rates in six month blocks to account for the rate change occurring in the middle of a state fiscal year.

The weighted rate is presented along with the percentage change from the previous six months as well as from the average rate of the entire previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit HH.

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

It is important to note that the overall weighted point estimate presented in the exhibit is weighted across two factors. First, the rate is weighted within an eligibility category (that is, weighted by the behavioral health organizations' proportion of claims processed within that eligibility category). Second, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the Weighted Mental Health Total rate may not be a clear indicator of the rate trends across all eligibility categories.

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

From January 1, 2009 to June 30, 2009, the Department paid rates 3% above the actuarial midpoint due to a new rate-setting methodology. Beginning September 1, 2009, in accordance with FY 2010-11 ES-2, the Department paid rates that were 2.5% below the actuarial midpoint. New rates were established for the 2010 calendar year and set 2.5% below their certified midpoint rates. However, the Department's rate setting process and federal regulation require that both the Department and the BHOs actuarially certify that they will be able to operate at the proposed paid rates. With the January 1, 2010 rates, two BHOs were unable to certify. The Joint Budget Committee voted to appropriate funding to continue those two BHOs at a continuation of their most recent previously certified rates, the September 1, 2009 rates. These two BHOs continued to be paid their September 1, 2009 rates through CY 2010. The 2.5% reductions to the BHOs' rates will continue to be in effect through future fiscal years, as they are now part of the encounter and historical data used in the rate-setting process. In addition, the rates were reduced by 1.71% in CY 2011. This was originally requested in FY 2010-11 BRI-6 as a 2.0% cut to be effective July 2010. The Joint Budget Committee decided to delay this cut until January 2011, and appropriated it as a savings of $2,170,355 to be achieved in FY 2010-11. The Department determined that

it would be able to realize savings in FY 2010-11 in this amount by cutting the CY 2011 rates by 1.71%. This rate reduction will continue to be built into the rates in the current and request years, as requested in FY 2011-12 BRI-5.

The Department is adding a new rate cell in FY 2011-12 for the adults without dependent children expansion population, which will be funded through the Hospital Provider Fee Cash Fund. The rate for CY 2012 for the adults without dependent children has not yet been actuarially certified. For this request, the Department assumes an estimated rate based on the encounter data for disabled individuals through 64 and low income adults. The Department estimates that the adults without dependent children will incur costs at about the average of those two eligibility categories, and calculated expenditure using this estimated rate and the projected caseload in Exhibit EE, in the same way as the other eligibility categories. Since the rate for this expansion is not based on actual encounter data for the specific population, the Department also assumes that it will make retroactive reconciliation payments to the BHOs based on actual costs, as outlined in Exhibit II.

EXHIBIT HH - FORECAST MODEL COMPARISONS

Exhibit HH produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in Exhibit EE. Pages F.HH-1 and F.HH-2 present the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in Exhibit FF.

On page F.HH-3, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into pages F.HH-1 and F.HH-2. Based on the point estimates, the adjustments presented in Exhibit FF are then applied and the final, adjusted point estimate is then used in the expenditure calculations of Exhibit EE.

Final Forecasts

Page F.HH-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page F.HH-3 (see below). For Funding Requests, the rate applied to the first six months of the current year is known due to the calendar year rate setting cycle (see the description of Exhibit GG, above). The rate applied to the next six months of the current year is then estimated from a series of trend models and historical changes (see below). That same rate is then carried forward into the first six months of the request year due to the calendar year rate setting cycle. The rate for the last six months of the request year is estimated by taking the percent change in rates from the last known rate to the first forecasted rate and carrying that percentage change forward.

For Supplemental Requests, the rate for the entirety of the current year and the first six months of the request year are known due to the calendar year rate setting cycle. The rate for the final six months of the request year is estimated using the various trend models and historical information described, below.

The projected rate is then adjusted by any policy impacts. In accordance with the FY 2010-11 ES-2 budget action, beginning September 1, 2009, the Department has paid rates that are 2.5% below the actuarial midpoint. This rate cut is now incorporated in the data used during the rate-setting process and is no longer included as an adjustment factor in exhibit HH. For Q3 and Q4 of FY 2010-11, the Department reduced rates by an additional 1.71%. The Department requested this reduction in FY 2010-11 BRI-6: Medicaid Reductions for the full year, but will be implemented for only two quarters of FY 2010-11 per instructions from the Office of State Planning and Budgeting. The 1.71% reduction will continue to be in effect in the current and request years.

The forecasted rate is also adjusted by the partial month adjustment multiplier, calculated on page F.FF-2. The multiplier is applied to adjust for the fact that the full capitation rate is not paid for every member month. The rate for paid claims is impacted by payments made for partial months of eligibility; this type of payment will not be for a "whole" capitation payment at the current fiscal period's capitation rate. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Finally the claims-based rate is adjusted a third time, this time by the retroactivity adjustment. From Exhibit FF, page F.FF-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit FF, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep mental health caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to drive the expenditure calculation presented in Exhibit EE. A similar methodology is applied to the rates in each eligibility category, and for each fiscal period.

Capitation Trend Models

The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page F.HH-3 and historical midpoint rates are presented in Exhibit GG.

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

exponential growth model assumes that the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

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

Capitation rates are required to be actuarially sound and are built from a blend of historical rates and recent year encounter data (provider expenditure on services). The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. Beginning with FY 2008-09 the Department has experienced unusual trends for the mental health capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models' reliance on historical performance for predicting future performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. As such, the Department believes that the most recent years' experience is the most predictive of the likely current year and future year experiences. The following table shows the trends selected for the current and request years by eligibility category.

Aid Category	CY 2013 Trend Selection	CY 2014 Trend Selection	Justification
Adults 65 and Older (OAP-A)	2.99% Rate change from FY 2009-10 to FY 2010-11	2.99% Rate change from FY 2009-10 to FY 2010-11	Historical capitation rates for adults 65 and older have increased slowly over time. The percentage change for the most recent calendar year was negative. It is anticipated that the rate will not continue to decline in future years, but grow at a moderate rate. The Department chose the percentage change in weighted fiscal year rates from FY 2009-10 to FY 2010-11 to trend the CY 2013 and CY 2014 rates.

Aid Category	CY 2013 Trend Selection	CY 2014 Trend Selection	Justification
Disabled Individuals Through 64 (AND/AB, OAP-B)	5.66% Rate change from FY 2009-10 to FY 2010-11	5.66% Rate change from FY 2009-10 to FY 2010-11	The rate for the disabled populations has increased along a linear trend since the incorporation of the Goebel settlement into the rate methodology, except for the last calendar year -- the percentage change was negative. The Department expects that the rate will not continue to decline but will grow slowly in future years due to rate reform initiatives that reward BHOs for cost-savings efforts. Therefore, the percentage change in weighted fiscal year rates from FY 2009-10 to FY 2010-11 was selected to trend the CY 2013 and CY 2014 rates.
Low Income Adults	3.44% Rate change from FY 2010-11 to FY 2011-12	3.44% Rate change from FY 2010-11 to FY 2011-12	The low income adults category has also seen steady increases in its rate, and that growth has followed closely to a linear trend since FY 2002-03. The percentage change for the most recent calendar year was negative. As with the Adults 65 and Older and Disabled Individuals Through 64 rates, the Department anticipates that the rate for this category will increase rather than decrease, but at a moderate rate. The most recent percentage change in weighted fiscal year rates was selected to trend the CY 2013 and CY 2014 rates.
Adults without Dependent Children	4.55% Average of trends selected for Disabled Individuals Through 64 and Low Income Adults	4.55% Average of trends selected for Disabled Individuals Through 64 and Low Income Adults	The adults without dependent children rate was set assuming expenditure would reflect the disabled individuals through 64 and low income adults mental health expenditure. Therefore, the Department assumes that the trend for this rate will be an average of the trends of the two categories.

Aid Category	CY 2013 Trend Selection	CY 2014 Trend Selection	Justification
Eligible Children (AFDC-C/BC)	5.20% Average growth model	5.20% Average growth model	The rate for the children category has been steadily increasing over recent years. The Department expects it to increase again to a similar degree in CY 2013 and CY 2014. The Department chose the average growth over the last six periods to trend the CY 2012 rate forward.
Foster Care	-2.01% One-fourth change from CY 2011 to CY 2012	-1.00% One-eighth of rate change from CY 2011 to CY 2012	The rate for this eligibility category has decreased over the last several years but has begun to level off; the Department expects that this will continue. The Department selected one-fourth of the CY 2012 percentage growth to trend the CY 2013 rate and one-eighth of the CY 2012 percentage growth to trend the CY 2014 rate.

The selected point estimates of the capitation rates are adjusted on pages F.HH-1 and F.HH-2, as described above, for use in the expenditure calculations presented in Exhibit EE.

EXHIBIT II - RECOUPMENTS AND RECONCILIATIONS

Recoupments

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System. When clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the Medicaid Management Information System. When clients are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is completed separately. Exhibit II summarizes the expected fiscal impacts.

The Department has worked to reduce the payments to the behavioral health organizations for clients later deemed ineligible for Medicaid. Historically, monthly capitation payments were made on a prospective basis. In February 2004, the Department converted to concurrent capitation payments. FY 2004-05 was the first full year for monthly capitation payments on a concurrent basis.

No recoupments were made during FY 2005-06 due to a computer programming change, and this has delayed the recoupment process. In FY 2006-07, recoupments from FY 2003-04 were processed. In FY 2007-08, no recoupments were processed as the Department sought to verify eligibility information provided by the behavioral health organizations. This process has proven to be complicated by

the various reporting practices of the community mental health centers that provide services to clients. The Department collaborated with the Centers for Medicare and Medicaid Services (CMS) to develop a retrospective eligibility validation process which the Department implemented in FY 2009-10. Recoupments from FY 2005-06 through FY 2007-08 were processed in the latter half of FY 2009-10. In FY 2010-11, recoupments were collected for FY 2004-05. The Department recouped expenditure for FY 2008-09 ineligibles at the beginning of FY 2011-12. The recoupments from incurred expenses in FY 2008-09 were altered in their federal fund split due to the impact of the American Recovery and Reinvestment Act. Since those expenditures were made with enhanced federal funds, any recoupments will also see a disproportionate share of federal funds retrieved. Recoupments from FY 2009-10 will be collected in FY 2012-13 and will be altered by the enhanced federal match from the year the claims were processed. Recoupments from FY 2010-11 will also be collected in FY 2012-13, and those from FY 2011-12 will be collected in FY 2013-14.

The most recent recoupment made by the Department was for FY 2008-09 ineligibles. The methodology used to calculate the recoupment for that year differs slightly from previous years. The data for that fiscal year is also more reliable than past fiscal years due to data standardization and verification efforts undertaken by the BHOs and the Department. For those reasons, the Department estimated future recoupments using the FY 2008-09 actual amount as a base and inflating it by the growth rate in caseload for that fiscal year.

Reconciliations

In FY 2011-12, the Department will enroll a maximum of 10,000 adults without dependent children into Medicaid as an expansion population under the Hospital Provider Fee. Since there is no previous encounter data to set a rate for this population, the Department must make assumptions in setting the rate about the clients' expected utilization of and expenditure on mental health services. The Department will not know whether this rate is sufficient to reimburse the BHOs for this population until actual cost data is available. Due to this uncertainty, the Department assumes that it will pay the BHOs a reconciliation amount on a regular basis based on actual costs. The Department is considering using a stop-loss methodology to determine the reconciliation amounts; under this methodology, the Department would pay the BHOs for those clients who incur costs greater than a certain threshold amount through a retroactive reconciliation. This would give the BHOs less risk in serving a population for which the expenditure pattern is uncertain at this time.

To estimate the amount paid in reconciliations, the Department assumes that it would pay 27.62% of the adults without dependent children capitation rate in retroactive reconciliation payments, and that it will make those payments every half year. This percentage was calculated using actual encounter data for disabled individuals through 64 and low income adults, since the Department assumes that the costs of the adults without dependent children will reflect incurred by these two eligibility categories. The Department analyzed current encounter data to estimate the amount of expenditure over the threshold amount that would be incurred by the new population. This amount was then averaged over the 10,000 adults without dependent children to determine the percentage of the capitation rate that would be paid retroactively.

EXHIBIT JJ - EXPANSION POPULATIONS

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Colorado Health Care Affordability Act (HB 09-1293) and other bills to the Medicaid Mental Health Community Programs. This exhibit presents projected caseload and costs itemized by eligibility category for the current year and the request year. Note that the caseloads shown are the average monthly number over each year and will fluctuate throughout the year.

Tobacco Tax Bill

HB 05-1262 established a number of funds, two of which provide funding to the Medicaid Mental Health Community Programs line: the Health Care Expansion Fund administered by the Department; and the Prevention, Early Detection, and Treatment Fund administered by the Department of Public Health and Environment. The Health Care Expansion Fund provided capitated mental health funding for expansion adults, individuals eligible as a result of the removal of the Medicaid asset test, the expansions of the Children's Extensive Support and Children's Home and Community Based Services waiver programs, optional legal immigrants eligible for services as a result of HB 05-1086, and foster care clients eligible for services up to the age of 21 as a result of beginning SB 07-002. The Health Care Expansion Fund became insolvent in FY 2010-11. Any additional revenue that comes into the fund will be used to offset General Fund expenditure in Medical Services Premiums; effective in FY 2011-12, there are no longer any mental health services funded by the Health Care Expansion Fund.

The Prevention, Early Detection, and Treatment Fund provides funding for cancer treatment through its Breast and Cervical Cancer Treatment program, and historically 30% of the Breast and Cervical Cancer Program caseload is paid for out of this fund. The Department is requesting a change to the allocation of traditional and expansion clients in FY 2012-13 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program is $1,215,340. The Department requested $1,215,340 in reappropriated funds for Breast and Cervical Cancer Program expansion clients in request S-1, "Request for Medical Services Premiums." As this is the total balance of available reappropriated funds, the Department is requesting to fund all Breast and Cervical Cancer Program clients in the Medicaid Mental Health Community Programs Long Bill Group from the Breast and Cervical Cancer Prevention and Treatment Fund and General Fund.

Colorado Health Care Affordability Act

HB 09-1293, the "Colorado Health Care Affordability Act" provided health care coverage for more than 100,000 uninsured Coloradans in FY 2009-10 and beyond. The Department began collecting fees from hospitals in April 2010 for the Hospital Provider Fee cash fund and started extending benefits to expansion clients in May 2010.

The first expansion population to be affected by HB 09-1293 is the expansion adult population with income limits up to 100% of the federal poverty level. The Department assumes that the costs for this population will be the same as for the traditional population as the vast majority of mental health services payments are made via capitation and do not change based on client utilization. An additional population will be added in FY 2011-12 consisting of disabled individuals with income limits up to 450% of the federal poverty line. As with adults, the Department assumes that the costs for this population will be the same as for the traditional population.

The Department is also expanding eligibility to cover adults without dependent children in FY 2011-12. The program will initially be limited to 10,000 clients. This population will receive the full range of mental health services provided by the BHOs, and the BHOs will be paid at a different capitation rate for these members than any of its other eligibility categories. The Department anticipates that it will also make reconciliation payments periodically to ensure that the BHOs are reimbursed for the true costs of this population, as there is no encounter data with which to set the initial rate. This methodology is described in Exhibit II.

The Department's caseload projections for all HB 09-1293 expansion populations are provided in this Budget Request (see exhibit B in Medical Services Premiums).

Aligning Medicaid Eligibility for Children and Eligibility for Pregnant Women in Medicaid

SB 11-008, "Aligning Medicaid Eligibility for Children," extends Medicaid eligibility to up to 133% of the federal poverty line for all children under the age of 19. Formerly, the eligibility limit for children ages 7 to 18 was 100%, and it was 133% for children 6 and under. The bill shifts impacted children from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for the Children's Basic Health Plan. As with most of the Hospital Provider Fee populations, the Department assumes that the per capita costs for this expansion population will be the same as for the traditional population since the majority of mental health expenditure is paid through the capitation program.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extends Medicaid eligibility from 133% to 185% of the federal poverty line for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from the Children's Basic Health Plan to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate and that the per capita costs will be the same as for the traditional population.

(B) OTHER MEDICAID MENTAL HEALTH PAYMENTS

All Medicaid Mental Health Community Programs payments which are not part of the capitation payments are under this Long Bill group as Mental Health Fee-For-Service Payments.

EXHIBIT KK - MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS

Medicaid Mental Health Fee-for-Service Payments is a separate budget line item in Medicaid Mental Health Community Programs. Expenditures for this line are shown in Exhibit KK. The data from Exhibit KK also appears in Exhibits AA, BB, and CC as well as the Schedule 13.

The Medicaid Mental Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a behavioral health organization to receive mental health services or enrolled Medicaid clients to receive mental health services not covered by the behavioral health organizations. The services are not covered either because the client is not enrolled in a behavioral health organization or the services are outside the scope of the behavioral health organization contract. Medicare crossover claims are included in the fee-for-service category; these are behavioral health organization covered services for clients enrolled in a behavioral health organization who are eligible for both Medicare and Medicaid.

Fee-for-service providers include, but are not limited to hospitals, psychiatrists, psychologists, primary care physicians, and mental health centers. The State also reimburses providers through fee-for-service if either the diagnosis or the procedure is not included in the behavioral health organization contract or the patient is not enrolled in a behavioral health organization.

History and Background Information

The nature of Medicaid Mental Health Fee-for-Service Payments has changed in recent years. Prior to FY 2002-03, Fee-for-Service Payments were included in the Medicaid Mental Health Capitation base appropriation. During FY 2002-03, case management services provided by community mental health centers were included in the Mental Health Fee-for-Service Payments appropriation. During FY 2003-04, case management services were provided by Single Entry Point agencies and were still part of the Mental Health Fee-for-Service Payments appropriation, but they were moved to the Medical Services Premiums appropriation in FY 2004-05. Also during FY 2004-05, fee-for-service mental health care for developmentally disabled clients living in Regional Centers was transferred from the Department of Human Services to the Department's Mental Health Fee-for-Service Payments appropriation. The changes to case management services and mental health care for developmentally disabled clients are discussed below.

Historically, community mental health centers provided case management services to the Children's Home and Community Based Services for the Mentally Ill waiver clients on a fee-for-service basis. Effective July 1, 2003, the Department began utilizing contracted Single Entry Point agencies for these services instead of the community mental health centers. Funding for these case management services remained in the fee-for-service payments appropriation for FY 2003-04. However, since Single Entry Point contracts are customarily paid from the Medical Services Premiums, the Department requested that these services be transferred to the Medical Services Premiums Long Bill group. The supplemental appropriation to the Department (SB 05-112) moved Single Entry Point case management from the Mental Health Fee-for-Service Payments line item to the Medical Services Premiums line item in FY 2004-05 and was effective July 1, 2004.

The supplemental appropriation to the Department (SB 05-112) also authorized the transfer of the fee-for-service mental health care for developmentally disabled clients living in Regional Centers from the Department of Human Services to the Department. This followed a September 3, 2004 1331 Supplemental which was approved by the Joint Budget Committee on September 21, 2004 for the transfer of funds from the Department of Human Services for Developmental Disability State Plan services. This action funded State Plan services provided to clients in the Developmentally Disabled waiver for Children's Home and Community Based Services as required by the Centers for Medicare and Medicaid Services, effective October 1, 2004.

The expenditures in Exhibit KK are broken out into the three major categories which make up Medicaid Mental Health Fee-for-Service: inpatient services, outpatient services, and physician services.

Current Calculations

The current fiscal year's total estimated expenditure is based on the actual expenditures made year to date, trended forward based upon the expected change in caseload from the first half of the year to the second half of the year. The request year estimate is the result of a forward trend of the current year estimate by the factor of the anticipated change in caseload, and this is then trended forward by the anticipated change in caseload for the out year estimate.

No rate or utilization increases are forecasted, although the Department is currently investigating the feasibility and necessity of incorporating such adjustments. Mental health fee-for-service expenditure has increased drastically over previous years. The Department has been performing data analysis using fee-for-service claims in an attempt to determine what caused the increase and whether or not it will continue to grow in the future. In the process, the Department discovered that there was an error in the MMIS in which certain services billed as fee-for-service claims for BHO-enrolled clients are paying when they should be denied by the MMIS and billed to the appropriate BHO. This error was corrected through a system change effective November 2011. Initial data analysis since November shows that there was a decline in the expenditure paid as mental health fee-for-service due to the system change. The

Department will continue to monitor its impact as more data becomes available over time and may request for a decrease in its appropriation if the expenditure decreases as expected through the standard budget process.

EXHIBIT LL - GLOBAL REASONABLENESS TEST FOR MENTAL HEALTH CAPITATION PAYMENTS

The Global Reasonableness Test presented in Exhibit LL compares the percent change between mental health capitation expenditures as reported in Exhibit DD and forecasted in Exhibit EE. The FY 2011-12 appropriation is 8.50% higher than FY 2010-11 actual expenditures, primarily due to caseload growth. The FY 2011-12 estimate incorporates increased caseload projections along with various rate adjustments for budget cutting initiatives and results in a 9.56% increase from FY 2010-11 actual expenditures and a 0.98% increase from the current appropriation. The FY 2012-13 estimate is built on the FY 2011-12 estimate and presents a 13.60% expenditure increase. This increase is primarily due to 1) increased caseload projections for traditional clients; 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations; and 3) adding adults without dependent children mental health expenditure to the Mental Health Community Programs request. The FY 2012-13 request represents a 14.71% increase over the current FY 2011-12 appropriation. The FY 2013-14 Budget Request is built on the FY 2012-13 estimate and presents an 12.15% expenditure increase over the FY 2012-13 request and a 28.65% increase over the FY 2011-12 appropriation.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: CBMS Improvements in FY 2011-12 and FY 2013-14

Priority Number: S-14

Dept. Approval by: John Bartholomew 2/10/12 Date

OSPB Approval by: 2/15/12 Date

- Decision Item FY 2012-13
- Base Reduction Item FY 2012-13
- ✓ Supplemental FY 2011-12
- Budget Amendment FY 2013-14

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$34,877,701	$13,283,246	$35,613,602	$0	$4,878,412
	FTE	313.0	11.0	313.5	0.0	11.0
	GF	$13,799,440	$6,128,387	$14,353,012	$0	$2,029,269
	GFE	$0	$0	$0	$0	$0
	CF	$2,443,506	$19,229	$2,387,775	$0	$6,015
	RF	$481,149	$997,655	$485,210	$0	$810,858
	FF	$18,153,606	$6,137,975	$18,387,605	$0	$2,032,270
(1) Executive Director's Office; (A) General Administration, Personal Services	Total	$21,290,686	$825,119	$21,847,209	$0	$707,245
	FTE	313.0	11.0	313.5	0.0	11.0
	GF	$7,675,241	$0	$7,954,067	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$1,974,533	$0	$2,058,349	$0	$0
	RF	$448,289	$825,119	$380,410	$0	$707,245
	FF	$11,192,623	$0	$11,454,383	$0	$0
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	Total	$2,024,577	$56,737	$1,970,066	$0	$48,631
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$627,749	$0	$725,970	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$255,164	$0	$159,483	$0	$0
	RF	$0	$56,737	$49,661	$0	$48,631
	FF	$1,141,664	$0	$1,034,952	$0	$0
(1) Executive Director's Office; (A) General Administration, Short-term Disability	Total	$32,188	$1,309	$39,128	$0	$1,122
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$12,334	$0	$15,826	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$2,503	$0	$2,957	$0	$0
	RF	$0	$1,309	$629	$0	$1,122
	FF	$17,351	$0	$19,716	$0	$0
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	Total	$532,854	$26,194	$707,419	$0	$22,815
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$190,728	$0	$286,121	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$53,148	$0	$53,468	$0	$0
	RF	$0	$26,194	$11,380	$0	$22,815
	FF	$288,978	$0	$356,450	$0	$0
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	Total	$427,325	$23,500	$607,938	$0	$20,596
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$151,785	$0	$245,885	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$42,482	$0	$45,949	$0	$0
	RF	$0	$23,500	$9,780	$0	$20,596
	FF	$233,058	$0	$306,324	$0	$0

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
(1) Executive Director's Office; (A) General Administration, Operating Expenses	Total	$1,586,232	$64,796	$1,546,560	$0	$10,449
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$679,994	$0	$708,357	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$101,248	$0	$53,049	$0	$0
	RF	$13,461	$64,796	$13,461	$0	$10,449
	FF	$791,529	$0	$771,693	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System[a]	Total	$8,983,839	$12,285,591	$8,895,282	$0	$4,067,554
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,461,609	$6,128,387	$4,416,786	$0	$2,029,269
	GFE	$0	$0	$0	$0	$0
	CF	$14,428	$19,229	$14,520	$0	$6,015
	RF	$19,399	$0	$19,889	$0	$0
	FF	$4,488,403	$6,137,975	$4,444,087	$0	$2,032,270

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:** [a]**Funding remaining by June 20, 2012 may be rolled over to FY 2012-13. The M Headnote does not apply during FY 2011-12, FY 2012-13, FY 2013-14.**

See attached tables for CF and RF adjsutments.

Cash or Federal Fund Name and COFRS Fund Number: CF: Children's Basic Health Plan Trust Fund 11G, Old Age Pension managed by Department of Human Services, FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☑ No: ☐ **Not Required:** ☐

Schedule 13s from Affected Departments: Department of Human Services, Govenor's Office of Information Technology

Other Information:

FY 2011-12	Cash Funds Source			Reappropriated Funds Source	
Long Bill Line	**Total CF**	**CBHP CF**	**OAP**	**RF Total**	**DHS**
(1) Executive Director's Office; (A) General Administration, Personal Services	**$0**	$0	$0	**$825,119**	$825,119
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	**$0**	$0	$0	**$56,737**	$56,737
(1) Executive Director's Office; (A) General Administration, Short-term Disability	**$0**	$0	$0	**$1,309**	$1,309
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	**$0**	$0	$0	**$26,194**	$26,194
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	**$0**	$0	$0	**$23,500**	$23,500
(1) Executive Director's Office; (A) General Administration, Operating Expenses	**$0**	$0	$0	**$64,796**	$64,796
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	**$19,229**	$4,793	$14,436	**$0**	$0
Total of All Lines	**$19,229**	**$4,793**	**$14,436**	**$997,655**	**$997,655**

FY 2013-14	Cash Funds Source			Reappropriated Funds Source	
Long Bill Line	**Total CF**	**CBHP CF**	**OAP**	**RF Total**	**DHS**
(1) Executive Director's Office; (A) General Administration, Personal Services	**$0**	$0	$0	**$707,245**	$707,245
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	**$0**	$0	$0	**$48,631**	$48,631
(1) Executive Director's Office; (A) General Administration, Short-term Disability	**$0**	$0	$0	**$1,122**	$1,122
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	**$0**	$0	$0	**$22,815**	$22,815
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	**$0**	$0	$0	**$20,596**	$20,596
(1) Executive Director's Office; (A) General Administration, Operating Expenses	**$0**	$0	$0	**$10,449**	$10,449
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	**$6,015**	$1,499	$4,516	**$0**	$0
Total of All Lines	**$6,015**	**$1,499**	**$4,516**	**$810,858**	**$810,858**

Colorado Health Care Affordability Act: Outlook FY 2009-10 to FY 2013-14						
		FY 2009-10 Actuals	**FY 2010-11 Actuals**	**FY 2011-12 Request**	**FY 2012-13 Request**	**FY 2013-14 Estimate [6]**
A. Hospital Provider Fee Cash Fund Revenue						
	Actual/Projected Revenue	$340,869,957	$441,057,840	$584,598,059	$641,224,885	$605,685,469
	Interest Earned	$900,117	$1,495,212	$1,981,821	$2,173,789	$2,053,309
	Previous Year's Cash Fund Balance	N/A	$5,714,436	$22,198,436	$17,370,137	$0
	Hospital Provider Fee Cash Funds Available	**$341,770,074**	**$448,267,488**	**$608,778,316**	**$660,768,811**	**$607,738,778**
B. Hospital Provider Fee Cash Fund Expenditures						
	(1) Executive Director's Office - Total Prior to Change Requests	**$1,321,599**	**$2,607,725**	**$9,324,555**	**$10,590,848**	**$12,155,903**
	Personal Services [1]	$704,444	$1,080,269	$1,846,620	$1,826,906	$1,977,846
	Legal Service & Third Party Recovery	$0	$27,998	$58,997	$95,113	$126,461
	Administrative Law Judge Services	$0	$14,305	$24,698	$45,499	$60,439
	Operating Expenses	$114,264	$36,803	$89,807	$41,608	$41,943
	Leased Space	$15,550	$97,790	$151,164	$151,164	$151,164
	General Professional Services and Special Projects	$128,858	$187,118	$337,500	$337,500	$337,500
	Information Technology Contracts [2]	$127,872	$227,415	$1,502,935	$1,449,800	$1,860,365
	Centralized Eligibility Vendor Contract Project	$0	$0	$964,169	$2,129,467	$3,206,328
	Customer Outreach	$5,852	$40,252	$56,109	$71,333	$75,935
	Medicaid Identification Cards	$0	$0	$0	$0	$0
	County Administration	$219,259	$880,251	$1,180,751	$1,290,536	$1,286,413
	Contracts for Special Eligibility Determinations	$0	$0	$2,801,268	$2,801,268	$2,647,808
	Professional Services Contracts	$5,500	$15,524	$60,537	$100,654	$133,701
	Professional Audit Contracts	$0	$0	$250,000	$250,000	$250,000
	Bottom-Line Adjustments	$0	$0	$1,290,521	$21,576	$21,576
	(1) Executive Director's Office - Total After Change Requests [3]	**$1,321,599**	**$2,607,725**	**$10,615,076**	**$10,612,424**	**$12,177,479**
	(2) Medical Service Premiums - Total Prior to Change Requests	**$130,563,456**	**$222,581,531**	**$355,543,816**	**$441,535,239**	**$411,443,016**
	Expansion Populations	$1,212,200	$34,324,731	$48,529,023	$115,990,338	$85,898,115
	Supplemental Payments to Hospitals	$129,351,256	$188,256,800	$307,014,793	$325,544,901	$325,544,901
	Bottom-Line Adjustments	$0	$0	($65,044)	($254,643)	($345,955)
	(2) Medical Services Premiums Request- Total After Change Request [3]	**$130,563,456**	**$222,581,531**	**$355,478,772**	**$441,280,593**	**$411,097,061**
	(3) Medicaid Mental Health Community Programs - Total Prior to Change Requests	**$321,539**	**$3,843,622**	**$5,722,911**	**$12,840,644**	**$11,529,532**
	Expansion Populations	$321,539	$3,843,622	$5,722,911	$12,840,644	$11,529,532
	Bottom-Line Adjustments	$0	$0	$0	$774,099	$1,214,729
	(3) Mental Health Request - Total After Change Request [3]	**$321,539**	**$3,843,622**	**$5,722,911**	**$13,614,743**	**$12,744,261**
	(4) Indigent Care Program - Total Prior to Change Requests [4]	**$124,429,144**	**$135,692,180**	**$153,046,277**	**$154,703,956**	**$156,180,272**
	Children's Basic Health Plan Administration	$0	$6,974	$8,692	$9,361	$9,361
	Expansion Populations	$61,047	$4,817,287	$8,650,652	$11,166,829	$12,643,145
	Supplemental Payments to CICP Providers	$124,368,097	$130,867,920	$144,386,933	$143,527,766	$143,527,766
	Bottom-Line Adjustments	$0	$0	($2,468)	($221,413)	($254,030)
	(4) Indigent Care Program- Total After Change Request [3]	**$124,429,144**	**$135,692,180**	**$153,043,809**	**$154,482,543**	**$155,926,242**
	(6) Department of Human Services Medicaid Funded Programs - Total Prior to Change Requests	**$19,900**	**$0**	**$114,591**	**$71,485**	**$86,715**
	DHS: Colorado Benefits Management System	$19,900	$0	$114,591	$71,485	$86,715
	Bottom-Line Adjustments	$0	$0	$733,020	$7,020	$7,020
	(6) Department of Human Services Medicaid Funded Programs - Total After Change Requests [3]	**$19,900**	**$0**	**$847,611**	**$78,505**	**$93,735**
C. Other Expenditures		**$41,400,000**	**$61,343,993**	**$65,700,000**	**$40,700,000**	**$15,700,000**
	General Fund Relief	$41,400,000	$53,493,993	$50,000,000	$25,000,000	$0
	CICP General Fund	$0	$7,850,000	$15,700,000	$15,700,000	$15,700,000
D. Provider Refunds		**$38,000,000**	**$0**	**$0**	**$0**	**$0**
E. Base Total Fund Hospital Provider Fee Expenditures - Prior to Change Requests		**$675,819,346**	**$902,424,375**	**$1,123,310,613**	**$1,294,755,498**	**$1,346,339,274**
	Total Change Requests: Total Funds	**$0**	**$0**	**$3,783,199**	**$342,826**	**$958,979**
	Final Total Fund Hospital Provider Fee Expenditures After Change Requests	**$675,819,346**	**$902,424,375**	**$1,127,093,812**	**$1,295,098,324**	**$1,347,298,253**
F. Base Hospital Provider Fee Expenditures Total Prior to Change Requests		**$336,055,638**	**$426,069,051**	**$589,452,150**	**$660,442,172**	**$607,095,438**
	Total Change Requests: Hospital Provider Fee Cash Funds	**$0**	**$0**	**$1,956,029**	**$326,639**	**$643,340**
	Final State Share After Change Requests: Hospital Provider Fee Cash Funds	**$336,055,638**	**$426,069,051**	**$591,408,179**	**$660,768,811**	**$607,738,778**
G. Cash Fund Reserve Balance [5]		**$5,714,436**	**$22,198,436**	**$17,370,137**	**$0**	**$0**

Notes for Hospital Provider Fee Cash Fund: Outlook FY 2009-10 to FY 2013-14

[1] The "Personal Services" line item consists of the following appropriations: Personal Services; Health, Life, and Dental; Short-Term Disability; Amortization Equalization Disbursement; and Supplemental Amortization Equalization Disbursement.

[2] The FY 2011-12 estimated expenditure for the "Information Technology Contracts" line item includes a $1,087,619 Total Funds rollforward from FY 2010-11, so will not match the year-to-date appropriations.

[3] Long Bill Group totals for projected Hospital Provider Fee Cash Fund expenditures incorporate Change Requests. For more detail on the specific requests affecting Hospital Provider Fee Cash Fund expenditures, please refer to the Schedule 9 submitted with the Department's November 1, 2011, FY 2012-13 Budget Request.

[4] The Total Prior to Change Requests for the Indigent Care Program Long Bill Group will not match that shown in the Indigent Care Program Expansions table of this report, as this summary includes the Children's Basic Health Plan Administration costs while the Expansion Populations table does not.

[5] The Department was granted authority by the Hospital Provider Fee Oversight and Advisory Board to create and maintain a reserve fund using unspent Hospital Provider Fee cash funds, although this policy is subject to annual reconsideration.

[6] Long Bill Group totals for FY 2013-14 will not match figures presented in the Schedule 9, which assumes constant expenditures after FY 2012-13. The population expenditures presented in this document are estimated separately throughout the forecast period.

	Medical Services Premiums - Rate, Caseload, and Expenditure Forecast					
		FY 2009-10 Actuals	**FY 2010-11 Actuals**	**FY 2011-12 Request**	**FY 2012-13 Request**	**FY 2013-14 Estimate [5]**
Medicaid Parents to 100% of the Federal Poverty Level [1]						
1	Per Capita Cost [2]	$748.73	$2,284.86	$2,540.84	$2,667.16	$2,688.71
2	% Change Over Prior Year	N/A	205.17%	11.20%	4.97%	0.81%
3	Caseload [2]	3,238	27,166	35,406	42,381	46,835
4	% Change Over Prior Year	N/A	738.97%	30.33%	19.70%	10.51%
5	**Total Fund Expenditures**	**$2,424,399**	**$68,649,463**	**$89,960,981**	**$113,036,908**	**$125,925,732**
6	**Cash Fund Expenditures**	**$1,212,200**	**$34,324,731**	**$44,980,492**	**$56,518,453**	**$31,481,434**
Buy-In Program for Individuals with Disabilities						
7	Per Capita Cost [3]	$0.00	$0.00	$9,764.90	$10,639.92	$11,069.97
8	% Change Over Prior Year	N/A	N/A	N/A	8.96%	4.04%
9	Per Client Premiums Contribution: Disabled Buy-In Cash Fund	$0.00	$0.00	$2,551.29	$2,052.52	$1,893.93
10	Effective Per Capita Cost	$0.00	$0.00	$7,213.60	$8,587.41	$9,176.04
11	Caseload [2]	0	0	58	2,208	5,671
12	% Change Over Prior Year	N/A	N/A	N/A	3706.90%	156.84%
13	**Total Fund Expenditures**	**$0**	**$0**	**$566,364**	**$23,492,951**	**$62,777,782**
14	**Cash Fund Expenditures - Hospital Provider Fee Cash Fund**	**$0**	**$0**	**$235,431**	**$10,305,385**	**$28,074,881**
15	**Cash Fund Expenditures - Medicaid Buy-In Cash Fund [4]**	**$0**	**$0**	**$147,975**	**$4,531,955**	**$10,740,500**
Adults without Dependent Children to 100% of the Federal Poverty Level						
16	Per Capita Cost [3]	$0.00	$0.00	$3,974.93	$9,833.30	$10,536.72
17	% Change Over Prior Year	N/A	N/A	N/A	147.38%	7.15%
18	Caseload [2]	0	0	1,667	10,000	10,000
19	% Change Over Prior Year	N/A	N/A	N/A	499.88%	0.00%
20	**Total Fund Expenditures**	**$0**	**$0**	**$6,626,200**	**$98,333,000**	**$105,367,200**
21	**Cash Fund Expenditures**	**$0**	**$0**	**$3,313,100**	**$49,166,500**	**$26,341,800**
22	**Expansion Populations Total Funds Expenditures**	**$2,424,399**	**$68,649,463**	**$97,153,545**	**$234,862,859**	**$294,070,714**
23	**Expansion Populations Hospital Provider Fee Cash Funds Expenditures**	**$1,212,200**	**$34,324,731**	**$48,529,023**	**$115,990,338**	**$85,898,115**
24	**Supplemental Payments to Hospitals - Total Fund Expenditures**	**$312,468,739**	**$455,348,284**	**$614,029,587**	**$651,089,802**	**$651,089,802**
25	**Supplemental Payments to Hospitals - Hospital Provider Fee Cash Fund Expenditures**	**$129,351,256**	**$188,256,800**	**$307,014,793**	**$325,544,901**	**$325,544,901**
Total Fund Hospital Provider Fee Expenditures (Row 22 + Row 24)		**$314,893,138**	**$523,997,747**	**$711,183,132**	**$885,952,661**	**$945,160,516**
State Share: Hospital Provider Fee Cash Funds (Row 23 + Row 25)		**$130,563,456**	**$222,581,531**	**$355,543,816**	**$441,535,239**	**$411,443,016**

Notes for Medical Services Premiums - Rate, Caseload, and Expenditure Forecast

[1] Expenditures for the Medicaid Parents to 100% FPL expansion are not eligible for enhanced Federal Financial Participation until January 2014, at which time eligibility under Medicaid for this population is mandated under federal health care reform.

[2] Projected caseload and per capita expenditures for the Medicaid Parents to 100% FPL population are taken from Exhibit J of the Department's FY 2012-13 February 15, 2012 S-1. Caseload estimates for the Buy-In Program for Individuals with Disabilities are based on American Community Survey uninsured estimates analyzed by the Colorado Health Institute. The caseload estimates for the Adults without Dependent Children is annual average of the enrollment cap of 10,000 in the program. In January 2014, the Department is required to expand eligibility for the Parents to 100% and AwDC populations to 133% FPL, however these caseload estimates do not reflect that increase. In the Department's November 1, 2012 Budget submission, the Department will provide caseload estimates up to that level along with other impacts of the federal Affordable Care Act (ACA).

[3] The per capita cost for the Buy-In Program for Individuals with Disabilities is lower than that for the Disabled Individuals to 59 population as the Department assumes that there will be fewer higher cost children in the program, enrollees will have lower utilization of high cost Long-Term Care Services, and many will be dually-eligible for Medicare. The per capita cost for the Adults without Dependent Children was developed using a weighting system and claims data of the Department's Disabled Individuals to 59 and Expansion Adults to 60% FPL populations.

[4] The Medicaid Buy-In Cash Fund expenditures are based on the Medicaid Buy-In Program for Working Adults with Disabilities premium schedule approved by the Medical Services Board and the estimated premium schedule for the Medicaid Buy-in program for Children with Disabilities. These expenditures are not eligible for a federal match.

[5] The FY 2013-14 fund split incorporates the 100% federal match provided under the Affordable Care Act beginning in CY 2014 for the Medicaid Parents to 100% and Adults without Dependent Children populations.

	Medicaid Mental Health - Rate, Caseload, and Expenditure Forecast					
		FY 2009-10 Actuals	FY 2010-11 Actuals	FY 2011-12 Request	FY 2012-13 Request	FY 2013-14 Estimate[2]
Medicaid Parents to 100% of the Federal Poverty Level						
1	Per Capita Cost [1]	$233.86	$281.78	$278.22	$286.97	$297.15
2	% Change Over Prior Year	N/A	20.49%	-1.26%	3.14%	3.55%
3	Caseload[1]	3,238	27,166	35,406	42,381	46,835
4	% Change Over Prior Year	N/A	738.97%	30.33%	19.70%	10.51%
5	**Total Fund Expenditures**	**$643,078**	**$7,687,244**	**$9,850,657**	**$12,162,076**	**$13,917,020**
6	**Cash Fund Expenditures**	**$321,539**	**$3,843,622**	**$4,925,328**	**$6,081,038**	**$3,479,255**
Buy-In Program for Individuals with Disabilities						
7	Per Capita Cost [1]	$0.00	$0.00	$1,790.10	$1,846.10	$1,950.03
8	% Change Over Prior Year	N/A	N/A	N/A	3.13%	5.63%
9	Caseload[1]	0	0	58	2,208	5,671
10	% Change Over Prior Year	N/A	N/A	N/A	3706.90%	156.84%
11	**Total Fund Expenditures**	**$0**	**$0**	**$103,826**	**$4,076,189**	**$11,058,620**
12	**Cash Fund Expenditures**	**$0**	**$0**	**$51,913**	**$2,038,094**	**$5,529,310**
Adults without Dependent Children to 100% of the Federal Poverty Level						
13	Per Capita Cost[1]	$0.00	$0.00	$894.63	$944.30	$1,008.39
14	% Change Over Prior Year	N/A	N/A	N/A	5.55%	6.79%
15	Caseload[1]	0	0	1,667	10,000	10,000
16	% Change Over Prior Year	N/A	N/A	N/A	499.88%	0.00%
17	**Total Fund Expenditures**	**$0**	**$0**	**$1,491,341**	**$9,443,024**	**$10,083,870**
18	**Cash Fund Expenditures**	**$0**	**$0**	**$745,670**	**$4,721,512**	**$2,520,967**
19	**Expansion Populations Total Funds Expenditures**	**$643,078**	**$7,687,244**	**$11,445,824**	**$25,681,289**	**$35,059,510**
20	**Expansion Populations Hospital Provider Fee Cash Funds Expenditures**	**$321,539**	**$3,843,622**	**$5,722,911**	**$12,840,644**	**$11,529,532**

Notes for Medicaid Mental Health - Rate, Caseload, and Expenditure Forecast

[1] Caseload projections are the same as those in the Medical Services Premiums exhibit. Projected per capita expenditures for the above populations are taken from the Department's FY 2012-13 February 15, 2012 S-2, Exhibit DD.

[2] The FY 2013-14 fund split incorporates the 100% federal match provided under the Affordable Care Act beginning in CY 2014 for the Medicaid Parents to 100% and Adults without Dependent Children populations

	Indigent Care Program Expansions - Rate, Caseload, and Expenditure Forecast					
		FY 2009-10 Actuals	**FY 2010-11 Actuals**	**FY 2011-12 Request**	**FY 2012-13 Request**	**FY 2013-14 Estimate**
Children's Basic Health Plan Children's Medical and Dental Premiums from 205-250% of the Federal Poverty Level						
1	Per Capita Cost [1]	$986.38	$2,398.67	$2,298.14	$2,407.52	$2,510.20
2	% Change Over Prior Year	N/A	143.18%	-4.19%	4.76%	4.26%
3	Enrollment [1]	136	4,023	7,891	9,785	10,737
4	% Change Over Prior Year	N/A	2858.09%	96.15%	24.00%	9.73%
5	**Total Fund Expenditures**	**$133,498**	**$9,628,000**	**$18,134,623**	**$23,557,583**	**$26,952,017**
6	**Cash Fund Expenditures [2]**	**$46,724**	**$3,369,800**	**$6,439,985**	**$8,360,318**	**$9,559,552**
Children's Basic Health Plan Prenatal Costs from 205-250% of the Federal Poverty Level						
7	Per Capita Cost [1]	$3,383.51	$15,199.81	$15,256.50	$15,973.31	$16,654.57
8	% Change Over Prior Year	N/A	349.23%	0.37%	4.70%	4.26%
9	Enrollment [1]	11	272	414	502	529
10	% Change Over Prior Year	N/A	2372.73%	52.21%	21.26%	5.38%
11	**Total Fund Expenditures**	**$37,219**	**$4,134,349**	**$6,316,191**	**$8,018,602**	**$8,810,268**
12	**Cash Fund Expenditures [2]**	**$13,027**	**$1,447,022**	**$2,210,667**	**$2,806,511**	**$3,083,593**
Children's Basic Health Plan Dental Costs from 205-250% of the Federal Poverty Level [3]						
13	Per Capita Cost	$27.23	N/A	N/A	N/A	N/A
14	% Change Over Prior Year	N/A	N/A	N/A	N/A	N/A
15	Enrollment	136	N/A	N/A	N/A	N/A
16	% Change Over Prior Year	N/A	N/A	N/A	N/A	N/A
17	**Total Fund Expenditures**	**$3,703**	N/A	N/A	N/A	N/A
18	**Cash Fund Expenditures**	**$1,296**	N/A	N/A	N/A	N/A
19	**Expansion Populations Total Fund Expenditures**	**$174,419**	**$13,762,349**	**$24,450,814**	**$31,576,185**	**$35,762,285**
20	**Expansion Populations Cash Funds Expenditures**	**$61,047**	**$4,816,822**	**$8,650,652**	**$11,166,829**	**$12,643,145**
21	**Safety Net Provider Payments: Supplemental Payments to Hospitals-Total Fund Expenditures**	**$248,736,194**	**$289,889,142**	**$288,773,866**	**$287,055,532**	**$287,055,532**
22	**Safety Net Provider Payments: Supplemental Payments to Hospitals-Hospital Provider Fee Cash Fund Expenditures**	**$124,368,097**	**$130,867,920**	**$144,386,933**	**$143,527,766**	**$143,527,766**
Total Fund Hospital Provider Fee Expenditures (Row 19 + Row 21)		**$248,910,613**	**$303,651,491**	**$313,224,680**	**$318,631,717**	**$322,817,817**
State Share: Hospital Provider Fee Cash Funds (Row 20 + Row 22)		**$124,429,144**	**$135,684,742**	**$153,037,585**	**$154,694,595**	**$156,170,911**

Notes for Children's Basic Health Plan Expansion - Rate, Caseload, and Expenditure Forecast

[1] Per capita costs and caseload figures for the Children's Basic Health Planare taken from Exhibits C.2 and C.3 in the Department's November 1, 2011 FY 2012-13 R-3.

[2] Children's Basic Health Plan expenditures receive an enhanced federal match rate of 65%. Enrollment fees are included in the Cash Fund Expenditures shown, but are not eligible for a federal match. Please refer to Exhibits C.2 and C.3 in the Department's November 1, 2011 FY 2012-13 R-3 for more details on the cash fund splits.

[3] For FY 2010-11 forward, the Children's Basic Health Plan Medical and Dental Benefits costs were consolidated into one line item in the Department's budget.

Health Care Expansion Fund: Outlook FY 2007-08 to FY 2013-14

	FY 2007-08 Actuals	FY 2008-09 Actuals	FY 2009-10 Actuals	FY 2010-11 Actuals	FY 2011-12 Estimate	FY 2012-13 Estimate	FY 2013-14 Estimate
A. Tobacco Tax Revenues							
Tax Revenue[1]	$162,987,630	$159,334,567	$148,454,086	$145,575,930	$145,879,017	$145,060,921	$143,708,041
B. Health Care Expansion Fund							
Transfer (46%)	$74,974,310	$73,293,901	$68,288,879	$66,964,928	$67,104,348	$66,728,024	$66,105,699
Interest Earned[2]	$6,535,878	$4,589,248	$2,788,748	$1,580,284	$162,490	$160,147	$158,654
Health Care Expansion Funds Available	$81,510,188	$77,883,149	$71,077,627	$68,545,212	$67,266,838	$66,888,171	$66,264,353
General Fund Transfers[3]	$0	$0	($7,377,996)	($1,580,284)	($162,490)	$0	$0
Net Health Care Expansion Funds Available to Support Program Expenses	**$81,510,188**	**$77,883,149**	**$63,699,631**	**$66,964,928**	**$67,104,348**	**$66,888,171**	**$66,264,353**
C. Health Care Expansion Fund Reserve Balance							
Previous Year's Reserve Fund Ending Balance	$94,635,520	$130,653,130	$119,601,623	$79,234,953	$100,000	$0	$0
Beginning Health Care Expansion Fund Reserve Balance	$130,653,130	$135,721,615	$119,601,623	$79,234,953	$100,000	$0	$0
Fund Required from the Reserve Balance in the Current Year	$0	$16,119,995	$40,366,669	$79,134,953	$100,000	$0	$0
Health Care Expansion Fund Year-End Reserve Balance	**$130,653,130**	**$119,601,623**	**$79,234,953**	**$100,000**	**$0**	**$0**	**$0**
D. Health Care Expansion Fund Expenditures							
(1) Executive Director's Office[4]	**$482,729**	**$550,255**	**$964,806**	**$921,799**	**$0**	**$0**	**$0**
(2) Medical Service Premiums	**$56,072,286**	**$69,577,006**	**$65,813,605**	**$65,532,641**	**$86,359,826**	**$92,645,736**	**$97,695,457**
(3) Medicaid Mental Health Community Programs	**$4,300,041**	**$5,202,175**	**$6,047,643**	**$5,680,612**	**$7,947,523**	**$8,774,692**	**$9,485,425**
(4) Indigent Care Program	**$15,005,337**	**$18,093,822**	**$30,037,096**	**$25,708,044**	**$20,297,666**	**$16,337,391**	**$4,513,872**
Children's Basic Health Plan Administration and Outreach	$518,545	$540,000	$326,951	$198,392	$0	$0	$0
Children's Basic Health Plan Premium and Dental Costs (FY 2010-11 Forward)	$13,653,510	$16,517,591	$28,318,710	$25,509,652	$20,297,666	$16,337,391	$4,513,872
Children's Basic Health Plan Dental Benefit Costs	$833,282	$1,036,231	$1,391,435	$0	$0	$0	$0
(6) Department of Human Services Medicaid Funded Programs	**$581,310**	**$579,886**	**$541,738**	**$568,907**	**$640,000**	**$640,000**	**$640,000**
General Fund Transfers[3]	**$0**	**$0**	**$661,413**	**$47,687,878**	**$0**	**$0**	**$0**
E. Total Health Care Expansion Fund Expenditures/Need[5]	**$76,441,703**	**$94,003,144**	**$104,066,301**	**$146,099,880**	**$115,245,014**	**$118,397,819**	**$112,334,754**
F. Health Care Expansion Fund Populations Funding Shortfall	**$0**	**$0**	**$0**	**$0**	**$48,040,667**	**$51,509,648**	**$46,070,401**
G. Health Care Expansion Fund Reserve Balance - Increase / (Decrease)	**$5,068,485**	**($16,119,995)**	**($40,366,669)**	**($79,134,953)**	**($48,140,667)**	**($51,509,648)**	**($46,070,401)**

Notes for Health Care Expansion Fund: Outlook FY 2007-08 to FY 2013-14

[1] Tobacco Tax revenue projections are taken from the December 2011 Amendment 35 Revenue Forecast published by Legislative Council.

[2] The interest rate used to project earnings for the fund is equal to the interest rate received in December 2011. Per SB 09-270, all interest earned on the balance of the Health Care Expansion Fund during FY 2008-09 through FY 2011-12 shall be transferred to the General Fund. The FY 2008-09 earned interest was not transferred to the General Fund until FY 2009-10.

[3] General Fund transfers for FY 2009-10 thru FY 2011-12 consists of the interest income earned, however FY 2009-10 also consists of an additional $1,293,900 which was transferred to the Medical Services Premiums line item, and a net amount of $3,956,761 due to audit adjustments. For FY 2010-11, the General Fund transfer also includes an amount of $47,687,878 to avoid payment delays.

[4] The Executive Director's Office appropriation was eliminated for FY 2011-12 forward pursuant to SB 11-209.

[5] For FY 2011-12 forward, the expenditures for Long Bill groups 2,3, and 4 are an estimate of what would be needed to support the expansion populations shown on Page R-2 of this Update.

[6] The impact of enhanced Federal Medical Assistance Percentage (FMAP) provided under the American Recovery and Reinvestment Act of 2009 (ARRA) for FY 2008-09 through FY 2010-11 is incorporated into Long Bill Group totals on this page.

	Health Care Expansion Fund Populations Expenditure History and Forecast							
		FY 2007-08 Actual	FY 2008-09 Actual[7]	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12	FY 2012-13	FY 2013-14
	Expansion Adults to 60% FPL[1]							
1	Total Expansion Adults to 60% FPL Medical Services Premiums Expenditures	$19,176,398	$34,055,796	$44,317,318	$60,314,804	$68,184,677	$76,149,713	$81,724,062
2	**Total Expansion Adults to 60% FPL Expansion Fund Expenditures**	**$9,588,199**	**$14,546,082**	**$17,022,282**	**$24,360,064**	**$34,092,339**	**$38,074,857**	**$40,862,031**
3	% Change Over Prior Year	159.92%	77.59%	30.13%	36.10%	13.05%	11.68%	7.32%
4	Total Expansion Adults to 60% FPL Mental Health Expenditures	$2,125,312	$3,111,446	$4,419,081	$5,636,127	$6,691,191	$7,604,131	$8,269,982
5	**Total Expansion Adults to 60% FPL Expansion Fund Expenditures**	**$1,062,656**	**$1,328,976**	**$1,697,424**	**$2,278,368**	**$3,345,596**	**$3,802,066**	**$4,134,991**
6	% Change Over Prior Year	106.61%	46.40%	42.03%	27.54%	18.72%	13.64%	8.76%
	Presumptive Eligibility[2]							
7	Total Presumptive Eligibility Expenditures	$5,983,219	$3,461,490	$2,769,787	$3,494,317	$3,101,780	$3,415,107	$3,516,050
8	**Total Presumptive Eligibility Expansion Fund Expenditures**	**$2,991,609**	**$1,478,489**	**$1,063,875**	**$1,405,319**	**$1,550,890**	**$1,707,553**	**$1,758,025**
9	% Change Over Prior Year	-23.77%	-42.15%	-19.98%	26.16%	-11.23%	10.10%	2.96%
	HB 05-1086 Optional Legal Immigrants[3]							
10	Total Optional Legal Immigrants Medical Services Premiums Expenditures	$12,433,504	$29,261,806	$31,549,557	$33,075,468	$34,111,328	$34,467,082	$34,951,800
11	**Total Optional Legal Immigrants Expansion Fund Expenditures**	**$6,216,752**	**$12,498,449**	**$12,118,185**	**$13,344,279**	**$17,055,664**	**$17,233,541**	**$17,475,900**
12	% Change Over Prior Year	0.00%	135.35%	7.82%	4.84%	3.13%	1.04%	1.41%
13	Total Optional Legal Immigrants Mental Health Expenditures		$1,113,662	$1,301,623	$1,454,268	$1,656,394	$1,830,679	$2,010,922
14	**Total Optional Legal Immigrants Expansion Fund Expenditures**		**$475,673**	**$499,953**	**$587,774**	**$828,197**	**$915,340**	**$1,005,461**
15	% Change Over Prior Year			16.88%	11.73%	13.90%	10.52%	9.85%
	Asset Test Removal - Adults and Children[4]							
16	Total Asset Test Removal Medical Services Premiums Expenditures	$57,260,250	$64,509,474	$66,400,818	$38,021,580	$40,025,868	$43,299,443	$46,401,601
17	**Total Asset Test Removal Expansion Fund Expenditures**	**$28,630,125**	**$27,553,609**	**$25,504,554**	**$15,225,763**	**$20,012,934**	**$21,649,722**	**$23,200,801**
18	% Change Over Prior Year	76.38%	12.66%	2.93%	-42.74%	5.27%	8.18%	7.16%
19	Total Asset Test Removal Mental Health Expenditures	$4,871,984	$5,229,325	$5,950,880	$2,768,660	$3,236,398	$3,730,915	$4,223,592
20	**Total Asset Test Removal Expansion Fund Expenditures**	**$2,435,992**	**$2,233,575**	**$2,285,733**	**$1,106,433**	**$1,618,199**	**$1,865,458**	**$2,111,796**
21	% Change Over Prior Year	48.61%	7.33%	13.80%	-53.47%	16.89%	15.28%	13.21%
	Children's Home- and Community-Based Services (CHCBS)[5]							
22	Total Children's Home- and Community-Based Services Medical Services Premiums Expenditures	$15,636,503	$21,322,871	$20,552,304	$21,823,493	$21,021,824	$21,480,098	$22,103,024
23	**Total Health Care Expansion Fund Expenditures**	**$7,818,252**	**$9,107,531**	**$7,894,140**	**$8,784,174**	**$10,510,912**	**$10,740,049**	**$11,051,512**
24	% Change Over Prior Year	101.94%	36.37%	-3.61%	6.19%	-3.67%	2.18%	2.90%
25	Total Children's Home- and Community-Based Services Mental Health Expenditures	$572,980	$978,282	$992,182	$999,706	$1,010,403	$1,042,032	$1,100,699
26	**Total Health Care Expansion Fund Expenditures**	**$286,490**	**$417,849**	**$381,097**	**$402,637**	**$505,202**	**$521,016**	**$550,350**
27	% Change Over Prior Year	37.01%	70.74%	1.42%	0.76%	1.07%	3.13%	5.63%
	Children's Extensive Support (CES)[5]							
28	Total Children's Extensive Support Medical Services Premiums Expenditures	$1,377,821	$3,288,883	$3,329,475	$3,149,801	$3,043,080	$3,109,440	$3,199,579
29	**Total Children's Extensive Support Expansion Fund Expenditures**	**$688,911**	**$1,404,764**	**$1,278,851**	**$1,265,650**	**$1,521,540**	**$1,554,720**	**$1,599,790**
30	% Change Over Prior Year	68.62%	138.70%	1.23%	-5.40%	-3.39%	2.18%	2.90%
31	Total Children's Extensive Support Mental Health Expenditures	$85,069	$114,920	$117,669	$109,070	$110,237	$113,688	$120,089
32	**Total Children's Extensive Support Expansion Fund Expenditures**	**$42,534**	**$49,085**	**$45,197**	**$43,915**	**$55,119**	**$56,844**	**$60,044**
33	% Change Over Prior Year	-62.15%	35.09%	2.39%	-7.31%	1.07%	3.13%	5.63%
	Expansion Foster Care[6]							
34	Total Expansion Foster Care Medical Services Premiums Expenditures	$276,877	$1,095,770	$2,425,715	$2,900,970	$3,231,095	$3,370,588	$3,494,796
35	**Total Foster Care Expansion Fund Expenditures**	**$138,439**	**$468,031**	**$931,717**	**$1,167,964**	**$1,615,547**	**$1,685,294**	**$1,747,398**
36	% Change Over Prior Year		295.76%	121.37%	19.59%	11.38%	4.32%	3.69%
37	Total Expansion Foster Care Mental Health Expenditures	$944,738	$1,622,720	$2,963,392	$3,138,306	$3,190,419	$3,227,935	$3,245,566
38	**Total Foster Care Expansion Fund Expenditures**	**$472,369**	**$693,104**	**$1,138,239**	**$1,261,484**	**$1,595,210**	**$1,613,968**	**$1,622,783**
39	% Change Over Prior Year		71.76%	82.62%	5.90%	1.66%	1.18%	0.55%
	Children's Basic Health Plan							
40	Total Children's Basic Health Plan Medical and Dental Expenditures	$41,390,834	$49,698,138	$84,886,129	$70,099,006	$57,993,330	$46,678,261	$12,896,778
41	**Total Children's Basic Health Plan Fund Expenditures**	**$14,486,792**	**$17,394,348**	**$29,710,145**	**$25,509,652**	**$20,297,666**	**$16,337,391**	**$4,513,872**
42	% Change Over Prior Year	60.26%	20.07%	70.80%	-17.42%	-17.27%	-19.51%	-72.37%
Total Health Care Expansion Fund Expenditures at Enhanced ARRA FMAP		**$74,859,119**	**$89,649,566**	**$101,571,393**	**$96,743,477**	**$114,605,014**	**$117,757,819**	**$111,694,754**

Notes for Expenditure History and Forecast

[1] Projected expenditures for the Expansion Adults to 60% FPL population are taken from the Department's February 15, 2012 FY 2012-13 S-1 and S-2.

[2] Presumptive Eligibility expenditures are projected using the average of 24 months of year-over-year percentage changes since July 2008 multiplied by the prior year expenditure.

[3] The Optional Legal Immigrants population expenditure is forecast using an Ordinary Least Squares (OLS) regression model.

[4] Expenditures for the Asset Test Removal population dropped significantly in FY 2010-11 due to eligibility redeterminations which resulted in clients being reclassified out of asset test. For FY 2011-12 forward, the forecasts are based upon a methodology that estimates the amount of expenditures using a weighted average growth rate calculated using the caseload and per capita growth rates from the AFDC-Adults and Eligible Children populations included in the Department's February 15, 2012 FY 2012-13 S-1 and S-2. This is the same methodology used historically from a lower FY 2010-11 base level.

[5] Expenditure projections for the Children's Home- and Community-Based Services and Children's Extensive Support Waiver programs are based on the trends in the Disabled Individuals to 59 category from Exhibit C and Exhibit DD in the Department's February 15, 2012 FY 2012-13 S-1 and S-2, respectively, applied to the average per capita cost for these waiver clients.

[6] Foster Care Medical Services Premiums expenditures are projected using the Denver-Boulder-Greeley CPI Index for Medical Care. Foster Care Mental Health expenditures are projected using the same mental health per capita as the traditional Foster Care population from Exhibit DD in the Department's FY 2012-13 S-2.

[7] Total Medical Services Premiums and Mental Health expenditures from the Health Care Expansion Fund for individual populations as given on this page calculate the costs of expansion populations at the blended average FY 2008-09 FMAP of 57.29% and will not match the total on the Outlook Page, which is actual expenditure that accounts for the timing of expenditures over the year.

Schedule 10
Summary of FY 2012-13 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: January 3, 2012
Number of Funding Requests: 17
Number of Non Prioritized Items: 4

Total Impact					**$332,070,448**	**1.8**	**$110,790,391**	**$0**	**$43,112,083**	**$291,180**	**$177,876,794**
Schedule 10 Priority	**Nov. 1, 2011 Priority**	**Jan. 3, 2012 Priority**	**Title**	**IT Request**	**Total Request (FY 2012-13)**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2012-13 Funding Requests											
1	R-1	N/A	Request for Medical Services Premiums	No	$330,806,255	0.0	$129,303,556	$0	$36,238,486	$303,982	$164,960,231
2	R-2	N/A	Medicaid Mental Health Community Programs	No	$36,614,308	0.0	$21,388,240	$0	($3,087,673)	($13,544)	$18,327,285
3	R-3	N/A	Children's Basic Health Plan Medical and Dental Costs	No	($3,434,456)	0.0	$0	$0	($862,887)	$0	($2,571,569)
4	R-4	N/A	Medicare Modernization Act State Contribution Payment	No	$5,518,142	0.0	$5,518,142	$0	$0	$0	$0
5	R-5	N/A	Medicaid Fee-for-Service Reform	No	($1,845,030)	1.8	($865,469)	$0	($57,047)	$0	($922,514)
6	R-6	N/A	Medicaid Budget Reductions	No	($29,699,322)	0.0	($30,471,105)	$0	$15,496,446	$0	($14,724,663)
7	R-7	N/A	Cost Sharing for Medicaid and CHP+	No	($3,407,194)	0.0	($1,438,020)	$0	$91,841	$0	($2,061,015)
8	R-8	N/A	Federally Mandated CHIPRA Quality Measures	No	$236,671	0.0	$82,835	$0	$0	$0	$153,836
9	R-9	N/A	CHP+ Eligibility for Children of State Employees	No	$0	0.0	$0	$0	$0	$0	$0
10	R-10	N/A	Utilize Supplemental Payments for General Fund Relief	No	($1,006,752)	0.0	($1,006,752)	$0	$0	$0	$0
11	R-11	N/A	CHIPRA Bonus Payment True-up	No	$0	0.0	($15,036,785)	$0	$0	$0	$15,036,785
12	R-12	N/A	Hospital Provider Fee Administrative True-up	No	($52,769)	0.0	$0	$0	$28,596	$0	($81,365)
13	R-13	N/A	CBMS Electronic Document Management System	No	$464,126	0.0	$230,708	$0	$462	$1,392	$231,564
14	N/A	BA-3	Smoking Cessation Quitline for Medicaid Clients	No	$1,373,470	0.0	$0	$0	$686,735	$0	$686,735
15	N/A	BA-4	Utilize Supplemental Payments for General Fund Relief	No	($10,527,400)	0.0	$400,246	$0	($5,946,273)	$0	($4,981,373)
16	N/A	BA-5	CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects	No	$296,486	0.0	($149,482)	$0	$298,257	($650)	$148,361
17	N/A	BA-6	MMIS Technical Adjustments	No	$1,065,358	0.0	$0	$0	$225,140	$0	$840,218
FY 2012-13 Funding Requests					**$326,401,893**	**1.8**	**$107,956,114**	**$0**	**$43,112,083**	**$291,180**	**$175,042,516**
Funding Requests R-1 through R-4					**$369,504,249**	**0.0**	**$156,209,938**	**$0**	**$32,287,926**	**$290,438**	**$180,715,947**
All Other Funding Requests					**($43,102,356)**	**1.8**	**($48,253,824)**	**$0**	**$10,824,157**	**$742**	**($5,673,431)**
FY 2012-13 Non-Prioritized Funding Requests											

Schedule 10
Summary of FY 2012-13 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: January 3, 2012
Number of Funding Requests: 17
Number of Non Prioritized Items: 4

Total Impact					**$332,070,448**	**1.8**	**$110,790,391**	**$0**	**$43,112,083**	**$291,180**	**$177,876,794**
Schedule 10 Priority	**Nov. 1, 2011 Priority**	**Jan. 3, 2012 Priority**	**Title**	**IT Request**	**Total Request (FY 2012-13)**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
1	NP-R1	N/A	DHS - New Funding – Developmental Disabilities Services	No	$4,877,540	0.0	$2,438,770	$0	$0	$0	$2,438,770
2	NP-R2	N/A	DHS - Statewide Vehicle Replacement	No	$15,149	0.0	$7,574	$0	$0	$0	$7,575
3	N/A	NP-BA1	DHS - Utilities Funding Request	No	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
4	N/A	NP-BA2	DHS - Colorado Mental Health Institutes Revenue Adjustment	No	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
FY 2012-13 Non-Prioritized Funding Requests					**$5,668,555**	**0.0**	**$2,834,277**	**$0**	**$0**	**$0**	**$2,834,278**

Schedule 11
Summary of Supplemental Requests for FY 2011-12

Department Name: Health Care Policy and Financing
Submission Date: January 3, 2012
Number of Prioritized Supplemental Requests: 14

Priority #	Page #	Title	IT Request	Total Request FY 2011-12	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Prioritized Supplemental Requests										
S-1	S-1.1	Request for Medical Services Premiums	No	$62,369,672	0.0	$51,312,453	$0	($22,107,528)	$80,723	$33,084,024
S-2	S-2.1	Medicaid Mental Health Community Programs	No	$4,292,211	0.0	$7,741,587	$0	($5,568,294)	($13,544)	$2,132,462
S-3	S-3.1	Children's Basic Health Plan Medical and Dental Costs	No	($29,603,573)	0.0	$0	$0	($10,052,683)	$0	($19,550,890)
S-4	S-4.1	Medicare Modernization Act State Contribution Payment	No	$2,356,099	0.0	$2,356,099	$0	$0	$0	$0
S-5	S-5.1	Medicaid Budget Reductions	No	($7,859,799)	0.0	($19,618,256)	$0	$15,625,858	$0	($3,867,401)
S-6	S-6.1	CHIPRA Bonus Payment True-up	No	$0	0.0	($5,633,177)	$0	$0	$0	$5,633,177
S-7	S-7.1	Hospital Provider Fee Administrative True-up	No	$3,920,338	0.0	$0	$0	$2,023,541	$0	$1,896,797
S-8	S-8.1	Cost Sharing for CHP+	No	($264,453)	0.0	($138,601)	$0	$136,133	$0	($261,985)
S-9	S-9.1	Smoking Cessation Quitline for Medicaid Clients	No	$577,316	0.0	$0	$0	$288,658	$0	$288,658
S-10	S-10.1	Utilize Supplemental Payments for General Fund Relief	No	($9,634,148)	0.0	($614,990)	$0	($5,306,633)	$0	($3,712,525)
S-11	S-11.1	Federally Mandated CHP+ PPS Payments to FQHCs and RHCs	No	$1,650,176	0.0	$0	$0	$577,562	$0	$1,072,614
S-12	S-12.1	CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects	No	$511,406	0.0	($42,022)	$0	$298,257	($650)	$255,821
S-13	S-13.1	Commission on Family Medicine Residency Training Program Adjustment	No	$350,000	0.0	$175,000	$0	$0	$0	$175,000
S-14	S-14.1	CBMS Placeholder		$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Supplemental Request Subtotal				**$28,665,245**	**0.0**	**$35,538,093**	**$0**	**($24,085,129)**	**$66,529**	**$17,145,752**
Supplemental Requests S-1 through S-4				**$39,414,409**	**0.0**	**$61,410,139**	**$0**	**($37,728,505)**	**$67,179**	**$15,665,596**
All Other Supplemental Requests				**($10,749,164)**	**0.0**	**($25,872,046)**	**$0**	**$13,643,376**	**($650)**	**$1,480,156**
FY 2011-12 Non-Prioritized Supplemental Requests										
NP-S1	NP-S1.1	Additional Federal Funds for Medicaid Facility Survey and Certification	No	$217,047	0.0	$0	$0	$0	$0	$217,047
NP-S2	NP-S2.1	DHS - Utilities Funding Request	No	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
NP-S3	NP-S3.1	DHS - Colorado Mental Health Institutes Revenue Adjustment	No	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
NP-S4	NP-S4.1	Suspension of ICF/ID Provider Fee	No	($1,867,655)	0.0	$933,828	$0	$0	($1,867,655)	($933,828)
NP-S5	NP-S5.1	Common Policy True-up for CCLS and ALJ	No	$39,104	0.0	$19,552	$0	$0	$0	$19,552
NP-S6	NP-S6.1	DHS - Annual Fleet True-Up	No	($15,765)	0.0	($7,882)	$0	$0	$0	($7,883)
NP-S7	NP-S7.1	DHS - FY 2011-12 Common Policy Allocation True-Up	No	$1,272	0.0	$636	$0	$0	$0	$636
Non-Prioritized FY 2011-12 Supplemental Requests Subtotal				**($850,131)**	**0.0**	**$1,334,067**	**$0**	**$0**	**($1,867,655)**	**($316,543)**
GRAND TOTAL FY 2011-12 Supplemental Requests				**$27,815,114**	**0.0**	**$36,872,160**	**$0**	**($24,085,129)**	**($1,801,126)**	**$16,829,209**

Schedule 12
Summary of FY 2012-13 Budget Amendments

Department Name: Health Care Policy and Financing
Submission Date: January 3, 2012
Number of Prioritized Budget Amendments: 6

Priority #	Page #	Title	IT Request	Total Request FY 2012-13	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Health Care Policy and Financing FY 2012-13 Late Budget Amendments										
BA-1	S-1, BA-1.1	Request for Medical Services Premiums	No		0.0					
BA-2	S-2, BA-2.1	Medicaid Mental Health Community Programs	No		0.0					
BA-3	S-9, BA-3.1	Smoking Cessation Quitline for Medicaid Clients	No	$1,373,470	0.0	$0	$0	$686,735	$0	$686,735
BA-4	S-10, BA-4.1	Utilize Supplemental Payments for General Fund Relief	No	($10,527,400)	0.0	$400,246	$0	($5,946,273)	$0	($4,981,373)
BA-5	S-12, BA-5.1	CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects	No	$296,486	0.0	($149,482)	$0	$298,257	($650)	$148,361
BA-6	BA-6.1	MMIS Technical Adjustments	No	$1,065,358	0.0	$0	$0	$225,140	$0	$840,218
FY 2012-13 Prioritized Subtotals				**($7,792,086)**	**0.0**	**$250,764**	**$0**	**($4,736,141)**	**($650)**	**($3,306,059)**
Health Care Policy and Financing FY 2012-13 Non-Prioritized Late Budget Amendments										
NP-BA1	NP-S2, NP-BA1.1	DHS - Utilities Funding Request	No	($350,000)	0.0	($175,000)	$0	$0	$0	($175,000)
NP-BA2	NP-S3, NP-BA2.1	DHS - Colorado Mental Health Institutes Revenue Adjustment	No	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
FY 2012-13 Non-Prioritized Subtotals				**$775,866**	**0.0**	**$387,933**	**$0**	**$0**	**$0**	**$387,933**
GRAND TOTAL FY 2012-13 Late Budget Amendments				**($7,016,220)**	**0.0**	**$638,697**	**$0**	**($4,736,141)**	**($650)**	**($2,918,126)**

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - Utilities Funding Request

Priority Number: NP-S2, NP-BA1

Dept. Approval by: John Bartholomew JAP for JB 12/19/11 Date

OSPB Approval by: [signature] 12/19/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$5,093,354	($350,000)	$5,184,971	($350,000)	($350,000)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	($175,000)	$2,592,486	($175,000)	($175,000)
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	($175,000)	$2,592,485	($175,000)	($175,000)
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	$5,093,354	($350,000)	$5,184,971	($350,000)	($350,000)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	($175,000)	$2,592,486	($175,000)	($175,000)
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	($175,000)	$2,592,485	($175,000)	($175,000)

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - Colorado Mental Health Institutes Revenue Adjustment

Priority Number: NP-S3, NP-BA2

Dept. Approval by: John Bartholomew 12/13/11 Date

OSPB Approval by: 12/18/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$4,129,919	$1,125,866	$4,196,912	$1,125,866	$1,125,866
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,064,959	$562,933	$2,098,456	$562,933	$562,933
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,064,960	$562,933	$2,098,456	$562,933	$562,933
(6) Department of Human Services Medicaid-Funded Programs; (F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding, Mental Health Institutes	**Total**	$4,129,919	$1,125,866	$4,196,912	$1,125,866	$1,125,866
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,064,959	$562,933	$2,098,456	$562,933	$562,933
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,064,960	$562,933	$2,098,456	$562,933	$562,933

Letternote Text Revision Required? Yes: ☐ No: ☑ If yes, describe the Letternote Text Revision:

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Smoking Cessation Quitline for Medicaid Clients

Priority Number: S-9, BA-3 (CDPHE NP-R-16)

Dept. Approval by: John Bartholomew TB 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$3,543,863,749	$577,316	$3,559,795,929	$1,373,470	$1,281,040
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$0	$981,320,305	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$288,658	$534,529,617	$686,735	$640,520
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	$288,658	$1,756,668,882	$686,735	$640,520
(2) Medical Services Premiums						
	Total	$3,543,863,749	$577,316	$3,559,795,929	$1,373,470	$1,281,040
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$0	$981,320,305	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$288,658	$534,529,617	$686,735	$640,520
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	$288,658	$1,756,668,882	$686,735	$640,520

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

FY 2011-12: (2) Medical Services Premiums: ...and $288,658 shall be from the Tobacco Education Cash Fund created in Section 24-22-117 (2) (c) (I), C.R.S.

FY 2012-13: (2) Medical Services Premiums: ...and ~~$288,658~~ $686,735 shall be from the Tobacco Education Cash Fund created in Section 24-22-117 (2) (c) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Tobacco Education Program Fund (18M)

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: Department of Public Health and Environment

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental and Budget Amendment

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-9, BA-3 (CDPHE NP-R-16)
Request Title: Smoking Cessation Quitline for Medicaid Clients

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Total Impact	**$865,974**	**$0**	**0.0**
Department of Health Care Policy and Financing	$577,316	$0	0.0
Department of Public Health and Environment	$288,658	$0	0.0
Summary of Incremental Funding Change for FY 2012-13	**Total Funds**	**General Fund**	**FTE**
Total Impact	**$2,060,205**	**$0**	**0.0**
Department of Health Care Policy and Financing	$1,373,470	$0	0.0
Department of Public Health and Environment	$686,735	$0	0.0

Request Summary:

The Department requests a transfer of spending authority from the Colorado Department of Public Health and Environment (CDPHE) to increase available funding for Medicaid client utilization of the smoking cessation QuitLine. Pursuant to recent federal guidance, the Department would be able to obtain federal matching funds for QuitLine expenditure for Medicaid clients. The Department estimates this request would have a total funds impact of $865,974 in FY 2011-12, $2,060,205 in FY 2012-13 and $1,921,560 in FY 2013-14. The Department would, however, like to note that the total funds impact reflects the funding transfer as an increase to reappropriated funds. The increase in federal funds as a result of the transfer in FY 2011-12 is $288,658, for FY 2012-13 the federal funds impact is $686,735 and the FY 2013 federal funds impact is $640,520.

The smoking cessation QuitLine has been administered through CDPHE and National Jewish Health since 2002 and provides Colorado residents over the age of 15 with a free telephone based smoking cessation coaching program and nicotine replacement therapy. The Department does not currently pay for QuitLine Services for Medicaid clients, although approximately 18% of the clients served in FY 2010-11 were Medicaid clients.

Section 4107 of the Affordable Care Act (ACA) requires states to provide smoking cessation benefits to pregnant women. In a State Medicaid Director (SMD) letter[1] on June 24, 2011, the Centers for Medicare and Medicaid Services (CMS) issued guidance on implementing the section 4107 and offered an additional provision stating that tobacco QuitLine services provided to Medicaid clients are eligible for federal matching funds. CMS will also provide matching funds for QuitLine marketing and evaluation targeted at Medicaid clients. The guidance allows the Department to claim expenditure beginning June 24, 2011 and does not require a state plan amendment.

In order to receive federal funds, the Department must ensure that payments for QuitLine services

[1] The State Medicaid Director Letter can be found at https://www.cms.gov/SMDL/SMD/list.asp

are compliant with the Office of Management and Budget (OMB) Circular A-87 (2 CFR 225). The Circular requires the Department to create a written cost allocation plan and to ensure payments are not duplicate costs that have been, or should have been, paid through another source. The departments would include a written cost allocation plan in an interagency agreement and would create regular reports with client information to ensure Medicaid eligibility and payment for exclusively Medicaid clients.

To finance QuitLine administration, the Department would enter into an interagency agreement with CDPHE to transfer funding for Medicaid Quitline services. Federal regulations at 42 CFR § 431.10 requires a single state agency to administer the Medicaid program and CMS requires funds to be appropriated directly to that agency. Given that the Department of Health Care Policy and Financing serves as the single state agency, the Department is requesting an appropriation from the Tobacco Education Programs Cash Fund in order to draw federal funds to pay for Medicaid client QuitLine administration. The Department would then transfer the cash funds and matching federal funds to CDPHE as reappropriated funds. Concurrently, the Department requests a corresponding change in CDPHE's appropriation for Tobacco Education, Prevention, and Cessation Grants.

Anticipated Outcomes:
This request would enable the Department to receive federal funds for QuitLine services offered through CDPHE and National Jewish Health provided to Medicaid clients. The Department anticipates this request would free up funding for CDPHE by requiring less funding for Medicaid clients utilizing the QuitLine. This would allow CDPHE to serve more Coloradoans through the QuitLine.

Assumptions for Calculations:
The Department's calculations are contained in Appendix A. To calculate estimated expenditure, the Department obtained historical Quitline data from CDPHE. The Department took the average total expenditure per client and trended utilization and costs to determine the fiscal impact of the transfer. Additionally, this request assumes the full level of funding from the tobacco excise revenue. If fiscal emergency is declared and the amount of money available to the program is reduced, the amount of spending authority needed may change accordingly.

Consequences if not Funded:
If this request is not funded, the Department would not be able to take advantage of the federal funding available to reimburse for the smoking cessation QuitLine. CDPHE would continue to pay for Medicaid client using the QuitLine which would restrict available funding for other Colorado residents to utilize the program.

Impact to Other State Government Agency:
This request will impact CDPHE through a transfer of spending authority from the Tobacco Education Programs Cash Fund. See table 1.1 through 1.3 for the impact by line item and fiscal year. In the event that the Department is not able to obtain a federal match on the full amount, or Medicaid utilization is less than expected, the Department will still transfer the full appropriation from the Tobacco Education Programs Cash Fund to CDPHE.

Relation to Performance Measures:
This request will assist the Department in meeting its performance measures to improve health outcomes and contain health care costs. By obtaining federal funds for Medicaid clients using the QuitLine program, the state is able to offer more Coloradoans smoking cessation counseling and pharmacotherapy.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
This request qualifies as a supplemental and budget amendment as it is a result of new data changing funding needs. The SMD letter from CMS was issued in June 2011 which did not allow the Department to request funding prior to the beginning of FY 2011-12.

Current Statutory Authority or Needed Statutory Change:
Effective June 24, 2011, CMS has indicated that states may consider administration of a smoking cessation Quitline for Medicaid clients is necessary for the "proper and efficient" administration of the State plan under its authority under section 1903(a)(7) of the Social Security Act.

Table 1.1 - FY 2011-12 Impact by Department						
FY 2011-12	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
Total Estimate	**$865,974**	**$0**	**$0**	**$577,316**	**$288,658**	
Health Care Policy and Financing	$577,316	$0	$288,658	$0	$288,658	Table 3.1
Public Health and Environment	$288,658	$0	($288,658)	$577,316	$0	Table 2.1

Table 1.2 - FY 2012-13 Impact by Department						
FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
Total Request	**$2,060,205**	**$0**	**$0**	**$1,373,470**	**$686,735**	
Health Care Policy and Financing	$1,373,470	$0	$686,735	$0	$686,735	Table 3.2
Public Health and Environment	$686,735	$0	($686,735)	$1,373,470	$0	Table 2.2

Table 1.3 - FY 2013-14 Impact by Department						
FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Source**
Total Request	**$1,921,560**	**$0**	**$0**	**$1,281,040**	**$640,520**	
Health Care Policy and Financing	$1,281,040	$0	$640,520	$0	$640,520	Table 3.3
Public Health and Environment	$640,520	$0	($640,520)	$1,281,040	$0	Table 2.3

Table 2.1 - FY 2011-12 Summary of Request for Health Care Policy and Financing Department						
FY 2011-12	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$577,316**	**$0**	**$288,658**	**$0**	**$288,658**	**0.0**
(2) Medical Services Premiums	$577,316	$0	$288,658	$0	$288,658	0.0

Table 2.2 - FY 2012-13 Summary of Request for Health Care Policy and Financing Department						
FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$1,373,470**	**$0**	**$686,735**	**$0**	**$686,735**	**0.0**
(2) Medical Services Premiums	$1,373,470	$0	$686,735	$0	$686,735	0.0

Table 2.3 - FY 2013-14 Summary of Request for Health Care Policy and Financing Department						
FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$1,281,040**	**$0**	**$640,520**	**$0**	**$640,520**	**0.0**
(2) Medical Services Premiums	$1,281,040	$0	$640,520	$0	$640,520	0.0

Table 3.1 - FY 2011-12 Summary of Request for Department of Public Health and Environment						
FY 2011-12	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$288,658**	**$0**	**($288,658)**	**$577,316**	**$0**	**0.0**
(9) Prevention Services; (A) Prevention Programs; (5) Tobacco Education, Prevention, and Cessation Program Administration	$288,658	$0	($288,658)	$577,316	$0	0.0

Table 3.2 - FY 2012-13 Summary of Request for Department of Public Health and Environment						
FY 2012-13	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$686,735**	**$0**	**($686,735)**	**$1,373,470**	**$0**	**0.0**
(9) Prevention Services; (A) Prevention Programs; (5) Tobacco Education, Prevention, and Cessation Program Administration	$686,735	$0	($686,735)	$1,373,470	$0	0.0

Table 3.3 - FY 2013-14 Summary of Request for Department of Public Health and Environment						
FY 2013-14	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FTE**
Total Request	**$640,520**	**$0**	**($640,520)**	**$1,281,040**	**$0**	**0.0**
(9) Prevention Services; (A) Prevention Programs; (5) Tobacco Education, Prevention, and Cessation Program Administration	$640,520	$0	($640,520)	$1,281,040	$0	0.0

Table 4.1 - FY 2011-12 Summary of Request for Health Care Policy and Financing Department								
Row	**Item**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**Description**
A	Medicaid Clients Growth Rate	-	-	-	4.32%	4.32%	4.32%	Average Growth Rate in Medicaid Client Utilization from FY 2008-09 to FY 2010-11
B	Estimated Medicaid Client Calls	3,995	2,112	3,290	5,038	11,040	11,040	Estimate[2]
C	Percentage of Clients with more than 6 Calls	10.32%	10.32%	10.32%	10.32%	10.32%	10.32%	Data from National Jewish
D	Total Medicaid Calls Eligible for Federal Match [1]	3,583	1,894	2,950	4,518	9,901	9,901	Row B * (1 - Row A)

[1] As mentioned in a question and answer session with CMS, the Department is not able to reimburse for more than 6 counseling calls.

[2] CDPHE estimates that with additional funding, provided through federal funds, the Quitline would be able to serve Medicaid clients at the same level as before budget cuts beginning in FY 2008-09. In addition, targeted outreach directed at Medicaid clients would likely increase the number of QuitLine utilizers.

Table 5.1 - FY 2011-12 Summary of Request for Health Care Policy and Financing Department					
Row	**Item**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**Description**
A	Actual Quitline Expenditure per Utilizer for FY 2010-11	$89.49	$89.49	$89.49	Actual per Utilizer Expenditure for FY 2010-11
B	Estimated Utilization	4,518	9,901	9,901	Table 4.1, Row D
C	Administrative Costs	$173,000	$487,430	$395,000	Table 6.1 Row C
D	Estimated Quitline Total Cost	$577,316	$1,373,470	$1,281,040	(Row A * Row B) + Row C

Table 6.1 Estimated Quitline Additional Administrative Costs					
Row	**Item**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**Description**
A	Marketing costs[(1)]	$173,000	$345,000	$345,000	Estimate
B	Evaluation	$0	$142,430	$50,000	Estimate
C	Total Administrative Costs	$173,000	$487,430	$395,000	Row A + Row B

[(1)] Marketing costs include brochures, posters, direct mailing and closed circuit television commercials. In addition, personnel/agency costs to put together promotional material targeting Medicaid clients are included in the marketing costs line. This includes activities such developing content for partner and state websites, newsletters and eligibility notifications.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Utilize Supplemental Payments for General Fund Relief
Priority Number: S-10, BA-4

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$3,853,688,855	($9,634,148)	$3,869,621,035	($10,527,400)	($10,527,400)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	($614,990)	$981,320,305	$400,246	$400,246
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$763,229,728	($5,306,633)	$689,442,170	($5,946,273)	($5,946,273)
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,901,056,618	($3,712,525)	$1,911,581,435	($4,981,373)	($4,981,373)
(2) Medical Services Premiums[a]	Total	$3,543,863,749	$6,262,092	$3,559,795,929	($10,527,400)	($10,527,400)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	($614,990)	$981,320,305	$400,246	$400,246
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$2,641,487	$534,529,617	($5,946,273)	($5,946,273)
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	$4,235,595	$1,756,668,882	($4,981,373)	($4,981,373)
(4) Indigent Care Program; Safety Net Provider Payments[b]	Total	$309,825,106	($15,896,240)	$309,825,106	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$154,912,553	($7,948,120)	$154,912,553	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$154,912,553	($7,948,120)	$154,912,553	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

FY 2011-12

[a] Of this amount, ~~$7,629,150~~ $10,271,637 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program...

[b] Of this amount, $144,686,653 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4) C.R.S., and $10~~,225,900~~ $3,277,780 shall be from public funds certified as representing expenditures by hospitals that are eligible for federal financial participation under the Medicaid upper payment limit and the Medicaid Disproportionate Share Payments to Hospitals program.

FY 2012-13

[a] Of this amount, ~~$7,732,438~~ $1,776,165 represents public funds certified as expenditures incurred by public hospitals and agencies that are eligible for federal financial participation under the Medicaid program...

Cash or Federal Fund Name and COFRS Fund Number: Certified Public Expenditure.

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A.

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental Request and FY 2012-13 Budget Amendment
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-10, BA-4
Request Title: Utilize Supplemental Payments for General Fund Relief

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Total Request	($9,634,148)	($614,990)	0.0

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Total Request	($10,527,400)	$400,246	0.0

Request Summary:
The Department requests to use $614,990 federal funds in FY 2011-12 to provide General Fund relief to the Medical Services Premiums line item. Similarly, the Department requests to use $606,506 federal funds in FY 2012-13, to true-up estimates included in the Department's FY 2012-13 R-10 "Utilize Supplemental Payments for General Fund Relief." These General Fund savings would be achieved by a reduction to certain certified public expenditure (CPE) based supplemental payments in the Medical Services Premiums line item. The Department also requests to move the inpatient high volume CPE supplemental payment currently in the Safety Net Provider Payments line to the Medical Services Premiums line item.

Currently, the Safety Net Programs Section of the Department manages and calculates several payments utilizing the CPE methodology, and is continuously working on new and innovative ways to increase payments to providers in order to reduce the uncompensated costs of providing care to under and uninsured Coloradans. However, due to the increasing strain on the state's General Fund, the Department is requesting to withhold 10% of the federal funds drawn under some of these payments in order to offset General Fund costs in the Department. Specifically, the Department requests to withhold 10% of the federal funds drawn under the physician supplemental payment and the inpatient high volume CPE supplemental payment currently in the Safety Net Provider Payments line item as authorized pursuant to the Department's FY 2011-12 DI-7 "Maximize Reimbursement for High Volume Medicaid and CICP Hospitals." Please see Table 2 in Appendix A below for more detailed information on these individual payments and the withholding calculations. Similar withholding of federal funds is already being done with some of the CPE based payments within the Medical Services Premiums line item, particularly the Home Health and Nursing Facility payments made under the Upper Payment Limit (UPL).

For FY 2011-12, the Department projects the federal funds drawn under these payments at a base Federal Medical Assistance Percentage (FMAP) of 50% to equal $6,149,897, resulting in General Fund relief in the amount of $614,990 after 10% of these funds are withheld. These payments will be eligible for the enhanced federal match provided through the American Recovery and Reinvestment Act (ARRA) as the

uncompensated costs being certified were incurred in 2010. The 10% withholding is calculated on the base FMAP, as the incremental federal funds from the enhanced FMAP will already be withheld by the State for General Fund relief.

The physician supplemental payment applies to Denver Health Medical Center and Memorial Hospital in Colorado Springs. The inpatient high volume CPE supplemental payment will be made only to Memorial Hospital. Denver Health Medical Center, which is also a High Volume Medicaid and CICP Hospital, has its hospital-specific UPL maximized under the Hospital Provider Fee supplemental payments, so would not receive any additional inpatient high volume CPE supplemental payments pursuant to the Department's FY 2011-12 DI-7.

In addition to the requested General Fund savings, the Department also requests to move the inpatient high volume CPE supplemental payment in the Safety Net Provider Payments line item to the Medical Services Premiums line item to place it with the other payments made under the Upper Payment Limit. This action will make both lines more transparent and limit the purpose of the Safety Net Provider Payment line item to only Hospital Provider Fee payments. First, the Department requests a reduction of $9,019,158 total funds in FY 2011-12, composed of $5,306,633 cash funds and $3,712,525 federal funds to align the appropriation with the new payment estimates. After this reduction is made, the Department requests to transfer the appropriation for this payment to the Medical Services Premiums line item. The withholding will take place after the reduction and transfer discussed above. Please see Table 1 in Appendix A for more detail on this transfer, and Table 4 for a comparison of this request to the Department's FY 2012-13 R-10 "Utilize Supplemental Payments for General Fund Relief."

Anticipated Outcomes:
If this request is approved, the Department anticipates savings in the amount of $614,990 General Fund in FY 2011-12 and $606,506 General Fund in FY 2012-13.

Assumptions for Calculations:
Assumptions used in this request include the approval of a State Plan Amendment (SPA) by the Centers for Medicare and Medicaid Services (CMS), which would allow the Department to implement the inpatient high volume CPE supplemental payment. The Department expects approval of this SPA by March 1, 2012. The Department also assumes that it will have received the data from all hospitals to calculate the payments, and that the data support payments in the amounts budgeted. Please see Appendix A for detailed calculations for this request.

Consequences if not Funded:
If this request is not approved, the Department will forego General Fund relief in the amount of $614,990 in FY 2011-12 and $606,506 in FY 2012-13. This process of retaining a portion of the federal funds distributed to providers has already been approved by CMS, and not approving this would limit the Department's ability to reduce its overall General Fund need.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
There are no federal regulations that prohibit the State from retaining all or a portion of the federal funds it earns through the CPE methodology. Indeed, Colorado already retains all federal funds from the Public Nursing Facility Supplemental Payment and the Public Home Health Agency Supplemental Payment. While the intent of the text of State Plan Amendments is not to address State retention of federal funds, the State must notify CMS if it intends to do so in its response to standard funding questions that are submitted with any proposed State Plan Amendment that modifies provider reimbursement methodologies or amounts.

Appendix A: Tables and Calculations

Table 1: Transfer of Inpatient High Volume Supplemental Payment			
Payment Type	Total Funds	Certified Public Expenditures	Federal Funds
(4) Safety Net Provider Payments	($6,877,082)	($2,641,487)	($4,235,595)
(2) Medical Services Premiums	$6,877,082	$2,641,487	$4,235,595
Net Transfer Request	$0	$0	$0

Table 2: Payments and Withholding Calculations				
FY 2011-12				
Payment Type	Total Funds	Certified Public Expenditures	Federal Funds (50% FMAP)	Withholding for General Fund
Physician Supplemental Payment	$5,422,712	$2,711,356	$2,711,356	($271,136)
Inpatient High Volume CPE Supplemental Payment	$6,877,082	$3,438,541	$3,438,541	($343,854)
Total	$12,299,794	$6,149,897	$6,149,897	($614,990)
FY 2012-13				
Payment Type	Total Funds	Certified Public Expenditures	Federal Funds (50% FMAP)	Withholding for General Fund
Physician Supplemental Payment	$7,161,512	$3,580,756	$3,580,756	($358,076)
Inpatient High Volume CPE Supplemental Payment	$4,968,594	$2,484,297	$2,484,297	($248,430)
Total	$12,130,106	$6,065,053	$6,065,053	($606,506)

Table 3: Inpatient High Volume CPE Supplemental Payment Adjustment			
FY 2011-12			
	Total Funds	Certified Public Expenditures	Federal Funds
Appropriated Inpatient High Volume CPE Supplemental Payment	$15,896,240	$7,948,120	$7,948,120
Needed Inpatient High Volume CPE Supplemental Payment	$6,877,082	$2,641,487	$4,235,595
Net Inpatient High Volume CPE Supplemental Payment	($9,019,158)	($5,306,633)	($3,712,525)
FY 2012-13			
	Total Funds	Certified Public Expenditures	Federal Funds
Appropriated Inpatient High Volume CPE Supplemental Payment	$15,896,240	$7,948,120	$7,948,120
Needed Inpatient High Volume CPE Supplemental Payment	$4,968,594	$2,001,847	$2,966,747
Net Inpatient High Volume CPE Supplemental Payment	($10,927,646)	($5,946,273)	($4,981,373)

Table 4: R-10 and S-10, BA-4 Request Comparison				
FY 2011-12				
	Total Funds	General Fund	Certified Public Expenditures	Federal Funds
R-10	$0	$0	$0	$0
S-10, BA-4	($9,634,148)	($614,990)	($5,306,663)	($3,712,525)
Net Request	($9,634,148)	($614,990)	($5,306,663)	($3,712,525)
FY 2012-13				
	Total Funds	General Fund	Certified Public Expenditures	Federal Funds
R-10	($1,006,752)	($1,006,752)	$0	$0
S-10, BA-4	($11,534,152)	($606,506)	($5,946,273)	($4,981,373)
Net Request	($10,527,400)	$400,246	($5,946,273)	($4,981,373)

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects

Priority Number: S-12, BA-5

Dept. Approval by: John Bartholomew JB 12/20/11 Date

OSPB Approval by: 12/28/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$8,983,839	$511,406	$8,895,282	$296,486	$296,486
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,461,609	($42,022)	$4,416,786	($149,482)	($149,482)
	GFE	$0	$0	$0	$0	$0
	CF	$14,428	$298,257	$14,520	$298,257	$298,257
	RF	$19,399	($650)	$19,889	($650)	($650)
	FF	$4,488,403	$255,821	$4,444,087	$148,361	$148,361
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	Total	$8,983,839	($300,994)	$8,895,282	($300,994)	($300,994)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,461,609	($149,482)	$4,416,786	($149,482)	($149,482)
	GFE	$0	$0	$0	$0	$0
	CF	$14,428	($483)	$14,520	($483)	($483)
	RF	$19,399	($650)	$19,889	($650)	($650)
	FF	$4,488,403	($150,379)	$4,444,087	($150,379)	($150,379)
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System Projects - HCPF Only (new line item)	Total	$0	$812,400	$0	$597,480	$597,480
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$107,460	$0	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$298,740	$0	$298,740	$298,740
	RF	$0	$0	$0	$0	$0
	FF	$0	$406,200	$0	$298,740	$298,740

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:** For Colorado Benefits Management System Projects HCPF Only line: $298,740 Cash Funds shall be from the Hospital Provider Fee Cash Fund.

Cash or Federal Fund Name and COFRS Fund Number: CF: $14,520 from Children's Basic Health Plan Trust Fund 11G, $19,889 from Old Age Pension Fund managed by Department of Human Services, $298,740 from Hospital Provider Fee Cash Fund 24A. FF: Title XXI and Title XIX.

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2011-12, Supplemental Request
January 3, 2012

Department Priority: S-12, BA-5
CBMS Technical Adjustment for Fund Splits in HB 09-1293 and HCPF Only Projects

Summary of FY 2011-12 Incremental Funding Change	Total Funds	General Fund	FTE
Department of Human Services	$0	($199,322)	0.0
Department of Health Care Policy and Financing	$511,406	($42,022)	0.0

Request Summary:
The Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Human Services (DHS) request a technical correction to funding for the Colorado Benefits Management System (CBMS). The combined impact for all Departments is an overall total funds increase of $511,406, but an overall decrease of $241,344 General Fund. Note that the total fund figure double counts reappropriated funds. The request represents no net change to CBMS total funding. HCPF and DHS share funding for CBMS. The Governor's Office of Information Technology (GOIT) would not be impacted because total funding for the CBMS vendor would not change.

In the FY 2011-12 Long Bill (SB 11-209) funding for CBMS changes related to HB 09-1293 "Colorado Health Care Affordability Act" was appropriated using fund splits expected to result from the Random Moment Sampling rather than from the Hospital Provider Fee Cash Fund. This has resulted in the use of more General Fund than is appropriate for HB 09-1293 related CBMS changes.

Currently, the bulk of CBMS funding is allocated by Random Moment Sampling. The methodology is based on the assumption that all programs at HCPF and DHS will contribute to the funding for all CBMS projects. For example, at DHS, Temporary Aid for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP or Food Stamps), Title IV-E Foster Care, Title XX Adult Protective Services, and Old Age Pension all contribute portions of the total funding for CBMS projects. Likewise, at HCPF, Medicaid, the Children's Basic Health Plan, and Old Age Pension State Medical programs all may contribute to portions of funding for CBMS projects. The problems with this approach are two-fold. This methodology is only appropriate for maintenance and operations funding and CBMS changes that impact all programs. However, not all CBMS projects impact all assistance programs. By using Random Moment Sampling for all projects, funding is forced into arbitrary fund splits that do not appropriately reflect the impacted programs.

To create better transparency for the funding of CBMS projects that disproportionately impact HCPF programs, the Department proposes establishing a separate line item for those CBMS projects that benefit HCPF programs only. This line item, called "Colorado Benefit Management System Projects - HCPF Only", would appear in both the HCPF and DHS budgets. Note that it would still be necessary to appropriate the funding to both HCPF and DHS because both Departments have a long-standing agreement that

DHS handles CBMS payment requests from the Governor's Office of Information Technology.

At this time, it is anticipated that funding for two projects would be transferred into the new line item. Those two projects are: 1) the HB 09-1293 Hospital Provider Fee project that covers adding expansion populations into Medicaid, and 2) FY 2011-12 DI-5 "CBMS Compliance with Low Income Subsidy and Disability Determination Services Federal Requirements" that was submitted on November 1, 2010 and included in the FY 2011-12 Long Bill, SB 11-209.

For future fiscal years, it is requested that this new line item continue because it is anticipated that HCPF only projects will exist every year. Projects will change from year to year as they are completed and rotate out of the line and new projects begin and rotate into the new line. For example, the funding for HB 09-1293 Hospital Provider Fee would continue into FY 2012-13, but the DI-5 project will complete in FY 2011-12.

In addition to transferring part of the existing appropriation into the new line item, HCPF requests that the incremental requests from S-7 and R-12 (both Hospital Provider Fee requests) also be incorporated into the new line item if the request is approved. Request S-7 includes $1,466,040 additional Hospital Provider Fee Cash Funds for CBMS, and Request R-12 includes $14,040 additional Hospital Provider Fee Cash Fund for CBMS.

Anticipated Outcomes:
If approved, the Departments anticipate greater transparency of funding related to projects that relate only to HCPF programs. Approval of the request would free up General Fund that was inadvertently appropriated for CBMS changes related to the Colorado Health Care Affordability Act (HB 09-1293).

Assumptions for Calculations:
The Departments assume that the costs associated with projects related to the new "Colorado Benefits Management System Projects - HCPF Only" line will no longer be included in the Random Moment Sampling process.

Furthermore, HCPF assumes that funding within this new line item would remain as appropriated, except for the requested technical correction to the funding related to the Colorado Health Care Affordability Act:

- HB 09-1293 projects would use the Hospital Provider Fee Cash Fund for the state share of 50%, joined with federal Medicaid funding of 50%.
- CBMS Compliance with Low Income Subsidy and Disability Determination Services Federal Requirements funding would use standard Medicaid funding of 50% General Fund and 50% federal funds as appropriated in Long Bill, SB 11-209.

Both Departments assume that the Random Moment Sampling allocation process will continue to be used for joint undertakings with the following adjustments:

- The DHS Colorado Benefits Management System Operating Expenses line has been adjusted for the removal of the HCPF Only projects from this line item, and the standard allocations have been reapplied to account for the correction and removal of the Colorado Health Care Affordability Act funding. .
- The FY 2011-12 RMS percentages of 62.95% for DHS and 37.05% for HCPF, as used in the Long Bill, SB 09-209, will continue to apply for the adjustments.

See Appendix 1 for detailed calculations.

Consequences if not Funded:
If this request is not approved, distortion of funding splits is likely to continue in the RMS allocation process that may also result in failure to claim the appropriate amount of dollars from each of various federal partners for the Departments. If not approved, $168,996 General Fund that could be refinanced using non-General Fund sources will remain appropriated for CBMS changes related to HB 09-1293.

Impact to Other State Government Agency:
There would be impacts to the Department of Human Services.

Cash Fund Projections:
The Old Age Pension Fund, managed by DHS, and the Children's Basic Health Plan Trust Fund, managed by HCPF, and the Hospital Provider Fee Cash Fund would be impacted by this request.

The Old Age Pension Fund, created in Article XXIV of the State Constitution, does not have a specific balance but is managed by the State Controller to have the amount needed for programs for eligible Old Age Pension clients.

The Children's Basic Health Plan Trust Fund projection is below.

Cash Fund Name	Children's Basic Health Plan Trust Fund
Cash Fund Number	11G
FY 2010-11 Expenditures	$43,062,875
FY 2010-11 End of Year Cash Balance	$7,745,026
FY 2011-12 End of Year Cash Balance Estimate	$9,332,096
FY 2012-13 End of Year Cash Balance Estimate	$8,028,945
FY 2013-14 End of Year Cash Balance Estimate	$6,908,297

The Hospital Provider Fee Cash Fund projection is below.

Cash Fund Name	Hospital Provider Fee Cash Fund
Cash Fund Number	24A
FY 2010-11 Expenditures	$426,069,052
FY 2010-11 End of Year Cash Balance	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$22,198,436

Relation to Performance Measures:
This request is a technical correction and does not relate specifically to a performance measure.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
This request meets the Supplemental Request and Budget Amendment criteria since it is a technical correction.

Current Statutory Authority or Needed Statutory Change:
Statutory authority is under 25.5.4-106 (3), C.R.S. (2011) and 25.5-4-204 (1), C.R.S. (2011). No changes to statutes are needed.

Table 1
Technical Adjustments

Current Total Funding at DHS for Colorado Benefits Management System Operating Expenses	$18,858,730
1) HB 09-1293 Hospital Provider Fee Project Inadvertently Appropriated Incorrectly	($597,480)
2) Low Income Subsidy and Disability Determination Services Federal Requirements	($214,920)
Total Funding Needing to be Separated from RMS Determined Fund Splits	**($812,400)**
Revised Funding for DHS Colorado Benefits Management System Operating Expenses (Echoed in GOIT Funding for CBMS)	$18,046,330

Table 2
Creation of new "Colorado Benefits Management System Projects - HCPF Only" line

Component 1: HB 09-1293 Hospital Provider Fee Project (50% CF & 50% FF)	$597,480
Component 2: Low Income Subsidy (LIS) and Disability Determination Project (50% GF & 50% FF)	$214,920
Create New Line Item: Colorado Benefits Management System Projects HCPF Only	**$812,400**

Table 2A
Fund Splits for "Colorado Benefits Management System Projects - HCPF Only"

Fund splits calculated based on corrected HB 09-1293 funding source and LIS funding appropriated through SB 11-209. (New Line Item to DHS and HCPF.)

	TF	GF	CF	RF	FF
HCPF	$812,400	$107,460	$298,740	$0	$406,200
DHS	$812,400	$0	$0	$812,400	$0

Table 3
New Fund Splits Based on RMS Estimates for DHS
"Colorado Benefits Management System Operating Expenses" line

	TF	GF	CF	RF	FF
DHS Current	$18,858,730	$4,585,647	$1,034,792	$6,924,731	$6,313,560
Remove 1293 & LIS	($812,400)	($199,322)	($37,655)	($300,994)	($274,429)
New Amount	**$18,046,330**	**$4,386,325**	**$997,137**	**$6,623,737**	**$6,039,131**

Table 4
New Fund Splits Based on RMS Estimates for HCPF
"Colorado Benefits Management System" line

	TF	GF	CF	RF	FF
HCPF Current	$8,983,839	$4,461,609	$14,428	$19,399	$4,488,403
Remove 1293 & LIS	($300,994)	($149,482)	($483)	($650)	($150,379)
New Amount	**$8,682,845**	**$4,312,127**	**$13,945**	**$18,749**	**$4,338,024**

Table 5
Incremental Adjustments for All Line Items in Request

Department of Human Services				
Colorado Benefits Management System Operating Expenses				
TF	GF	CF	RF	FF
($812,400)	($199,322)	($37,655)	($300,994)	($274,429)
Colorado Benefits Management System Projects - HCPF Only (New Line)				
TF	GF	CF	RF	FF
$812,400	$0	$0	$812,400	$0
Health Care Policy and Financing				
Colorado Benefits Management System				
TF	GF	CF	RF	FF
($300,994)	($149,482)	($483)	($650)	($150,379)
Colorado Benefits Management System Projects - HCPF Only (New Line)				
TF	GF	CF	RF	FF
$812,400	$107,460	$298,740	$0	$406,200

Table 6
Combined Adjustments for Each Department

	TF	GF	CF	RF	FF
DHS	$0	($199,322)	($37,655)	$511,406	($274,429)
HCPF	$511,406	($42,022)	$298,257	($650)	$255,821
Total	**$511,406**	**($241,344)**	**$260,602**	**$510,756**	**($18,608)**

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: MMIS Technical Adjustments

Priority Number: BA-6

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/28/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☐ Supplemental FY 2011-12
- ☑ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$32,412,990	$0	$31,767,217	$1,065,358	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,581,901	$0	$6,459,471	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$1,479,670	$0	$1,698,513	$225,140	$0
	RF	$100,328	$0	$100,328	$0	$0
	FF	$24,251,091	$0	$23,508,905	$840,218	$0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts[a]	Total	$32,412,990	$0	$31,767,217	$1,065,358	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,581,901	$0	$6,459,471	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$1,479,670	$0	$1,698,513	$225,140	$0
	RF	$100,328	$0	$100,328	$0	$0
	FF	$24,251,091	$0	$23,508,905	$840,218	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**
FY 2012-13

[a] Of this amount, ~~$1,449,800~~ $1,674,940 shall be from the Hospital Provider Fee Cash Fund...

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A); FF: Title XIX, Title XXI

Reappropriated Funds Source, by Department and Line Item Name: None

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: None

Other Information: None

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2012-13 Budget Amendment
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: BA-6
Request Title: MMIS Technical Adjustments

Summary of Incremental Funding Change for FY 2012-13	Total Funds	General Fund	FTE
Total Request	$1,065,358	$0	0.0

Request Summary:
The Department requests an increase of $1,065,358 total funds in FY 2012-13, comprised of $225,140 hospital provider fee cash funds and $840,218 federal funds. The Department also requests roll forward authority for any unused FY 2011-12 General Fund appropriated for the Medicaid Management Information System (MMIS) system development projects. The Department makes these requests in order to true up appropriated funding with actual need for MMIS system development projects.

For many MMIS system development projects, timelines and costs have changed since the original estimates were made. These changes require flexibility in funding for MMIS system development projects in order to shift funding between fiscal years and reorganize funding from development projects that cost less than the original estimate to development projects that cost more than the original estimate.

The MMIS system development projects affected by this request include Reimbursement Reporting and the All Patient Refined Diagnosis Related Groups (APR-DRG) inpatient hospital rate reform system development projects funded under HB 09-1293. The Department is requesting to update the appropriations provided under HB 09-1293 for these projects to reflect updated estimates. The Department is also refinancing General Fund appropriated to several system-wide projects to hospital provider fee cash fund.

It has been the Department's experience that many initial cost and timeline estimates for MMIS system development projects prove to be inaccurate relative to the final cost and time required to complete the project. This occurs because the Department is often required to request funding based on high-level estimates due to the State budgeting process, and more refined estimates are developed as the Department and its fiscal agent complete detailed business requirements for these development projects. Two major examples of this experience are the Adults without Dependent Children (AwDC) and Buy-In Programs for Individuals with Disabilities (Buy-In) expansions system development under HB 09-1293 and the federally-mandated Health Insurance Portability and Accountability Act (HIPAA) version 5010/D.0 system development as outlined in the Department's FY 2010-11 BA-15.

For AwDC and Buy-In expansions system development costs, the Department received an original estimate of $4,335,912 total funds, spanning three fiscal years with 79% of the cost in FY 2010-11. However, the most recent cost estimate for this system development is $601,650, with all work to be completed in FY 2011-12. This represents an 87% decrease in cost and

roughly a one year delay from the original estimate.

For HIPAA v5010/D.0 system development costs, the Department received an original estimate of $1,665,598 total funds, to be completed by January 2012. However, the most recent cost estimate for this system development is $3,546,245, to be completed by July 2012. This represents a 112% increase in cost and a six month delay from the original estimate.

Due to the volatile nature of MMIS system development cost and timeline estimates, the Department requests roll forward authority for any unused General Fund in FY 2011-12 to be applied toward any MMIS system development costs in FY 2012-13 due to updated timelines and cost estimates.

Anticipated Outcomes:
This request would allow the Department to have appropriately allocated funding for numerous MMIS system development projects by truing up hospital provider fee cash funds with actual need as well as allowing any unused General Fund to be rolled forward from FY 2011-12 to cover development costs in FY 2012-13 due to changing timelines and cost estimates.

Assumptions for Calculations:
In order to calculate funding needs for MMIS system development projects, the Department used the latest cost estimates and timelines from the Department's fiscal agent. See Appendix A for detailed costs for HB 09-1293 development projects in FY 2012-13.

Consequences if not Funded:
If this request is not approved, hospital provider fee funding for MMIS system development projects will be inadequate to complete all necessary systems development projects. Without General Fund roll forward authority for FY 2011-12, the Department may need to request additional General Fund in FY 2012-13 in order to adequately fund and meet federally-mandated implementation deadlines for a number of development projects with shifting timelines and cost estimates.

Cash Fund Projections:

Cash Fund Name	Hospital Provider Fee Cash Fund
Cash Fund Number	24A
FY 2010-11 Expenditures	$426,069,052
FY 2010-11 End of Year Cash Balance	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$22,198,436

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
The Department is the single state Medicaid agency and has authority to administer the MMIS through 25.5-4-204 (3), C.R.S. (2011) and §1903 (a) of the Social Security Act [42 U.S.C. 1396b].

Appendix A: Calculations for HB 09-1293 MMIS Projects

FY 2012-13 Hospital Provider Fee Need

Table A.1 contains a detailed breakdown of FY 2012-13 hospital provider fee need for MMIS. The total funds amount needed is $5,336,610, comprised of $1,317,953 hospital provider fee cash funds and $4,018,657 federal funds. This amount includes $4,071,252 total funds for MMIS ongoing operating costs and development project costs of $924,839 total funds for APR-DRG rate reform implementation, Reimbursement Reporting, and any unforeseen development needs as requested in the Department's November 1, 2011 FY 2012-13 R-12, "Hospital Provider Fee Administrative True-up." Also included are $340,519 total funds to refinance 7.92% of General Fund appropriations for a number of system-wide MMIS development projects. This refinance applies to HIPAA v5010/D.0 and International Classification of Diseases, 10th Revision (ICD-10) changes, Medicaid Information Technology Architecture (MITA) and MMIS reprocurement projects, and the implementation of the National Correct Coding Initiative (NCCI.) This refinance is done with the goal of equalizing the hospital provider fee allocation with the proportion of the expansion populations funded under the hospital provider fee relative to the total Medicaid caseload. Because these development projects are system-wide, the department believes it is appropriate to refinance these projects with hospital provider fee cash funds. Please see the Department's January 3, 2012 S-7, "Hospital Provider Fee Administrative True-up" for details regarding the cost allocation methodology used for refinancing.

Table A.1: FY 2012-13 MMIS Hospital Provider Fee Cash Funds Need

	Total Funds	Cash Funds (Hospital Provider Fee)	Federal Funds
Ongoing Operations			
Claims Processing	$3,971,252	$992,813	$2,978,439
Postage	$100,000	$50,000	$50,000
Subtotal: Ongoing Operations	$4,071,252	$1,042,813	$3,028,439
Development Projects			
APR-DRG	$475,146	$118,786	$356,360
Reimbursement Reporting	$249,693	$62,423	$187,270
Additional Need	$200,000	$50,000	$150,000
Subtotal: Development Projects	$924,839	$231,209	$693,630
Hospital Provider Fee Refinancing			
HIPAA v5010/D.0 and ICD-10 Refinance	$265,909	$28,526	$237,383
NCCI Refinance	$52,965	$13,241	$39,724
MITA and Reprocurement Refinance	$21,645	$2,164	$19,481
Subtotal: Hospital Provider Fee Refinance	$340,519	$43,931	$296,588
Total FY 2012-13 Need	**$5,336,610**	**$1,317,953**	**$4,018,657**

FY 2012-13 Incremental Request

Table A.2 shows the calculations used to obtain the incremental amount included in this request. For hospital provider fee operations and development, the Department's FY 2012-13 base request is $4,885,226 total funds. The Department requested a reduction of $613,974 total funds in its November 1, 2011 FY 2012-13, "Hospital Provider Fee Administrative True-up" for reduced postage costs, for a total year-to-date FY 2012-13 request of $4,271,252 total funds. The FY 2012-13 incremental request is an increase of $1,065,358 total funds, comprised of $225,140 provider fee cash funds, and $840,218 federal funds. Please note that the reduction of $356,987 in provider fee cash funds requested in the Department's November 1, 2011 FY 2012-13 R-12, "Hospital Provider Fee Administrative True-up" for reduced postage costs and the increase of $225,140 in provider fee cash funds in this request for development projects results in a the net reduction of $131,847 in provider fee cash funds for FY 2012-13.

Table A.2: FY 2012-13 MMIS Hospital Provider Fee Cash Funds Incremental Request			
	Total Funds	**Cash Funds (Hospital Provider Fee)**	**Federal Funds**
FY 2012-13 Base Request	$4,885,226	$1,449,800	$3,435,426
November 1, 2011 FY 2012-13 R-12	($613,974)	($356,987)	($256,987)
Year-to-Date FY 2012-13 Request	**$4,271,252**	**$1,092,813**	**$3,178,439**
Total FY 2012-13 Need (See Table A.2)	$5,336,610	$1,317,953	$4,018,657
Incremental Request	**$1,065,358**	**$225,140**	**$840,218**

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Additional Federal Funds for Medicaid Facility Survey and Certification

Priority Number: NP-S1 (See CDPHE S-10)

Dept. Approval by: John Bartholomew PM for JB 12/28/11 (Date)

OSPB Approval by: 12/28/11 (Date)

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$4,945,441	$217,047	$5,232,683	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,539,788	$0	$1,572,708	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,405,653	$217,047	$3,659,975	$0	$0
(1) Executive Director's Office; (B) Transfers to Other Departments, Transfer to Department of Public Health and Environment Facility for Survey and Certification	Total	$4,945,441	$217,047	$5,232,683	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,539,788	$0	$1,572,708	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,405,653	$217,047	$3,659,975	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: Colorado Department of Public Health and Environment

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Suspension of ICF/ID Provider Fee

Priority Number: NP-S4

Dept. Approval by: John Bartholomew 12/15/11 Date

OSPB Approval by: 12/21/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$46,829,800	($1,867,655)	$47,801,815	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,547,245	$933,828	$22,033,253	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$1,867,655	($1,867,655)	$1,867,655	$0	$0
	FF	$23,414,900	($933,828)	$23,900,907	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding, Regional Centers	**Total**	$46,829,800	($1,867,655)	$47,801,815	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,547,245	$933,828	$22,033,253	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$1,867,655	($1,867,655)	$1,867,655	$0	$0
	FF	$23,414,900	($933,828)	$23,900,907	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Common Policy True-up for CCLS and ALJ

Priority Number: NP-S5

Dept. Approval by: John Bartholomew 12/29/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$820,758	$39,104	$979,109	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$385,681	$19,552	$444,056	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$24,698	$0	$45,499	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$410,379	$19,552	$489,554	$0	$0
(1) Executive Director's Office; (A) General Administration, Administrative Law Judge Services	**Total**	$422,830	$26,297	$536,111	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$186,717	$13,148	$222,557	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$24,698	$0	$45,499	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$211,415	$13,149	$268,055	$0	$0
(1) Executive Director's Office; (A) General Administration, Capital Complex Leased Space	**Total**	$397,928	$12,807	$442,998	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$198,964	$6,404	$221,499	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$198,964	$6,403	$221,499	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF - Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: Department of Personnel and Administration

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - Annual Fleet True-Up

Priority Number: NP-S6

Dept. Approval by: John Bartholomew TP for JB 12/23/11 Date

OSPB Approval by: 12/23/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$5,093,354	($15,765)	$5,184,971	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	($7,882)	$2,592,486	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	($7,883)	$2,592,485	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	$5,093,354	($15,765)	$5,184,971	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	($7,882)	$2,592,486	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	($7,883)	$2,592,485	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - FY 2011-12 Common Policy Allocation True-Up

Priority Number: NP-S7

Dept. Approval by: John Bartholomew for SB 12/22/11 Date

OSPB Approval by: [signature] 12/23/11 Date

- Decision Item FY 2012-13
- Base Reduction Item FY 2012-13
- Supplemental FY 2011-12
- Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$5,093,354	$1,272	$5,184,971	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	$636	$2,592,486	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	$636	$2,592,485	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	$5,093,354	$1,272	$5,184,971	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,546,677	$636	$2,592,486	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,546,677	$636	$2,592,485	$0	$0

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: No: Not Required:

Schedule 13s from Affected Departments: Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Request for Medical Services Premiums

Priority Number: S-1

Dept. Approval by: John Bartholomew 12/23/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$3,543,863,749	$62,369,672	$3,559,795,929	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$51,312,453	$981,320,305	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	($22,107,528)	$534,529,617	$0	$0
	RF	$6,388,059	$80,723	$3,101,708	$0	$0
	FF	$1,746,144,065	$33,084,024	$1,756,668,882	$0	$0
(2) Medical Services Premiums						
	Total	$3,543,863,749	$62,369,672	$3,559,795,929	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	$51,312,453	$981,320,305	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	($22,107,528)	$534,529,617	$0	$0
	RF	$6,388,059	$80,723	$3,101,708	$0	$0
	FF	$1,746,144,065	$33,084,024	$1,756,668,882	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

See Page ED-2 of the Department's FY 2012-13 R-1: "Medical Services Premiums" request.

Cash or Federal Fund Name and COFRS Fund Number: Certified Funds (22V), Local Funds, Hospital Provider Fee Cash Fund (24A), Medicaid Buy-In Fund (22W), Tobacco Tax Cash Fund, Health Care Expansion Fund (18K), Breast and Cervical Cancer Prevention and Treatment Fund (15D), Colorado Autism Treatment Fund (18A), Coordinated Care for People with Disabilities Fund (19Z), Nursing Facility Cash Fund (22X), Home Health Telemedicine Fund (25J), Tobacco Education Program Fund (18M), Supplemental Old Age Pension Health and Medical Care Fund (15K), Prevention, Early Detection, and Treatment Fund (18N), Primary Care Fund (18L), Department Recoveries, Title XIX Federal Funds

Reappropriated Funds Source, by Department and Line Item Name:

Department of Public Health and Environment

(1) Administration and Support; (B) Special Health Programs, (1) Health Disparities Program

(9) Prevention Services Division; (A) Prevention Programs, (1) Programs and Administration

(9) Prevention Services Division; (B) Women's Health - Family Planning

(9) Prevention Services Division; (A) Prevention Programs, (3) Chronic Disease and Cancer Prevention Grants Program

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments:

Other Information: None.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medicaid Mental Health Community Programs

Priority Number: S-2

Dept. Approval by: John Bartholomew 12/23/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$276,400,984	$4,292,211	$277,590,898	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$127,777,722	$7,741,587	$128,194,192	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$10,510,223	($5,568,294)	$10,510,223	$0	$0
	RF	$13,544	($13,544)	$13,544	$0	$0
	FF	$138,099,495	$2,132,462	$138,872,939	$0	$0
(3) Medicaid Mental Health Community Programs; Mental Health Capitation Payments	Total	$272,492,157	$4,089,576	$273,682,071	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$125,823,308	$7,640,270	$126,239,778	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$10,510,223	($5,568,294)	$10,510,223	$0	$0
	RF	$13,544	($13,544)	$13,544	$0	$0
	FF	$136,145,082	$2,031,144	$136,918,526	$0	$0
(3) Medicaid Mental Health Community Programs; Medicaid Mental Health Fee for Services Payments	Total	$3,908,827	$202,635	$3,908,827	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,954,414	$101,317	$1,954,414	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,954,413	$101,318	$1,954,413	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

*Of this amount, ~~$10,466,206~~ $4,877,953 (H) shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., and ~~$44,017~~ $63,976 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: Breast and Cervical Cancer Prevention and Treatment Fund (Fund 15D); Hospital Provider Fee Cash Fund (24A). FF: Title XIX.

Reappropriated Funds Source, by Department and Line Item Name: Transfer from the Department of Public Health and Environment, Prevention, Early Detection, and Treatment Fund.

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: None.

Other Information:

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Children's Basic Health Plan Medical and Dental Costs

Priority Number: S-3

Dept. Approval by: John Bartholomew 12/23/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	**$213,086,149**	**($29,603,573)**	**$187,766,874**	**$0**	**$0**
	FTE	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	GF	**$29,551,808**	**$0**	**$25,066,119**	**$0**	**$0**
	GFE	**$446,100**	**$0**	**$446,100**	**$0**	**$0**
	CF	**$44,582,245**	**($10,052,683)**	**$40,206,188**	**$0**	**$0**
	RF	**$0**	**$0**	**$0**	**$0**	**$0**
	FF	**$138,505,996**	**($19,550,890)**	**$122,048,467**	**$0**	**$0**
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	Total	$213,086,149	($29,603,573)	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	$0	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	($10,052,683)	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	($19,550,890)	$122,048,467	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

Of this amount, ~~$38,737,097~~ $22,413,342 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105 (1) C.R.S., ~~$12,389,580~~ $8,650,652 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., $461,700 shall be from the Colorado Immunization Fund created in Section 25-4-2301, C.R.S., and $1 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Children's Basic Health Plan Trust Fund 11G, Health Care Expansion Fund 18K, Hospital Provider Fee Cash Fund 24A and Colorado Immunization Fund; FF: Title XXI

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: N/A

Other Information:

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2011-12 Supplemental Request
January 3, 2012

Department Priority: S-3
Request Title: Children's Basic Health Plan Medical Premium and Dental Benefit Costs

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Children's Basic Health Plan Medical and Dental Costs	($29,603,573)	$0	0.0

Request Summary:
The Department is requesting to adjust the Children's Basic Health Plan Medical and Dental Costs line item to account for updated caseload and per capita estimates. The FY 2011-12 request is a decrease of $29,603,573 from the current FY 2011-12 appropriation, of which $10,052,683 is cash funds and $19,550,890 is federal funds. The request for FY 2012-13 funding is included in the Department's November 1, 2011 FY 2012-13 Budget Request R-3 "Children's Basic Health Plan Medical and Dental Costs."

The Department is not requesting any change to appropriations for the Children's Basic Health Plan Administration line item, though updated appropriations for internal administration (Personal Services, Operating Costs, Medicaid Management Information System, etc.) are incorporated in the Department's analysis of the Children's Basic Health Plan Trust Fund in its November 1, 2011 Budget Request R-3 "Children's Basic Health Plan Medical and Dental Costs."

The Department's decreased estimate for funding for the Children's Basic Health Plan, marketed as the Child Health Plan *Plus* (CHP+), for FY 2011-12 is the result of two factors. First, the caseload decrease during FY 2010-11 left caseload at a low starting point for FY 2011-12. To account for this downwards level shift, the Department's latest caseload estimate is lower than its previous forecast. Second, the Department has revised its per capita estimates for FY 2011-12 downwards due to lower than forecasted per capita expenditures in FY 2010-11, combined with the actuarially calculated capitation rates for FY 2011-12. The updated medical per capita estimates for children and prenatal women are lower than the Department's previous estimate, while the dental per capita estimates are higher.

These updated caseload and per capita estimates have led to lower forecasted expenditures for the CHP+ program compared to the Department's previous estimate. Thus, the Department is requesting a decrease to the current FY 2011-12 appropriation for the Children's Basic Health Plan Medical and Dental Costs to true up its latest expenditures forecast.

Anticipated Outcomes:
This request would result in an appropriation to the Children's Basic Health Plan Medical and Dental Costs line item that accounts for the Department's latest expenditures forecast.

Assumptions for Calculations:
Please see Attachment A and Exhibits C.1 through C.8 in the Department's November 1, 2011 FY 2012-13 Budget Request R-3 "Children's Basic Health Plan Medical and

Dental Costs" for detailed descriptions of the assumptions and calculations for this request.

Consequences if not Funded:
Not applicable. Under the Patient Protection and Affordable Care Act of 2009, there is a Maintenance of Effort provision on CHP+ eligibility until September 30, 2019. As such, CHP+ resembles an entitlement program like Medicaid. If the funding were not appropriated to support any increased costs, the entire CHP+ program would have to be eliminated.

Cash Fund Projections:

Cash Fund Name	Children's Basic Health Plan Trust Fund	Hospital Provider Fee Cash Fund
Cash Fund Number	11G	24A
FY 2010-11 Expenditures	$43,062,875	$426,069,052
FY 2010-11 End of Year Cash Balance	$7,745,026	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$9,332,096	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$8,036,989	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$6,924,385	$22,198,436

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj).

The Children's Basic Health Plan Trust fund is created by 25.5-8-105 C.R.S. (2011). An "eligible person" for the program is defined in 25.5-8-103 (4) C.R.S. (2011). 25.5-8-107 (1) (a) (II), C.R.S. (2011) allows the Department to provide dental benefits though the Children's Basic Health Plan.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing
Request Title: Medicare Modernization Act State Contribution Payment
Priority Number: S-4

Dept. Approval by: John Bartholomew 12/23/11 (Date)

OSPB Approval by: 12/27/11 (Date)

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	**$91,156,720**	**$2,356,099**	**$91,156,720**	**$0**	**$0**
	FTE	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	GF	**$66,146,615**	**$2,356,099**	**$60,127,929**	**$0**	**$0**
	GFE	**$0**	**$0**	**$0**	**$0**	**$0**
	CF	**$0**	**$0**	**$0**	**$0**	**$0**
	RF	**$0**	**$0**	**$0**	**$0**	**$0**
	FF	**$25,010,105**	**$0**	**$31,028,791**	**$0**	**$0**
(5) Other Medical Services; Medicaid Modernization Act of 2003 State Contribution Payment	Total	$91,156,720	$2,356,099	$91,156,720	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$66,146,615	$2,356,099	$60,127,929	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$25,010,105	$0	$31,028,791	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number:

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: N/A

Other Information:

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

FY 2011-12 Supplemental Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-4
Medicare Modernization Act of 2003 State Contribution Payment

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
MMA State Contribution Payment	$2,356,099	$2,356,099	0.0

Request Summary:
This request is for additional General Fund totaling $2,356,099 for FY 2011-12 for the Medicare Modernization Act of 2003 State Contribution Payment line item. This request is the result of a projected increase in the caseload of dual-eligible individuals in conjunction with a projected increase in the per-member per-month (PMPM) rate paid by the State as required by federal regulations. The Department requested to adjust the FY 2012-13 appropriation for this line item in its November 1, 2011, FY 2012-13 R-4, and any FY 2012-13 amount presented in this request is for informational purposes only.

On January 1, 2006, the federal Centers for Medicare and Medicaid Services (CMS) assumed responsibility for the Medicare Part D prescription-drug benefit that replaced the Medicaid prescription-drug coverage for dual-eligible clients (individuals eligible for both Medicare and Medicaid). In lieu of the states' obligation to cover prescription drugs for this population, CMS began requiring states to pay a portion of what their anticipated dual-eligible drug cost would have been had this cost shift not occurred.

In January 2006, states began to pay CMS these "clawback" payments. The payments were calculated by taking 90% of the federal portion of each state's average PMPM dual-eligible drug benefit from calendar year 2003, inflated to 2006 using the average growth rate from the National Health Expenditure (NHE) per-capita drug expenditures. This inflated PMPM amount is then multiplied by the number of dual-eligible clients, including retroactive clients, back to January 2006. As each calendar year passes, the 90% factor is lowered by 1.67% each year – which is known as the phase-down percentage – until it reaches 75%, where it will remain beginning in 2015. In addition, CMS inflates each state's PMPM rates based on either NHE growth or actual growth in Part D expenditures.

With new data available, the Department has recalculated its estimate for FY 2011-12 and projects the MMA clawback payment will total $93,512,819, which is $2,356,099 higher than the FY 2011-12 appropriation.

On July 26, 2011, CMS released the National Health Expenditure Projections for 2010-2020, which the Department is currently analyzing to determine the impact these projections may have on the MMA State Contribution Payment line item. While the Department's analysis is ongoing, initial results indicate that MMA FY 2011-12 total expenditures could increase by as much as 3.2%.

Anticipated Outcomes:
Approval of this request would allow the Department to meet its obligation to the federal

government and ensure the Department would not have the amount of payment plus interest deducted from the federal funds received for the Medicaid program. Such a deduction could cause the Department to be under-funded to provide services and would necessitate a General Fund appropriation or program cuts to make up the difference, as Medicaid is an entitlement program in which the Department cannot cap enrollment.

Assumptions for Calculations:
The Department assumes the changes in the PMPM rate paid by the Department will be based on the growth in the 2009 NHE prescription-drug per-capita estimates between years 2012 and 2013 and offset by the corresponding phase-down percent. The Department further assumes the changes in dual-eligible caseload will follow a trend of 3.75% annual growth, as has been evidenced historically.

Tables detailing these calculations are attached in Appendix A of the Department's November 1, 2011, FY 2012-13 R-4 funding request.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
42 C.F.R. §423.910 (a) (2011) General rule: *Each of the 50 States and the District of Columbia is required to provide for payment to CMS a phased-down contribution to defray a portion of the Medicare drug expenditures for individuals whose projected Medicaid drug coverage is assumed by Medicare Part D.*

25.5-5-503, C.R.S. (2011) *(1) The state department is authorized to ensure the participation of Colorado medical assistance recipients, who are also eligible for medicare, in any federal prescription drug benefit enacted for medicare recipients. (2) Prescribed drugs shall not be a covered benefit under the medical assistance program for a recipient who is eligible for a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", Pub.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.*

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medicaid Budget Reduction

Priority Number: S-5

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$3,551,534,588	($7,859,799)	$3,567,597,651	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$900,939,403	($19,618,256)	$983,420,675	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,377,712	$15,625,858	$534,630,271	$0	$0
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,751,653,997	($3,867,401)	$1,762,269,580	$0	$0
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	Total	$7,670,839	$250,000	$7,801,722	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,100,370	$62,500	$2,100,370	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$60,537	$0	$100,654	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$5,509,932	$187,500	$5,600,698	$0	$0
(2) Medical Services Premiums	Total	$3,543,863,749	($8,109,799)	$3,559,795,929	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$898,839,033	($19,680,756)	$981,320,305	$0	$0
	GFE	$284,175,417	$0	$284,175,417	$0	$0
	CF	$608,317,175	$15,625,858	$534,529,617	$0	$0
	RF	$6,388,059	$0	$3,101,708	$0	$0
	FF	$1,746,144,065	($4,054,901)	$1,756,668,882	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

FY 2012-13: b Of this amount, ~~$354,642,186~~ $370,277,142 shall be from the Hospital Provider Fee Cash Fund Created in Section 25.5-4-402.3 (4),...~~$2,743,722~~ $2,734,624 shall be from the Breast and Cervical Cancer Prevention and Treatment Fund created in Section 25.5-5-308 (8) (a) (I)

Cash or Federal Fund Name and COFRS Fund Number: Hospital Provider Fee Cash Fund (24A), Breast and Cervical Cancer Prevention and Treatment Fund (15D), Title XIX

Reappropriated Funds Source, by Department and Line Item Name: None.

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: None.

Other Information: None.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Funding Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-5
Request Title: Medicaid Budget Reductions

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Medicaid Budget Reductions	($7,859,799)	($19,618,256)	0.0

Request Summary:
The Department requests a reduction of $7,859,799 total funds and $19,618,256 General Fund in FY 2011-12 to account for the current year impact of the savings initiatives the Department proposed in its November 1, 2011 budget request R-6, "Medicaid Budget Reductions". The Department is not requesting funding changes for any initiatives that were not detailed in R-6 as part of this request.

Initiatives with FY 2011-12 impacts include the following: Preterm Labor Prevention, Synagis PAR Review, Expansion of the Physician Administered Drug Rebate Program, Reimbursement Rate Alignment for Developmental Screenings, Physician Administered Drug Pricing and Unit Limits, Public Transportation Utilization, Home Health Therapies Cap, Home Health Care Cap, Seroquel Restrictions, Dental Efficiencies, Augmentative Communication Devices, Ambulatory Surgical Centers, Utilization Management Vendor Funding, Pharmacy Rate Methodology Transition, and Hospital Provider Fee Financing. A detailed description of each initiative can be found in the Department's FY 2012-13 Budget Request R-6: "Medicaid Budget Reductions".

Assumptions for Calculations:
Calculations for the FY 2011-12 impact of each initiative are included in the Department's FY 2012-13 Budget Request R-6: "Medicaid Budget Reductions".

Consequences if not Funded:
The Department has already begun implementing these initiatives. If the Department's FY 2011-12 appropriation is not reduced to account for these initiatives, the Department will be overfunded.

Cash Fund Projections:
See Table 5.1 in Appendix A of the Department's FY 2012-13 Budget Request R-6, "Medicaid Budget Reductions".

Relation to Performance Measures:
HCPF Performance Measure 4: Contain Health Care Costs: The initiatives contained in this request ensure care is both necessary and appropriate without sacrificing the integrity of clients' health.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
The Executive Director has the authority to limit the amount, scope, and duration of services and can implement reductions and programmatic efficiencies via rule change, per 25.5-4-401 (1) (a), C.R.S. (2011).

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: CHIPRA Bonus Payment True-up

Priority Number: S-6

Dept. Approval by: John Bartholomew 12/21/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	**Total**	**$91,156,720**	**$0**	**$91,156,720**	**$0**	**$0**
	FTE	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	GF	**$66,146,615**	**($5,633,177)**	**$60,127,929**	**$0**	**$0**
	GFE	**$0**	**$0**	**$0**	**$0**	**$0**
	CF	**$0**	**$0**	**$0**	**$0**	**$0**
	RF	**$0**	**$0**	**$0**	**$0**	**$0**
	FF	**$25,010,105**	**$5,633,177**	**$31,028,791**	**$0**	**$0**
(5) Other Medical Services; Medicaid Modernization Act of 2003 State Contribution Payment	Total	$91,156,720	$0	$91,156,720	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$66,146,615	($5,633,177)	$60,127,929	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$25,010,105	$5,633,177	$31,028,791	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XXI

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: N/A.

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-6
CHIPRA Bonus Payment True-up

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
(5) Other Medical Services; Medicaid Modernization Act of 2003 State Contribution Payment	$0	($5,633,177)	0.0

Request Summary:
The Department requests a reduction to the General Fund appropriation to the Medicaid Modernization Act of 2003 State Contribution Payment (MMA) line item in the amount of $5,633,177 in FY 2011-12 with corresponding increases in the federal funds appropriation. The requested change is the result of updated calculations for the State's projected CHIPRA bonus payments for FFY 2010 forward. The Department requested to adjust the FY 2012-13 appropriation for the CHIPRA bonus payment in its November 1, 2011 FY 2012-13 R-11, and any FY 2012-13 amount presented in this request is for informational purposes only. Please note that the Department's estimate for the FFY 2011 CHIPRA bonus payment have been updated from that included in its November 1, 2011 FY 2012-13 R-11 due to new information provided by the Centers for Medicare and Medicaid Services.

As discussed in the Department's November 1, 2010 DI-6 "Cash Fund Insolvency Financing" and February 15, 2011 "Cash Fund Insolvency True-Up," under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), federal funding was made available to states for performance bonuses to support the additional number of enrollees in Medicaid and CHP+ that states attract due to outreach and retention activities. Five of eight outreach and retention policies must be in place for at least half of the federal fiscal year for a state to qualify to receive a bonus. Once a state has qualified for the performance bonuses through the implementation of five out of the eight specified provisions, the state must exceed an enrollment target.

The CHIPRA bonuses are made in two distinct payments- an initial payment in the December following the end of the federal fiscal year for which the bonus payment is being made, and a second payment in approximately the following August. The second payment is made in order to allow for retroactive enrollments or disenrollments to occur, which makes the enrollment number used to calculate the payment more comparable to the baseline enrollment level.

The Department received notification that Colorado qualified for the FFY 2010 payment on December 23, 2010, and the Department received the first payment of $13,671,043 in late December 2010. The Department received an award letter for the second payment in the amount of $4,532,230 on August 10, 2011.

The Department's MMA line item was appropriated $25,010,105 federal funds in FY 2011-12 for the initial FFY 2011 CHIPRA bonus payment, with a corresponding decrease in the General Fund appropriation. This request is to

adjust this appropriation for two factors. First, the Department did not receive an appropriation for the second FFY 2010 payment, which was received in FY 2011-12. Second, the Department is adjusting the projected CHIPRA bonus payments for FFY 2011 forward to account for the revised Medicaid caseload forecast that is included in the Department's November 1, 2011 Budget Request.

Please note that the Department's request for FY 2011-12 includes a reduction of $30,000 from the full amount of the second FFY 2010 payment. Pursuant to HB 10-1264, the Department submitted an IDEA application to reward 11 Department employees for the extraordinary effort that went into ensuring that the State qualified for the FFY 2010 bonus payment. In accordance with 24-50-903 et seq. C.R.S. (2011), this application was approved by the Executive Director of the Department, the savings were reviewed and verified by the State Auditor, and the State Auditor presented these findings to the Legislative Audit Committee on July 11, 2011. As such, the Department has been granted authority to reduce the federal award by $30,000: $25,000 in discretionary funds for the Department and $5,000 to be equally distributed among the 11 Department employees on the team that won the award. This amount will be placed in a non-appropriated line item by the Office of the State Controller for disbursement.

Assumptions for Calculations:
The projected bonus payments for FFY 2011 forward are based on formulas set in federal law at 42 U.S.C. 1397ee(a)(3), and have been updated for the revised Medicaid caseload forecast that is included in the Department's November 1, 2011 Budget Request. Please see Attachment A for details assumptions, and calculations regarding the calculation of this request.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
42 U.S.C. 1397ee(a)(3) Performance bonus payment to offset additional Medicaid and CHIP child enrollment costs resulting from enrollment and retention efforts

(A) In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2009 and ending with fiscal year 2013), the Secretary shall pay from amounts made available under subparagraph (E), to each State that meets the condition under paragraph (4) for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year. The payment under this paragraph shall be made, to a State for a fiscal year, as a single payment not later than the last day of the first calendar quarter of the following fiscal year.

Attachment A
CHIPRA Bonus Payment True-up

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), federal funding was made available to states for performance bonuses to support the additional number of enrollees in Medicaid and CHP+ that states attract due to outreach and retention activities.

Bonus payments were made available beginning in federal fiscal year (FFY) 2009. For each year, bonuses will be paid by December 31st following the end of the federal fiscal year (e.g., FFY 2011 bonuses will be paid by December 31, 2011). Five of the eight policies must be in place for at least half of the federal fiscal year for a state to qualify to receive a bonus. The qualifying policies are shown in Table 1, along with Colorado's status. Colorado received approval for a Medicaid State Plan Amendment in FY 2010-11 that will clarified that Colorado's Medicaid Health Insurance Buy-In program meets all of the requirements for the Premium Assistance Subsidy provisions set forth in CHIPRA. This State Plan Amendment qualified Colorado to receive the CHIPRA bonus payment beginning in FFY 2010.

The CHIPRA bonuses are made in two distinct payments- an initial payment in the December following the end of the federal fiscal year for which the bonus payment is being made, and a second payment in approximately the following summer. The second payment is made in order to allow for retroactive enrollments or disenrollments to occur, which makes the enrollment number used to calculate the payment more comparable to the baseline enrollment level. The Department has assumed that 6 months of retroactivity will result in an increase in enrollment of approximately 1.17% based on enrollment data from the Medicaid Management Information System (MMIS) for January through December 2009 as well as the FFY 2010 final retroactive adjustment, though this percent is not known at this time.

Table 1: 8 Enrollment and Retention Provisions

Provision	Description	Medicaid	CHP+
12-Month Continuous Eligibility under Title XIX and Title XXI *	Establishment of a 12-month continuous eligibility period for children under age 19 in the Medicaid and/or CHIP State Plans.		✓
Elimination of Asset Test under Title XIX and Title XXI*	The State has liberalized asset test requirements for determining eligibility of children for Medicaid or CHIP by either removing asset/resource tests or reducing the documentation requirements for eligibility.	✓	✓
Elimination of In-Person Interview under Title XIX and Title XXI*	The State has eliminated in-person interview requirements for applying for Medicaid or CHIP (with exception for circumstances that justify a face-to-face interview).	✓	✓
Joint Application	The State has established a joint application and verification process for initial enrollment into Medicaid or CHIP and renewals of enrollment.	✓	✓
Auto Renewal under Title XIX and Title XXI	The State's Medicaid or CHIP program utilizes a renewal form with pre-printed eligibility information that is sent to the parent/caretaker relative of the child with notice that the child's eligibility will be automatically renewed unless other information is provided to the State that affects the child's continued eligibility.		
Presumptive Eligibility under Title XIX and Title XXI*	The State has implemented presumptive eligibility for children under the Medicaid and/or CHIP State Plans.	✓	✓
Express Lane under Title XIX and Title XXI*	The State is implementing the option to utilize express lane agencies under the Medicaid and CHIP State Plans.		
Premium Assistance Subsidy under Title XIX and Title XXI	The State has implemented the option of providing premium assistance subsidies under the Medicaid and/or CHIP State Plans.	✓	✓
* Both Medicaid and CHIP must implement these provisions.			

Once a state has qualified for the performance bonuses through the implementation of five out of the eight specified provisions, the state must exceed an enrollment target. The enrollment target will be set each year by applying the formula set out in CHIPRA to state enrollment data. Specifically, the Centers for Medicare and Medicaid Services will calculate the target for each state, which is based on the state's child enrollment in Medicaid in 2007 adjusted each year by the state's child population growth and a standard enrollment growth factor that changes over time as specified in CHIPRA. The standard enrollment growth factor, which is the same for all states, is based on national projected caseload growth. Because of the recession, it is pegged at a fairly high rate. The rate starts at 4% but drops to 3.5%, 3%, and ultimately to 2%.

The CHIPRA bonus payment is equal to a percentage of the state's share of the average per capita cost of a Medicaid child, applied to the number of Medicaid children that exceed the enrollment target. The percentage depends on how much enrollment exceeds the enrollment target. A state with enrollment between the target level and 110% of the target level (Tier 1 enrollment) would receive a bonus payment equal to 15% of the state's share of the average per capita cost of a Medicaid child, multiplied by the number of children above the target. The percentage would rise to 62.5% of the state's share of the average cost per child for enrollment above 110% of the target (Tier 2 enrollment).

Table 2a: CHIPRA Bonus Caseload Calculations- Initial Payment

	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Baseline Enrollment	263,497	276,400	288,230	300,912
Estimated Child Population Growth Factor[1]	4.90%	4.50%	4.40%	4.07%
Tier 1 Bonus Target Enrollment Estimate[2]	276,400	288,834	300,912	313,159
Tier 2 Bonus Target Enrollment Estimate[3]	304,040	317,717	331,003	344,475
Projected Enrollment	313,759	342,341	368,568	381,204
Projected Tier 1 Bonus Enrollment	27,640	28,883	30,091	31,316
Projected Tier 2 Bonus Enrollment	9,719	24,624	37,565	36,729

[1] Estimated Child population growth equals estimated population growth for age 0-18. The FFY 2010 estimate is provided by the Centers for Medicare and Medicaid Services, and future growth rates are estimates from the U.S. Census Bureau plus 3.5% in FFY 2011 through FFY 2012, and 3.0% in FFY 2013 thereafter.
[2] Tier 1 Bonus target is the Baseline Enrollment increased by the Estimated Child Population Growth Factor.
[3] Tier 2 Bonus target is 10% above the Tier 2 Bonus Enrollment target.

Table 2b: CHIPRA Bonus Per Capita Calculations

	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Kaiser State Health Facts CO Child Medicaid Cost[4]	$2,478.75	$2,650.89	$2,887.39	$3,116.32
Estimated Increase in National Health Expenditures	7.93%	6.96%	7.93%	7.93%
State FMAP Rate	50.00%	50.00%	50.00%	50.00%
Applicable Per Capita	$1,337.64	$1,325.45	$1,558.16	$1,681.70

[4] Per capita costs used to calculate the bonus payment is the average cost of a non-SSI, non-waiver child in Medicaid including retroactivity. Because the Department does not report a similar per capita cost in its budget, the Kaiser State Health Facts CO Child Medicaid Cost is used as the closest available proxy to that used by the Centers for Medicare and Medicaid Services to calculate the payment.

Table 2c: CHIPRA Bonus Payment Calculation- Initial Payment

	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Projected Tier 1 Bonus Enrollment	27,640	28,883	30,091	31,316
Projected Tier 1 Per Capita Bonus[5]	$200.64	$198.82	$233.72	$252.26
Projected Tier 1 Bonus Payment	**$5,545,765**	**$5,742,446**	**$7,032,869**	**$7,899,774**
Projected Tier 2 Bonus Enrollment	9,719	24,624	37,565	36,729
Projected Tier 2 Per Capita Bonus[5]	$836.02	$828.41	$973.85	$1,051.06
Projected Tier 2 Bonus Payment	**$8,125,278**	**$20,398,606**	**$36,582,763**	**$38,604,278**
Projected Total Initial CHIPRA Bonus Payment	**$13,671,043**	**$26,141,052**	**$43,615,632**	**$46,504,052**

[5] Projected Tier 1 Bonus Per Capita is equal to the estimated base per capita cost for Medicaid children multiplied by the State's FMAP rate multiplied by 15%. Projected Tier 1 Bonus Per Capita is equal to the estimated base per capita cost for Medicaid children multiplied by the State's FMAP rate multiplied by 62.5%.

Table 2d: CHIPRA Bonus Payment Calculation- Final Caseload Projections				
Projected Enrollment with Retroactivity[6]	319,961	346,346	372,880	385,664
Projected Tier 1 Bonus Enrollment	27,640	28,883	30,091	31,316
Projected Tier 2 Bonus Enrollment	15,921	28,629	41,877	41,189
Applicable Per Capita	$1,291.35	$1,393.74	$1,504.24	$1,623.50

[6] Based on enrollment data from the MMIS for January through December 2009 as well as the FFY 2010 final retroactive adjustment, the Department estimates that 6 months of retroactivity will result in an increase in enrollment of approximately 1.17%.

Table 2e: CHIPRA Bonus Payment Calculation- Final Payment				
	FFY 2010	FFY 2011	FFY 2012	FFY 2013
Projected Tier 1 Bonus Enrollment	27,640	28,883	30,091	31,316
Projected Tier 1 Per Capita Bonus	$193.70	$192.96	$225.64	$243.53
Projected Tier 1 Bonus Payment	**$5,353,937**	**$5,573,267**	**$6,789,613**	**$7,626,229**
Projected Tier 2 Bonus Enrollment	15,921	28,629	41,877	41,189
Projected Tier 2 Per Capita Bonus	$807.09	$804.00	$940.15	$1,014.69
Projected Tier 2 Bonus Payment	**$12,849,336**	**$23,017,729**	**$39,370,662**	**$41,793,963**
Projected Total CHIPRA Bonus Payment	**$18,203,273**	**$28,590,996**	**$46,160,275**	**$49,420,192**
Projected Second Payment	**$4,532,230**	**$2,449,944**	**$2,544,643**	**$2,916,140**

Table 3: CHIPRA Bonus Payments by State Fiscal Year					
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Projected Initial Bonus Payment (December of Respective State Fiscal Year)	$13,671,043	$26,141,052	$43,615,632	$46,504,052	$0
Projected Second Bonus Payment (August of Following State Fiscal Year)*	$0	$4,502,230	$2,449,944	$2,544,643	$2,916,140
Projected Total Bonus Payments by State Fiscal Year	**$13,671,043**	**$30,643,282**	**$46,065,576**	**$49,048,695**	**$2,916,140**

* The amount appropriated from the second payment from FFY 2010 is reduced by $30,000 for IDEA awards. Please see narrative for details.

Table 4: Estimated/Requested Appropriation Adjustments for CHIPRA Bonus Payments				
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
Projected Total Bonus Payments by State Fiscal Year	$13,671,043	$30,643,282	$46,065,576	$49,048,695
Appropriation/Base Request	$13,671,043	$25,010,105	$31,028,791	$0
Estimated/Requested Incremental Increase in Federal Funds Appropriation (Corresponding Decrease in General Fund Appropriation)	**$0**	**$5,633,177**	**$15,036,785**	**$49,048,695**

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Hospital Provider Fee Administrative True-up

Priority Number: S-7

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$96,766,237	$3,920,338	$98,483,655	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$27,485,261	$0	$27,272,835	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$9,809,945	$2,023,541	$11,183,319	$0	$0
	RF	$121,320	$0	$121,810	$0	$0
	FF	$59,349,711	$1,896,797	$59,905,691	$0	$0
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects[a]	**Total**	$6,596,052	($120,000)	$6,410,052	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,430,918	$0	$1,487,168	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$721,750	($60,000)	$497,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,443,384	($60,000)	$4,425,384	$0	$0
(1) Executive Director's Office; (C) Information Technology Contracts, Centralized Eligibility Vendor Contract Project[b]	**Total**	$2,221,482	$2,230,940	$4,584,648	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$964,169	$1,246,853	$2,129,467	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,257,313	$984,087	$2,455,181	$0	$0
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Identification Cards[c]	**Total**	$120,000	$9,240	$120,000	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$59,203	$0	$59,203	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$4,620	$0	$0	$0
	RF	$1,593	$0	$1,593	$0	$0
	FF	$59,204	$4,620	$59,204	$0	$0
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, County Administration[d]	**Total**	$33,547,878	($2,361,502)	$34,008,773	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$10,300,790	$0	$10,373,188	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$6,513,282	($1,180,751)	$6,671,332	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$16,733,806	($1,180,751)	$16,964,253	$0	$0

Line Item Information	Fund	FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
		Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration *(new line item)* [e]	Total	$0	$2,361,502	$0	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$1,180,751	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$0	$1,180,751	$0	$0	$0
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach [f]	Total	$5,213,157	$90,506	$4,895,961	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,550,470	$0	$2,376,649	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$56,109	$45,253	$71,333	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,606,578	$45,253	$2,447,979	$0	$0
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts [g]	Total	$7,670,839	$243,612	$7,801,722	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,100,370	$0	$2,100,370	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$60,537	$53,795	$100,654	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$5,509,932	$189,817	$5,600,698	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System [h]	Total	$8,983,839	$1,466,040	$8,895,282	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$4,461,609	$0	$4,416,786	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$14,428	$733,020	$14,520	$0	$0
	RF	$19,399	$0	$19,889	$0	$0
	FF	$4,488,403	$733,020	$4,444,087	$0	$0

Letternote Text Revision Required? **Yes:** ☑ **No:** ☐ **If yes, describe the Letternote Text Revision:**

a Of this amount, ~~$2,545,858~~ $2,485,858 shall be from the Hospital Provider Fee Cash Fund...

b Of this amount, ~~$964,169~~ $2,211,022 shall be from the Hospital Provider Fee Cash Fund...

c Of this amount $4,620 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-402.3 (4) C.R.S.

d Of this amount, ~~$1,180,751~~ $0 shall be from the Hospital Provider Fee Cash Fund...

e Of this amount, $1,180,751 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-402.3 (4) C.R.S.

f Of this amount, ~~$56,109~~ $101,362 shall be from the Hospital Provider Fee Cash Fund...

g Of this amount ~~$60,537~~ $114,332 shall be from the Hospital Provider Fee Cash Fund...

h Of this amount. $733,020 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-402.3 (4) C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A); FF: Title XIX, Title XXI

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? **Yes:** ☐ **No:** ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: Department of Human Services, Governor's Office of Information Technology

Other Information: N/A.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Governor's Office of Information Technology
Request Title: Hospital Provider Fee Administrative True-up
Priority Number: HCPF S-12

Dept. Approval by: _____ Date

OSPB Approval by: _____ 12/29/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 6 Continuation Amount FY 2013-14
Total of All Line Items	Total	19,007,729	1,466,040	19,127,288	-	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	19,007,729	1,466,040	19,127,288	-	-
	FF	-	-	-	-	-
(5) Office of Information Technology, (E) Colorado Benefits Management System, Operating Expenses	Total	19,007,729	1,466,040	19,127,288	-	-
	FTE	-	-	-	-	-
	GF	-	-	-	-	-
	GFE	-	-	-	-	-
	CF	-	-	-	-	-
	RF	19,007,729	1,466,040	19,127,288	-	-
	FF	-	-	-	-	-

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: COFRS Fund 613 (IT Revolving Fund)
Reappropriated Funds Source, by Department and Line Item Name: User charges
Approval by OIT? Yes: ☑ No: ☐ Not Required: ☐
Schedule 13s from Affected Departments: Departments of Health Care Policy & Financing
Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2011-12 Supplemental Request
January 3, 2012

Department Priority: S-7
Request Title: Hospital Provider Fee Administrative True-up

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Total Request	$3,920,338	$0	0.0

Request Summary:
The Department requests an increase of $3,920,338 total funds, comprised of $2,023,541 hospital provider fee cash funds and $1,896,797 federal funds in FY 2011-12, in order to true-up appropriations with actual need for hospital provider fee administration.

To date, appropriations for hospital provider fee administration have for the most part been directly from the original fiscal note developed for HB 09-1293. Since then however, implementation dates of programs have changed and caseload forecasts have begun to deviate from those originally estimated, requiring a true-up to bring the appropriations in line with actual need based on the current caseload and program implementation dates. This request will make the hospital provider fee more efficient by ensuring that the appropriate level of fee is being assessed on hospitals and that the fees collected for administration are being allocated accurately.

HB 09-1293 authorized the Department to collect a hospital provider fee for the purpose of obtaining federal financial participation, and to use the combined funds to increase reimbursement to hospitals that provide medical care under the State Medical Assistance Program and the Colorado Indigent Care Program (CICP), increase the number of persons covered by public medical assistance, and to pay the administrative costs of the Department in implementing and administering the program. This request is to true-up the hospital provider fee appropriations to administrative lines that are required in the implementation and administration of the program. All adjustments to medical, mental health, and dental costs due to updated caseload forecasts for Medicaid and Children's Basic Health Plan (CHP+) expansions under the hospital provider fee are incorporated in the Department's November 1, 2011 R-1, R-2, and R-3.

Anticipated Outcomes:
This request will make the hospital provider fee more efficient by ensuring that the appropriate level of fee is being assessed on hospitals and that the fees collected for administration are being allocated accurately.

Assumptions for Calculations:
To estimate the adjustments required to individual line items, the most recent caseload forecasts for FY 2011-12 and FY 2012-13 are used with the goal of equalizing the hospital provider fee spending authority with the proportion of the expansion populations funded under the hospital provider fee relative to the appropriate total caseload. Each line item is adjusted to reflect the proportion of the relevant expansion caseload to the total caseload. Appendix A outlines which proportions are used to adjust each line item in this request, along with

justifications for each adjustment. Please refer to Table B.1 in Appendix B for the calculations of the different percentages used to adjust the various line items in the request.

Consequences if not Funded:
If this request is not approved, funding would be appropriated to the administrative functions of the hospital provider fee program in a disproportionate and inadequate manner. These appropriations would be for the most part directly from the original fiscal note, which was developed more than two years ago. Since then, the need for administrative appropriations has deviated due to adjusted expansion population implementation dates and updated caseload forecasts. This results in inefficiencies in the hospital provider fee model, and may result in over-collection of provider fee or the need to request spending authority at a later date.

Impact to Other State Government Agency:
There would be impacts to the Department of Human Services and to the Governor's Office of Information Technology.

See Attachment A for financial impacts.

Cash Fund Projections:
Cash Funds used in this request are exclusively from the Hospital Provider Fee Cash Fund, which is created at 25.5-4-402.3 C.R.S. (2011). Revenue into the fund is from provider fees collected from hospitals, which is modeled to match projected expenditures. For more detail, please refer to the Colorado Health Care Affordability Act Update included in the Department's November 1, 2011 Budget Request.

Cash Fund Name	Hospital Provider Fee Cash Fund
Cash Fund Number	24A
FY 2010-11 Expenditures	$426,069,052
FY 2010-11 End of Year Cash Balance	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$22,198,436

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
25.5-4-402.3 C.R.S. (2011) establishes the Hospital Provider Fee and authorizes the Department to charge and collect hospital provider fees.

25.5-4-402.3 (3) (a) (I) (III) C.R.S. (2011) and 25.5-4-402.3 (4) (b) (VI) C.R.S. (2011) allow the provider fee and federal matching funds collected to be used to pay the administrative costs of the Department in implementing and administering the Hospital Provider Fee.

General Administration, Legal Services and Third Party Recovery Legal Services and Administrative Law Judge Services

These lines are for legal services provided by the Department of Law and administrative law judges and paralegals from the Office of Administrative Courts. The services cover the Department as a whole, and will be adjusted to be proportionate with all of the expansions funded under the Hospital Provider fee relative to Medicaid and the Children's Basic Health Plan (CHP+) in total. This adjustment, however, is not being done through this request; rather, it will be done through the Common Policy adjustments toward the end of FY 2011-12. At that time, the Department will collaborate with the affected Departments to ensure that the FY 2011-12 and FY 2012-13 appropriations from the hospital provider fee are brought in line with the proportion of all expansion populations relative to total caseload in Medicaid and CHP+.

General Administration, General Professional Services and Special Projects

The appropriation to this line item is used to fund some of the contracts required to implement and administer the hospital provider fee. These contracted activities include assisting the Department in responding to questions from the Centers for Medicare and Medicaid Services (CMS) after submission of the provider fee model each year, reviewing the Department's upper payment limit calculations and recommending any necessary changes, assisting in development of benefit packages and cost-effective rates for the Disabled Buy-In and the Adults without Dependent Children (AwDC) programs, and assistance in the development of hospital quality incentive payments. The original fiscal note for HB 09-1293 also included funding of $120,000 for a project manager for the significant and complex information technology work required to implement the bill. Since the implementation of HB 09-1293 however, the Department has been able to perform this function internally, and therefore the Department requests to reduce this appropriation by $120,000 in FY 2011-12.

Information Technology Contracts and Projects, Information Technology Contracts

This line contains funding for the Medicaid Management Information System (MMIS), which is a system of hardware and software used to process Medicaid claims and manage information about Medicaid and CHP+ beneficiaries and services. In addition to the FY 2011-12 Long Bill appropriation of $4,402,843, the Department also received rollforward authority in the amount of $1,087,619 for hospital provider fee projects that were not completed in FY 2010-11, resulting in total FY 2011-12 spending authority of $5,490,462. The Department is adjusting the MMIS appropriation for hospital provider fee projects in its FY 2012-13 BA-6 "MMIS Technical Adjustments."

Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project

This line has a FY 2011-12 appropriation of $2,221,482. The Department did not expend any of the appropriation to this line item in FY 2009-10 or FY 2010-11 because the volume triggers included in the Department's contract with Maximus, the CHP+ eligibility and enrollment vendor, were not reached. As such, the funding was not needed. However, effective FY 2011-12, the Department has executed a contract amendment with Maximus in the amount of $843,877 due to increased call volume per the terms of the eligibility and enrollment contract. The Department is requesting to adjust the FY 2011-12 appropriation to the amounts shown in Table A.1 below. The updated estimates are based on the actual contract amendment for the CHP+ expansion, updated caseload estimates for the Disabled Buy-In and AwDC expansions, and the Department's implementation of a waitlist for the AwDC population, which the Centralized Eligibility Vendor will manage.

Table A.1: Revised Centralized Eligibility Vendor Costs			
	FY 2011-12	FY 2012-13	FY 2013-14
Estimated Eligibility and Enrollment Vendor Cost for CHP+- Eligibility	**$843,877**	**$843,877**	**$843,877**
State Costs (Provider Fee)	$406,749	$406,749	$406,749
Federal Funds	$437,128	$437,128	$437,128
Estimated Eligibility and Enrollment Vendor Cost for Disabled Buy-In and AwDC	**$3,608,545**	**$4,254,910**	**$5,306,068**
State Costs (Provider Fee)	$1,804,273	$2,127,455	$2,653,034
Federal Funds	$1,804,272	$2,127,455	$2,653,034
Total	**$4,452,422**	**$5,098,787**	**$6,149,945**
State Costs (Provider Fee)	$2,211,022	$2,534,204	$3,059,783
Federal Funds	$2,241,400	$2,564,583	$3,090,162

Medical Identification Cards
Currently, this line does not have a hospital provider fee appropriation as total funding to this line has historically exceeded overall need. Going forward however, with the growing and upcoming expansions funded under the hospital provider fee, the Department is requesting to include a hospital provider fee appropriation in proportion with the Medicaid expansions funded under the Hospital Provider fee to total Medicaid. Based on the most recent caseload estimates, the Department is requesting total funds appropriations to this line item of $9,240 in FY 2011-12.

Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations
This line has a FY 2011-12 appropriation of $5,602,536. This funding was for two separate items: $3,074,400 for Hospital Outstationing and $2,528,136 for disability determinations for the Disabled Buy-In population. In FY 2010-11, the Department was working to develop a model to distribute the Hospital Outstationing funding and the expansions to the Disabled Buy-In populations were delayed, both of which contributed to the Department not expending any of this appropriation. For FY 2011-12, the Department will implement the model to pay the $3,074,400 appropriated for Hospital Outstationing. Further, the Disabled Buy-In populations for which money was appropriated for disability determinations will be implemented in FY 2011-12, creating the need for the disability determination portion of the appropriation. In addition to the Disabled Buy-In populations for which the Department originally anticipated the need for disability determination funding, the Department has subsequently learned that there will be funding needs for two other types of disability determinations. First, a portion of the AwDC population will require a disability determinations due to federal requirements prohibiting individuals that are deemed "medically frail" from being enrolled in a benchmark benefit package. Second, some Disabled Buy-in clients may require extra services through Consumer Directed Attendant Support Services (CDASS), which will require a separate disability determination. These costs were not included in the fiscal note for HB 09-1293, and thus are not built into the appropriation. Policy decisions still need to be made in these areas, and estimates of costs are still unknown. Due to these unknown factors, the Department is not requesting to change the appropriation for disability determinations at this time. If the anticipated costs for disability determinations differ from the appropriation once these policy decisions are made, the Department will request an adjustment to this appropriation through the normal budget process.

Eligibility Determinations and Client Services, County Administration and Eligibility Determinations and Client Services, Hospital Provider Fee County Administration *(new line item)*
The County Administration line item has a FY 2011-12 hospital provider fee related appropriation of $2,361,502 total funds. Currently, the funding for the County Administration line item as a whole is composed of General Fund, cash funds, and federal funds, with the cash funds portion consisting of both

the hospital provider fee and a local match from the counties. The Department reimburses local county departments of social/human services for processing Medicaid applications and on-going case management according to the methodology agreed upon by the Department and the Department of Human Services, which is based on actual costs incurred by the county and a random moment time study. The Hospital Provider Fee appropriation however, contains no local match, and the Department is currently developing an alternate methodology to the random moment time study mentioned above to distribute these funds to the counties to ensure that expenditures are appropriately aligned with actual workloads related to the hospital provider fee expansions. Because of these factors, the Department requests to move the hospital provider fee funding for county administration to a new line item, Eligibility Determinations and Client Services, Hospital Provider Fee County Administration. The movement of the hospital provider fee funding to this new line item will make the budget more transparent, allow for easier tracking of hospital provider fee funds, and separate funding sources that are allocated based on differing methodologies. The Department will work with the counties to develop an allocation methodology for these funds that more accurately reflects hospital provider fee related expenditures.

While the Centralized Eligibility Vendor discussed above is intended to complete eligibility determinations and provide on-going case management services for the CHP+ expansion to 250% FPL, Disabled Buy-In, and AwDC, clients would still have the option of applying for assistance at a county office. The Department does anticipate that some of these expansion clients will apply at local county departments of social/human services, but the number of applications for these expansion populations, time allocated to them, and the cost associated with the initial processing are all unknown at this time. The Department will reimburse counties for the costs associated with the initial intake of any such application through a methodology to be developed and agreed upon by the Department and counties based on actual costs incurred by the county. Because these factors are currently unknown, the Department is not requesting to adjust this appropriation amount at this time.

Eligibility Determinations and Client Services, Customer Outreach

This line contains the funding for both the S.B. 97-05 Enrollment Broker, which is contracted to provide information on health plan choices and Medicaid benefits offered through the plans, and the administrative cost to provide outreach and case management for the federally required Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) program. The Enrollment Broker appropriation includes 3.7% hospital provider fee and federal matching funds for FY 2011-12. Since the services provided are to Medicaid populations only, the Department requests to bring this budget line's hospital provider fee funding in proportion with the Medicaid expansions funded under the Hospital Provider fee to total Medicaid. This results in the hospital provider fee appropriation being increased to 7.15% of the total appropriation for FY 2011-12. This increase is due to the inclusion of the Disabled Buy-In and AwDC populations. In the original fiscal note for HB 09-1293, the Department had assumed that enrollment broker functions for these populations would be performed by the Centralized Eligibility Vendor, similar to the current process in CHP+. However, because these clients will be enrolled in traditional Medicaid, the Department has determined that the Medicaid enrollment broker must be used for these functions. For the EPSDT program, the appropriation includes 0.44% hospital provider fee and federal matching funds for FY 2011-12. However, because Continuous Eligibility for Medicaid Children is not currently scheduled to be implemented in FY 2011-12, the Department is eliminating the hospital provider fee appropriation to this line item at this time.

Utilization and Quality Review Contracts, Professional Services Contracts

This line contains funding for external quality review, acute care utilization review, and drug utilization review. External quality review funds performance improvement projects and calculation of required

quality measures such as Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS); acute care utilization review funds prospective and retrospective reviews of specified services to ensure proper coverage and medical necessity, and; drug utilization review is federally required to ensure appropriate use of drug therapy through prospective and retrospective reviews. The appropriation to this line item includes 3.33% hospital provider fee and federal matching funds for FY 2011-12. As these services are for the Medicaid program only, the Department requests that this line's hospital provider fee funding be brought in line with the Medicaid expansions funded under the Hospital Provider fee to total Medicaid. This results in the hospital provider fee appropriation being increased to 7.15% of the total appropriation for FY 2011-12.

Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System

This line contains funding for the Colorado Benefits Management System (CBMS), which tracks clients, data, determines eligibility, and calculates benefits for medical, food, and financial-assistance programs in the State of Colorado. The Department's hospital provider fee appropriation to this line item in FY 2011-12 is $228,864 total funds. In addition, the Department of Human Services has a Hospital Provider Fee appropriation of $368,616 total funds, for a total appropriation between the two departments of $597,480. However, due to the delayed implementation of the Disabled Buy-In and AwDC expansion populations, this funding is inadequate to complete systems development. The Department requests an increase of $1,466,040 to the appropriation to have sufficient funds to complete the system development work within CBMS to implement the Working Adults Buy-in and AwDC on March 1, 2012 and the Children's Buy-in 4 to 6 months later. The purpose of this request is only to true-up the amount of funding needed for system development. If the Department's FY 2012-13 S-12, BA-5 "CBMS Technical Adjustment for HB 09-1293 and HCPF Only Projects" is approved, the Department requests that the incremental appropriations from both this request and the Department's FY 2012-13 R-12 "Hospital Provider Fee Administrative True-up" be made to the new line item, "Colorado Benefits Management System Projects HCPF Only."

Please note that the FY 2011-12 request includes $187,800 for correspondence costs. Of this amount, $87,800 is for those clients that the Department anticipates to enroll in FY 2011-12, and assumes three mailings per year at a cost of $0.63 each for an annual average of 46,455 clients. An additional $100,000 is also being requested for correspondence costs for those individuals that will be placed on the waitlist for AwDC and those that may apply and be denied for the expansion populations. This $100,000 would allow for approximately 52,910 individuals on the waitlist to receive three mailing a year at $0.63 each. This funding would also cover the cost of the mailings for those who apply for the program and are denied. Many individuals applying may not know their income level, so there may be many denials resulting solely from applicants being over the income limit for AwDC. The Department expects the largest influx of applicants to occur in FY 2011-12, with FY 2012-13 only having the costs associated with churn in the waitlist and a reduced number of applicants applying and being denied compared to FY 2011-12. Please see Table A.2 below for the CBMS costs for FY 2011-12.

Table A.2: FY 2011-12 CBMS Need

	Hours	Cost per Hour	Total Cost
AwDC Development	5,159	$108	$557,172
Working Adults Buy-in Development	7,239	$108	$781,812
Children's Buy-in Development	4,068	$108	$439,344
Waitlist Development	624	$108	$67,392
CBMS Correspondence	-	-	$187,800
Pipeline Expansion	-	-	$30,000
Total	17,090		$2,063,520

Appendix B: Tables and Calculations

Table B.1: Calculations of Medicaid/CHP+ Percentages		
Row		FY 2012-13
1	FY 2012-13 Total Medicaid Caseload Projection	673,956
2	FY 2012-13 Total CHP+ Caseload Projection	79,257
3	FY 2012-13 Total Medicaid and CHP + Caseload Projection (Row 1 + Row 2)	753,213
4	FY 2012-13 Expansion Adults to 100% Caseload Projection	36,083
5	FY 2012-13 Adults Without Dependent Children (AwDC) Caseload Projection	10,000
6	FY 2012-13 Disabled Buy-In Caseload Projection	2,126
7	FY 2012-13 Medicaid Expansion Projections (Row 4 + Row 5 + Row 6)	48,209
8	FY 2012-13 CHP+ Expansion to 250% Caseload Projection (Children + Prenatal)	11,436
9	FY 2012-13 Medicaid and CHP + Expansion Projections (Row 7 + Row 8)	59,645
10	**Expansion Adults to 100% as % of Medicaid Caseload (Row 4 / Row 1)**	**5.35%**
11	**All Medicaid Expansions as % of Medicaid (Row 7 / Row 1)**	**7.15%**
12	**All Expansions as % of Medicaid and CHP+ (Row 9 / Row 3)**	**7.92%**

Table B.2: Summary of Incremental Request FY 2011-12				
	Total Funds	**General Fund**	**Cash Funds (Provider Fee)**	**Federal Funds**
Total Request	**$3,920,338**	**$0**	**$2,023,541**	**$1,896,797**
(A) General Administration, General Professional Services and Special Projects	($120,000)	$0	($60,000)	($60,000)
(C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	$2,230,940	$0	$1,246,853	$984,087
(D) Medical Identification Cards	$9,240	$0	$4,620	$4,620
(D) Eligibility Determinations and Client Services, County Administration	($2,361,502)	$0	($1,180,751)	($1,180,751)
(D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration (*new line item*)	$2,361,502	$0	$1,180,751	$1,180,751
(D) Eligibility Determinations and Client Services, Customer Outreach	$90,506	$0	$45,253	$45,253
(E) Utilization and Quality Review Contracts, Professional Services Contracts	$243,612	$0	$53,795	$189,817
(6) (B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	$1,466,040	$0	$733,020	$733,020

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Cost Sharing for CHP+

Priority Number: S-8

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	**Total**	$213,086,149	($264,453)	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	($138,601)	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$136,133	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	($261,985)	$122,048,467	$0	$0
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	**Total**	$213,086,149	($264,453)	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	($138,601)	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$136,133	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	($261,985)	$122,048,467	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ If yes, describe the Letternote Text Revision:

Of this amount, ~~$28,727,097~~ $28,865,698 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105 (1) C.R.S., ~~$12,389,580~~ $12,387,112 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., $461,700 shall be from the Colorado Immunization Fund created in Section 25-4-2301, C.R.S., and $1 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A), Children's Basic Health Plan Trust Fund (11G); FF: Title XXI.

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: N/A.

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-8
Request Title: Cost Sharing for CHP+

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Cost Sharing for CHP+	($264,453)	($138,601)	0.0

Request Summary:
The Department requests a reduction of $264,453 total funds, $138,601 General Fund in FY 2011-12 from increased cost sharing for the Child Health Plan *Plus* (CHP+). In its November 1, 2011 FY 2012-13 Budget Request R-7 "Cost-sharing for Medicaid and CHP+," the Department outlines its plan to increase cost-sharing in CHP+ by increasing co-payments and tripling annual enrollment fees for certain CHP+ families. While the increased co-payments would take effect in FY 2012-13, the increased enrollment fees would become effective in January 2012.

Thus, this supplemental request reflects six months of estimated savings realized in FY 2011-12 from tripling the current annual enrollment fees for CHP+ families with incomes above 205% of the Federal Poverty Level (FPL). The Department currently requires these families to pay an enrollment fee of $25 for one child or $35 for 2 or more children; these enrollment fees would be increased to $75 and $105, respectively. The Department estimates this would result in savings of $264,453 total funds, $138,601 General Fund in FY 2011-12. Please see the Department's budget request cited above for further details.

The Department has actively engaged stakeholders to determine what level of increases to CHP+ cost sharing would result in the lowest attrition of clients and maintain affordability for families while still increasing clients' responsibility in their personal and family health care while realizing savings to the State.

Anticipated Outcomes:
The Department anticipates that the higher CHP+ enrollment fees for clients in higher income brackets would ease some financial burden from the Department while moderately increasing costs for the families that are best able to absorb them.

Assumptions for Calculations:
Please see the Department's November 1, 2011 FY 2012-13 Budget Request, R-7 "Cost-sharing for Medicaid and CHP+."

Consequences if not Funded:
If this request is not funded, the Department would not be able to realize the proposed savings and mitigate long-term cost growth by requiring clients to be more financially involved in their health care decisions.

Cash Fund Projections:

Cash Fund Name	Children's Basic Health Plan Trust Fund	Hospital Provider Fee Cash Fund
Cash Fund Number	11G	24A
FY 2010-11 Expenditures	$43,062,875	$426,069,052
FY 2010-11 End of Year Cash Balance	$7,745,026	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$9,332,096	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$8,036,989	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$6,924,385	$22,198,436

Relation to Performance Measures:
This request will assist the Department in meeting its performance measures to improve health outcomes and contain health care costs. This request will increase clients' responsibility for their health care and reduce costs to the Department.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data has resulted in a substantive change in funding need.

Current Statutory Authority or Needed Statutory Change:
Sections 25.5-8-107 (1)(b) and (c), C.R.S. (2011) authorize the Department to implement a cost sharing structure for the Children's Basic Health Plan that includes an annual enrollment fee based on a sliding fee scale and co-payments. Families with incomes below 151% FPL and pregnant women are exempt from paying enrollment fees.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Federally Mandated CHP+ PPS Payments to FQHCs and RHCs

Priority Number: S-11

Dept. Approval by: John Bartholomew 12/20/11 (Date)

OSPB Approval by: 12/27/11 (Date)

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information		FY 2011-12		FY 2012-13		FY 2013-14
		1	2	3	4	5
	Fund	Appropriation FY 2011-12	Supplemental Request FY 2011-12	Base Request FY 2012-13	Funding Change Request FY 2012-13	Continuation Amount FY 2013-14
Total of All Line Items	Total	$213,086,149	$1,650,176	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	$0	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$577,562	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	$1,072,614	$122,048,467	$0	$0
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	Total	$213,086,149	$1,650,176	$187,766,874	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$29,551,808	$0	$25,066,119	$0	$0
	GFE	$446,100	$0	$446,100	$0	$0
	CF	$44,582,245	$577,562	$40,206,188	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$138,505,996	$1,072,614	$122,048,467	$0	$0

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision:**

Of this amount, ~~$28,727,097~~ $29,266,985 shall be from the Children's Basic Health Plan Trust created in Section 25.5-8-105 (1) C.R.S., ~~$12,389,580~~ $12,427,254 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., $461,700 shall be from the Colorado Immunization Fund created in Section 25-4-2301, C.R.S., and $1 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2) (a) (I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund (24A), Children's Basic Health Plan Trust Fund (11G); FF: Title XXI.

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑

Schedule 13s from Affected Departments: N/A.

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-11
Request Title: Federally Mandated CHP+ PPS payments for FQHCs and RHCs

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Federally Mandated CHP+ PPS Payments	$1,650,176	$0	0

Request Summary:
The Department is requesting to increase funding to the Children's Basic Health Plan Medical and Dental Costs line item in FY 2011-12 in order to comply with federal regulations requiring that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) receive certain reimbursement for services provided to CHP+ clients. The Department is requesting one-time funding of $1,650,176 total funds in FY 2011-12, of which $539,888 is cash funds from the CHP+ Trust Fund, $37,674 is cash funds from the Hospital Provider Fee and $1,072,614 is federal funds. This funding is necessary to make the required retroactive payments back to the effective date of the federal regulation. Beginning in FY 2012-13, the Department will implement a budget neutral reimbursement methodology that complies with federal requirements.

Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) created a new section 1902(bb) in the Social Security Act that requires Medicaid programs to make payments for FQHC and RHC services in an amount calculated on a per-visit basis. This reimbursement methodology is called a prospective payment system (PPS) and requires reimbursement to be set at 100% of the clinic's average cost of providing covered services during certain "base years." These rates are then adjusted annually by a health care costs index. States may also implement an alternative payment system that reimburses FQHCs and RHCs at or above the PPS rate specified in BIPA.

Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amended section 2107(e)(1) of the Social Security Act to make section 1902(bb) applicable to CHIP effective October 1, 2009. The Department is thus required to pay FQHCs and RHCs the BIPA PPS rate (or an agreed-upon alternative payment system) for CHP+ services provided from October 1, 2009 forward.

When this federal regulation was passed, the Department received a grant from the Centers for Medicare and Medicaid Services to develop an alternative payment system that would have included incentive payments for FQHCs and RHCs based on health outcomes. After multiple discussions, the Department was unable to reach an agreement with FQHCs and RHCs on an incentive-based alternative payment system. Consequently, the Department is implementing the BIPA PPS rates for FQHCs and RHCs.

Due to the various agreed upon reimbursement levels currently in place between the CHP+ Managed Care Organizations (MCOs) and the FQHCs and RHCs, some of which are above the BIPA PPS rate and some of which are below, the Department anticipates that the future prospective payment methodology would have no net impact on the CHP+ budget. The Department will

implement the BIPA PPS rates going forward beginning in FY 2012-13, and all necessary changes resulting from this new reimbursement methodology will be incorporated into the FY 2012-13 rate setting and contracting processes.

The Department is requesting funding in FY 2011-12 to make retroactive payments to FQHCs and RHCs for services provided between October 1, 2009 and June 30, 2012. Because the Department cannot adjust reimbursement policy for services provided during this retroactive period, the Department has no way of making the retroactive reimbursement budget neutral- this can only be done by decreasing payments where the encounter rate exceeds the BIPA PPS in order to increase those where the payment is less than the BIPA PPS minimum.

The Department has estimated the retroactive payments based on newly available data on FQHC and RHC services. The Department estimates that the total aggregate retroactive payments due to FQHCs and RHCs are $1,650,176 total funds. Once the retroactive payments are made, the Department does not anticipate a need for any additional funding resulting from this request.

Anticipated Outcomes:
The approval of this proposal would result in reimbursement to FQHCs and RHCs for CHP+ services that complies with existing federal regulations.

Assumptions for Calculations:
Please see Appendix A for the Department's assumptions and calculations for this request.

Consequences if not Funded:
This request is for funding to implement federally mandated changes. If this request is not funded, federal financial participation in CHP+ will be at risk. The Department's FY 2011-12 appropriation includes $141,179,458 federal funds for CHP+.

Relation to Performance Measures:
Federal mandate.

Cash Fund Projections:

Cash Fund Name	Children's Basic Health Plan Trust Fund	Hospital Provider Fee Cash Fund
Cash Fund Number	11G	24A
FY 2010-11 Expenditures	$43,062,875	$426,069,052
FY 2010-11 End of Year Cash Balance	$7,745,026	$22,198,436
FY 2011-12 End of Year Cash Balance Estimate	$9,332,096	$22,198,436
FY 2012-13 End of Year Cash Balance Estimate	$8,036,989	$22,198,436
FY 2013-14 End of Year Cash Balance Estimate	$6,924,385	$22,198,436

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
New data on FQHC and RHC services provided in CHP+ has become available which allows the Department to estimate the retroactive payments from paying BIPA PPS rates on a per-encounter basis since October 1, 2009.

Current Statutory Authority or Needed Statutory Changes:
The federal Children's Health Insurance Program is established in the Social Security Act, Title XXI (42 U.S.C. 1397aa et seq.) and amended by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

42 U.S.C. 1397GG (e)(1)(E) applies Medicaid law at 42 U.S.C. 1396a (bb) relating to payment for services provided by Federally-qualified health centers and rural health clinics to CHP+.

25.5-8-101 C.R.S. (2011) et seq. authorizes the Children's Basic Health Plan.

Appendix A: Assumptions and Calculations for this Request

Detailed Background

Prior to 2001, federal law required State Medicaid programs to reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) based on reasonable costs. States were allowed to establish their own definition of "reasonable costs" based on Medicare regulations and cost reports. However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) changed the payment requirements for FQHCs and RHCs. Section 702 of BIPA ("New Prospective Payment System For Federally-Qualified Health Centers and Rural Health Clinics") created section 1902(bb) in the Social Security Act (the Act). This section requires Medicaid programs to make payments for FQHC and RHC services using a prospective payment system (PPS). Unlike a cost-based reimbursement system, a PPS establishes a provider's payment rate for a service before the service is delivered; the rate is not dependent on the provider's actual costs or the amount charged for the service. The Medicaid PPS specified in section 1902(bb) is determined separately for each individual FQHC or RHC (calculated on a per-visit basis) using 1999 and 2000 as the baseline period. These rates do not include any adjustment factors other than a growth rate to account for inflation (Medicare Economic Index) and any change in the scope of services furnished during that fiscal year. Medicaid programs may also develop an alternative payment methodology that reimburses at least at the BIPA PPS rates for FQHC and RHC services.

Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amended section 2107(e)(1) of the Act to make section 1902(bb) of the Act applicable to CHIP in the same manner as it applies to Medicaid. This payment provision became effective October 1, 2009. As outlined in State Health Official Letter #11-004 released by the Centers for Medicare and Medicaid Services (CMS) on February 4, 2010, any States that did not implement this payment methodology by its effective date must make retroactive payments to FQHCs and RHCs based on the BIPA PPS rates back to that date.

When this regulation was passed, the Department considered it an opportunity to implement an alternative payment system that would improve the quality of health care provided by FQHCs and RHCs and contain costs for services provided in CHP+. The Department received a grant from CMS to develop an alternative payment system that would have included incentive payments for FQHCs and RHCs based on health outcomes. After multiple discussions, the Department was unable to reach an agreement with the FQHCs and RHCs on an incentive-based alternative payment system. Consequently, the Department is implementing the BIPA PPS rates for FQHCs and RHCs in CHP+.

The Department does not contract directly with FQHCs and RHCs for CHP+, rather it contracts with several managed care organizations (MCOs) which subcontract with providers, including FQHCs and RHCs, to provide services to clients. The Department is currently in the process of coordinating with these MCOs to implement the BIPA PPS rate for each of their subcontracted FQHCs and RHCs going forward. The Department will implement contractual arrangements to ensure these rates are paid to FQHCs and RHCs beginning on July 1, 2012 so that retroactive payments will not be necessary after FY 2011-12.

Retroactive Payments to Providers

With newly available data, the Department's contracted actuary has calculated the number of encounters and the payments received by FQHCs and RHCs for these encounters. Due to varying payment

arrangements between MCOs and FQHCs and RHCs, some payments for individual encounters were below the BIPA PPS rate for that FQHC or RHC, while others were above the rate. Per the federal regulations in section 1902(bb) of the Act described above, the Department must ensure that FQHCs and RHCs receive *at least* the BIPA PPS rate for each encounter. As a result, for the retroactive payments, the Department has omitted from its calculations any encounters for which FQHCs and RHCs received a payment greater than the BIPA PPS rate. Table 1 below summarizes the data provided by the CHP+ actuary.

Table 1- Data for Payments Below the BIPA PPS Rate				
Number of FQHCs and RHCs	Total Number of Encounters	Total Paid to FQHCs and RHCs	Total BIPA PPS Encounter Payments	Net Due to Providers
46	16,054	$1,921,316	$2,697,695	$776,379

While the available data includes some encounters through October 2011, it is not a complete list of all FQHC and RHC encounters through that date. The Department has taken this into account in its projection of the total retroactive payments for services provided through June 30, 2012. The Department assumes that the utilization and payment patterns in the data would not change significantly by June 30, 2012. Table 2 below summarizes the Department's estimated retroactive payments by year.

Table 2- Retroactive Payments due to FQHCs and RHCs			
FY 2009-10*	FY 2010-11	FY 2011-12	TOTAL
$449,150	$600,514	$600,512	$1,650,176
* Includes 9 months of payments as the regulation is effective October 1, 2009.			

The Department is thus requesting $1,650,176 total funds to make retroactive payments to FQHCs and RHCs for services provided up to FY 2012-13, when the Department will implement BIPA PPS rates going forward. The Department will receive the same 65% federal financial participation it receives for all other CHP+ premiums expenditures to make these retroactive payments. Thus, $1,072,614 of the total funds requested would be federal funds. Since CHP+ families with incomes between 206% of the Federal Poverty Level (FPL) and 250% FPL are funded through the Hospital Provider Fee implemented in May 2010 pursuant to HB 09-1293, the Department assumes that a proportion of these retroactive payments would have the same funding source. Using historical caseload data and the caseload forecast from its November 1, 2011 FY 2012-13 Budget Request, R-3 "Children's Basic Health Plan Medical Premium and Dental Benefit Costs," the Department estimates that 6.5% of the total CHP+ caseload is between 205% and 250% FPL for the retroactive period of October 2009 through June 2012. Hence, the Department assumes that 6.5% of the state's share of retroactive payments, or $37,674, would be funded through the Hospital Provider Fee. Since CHP+ families with incomes below 206% FPL are funded through the CHP+ Trust Fund, the Department assumes that the remaining portion of the state's share of retroactive payments, $539,888, would also be from the CHP+ Trust Fund.

Implementation of BIPA PPS Going Forward

While the Department pays each CHP+ MCO a monthly capitation for enrolled clients, it does not control the level of reimbursement from MCOs to each provider. MCOs may reimburse different providers, including different FQHCs and RHCs, varying rates for the same services. According to the data from the Department's actuary, actual reimbursement amounts calculated on an encounter basis vary widely. In fact, the total reimbursement received by FQHCs and RHCs for all encounters (including reimbursements above the BIPA PPS rate) is significantly higher than what it would be if BIPA PPS rates were paid for all encounters. When all encounter and payment data available from the CHP+ actuary for services provided

by FQHCs and RHCs from October 2009 through October 2011 is aggregated, FQHCs and RHCs were actually reimbursed an estimated $1,000,000 above the BIPA PPS rates. Since the available data is not an exhaustive account of all encounters over this time period, the actual aggregated payments for this two year time period may be even greater than this initial estimate. This suggests that the capitation payments the Department has made to MCOs have allowed them, on average, to reimburse FQHCs and RHCs at a rate above the BIPA PPS rate. As a result, the Department is working towards a budget neutral implementation of BIPA PPS rates going forward.

Since CHP+ is a separate state CHIP program rather than a Medicaid expansion or combination program, the Department has additional flexibility in implementing BIPA PPS rates. Federal CHIP regulations, for example, do not define "encounters" nor include a definition of the scope of services for FQHCs and RHCs. In order to implement its payment methodology going forward, the Department will amend its contracts with MCOs to ensure that each FQHC and RHC receives the BIPA PPS rate at the time of service. At the same time, the Department will work with its CHP+ actuary so that capitation rates for FY 2012-13 forward reflect the BIPA PPS rates. The Department has been in continued conversations with the CHP+ MCOs and FQHCs and RHCs regarding the implementation of BIPA PPS rates going forward beginning in FY 2012-13. Once implemented, the Department would provide FQHCs and RHCs and MCOs with a list of BIPA PPS rates for CHP+ services on an annual basis, adjusted by the Medicare Economic Index as specified in 1902(bb)(3)(A) of the Act.

Schedule 13
Funding Request for the 2012-13 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Commission on Family Medicine Residency Training Program Adjustment

Priority Number: S-13

Dept. Approval by: John Bartholomew 12/20/11 Date

OSPB Approval by: 12/27/11 Date

- ☐ Decision Item FY 2012-13
- ☐ Base Reduction Item FY 2012-13
- ☑ Supplemental FY 2011-12
- ☐ Budget Amendment FY 2012-13

Line Item Information	Fund	FY 2011-12 1 Appropriation FY 2011-12	FY 2011-12 2 Supplemental Request FY 2011-12	FY 2012-13 3 Base Request FY 2012-13	FY 2012-13 4 Funding Change Request FY 2012-13	FY 2013-14 5 Continuation Amount FY 2013-14
Total of All Line Items	Total	$1,391,077	$350,000	$1,391,077	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$695,538	$175,000	$695,538	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$695,539	$175,000	$695,539	$0	$0
(5) Other Medical Services; Commission on Family Medicine Residency Training Programs	Total	$1,391,077	$350,000	$1,391,077	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$695,538	$175,000	$695,538	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$695,539	$175,000	$695,539	$0	$0

Letternote Text Revision Required? Yes: ☐ No: ☑ If yes, describe the Letternote Text Revision:

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑

Schedule 13s from Affected Departments: Commission on Family Medicine

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2011-12 Supplemental Request
January 3, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Department Priority: S-13
Request Title: Commission on Family Medicine Residency Training Program Adjustment

Summary of Incremental Funding Change for FY 2011-12	Total Funds	General Fund	FTE
Commission on Family Medicine Residency Training Program Adjustment	$350,000	$175,000	0.0

Request Summary:
The Department is requesting an increase of $350,000 total funds, of which $175,000 is General Fund and the remainder is federal funds, to the Commission on Family Medicine Residency Training Program in FY 2011-12. This increased appropriation reflects a technical adjustment to comply with current state law.

During the 2011 legislative session, Colorado's General Assembly passed SB 11-184, "Concerning Tax Reporting," which adds section 39-21-202 to state statute. Section 39-21-202 (1) C.R.S. (2011) creates the Tax Amnesty cash fund (the Fund), which receives funds from the taxpayer amnesty program authorized at 39-21-201 C.R.S. (2011). Further, section 39-21-202 (2) C.R.S. (2011) mandates the following:

"(b) The state treasurer shall transfer the balance of the fund as of December 31, 2011, minus one million dollars, as follows:

(I) One hundred seventy-five thousand dollars shall be transferred to the general fund. If such transfer occurs, it is the intent of the general assembly that such amount be included in a supplemental appropriation to the department of health care policy and financing for the fiscal year commencing on July 1, 2011, for allocation to the commission on family medicine residency training programs."

The Department assumes that the balance in the Fund will be sufficient for the transfer of $175,000 to occur per 39-21-202 (2)(b)(I) C.R.S. (2011). As a result, the Department is requesting a corresponding one-time increase to its FY 2011-12 appropriation. Since the Commission on Family Medicine Residency Training Program receives a 50% federal financial participation rate, the Department's total fund request of $350,000 is comprised of $175,000 General Fund and $175,000 federal funds.

Impact to Other State Government Agency:
The Colorado Family Medicine Residency Training Program is administered by the Advisory Commission on Family Medicine in the Department of Higher Education, Health Sciences Center.

Relation to Performance Measures:
State mandated increase.

Supplemental, 1331 Supplemental, or Budget Amendment Criteria:
Technical adjustment to abide by current law.

Current Statutory Authority or Needed Statutory Change:
39-21-202 (2) C.R.S. (2011) mandates the transfer and specifies the intent to include a supplemental appropriation to the Department.