Department of Health Care Policy & Financing
Department Description
FY 2012-13 Budget Request

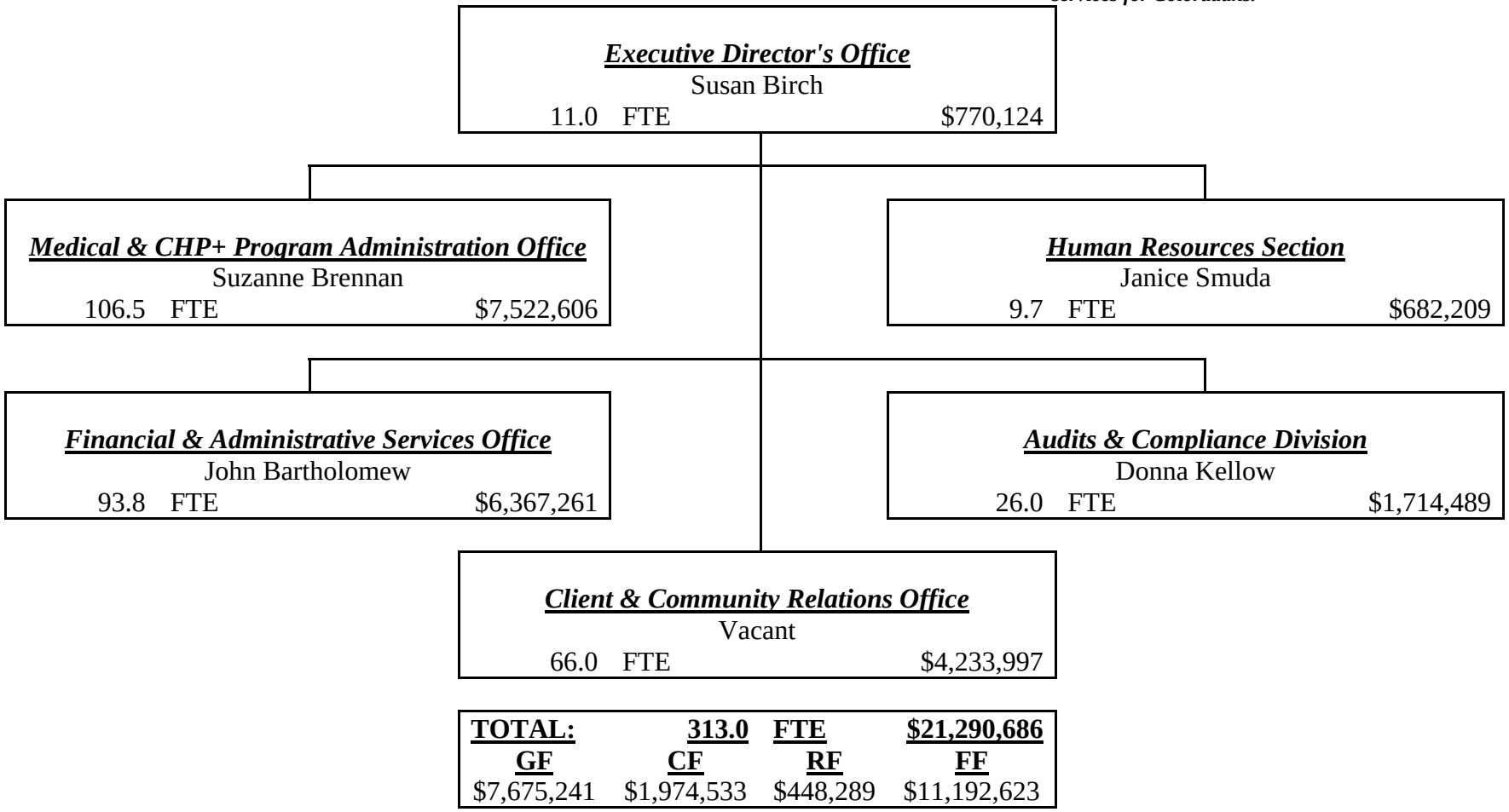
November 1, 2011

TABLE OF CONTENTS

I. ORGANIZATIONAL CHART

State of Colorado

The mission of the Department of Health Care Policy & Financing is to improve access to cost-effective, quality health care services for Coloradans.



II. BACKGROUND INFORMATION

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

Executive Director's Office

Sue Birch was appointed Executive Director of the Department effective January 18, 2011. The Executive Director has organized the Department to allow for greater focus on key program and operational areas. Areas of responsibility for the Executive Director include general governance and financial accountability for the Department, communication with partners within and outside of state government, and research and development for current and future refinement of Department operations and programs.

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

The Department is committed to providing accurate, understandable, and consistent information to the public, clients, providers, legislators, internal staff, and advocates. The Department's Legislative Liaison is the Department's primary representative to the General Assembly and the main point of contact for legislators, lobbyists and stakeholders with interests or concerns regarding the Department's legislative agenda. The Legislative Liaison coordinates the dissemination of information that helps guide informed decision making by members of the General Assembly. The Legislative Liaison promotes the Department's legislative agenda and initiatives and engages stakeholders to assist with advocacy. In addition, the Legislative Liaison coordinates with internal staff to implement legislation and communicates progress to stakeholders and members of the General Assembly. The Public Information Officer ensures accurate communication is provided in a timely and consistent manner. Communication is conducted through the Department's website, client correspondence, brochures, program newsletters, and email. The Public Information Officer works with

the Governor's Office in coordinating messages to the media and with the Lieutenant Governor's Office on outreach to eligible populations.

Audits and Compliance Division

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

Program Integrity

The Program Integrity section monitors and improves provider accountability for the Medicaid program. The section identifies fraud, potentially excessive and/or improper utilization, and improper billing of the Medicaid program by providers. If aberrancies are identified, staff investigate, classify, and recover payments and/or refer the providers to legal authorities for possible prosecution when appropriate. Administrative, civil, and/or criminal sanctions may also be pursued by the Department in coordination with the Attorney General's Medicaid Fraud Control Unit or the U.S. Attorney's office. Between July 1, 2007 and July 31, 2011, the Program Integrity section recovered approximately $29 million in improper payments. The section's goal is to have recovered $47.7 million between July 1, 2007 and June 30, 2012.

Audits Section

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

- Medicaid Eligibility Quality Control Unit: The Medicaid Eligibility Quality Control unit assesses eligibility determinations to assure accuracy and timeliness of the eligibility determination to avoid inappropriate payments and client determination delays. This program is required by the federal government.
- County Audits: This function was transferred from the Department of Human Service with the passage of SB 06-219. This ensures that the Department is able to issue Management Decisions on all county Single Audits, follow-up on county audit findings and review county financial statements.
- Payment Error Rate Measurement (PERM) Program: The Payment Error Rate Measurement program is required by the federal Centers for Medicare and Medicaid Services to comply with the Improper Payments Information Act of 2002. The purpose of the program is to examine the accuracy of eligibility determinations and claims payment to ensure that the Department only pays for appropriate expenditures.

- Internal Audits/Review: Internal auditing/reviewing is an independent, objective assurance activity designed to add value and improve an organization's operations and assist with compliance with federal and state laws and regulations.
- Department Audit Coordination: The Department is routinely audited by the State Auditor's Office, the U.S. Office of the Inspector General, and the federal Centers for Medicare and Medicaid Services. The Department is committed to implementing all agreed audit findings and continually improving processes and policies. The Audits Section actively monitors the implementation of all audit findings and is responsive to all information requests from auditors.

Financial & Administrative Services Office

The Financial & Administrative Services Office consists of the Budget Division, the Controller Division, the Claims Systems and Operations Division, the Purchasing and Contracting Services Section, and the Safety Net Programs Section. The Budget Division includes the Financing and Indigent Care Unit, the Medical Premiums Unit, and the Personal Services and Other Agencies Unit. The Claims Systems and Operations Division is comprised of the Fiscal Agent Operations Section, the Claims Systems Section, and the Program Management Unit. The Controller Division oversees the Accounting Section, which includes the Operations Unit, the Financial Reporting and Grants Unit, and the Medicaid and Other Programs Unit.

Budget Division

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

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

Controller Division

The Controller's Division oversees the accounting functions of the Department. The division ensures the proper recording and reporting of revenues and that expenditures in the Department are in compliance with generally accepted accounting principles and state and federal rules and regulations. All positions are responsible for monitoring the accurate reporting of assigned appropriations and working with Budget and Program personnel to resolve issues.

The Operations Unit is responsible for the proper recording of cash receipts, accounts receivable, accounts payable, and payroll. This includes processing and depositing checks and other receipts and properly recording this information in the State's financial records system, monitoring receivable balance sheet accounts and adjusting vendor accounts to properly account for amounts owed the State's Medicaid program, processing manual payments to vendors in the State's financial records system, and processing the Department's monthly and bi-weekly personnel payments through the State's central payroll system.

The Financial Reporting and Grants Unit is responsible for all accounting activities for the Children's Basic Health Plan, the Department of Human Services and County Administration Program, and Cash Management. Each accountant responds to the accounting needs of their Program, and the Cash Management Accountant manages the State and Federal Cash as well as the reporting of private grants and non-Medicaid Federal grants.

The Medicaid and Other Programs Unit is primarily responsible for all accounting entries and issues related to the Medical Services Premiums and Medicaid Mental Health Long Bill Groups, the Hospital Provider Fee, the Nursing Home Provider Fee, and Tobacco Taxes. Additional duties include recording the Departmental budget in the Colorado Financial Reporting System and performing and reconciling all entries related to the enhanced federal medical assistance percentage provided by the American Recovery and Reinvestment Act of 2009 (ARRA).

Purchasing and Contracting Services Section

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

Claims Systems and Operations Division – Fiscal Agent Operations Section

Within the Claims Systems and Operations Division, the Fiscal Agent Operations Section manages the Department's Information Technology (IT) contracts and agreements, monitors IT vendors for contractual compliance, and provides IT vendor operational oversight. The section drafts and negotiates contracts and monitors contract performance as well as federal oversight of IT contracts.

The primary IT contract that the section manages and monitors is the Medicaid Management Information System (MMIS) contract, which is a multi-year, multi-million-dollar contract. The section also works with the Budget Division to provide estimates for building in modifications to the system to reflect changes needed to implement legislation or shifts in policy direction.

The Fiscal Agent Operations Section also provides oversight of all operational aspects of the MMIS contract. This includes, but is not limited to, oversight of provider enrollment and claims processing. Claims processing responsibilities include management of claim edits, prior authorizations, claim reconsiderations, financial transactions and mass adjustments. The section is also responsible for provider call center functions and provider communication. Responsibilities regarding provider communication include facilitating provider training, preparing training materials, updating and maintaining billing manuals and provider services web pages, ensuring a secured provider web portal, and preparing the provider bulletin.

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

The Fiscal Agent Operations Section manages contracts for the production and issuance of medical identification cards, interagency agreements, the provider-secured Web portal, and data use agreements between the Department and other state and federal organizations. Lastly, the section manages external audit coordination for the Claims Systems and Operations Division.

Claims and Operations Division – Claims Systems Section

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

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

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

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

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

Claims and Operations Division – Program Management Unit

The Program Management Unit (PMU) was formed to assist in developing and implementing large projects such as the MMIS re-procurement and ICD-10 implementation. Additionally, the PMU acts as a bridge between multiple departments to reduce inefficiencies and timeframes for approvals and increases the lines of communication for smaller projects or for projects that do not have legislative approval. The PMU fills gaps that may exist between the Department's fiscal agent, Departmental business analysts, and the various departments that are required to act together to complete projects in a timely manner. The PMU provides project management services for Claims and Operations Division projects, consolidated reporting of Claims and Operations Division projects, support division activities through strategic planning and develop methodologies and training for stakeholders on the methods and processes utilized in functional areas.

Safety Net Programs Section

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

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

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

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

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

The Safety Net Programs section is also responsible for all modeling of provider fees utilized within the Department. Currently, these include the Nursing Facility Provider Fee and the Hospital Provider Fee. The Safety Net Programs section develops fee models, works with external stakeholders, advisory boards and providers, coordinates the approval of the fee models with the Medical Services Board, and submits State Plan Amendments to the federal Centers for Medicare and Medicaid Services for approval of these fee models.

Client and Community Relations Office

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

The functions within the office that are client- and community-facing include: Medicaid eligibility operations and policy; legal functions, including federal policy and rules, the Medical Services Board, and benefits coordination; functions of the Customer Service Center and program and policy training; County oversight and outreach; and, management of the Health Resources and Services Administration (HRSA) State Health Access Program grant.

Eligibility Section

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

Client Services Section

The Client Services Section provides a high level of communication and assistance to all clients who contact the Department. The section acts as a major focal point for callers who require assistance with questions about eligibility and program information and who need help in navigating a complex health care system. This section also includes the Program and Policy Training Unit, which produces and conducts trainings for a wide variety of internal and external customers regarding the Department's policies and initiatives.

County Oversight and Outreach

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

Legal Division

The Legal Division is responsible for handling privacy and Health Insurance Portability and Accountability Act (HIPAA) training and compliance. The division also acts as records custodian and coordinates Colorado Open Records Act requests. Other responsibilities of the division include managing and coordinating external data requests through the Department's data review board, managing the Department's privacy database, managing the Department's State Plan and drafting amendments to the State Plan, providing assistance in drafting rules, coordinating the Department's relationship with the Attorney General's office, providing analysis and guidance to Department personnel on various regulatory and legal issues, and monitoring the impacts of federal health care reform.

The Legal Division includes the Benefits Coordination section, whose mission is to ensure Medicaid is the payer of last resort, extending public purchasing power by pursuing third-party payment of medical costs for Medicaid-eligible persons. The Benefits Coordination Section pursues responsible payment sources to recover costs for medical care paid for by Medicaid. The sources the Benefits Coordination Section pursues include trusts, estate recoveries, and recovery of any payments for clients who were discovered to be ineligible for Medicaid retroactively. In FY 2010-11, the Benefits Coordination Section collected $40.4 million in recoveries from trusts, estate recoveries, and recovery of any payments for clients who were discovered to be ineligible for Medicaid retroactively. This was an increase of 12.5% over the FY 2009-10 recoveries.

Health Resources and Services Administration

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

Human Resources Section

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

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

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

Medical and Child Health Plan *Plus* Program Administration Office

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

Medicaid and CHP+ Managed Care and Contracts and Benefits and Policy Divisions

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

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

Long-Term Care Benefits Division

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

Rates and Analysis Division

The Rates Section of the Rates and Analysis Division develops rate-setting methodology and implements managed care rates for health maintenance organizations, behavioral health organizations, and the Program of All Inclusive Care for the Elderly providers.

The section also monitors and updates rates paid for home and community-based services. In addition, this section is responsible for rate analysis and operations for hospitals, federally qualified health centers, and rural health clinics. It is the responsibility of this section to make sure that rates comply with all applicable state statutes and federal regulations.

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

Pharmacy Section

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

Health Outcomes and Quality Management Unit

The Health Outcomes and Quality Management Unit is responsible for directing, conducting, and coordinating performance-improvement activities for the care and services Medicaid and Children's Basic Health Plan clients receive. The unit works across programs, offices, and divisions to promote effectiveness and efficiency initiatives that support the Department's mission. Specific functions of the unit include process and outcome measurement and improvement, managing the external quality review of physical and behavioral managed care contractors and fee-for-service providers, monitoring managed care plan contract compliance, overseeing external review organization administration of satisfaction surveys to clients enrolled in managed care as well as clients enrolled in the Children's Basic Health Plan, development of long-term care quality tools and interagency quality collaborations, and development and implementation of quality strategies and consulting to program managers regarding performance measurement and improvement.

III. PRIOR-YEAR LEGISLATION

The following is a summary of major legislation enacted in 2011 that affects Department policies and procedures.

HB 11-1030 (B. Gardner, Boyd) Modifications to the Set Aside Program

This bill requires any state agency that awards services to a self-certified vendor to use existing resources to monitor and ensure that the self-certified vendor is meeting the requirements of the program.

HB 11-1101 (Swalm, Morse) License Exemptions for Federally Qualified Health Centers

Community clinics are required to obtain a license from, submit to on-site inspections by, and obtain approval of construction plans from the Department of Public Health and Environment (DPHE). This bill excludes from the definition of a community clinic any Federally Qualified Health Center (FQHC). FQHCs continue as providers under the Colorado Indigent Care Program.

HB 11-1144 (Solano, Tochtrop) Fetal Alcohol Spectrum Disorders

This bill includes a legislative declaration of the General Assembly's findings regarding fetal alcohol spectrum disorders (FASD), the FASD commission (commission), and requires insurers to cover multidisciplinary evaluations of children suspected of having fetal alcohol spectrum disorders.

HB 11-1189 (Fields, K. King) Substance Abuse Driving Offenses

If a person is arrested for driving under the influence or driving while ability impaired and has been convicted of either offense at least twice previously, this bill requires the court to impose certain conditions on the person's bail bond, including participation in a substance abuse treatment program.

HB 11-1196 (Summers, Foster) Funding Flexibility for Counties

This bill allows county departments of human services to provide family preservation services to families that are not involved in the child welfare, mental health, or juvenile justice systems, but that may be if they do not receive the services.

HB 11-1212 (Tyler, Spence) Performance-Based Budgeting

This bill allows a department to apply lean government principles in establishing performance-based goals for purposes of performance-based budgeting.

HB 11-1216 (Riesberg, Aguilar) Benefits for People with Disabilities

This bill creates a contract committee to contract with a private entity to help persons with disabilities obtain benefits. It also authorizes the creation of a license plate auction group.

HB 11-1242 (Ferrandino, Nicholson) Integrated Health Care Services

This bill requires the Department to review certain issues that relate to the provision of both physical and mental health care services to a patient during the same appointment as part of an integrated system of patient care and any barriers to the integrated care.

HB 11-1281 (Joshi, Boyd) Health Care Professional Loan Forgiveness Program

This bill repeals the nursing teacher loan forgiveness pilot program and nursing faculty fellowship program and replaces them with the Colorado Health Service Corps, an expanded health professional loan repayment program, which is administered by the primary care office in DPHE. It allows health care professional faculty members to obtain loan repayment through the Colorado Health Service Corps.

HB 11-1307 (Becker, Steadman) Recovery Audits

This bill makes the recovery audit process ongoing by requiring the state controller to enter into new recovery audit contracts for three-year periods every three years and allowing the state controller to propose changes to the recovery audit exemptions.

HB 11-1323 (Massey, Boyd) Exempt Rural Health Clinics

This bill excludes from the definition of a community clinic any clinic that is a "rural health clinic" under the federal Social Security Act, thereby exempting rural health clinics from state licensure and related requirements. It also clarifies that while a rural health clinic will no longer be licensed by the Department, a rural health clinic continues as providers under the Colorado Indigent Care Program.

SB 11-008 (Boyd, Gerou) Medicaid Eligibility for Children

This bill increases the current Medicaid income eligibility threshold of 100% to 133% of the federal poverty line (FPL) for children who are between six and 19 years of age, making it equal to the income eligibility threshold for pregnant women and children from birth to five years of age.

SB 11-025 (Carroll, Ferrandino) Taxpayer Empowerment Act

This bill requires each contract entered into by a governmental body under the state Procurement Code to contain a provision reflecting this current law and specifies that records relating to the costs of or any performance measures under the contract are available to the contracting governmental body, legislative leaders, and legislative oversight committees of the General Assembly.

SB 11-062 (Cadman, Murray) OIT Administrative Duties

This bill modifies the responsibilities of the Office of Information Technology (OIT) in the Governor's office with respect to the dissemination of services to the web, the maintenance of information for state agencies, the execution or approval of information technology procurement, and the acquisition and management of the statewide communications and information infrastructure. The bill also modifies the responsibilities of state agencies regarding their consultation with OIT.

SB 11-076 (Steadman, Becker) PERA Reductions

This bill extends FY 2010-11 changes to the employer and member contribution rates for FY 2011-12.

SB 11-083 (Roberts, Barker) Changes to Colorado Probate Code

This bill clarifies that, after all right to appeal has been waived or exhausted following the entry of a judgment of conviction, a plea of guilty, or a plea of *nolo contendere*, thereby establishing criminal accountability for the felonious killing of the decedent, the judgment conclusively establishes the convicted individual as the decedent's killer for probate purposes.

SB 11-084 (Boyd, Summers) Physicians at Long Term Care Facilities

This bill expands the definition of "health care facility" to include "long-term care facility" and allows long-term care facilities to employ physicians directly or indirectly.

SB 11-105 (Guzman, Levy) In-Home Support Services

This bill extends the repeal date for the in-home support services program by three years to September 1, 2014, and requires Department of Regulatory Agencies (DORA) to review the program prior to its repeal.

SB 11-115 (Carroll, Miklosi) State Audits of Government Entities

This bill gives the state auditor authority to conduct, or cause to be conducted, post audits of financial transactions and accounts as well as performance post audits of any state special purpose authority and any state entity designated as an enterprise as defined in the state constitution.

SB 11-125 (White, Sonnenberg) Nursing Home Fees and Order of Payments

Effective FY 2011-12, this bill increases the cap on the provider fee on health care items or services provided by nursing home facility providers for purposes of obtaining federal financial participation under Medicaid from a maximum of $7.50 to a maximum of $12.00 per non-Medicare-resident day. It also reorders the priority in which the supplemental payments to the nursing home facility providers are made.

SB 11-128 (Newell, McCann) Child Only Health Plans

This bill establishes two specified enrollment periods for child-only plan coverage. A carrier may accept an application outside of the open enrollment periods if the child does not have a preexisting condition. The plans must be issued on a guaranteed-issue basis without any limitations or riders based on health status.

SB 11-166 (Johnston, Wilson) Uniform Disclaimer of Property Rights

This bill establishes the "Uniform Disclaimer of Property Interests Act." This legislation shall not apply to a disqualification of medical assistance benefits under title 25.5 to a disclaimant who is or was an application for, or recipient of, such benefits.

SB 11-175 (Carroll, Levy) Amendments to Uniform Trust Code

This bill enacts the insurable interest amendments to the uniform trust code and specifies when a trustee of a trust has an insurable interest in the settler of the trust or an individual in whom the settlor of the trust has or had an insurable interest.

SB 11-177 (Nicholson, Coram) Pregnancy and Dropout Prevention

This bill extends the repeal date for the teen pregnancy and dropout prevention program by five years to September 1, 2016, and requires DORA to review the program prior to its repeal.

SB 11-183 (Aguilar, Gardner) State Board of Human Services

This bill mandates that the governor include representation by a person with a disability, a family member of a person with a disability, or a member of an advocacy group for persons with disabilities on the state boards of housing, medical services, and human services.

SB 11-187 (Newell, Fields) Sunset of Mental Health Professions

This bill implements the recommendations of the sunset review and report on state-regulated mental health professionals.

SB 11-200 (Boyd, Stephens) Colorado Health Benefit Exchange

This bill creates the Colorado Health Benefit Exchange Act in connection with federal health care laws enacted in 2010, and establishes a non-profit organization that is an instrumentality of the State to oversee the inplementation and operation of a health benefit exchange in Colorado. It also creates a board of directors for the exchange and describes the duties of the board, as well as creates the legislative health benefit exchange implementation review committee.

SB 11-250 (Boyd, Ferrandino) Eligibility for Pregnant Women

In order to comply with federal requirements to preserve federal funding for prenatal coverage in the CHP+ program, this bill increases the income level for eligibility for pregnant women in Medicaid from 133% to 185% FPL.

IV. HOT ISSUES

The Department's strategic initiatives can be organized into four general umbrellas: Client focus, payment reform, systems of care, and agency coordination. Client focus includes all activities and initiatives that relate to expanding eligibility, ensuring that all Coloradans that are eligible for public assistance become enrolled, expanding and improving application processes, improving enrollment and retention processes, and providing client and family centeredness, engagement, and excellent customer service. Payment reform includes initiatives related to reforming payment systems to ensure that Medicaid pays for improved outcomes rather than quantity of services, aligning provider incentives with delivering quality, efficient care, and define and implement benefit coverage policies are based on the best available clinical evidence while promoting the health and functioning of Medicaid clients. Systems of care encompass initiatives to improve the acute care and long-term care delivery systems and integration of physical, behavioral, and dental health. Agency coordination refers to the commitment of improved coordination between the Department and other state agencies involved in the administration of health-related programs, namely the Department of Human Services (DHS) and the Department of Public Health and Environment (DPHE), an effort which has never before been attempted.

Client Focus

Hospital Provider Fee

On April 21, 2009, Governor Ritter signed Colorado House Bill 09-1293 "Health Care Affordability Act" into law. Once fully implemented, the legislation will provide health care coverage for more than 100,000 uninsured Coloradans, reduce uncompensated care costs, and benefit the state as a whole. The Colorado Hospital Association, the Department of Health Care Policy and Financing ("the Department"), and the Governor's Office worked together for nearly one year to develop House Bill 09-1293, which passed both the House and the Senate with more than 40 co-sponsors and bipartisan support. The Hospital Provider Fee, State Plan Amendments, and Upper Payment Limit were officially approved by the Centers for Medicare and Medicaid Services (CMS) on March 31, 2010.

The bill requires the Department to assess and collect a provider fee from all licensed or certified hospital providers, including providers that do not serve Medicaid clients. By partnering with hospitals, the Colorado Health Care Affordability Act (CHCAA) will allow Colorado to generate up to approximately $600 million in additional funding per year through a hospital provider fee and draw down approximately $600 million in federal Medicaid matching funds for the purposes of increasing reimbursement to hospitals for providing medical care, increasing the number of persons covered by public medical assistance, and paying the administrative costs of the Department in administering the hospital provider fee. Providing a payer source for more low-income and uninsured populations, who may otherwise be cared for in emergency departments, and increasing

reimbursement to Colorado hospitals participating in publicly funded health insurance programs will reduce the cost shift of uncompensated care to other payers.

In FY 2010-11, the Department distributed approximately $441 million in fees from hospitals which, with federal matching funds, funded health coverage expansions, supplemental payments to hospitals, the Department's administrative expenses, and General Fund relief per SB 10-169. The following table outlines the Hospital Provider Fee expenditures in FY 2009-10 and FY 2010-11:

Hospital Provider Fee Expenditures (Total Funds)		
Payment Type	**FY 2009-10**	**FY 2010-11**
Supplemental Hospital Payments	$590,238,706	$745,237,426
Department Administration	$2,938,742	$5,804,234
Expansion Populations	$3,241,897	$88,022,900
General Fund Offset	$46,329,410	$61,343,993
Total Expenditures	**$642,748,755**	**$900,408,553**

Through this financing mechanism, Colorado was able to draw down and distribute $459 million in additional federal dollars in FY 2010-11. The net gain to hospitals in federal fiscal year 2010-11 was approximately $159.4 million and is estimated to be $122 million in federal fiscal year 2011-12. These net gains represent the reduction in uncompensated costs incurred by hospitals.

As of September 30, 2011, the Department had enrolled approximately 33,200 Medicaid Parents, 7,300 CHP+ children, and 380 CHP+ pregnant women in the expansion populations funded under the hospital provider fee. Of these enrollees, approximately 20,200 Medicaid Parents, 4,400 CHP+ children, and 370 CHP+ pregnant women were newly eligible for public assistance.

The Department is now focused on implementing a Medicaid Disabled Buy-In Program for Working Adults and an Adults without Dependent Children (AwDC) program, both on March 2012, and a Medicaid Disabled Buy-In Program for Children approximately four to six months later. The Department intends to implement the AwDC program through a Section 1115 Medicaid Demonstration Waiver to limit the program only to those up to 10% of the federal poverty level (FPL) and place a cap at an initial caseload level of 10,000. The Department will also seek to require that all non-medically frail individuals in the AwDC program enroll in the Accountable Care Collaborative. This will allow the Department to design benefits that specifically target the health needs of this population and receive the enhanced medical management provided under the

Accountable Care Collaborative, including care coordination and integrated disease management. As the expansion populations are implemented and continue to grow, the Department will have to closely monitor the costs of these newly eligible populations to ensure that adequate fee revenue can be collected within federal limitations. The provisions of CHCAA leave Colorado well-positioned to implement the Affordable Care Act of 2010 (ACA). With the expansion of Medicaid parents to 100% FPL and the phased-in implementation of the AwDC program, Colorado will be better prepared to expand to the new federal Medicaid minimum eligibility level of 133% FPL for all individuals. The enhanced federal financial participation that will be available through ACA beginning in January 2014 for expansion populations included in CHCAA will help ensure the viability of the Hospital Provider Fee. In addition, ACA has numerous provisions that are anticipated to reduce the level of uncompensated care, decrease the rate of growth in health care costs, and improve health outcomes of individuals, all of which are goals of the Department in implementing CHCAA.

Under the original fiscal note for HB 09-1293, the Department expected to implement Continuous Eligibility for Medicaid children in the spring of 2012. The Department is delaying the implementation of Continuous Eligibility to allow the Department to further analyze the fiscal impact and the effect of federal health reform on this population. The Department continues to explore the interplay between ACA and CHCAA.

Program Eligibility and Application Kit (PEAK)

PEAK is an online service for Coloradans to screen themselves and apply for medical, food, and cash assistance programs from a home computer, library, kiosk, or anywhere the Internet can be accessed. PEAK enables individuals to conveniently access a full suite of services right at the touch of a mouse, including the ability to anonymously screen for program eligibility, apply for benefits, check the status of benefits, and update case information, including address changes and contacts. Individuals can complete the PEAK application and update information on their own or care providers can make applications on behalf of their clients, further streamlining the application process, transforming how the Department delivers critical benefits to the most vulnerable Coloradans.

County Administration/CBMS Audit

County administration funding provides local county departments of social and human services with reimbursement for costs associated with performing Medicaid, Children's Basic Health Plan, and Old-Age Pension State Medical Program eligibility determinations. With increased caseloads and population expansions during the recession, county workloads have increased. On July 1, 2011, CMS issued a final audit report on Medicaid eligibility determinations and redeterminations. In the report, CMS noted several identifiable weaknesses in the State’s remediation efforts with CBMS and related processes in response to

a 2006 CMS review. To meet the requirements put forth by federal officials, the Department has implemented several system and process remediations and plans to undertake additional mitigation efforts to improve the functionality of CBMS as well as towards relieving the additional burden on the counties. As outlined in the report, CMS "commend[s] the State for these remediation efforts and want to especially recognize the innovations and extraordinary undertakings performed by the State especially the State Medicaid Agency." Some of these efforts are:

- Colorado Comprehensive Health Access Modernization Program;
- Maximizing Outreach and Retention and Enrollment Project;
- Streamlining the application process, including redesign of the CBMS system interfaces with Income Eligibility and Verification System, Social Security Administration for citizenship verification, Department of Motor Vehicles for identity verification, and Department of Health and Vital Statistics for birth certificates;
- Business redesign effort with the county departments of human/social services;
- Overflow contracts with selected private contractors;
- Colorado Program Eligibility and Application Kit (PEAK) Web Application; and,
- Securing a CHIPRA Performance Bonus payment grant for removing barriers to eligibility and enrollment.

The Department will continue to work with the Department of Human Services, the Governor's Office of Information Technology, county departments of human and social services, and CMS to implement all remediation efforts and corrective actions to comply with federal regulations and to improve the eligibility and enrollment process.

Client Cost Sharing

The Department currently charges nominal co-payment amounts to clients for various services including inpatient hospital, outpatient hospital, practitioner, and psychiatric services in Medicaid and CHP+. In addition to co-payments, the Department currently charges enrollment fees for clients with family income above 150% of the Federal Poverty Level (FPL) in CHP+. The Department currently waives all cost sharing for CHP+ clients at or below 100% FPL except for a nominal co-payment on emergency and urgent/after hours care mandated in state rules.

During the 2011 Legislative Session, the General Assembly passed SB 11-213 "Concerning Enrollee Cost-Sharing for Children Enrolled in the Children's Basic Health Plan." This legislation would have increased cost sharing in CHP+ by

implementing monthly premiums for families with incomes between 206% and 250% FPL. Each of these families would be required to pay a monthly premium of $20 for the first child and $10 for each additional child up to a maximum of $50 per month. The intent of this legislation was to foster a greater sense of personal responsibility in the health care decisions of CHP+ families, while generating savings to the State. The 1,000% increase in costs to the families affected by the new premiums, however, was estimated to have a significant negative impact on enrollment in CHP+. The Department and Joint Budget Committee Staff estimated that approximately 20% of affected children would drop CHP+ coverage if SB 11-213 was implemented. Because the cost of private insurance is relatively high, it is unlikely that children dropping out of CHP+ would become privately insured. Thus, this legislation would inevitably lead to higher uninsurance and worse health outcomes among children in Colorado. It is also likely that the children dropping CHP+ coverage would include a disproportionally large number of healthy children whose lower health care costs would not make the increased premiums worthwhile, and relatively sicker children with higher utilization and costs would remain in CHP+. This adverse selection would have led to increased per capita costs in CHP+ as the number of healthy relative to unhealthy children declines, resulting in a higher cost risk pool and increased per member per month rates for health care.

After considering the potential negative outcomes described above, Governor John Hickenlooper vetoed SB 11-213 and committed his staff and the Department to developing an approach to increase cost sharing while minimizing any negative impact on CHP+ families. As a result, the Department has included FY 2012-13 R-7, S-8 "Cost Sharing for Medicaid and CHP+" as part of its FY 2012-13 Budget Request. As part of this proposal, the Department proposes five initiatives that increase cost sharing for its beneficiaries. The Department believes that the measures it is proposing, which include a wider range of more reasonable cost increases, will be more effective in fostering a sense of responsibility in the health care decisions of all of its clients while minimizing negative impacts to families and generating savings to the State.

Client Fraud

The National Health Care Anti-Fraud Association estimates that at least three percent of spending for health services – more than $60 billion each year – is lost to health care fraud in the private and public sectors, including Medicaid.[4] In Colorado, investigations into provider fraud of public assistance programs are handled at the state level, and investigations of beneficiary fraud are handled at the county level. County departments investigate and file fraud claims directly with their local District Attorneys. Counties retain fifty percent of the state share paid when recovered from fraudulent activity and twenty-five percent of the state share paid out if due to unintentional error.

[4] Daniel R. Levinson, Inspector General, Office of the Inspector General, before the Senate Special Committee on Aging, U.S. Senate, May 6, 2009, available at http://www.hhs.gov/asl/testify/2009/05/t20090506d.html.

In FY 2010-11, counties recovered $428,946 of improper payments resulting from beneficiary fraud or error. With increasing caseloads as a result of the economic recession and the expansion of eligibility for many populations, the Department estimates that this total is only a fraction of what may be recoverable. The Department is currently exploring options to increase awareness of beneficiary fraud, further assist the counties with their investigative efforts, and maintain the integrity of the Medicaid program. Among consideration are changes to better align the Department's fraudulent activity statute with that of other public assistance programs, a public awareness campaign, and interfaces with other state agencies to minimize opportunities for error or fraud.

In the current economic climate, public assistance programs must reach more people with fewer resources. Obtaining public assistance benefits either by mistake or by committing fraud costs all taxpayers. The Department is committed to its anti-fraud, waste, and abuse efforts and to assisting the counties in their pursuit of recipient fraud.

Payment Reform

Accountable Care Collaborative

The Department intends to deliver high-quality, patient-centered, coordinated care to Medicaid clients across Colorado. The Accountable Care Collaborative (ACC) is Colorado's newest Medicaid program designed to improve health outcomes and control costs by providing coordinated care to fee-for-service clients. The ACC is comprised of Regional Care Collaborative Organizations (RCCOs), ultimately accountable for improving the health of our clients and reducing costs, Primary Care Medical Providers (PCMPs), responsible for providing comprehensive primary care, and the Statewide Data and Analytics Contractor. The ACC changes the incentives and health care delivery processes for providers from one that rewards a high volume of services, to one that focuses on the health outcomes of patients. The ACC controls costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources. Medicaid clients enrolled in the ACC receive services using the fee-for-service model, and also belong to a RCCO that provides care-coordination among providers and other community and government services. The Department has procured seven RCCOs as well as a Statewide Data and Analytic Contractor (SDAC) to assist RCCOs in coordinating care and collecting data. The ACC intends to enroll 123,000 clients by November 2011.

Duals Grant

In April 2011, the Department was awarded a federal design contract from the CMS Innovations Center, which was established by ACA, to develop a plan for a State Demonstration to Integrate Care for Dual-Eligible Individuals. Providing dual-eligibles

with integrated, coordinated care, combined with implementation of an effective and innovative payment model, will improve client experience and access to quality care while controlling Medicare and Medicaid expenditures for these clients over time. As such, the Department plans to implement an approach to integration centered around the ACC program. The ACC Program began rolling out in spring of 2011 with approximately 30,000 clients, none of which yet are dual-eligibles. By extending the ACC model to dual-eligibles, the Department hopes to address the combination of underlying factors that, together, lead to poor outcomes and high costs for this population, resulting in better outcomes, reduced costs, and, ultimately, increased efficiencies.

Fee-for-Service Payment Reform

The Department is proposing to reform its fee-for-service payment system through a series of initiatives that will better align provider incentives with delivering quality, efficient care. Most of the initiatives involve an element of gainsharing, which is a payment methodology whereby providers receive a percentage of savings that result in other service categories from greater care management of their clients. Gainsharing puts an emphasis on providing appropriate treatments to clients and preventing more costly care. Incentive payments are only paid to providers when they are able to demonstrate savings against benchmarks in predetermined service areas, so the gainsharing reforms are guaranteed to be either budget neutral or negative. The Department has identified payment reforms that are ready to be implemented in physical and behavioral health in FY 2012-13. In addition, the Department is proposing to study other potential reforms that would be implemented in a later fiscal year, particularly in the long-term care delivery system. For more information, please see FY 2012-13 R-5 "Medicaid Fee-for-Service Reform" in the Department's November 1, 2012 Budget Request.

Benefits and Utilization Management

The Department initiated the Benefits Collaborative pursuant to the Department's FY 2009-10 BRI-2 "Medicaid Program Efficiencies," which serves as the Department's formal benefit coverage policy development process. The overarching objective of the Benefits Collaborative is to ensure that benefit coverage policies are based on the best available clinical evidence while promoting the health and functioning of Medicaid clients. The Benefits Collaborative process is a transparent process that allows for stakeholders – including providers, clients, and client advocates – to collaborate with the Department to review draft coverage policies, which outline the appropriate amount, scope, and duration of Medicaid benefits.

During FY 2010-11, the Benefits Collaborative made significant progress toward its goals and had 39 of 47 policies submitted by external vendors reviewed by the public. Each of these policies is now in various stages of being vetted by the Department's advisory committees and Medicaid Director and is open for further public comment. As a result, the Department

has gained valuable information regarding how benefit coverage policies impact clients and providers and will be implementing new policies to ensure consistent clinical criteria, reduce inappropriate utilization, and promote proper billing practices.

In FY 2011-12, the Department will continue to appraise the remaining eight policies through the public stakeholder meetings, the Department's advisory committees, the public comment period, and the Medicaid Director. The Department will focus on the enforcement of the approved policies via the following mechanisms: 1) claim system edits, 2) utilization management, and 3) administrative rules. Establishing claim system edits will help enforce coverage limitations through the claim adjudication process; prior authorization criteria with the new utilization management vendor will reduce inappropriate utilization and ensure services are rendered according to evidence-based criteria; and administrative rules through the incorporation of benefit coverage policies by reference will have the binding effect of law and inform providers of how the Department administers the Colorado Medicaid program.

The new utilization management (UM) contract will be implemented in FY 2011-12 and is anticipated to achieve substantial savings for the State. The Department has awarded the UM contract to APS Healthcare and is currently working to transition to this new vendor. Utilization management ensures clients receive appropriate services at the appropriate time and that unnecessary and duplicative services are avoided. Through this new contract, the Department will modernize the UM program so that it is more efficient, customer-focused, and cost-effective. A central component of UM modernization is to use available industry technologies to streamline and modernize UM processes and activities. Such technologies will include automated review of some prior authorization reviews (PARs) and "smart" electronic and web-based PAR submission technologies to allow for easier communication with providers and reduce inefficiencies and errors.

Additionally, the Department will identify baselines for current benefits and monitor data in an effort to track any changes or trends attributable to policy implementation. Reviewing utilization and expenditure data will help determine whether the goals of the Benefits Collaborative – defining clinical criteria, reducing inappropriate utilization, and promoting proper billing practices – have been met. The Department anticipates that these initiatives will not only result in cost savings but will also result in better health outcomes for clients as the Department begins to move the perception of Medicaid toward a commercial insurance product rather than a public benefit. As a result, the Department hopes to see fewer appeals for denial of non-medically necessary services and non-covered services and utilization data that aligns with the generally accepted best practices outlined in the benefit coverage policies.

Physician payments

Under the ACA, states are required to pay 100 percent of Medicare's payment rate for primary care services provided by family medicine, general internal medicine, or pediatric medicine practitioners in 2013 and 2014. During those two years, the federal government will provide the funds to pay for the difference between each state's primary care Medicaid payment and the Medicare payment. As there is no additional federal funding specified for subsequent years, presumably states would have to carry their traditional share of funding beginning in 2015 or reduce reimbursement to the Medicaid payment level.

The most straightforward means to implement the payment increase mandated by ACA would be to increase reimbursement for service codes eligible under federal law. However, rather than feeding a fee-for-service system that fails to incentivize quality and efficiency, Colorado is exploring options to use this additional funding to align provider incentives and payments. Payments in a value-based framework are more likely to provide measureable benefits in quality improvement and cost containment, and as such would be more attractive for continuation funding by the Colorado General Assembly after the expiration of federal funding. Value-based payment offers physicians financial incentives to manage and coordinate the care of their clients. For more information, please see FY 2012-13 R-5 "Medicaid Fee-for-Service Reform" in the Department's November 1, 2012 Budget Request.

Systems of Care

Long-Term Care: Developmentally Disabled Reform

The Department retains oversight of the Department of Human Services' (DHS) operating responsibility for three Medicaid waivers for the developmentally disabled (DD). Over the past several years, expenditures through these waivers have increased much more rapidly than the number of DD clients being served. In January 2011, the legislative Joint Budget Committee (JBC) requested that the departments work together with Community Centered Boards and submit a report with recommendations regarding whether the DHS Division for Developmental Disabilities should be transferred from DHS to the Department. Governor Hickenlooper redirected the departments to instead cooperate with each other in efforts to improve efficiencies in the delivery of services to the developmentally disabled and to inform the JBC and General Assembly in writing as efforts progressed. The departments are working together to develop a plan for implementing the Governor's direction in a manner that would entail stakeholder participation, assessing existing processes and frameworks, and seeking solutions for effectively and efficiently meeting the diverse needs of various affected groups.

Long-Term Care: Money Follows the Person

Colorado has 11 waiver programs serving a variety of populations and currently supports 70.5% of individuals receiving Medicaid long-term care (LTC) services in community settings. In 2008, Colorado ranked fifth among states in the proportion of Medicaid Community Based Long-Term Care (CBLTC) spending for persons with developmental disabilities and tenth among states in the proportion of Medicaid CBLTC spending for aged or disabled.

Money Follows the Person (MFP) is a federal grant opportunity to build and improve the infrastructure supporting Home- and Community-Based Services (HCBS) for people of all ages with LTC needs. The MFP grant is designed to provide enhanced transition services to clients currently living in nursing facilities in order to transition them to the community. Clients residing in nursing facilities for greater than 90 days are eligible for the program and can receive MFP services for 365 days. Colorado Access to Community-Based Transitions & Services (CO-ACTS) is Colorado's MFP initiative for which the Department received $22 million for five years from CMS in February 2011. The vision for this grant is to transform long-term care services and support from institutionally-based and provider-driven care to person-centered, consumer-directed and community-based. The Department anticipates 100 clients per year will receive services and transition to the community setting starting in July 2012. With the ability to provide additional services through the grant, the Department intends to improve clients' quality of life and realize savings as clients move from nursing facilities. Colorado's LTC system will become more person-centered, navigable, and integrated, making it easier to coordinate between agencies, providers, consumers and families, so that the elderly and adults with disabilities have greater access to home and community services instead of facing institutionalization, and can continue to successfully transition into the community.

Integration of Behavioral/Physical Health

Recent studies suggest a high prevalence of untreated mental health disorders within youth and low-income populations. By screening for behavioral health issues in primary care settings, clients experience improved health outcomes and increased efficiency in the delivery of services. In addition, integration of behavioral and physical health treatment reduces the stigma associated with receiving mental health services. In response, Governor Hickenlooper signed HB 11-1242, requiring the Department to submit a report to the General Assembly outlining the barriers and potential incentives to increasing the delivery of integrated physical and behavioral health care services. Prior to the April 2012 submission deadline, the Department will develop outreach plans with behavioral health organizations, community mental health centers, primary care providers, relevant state and local agencies, and community stakeholders to share information and solicit feedback. The report will be used as a framework to outline future initiatives and policies to improve the coordination of these services.

Dental Health

In addition to the integration of physical and behavioral health services, the Department also recognizes the importance of the integration of dental health. Many studies link gum disease to serious health conditions, such as heart disease, stroke, and diabetes. In addition, research indicates that pregnant women with gum disease are three to five times more likely to have a baby born preterm compared to those without any form of gum disease. Women are also more susceptible to gingivitis when pregnant. Thus, there are medical benefits to providing preventive dental benefits to adults, and dental benefits would most likely lead to long-term savings on medical services.

Currently, children in Medicaid receive extensive dental benefits through the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) program. The dental benefit under CHP+, however, resembles a commercial dental benefit package with limits and an annual cap on benefits of $600. For adults, those in Medicaid currently receive only emergent dental services, while pregnant women in CHP+ receive no dental benefits. Equalizing dental benefits for children in Medicaid and CHP+ and expanding dental coverage for adults would initially result in increased costs in both Medicaid and CHP+; however, the benefits associated with improved dental health would most likely result in long-term savings in other areas of the Medicaid and CHP+ programs.

Agency Coordination

Executive Order 005

As an effort to improve intergovernmental relationships, on January 11, 2011, Governor Hickenlooper signed Executive Order 005, instructing state agencies to consult with local governments prior to mandating new regulations or other obligations. In response, the Department has included mandatory consultation with local government representatives as part of its stakeholder outreach and rule making process.

In the spirit of the executive order, the Department has also committed to improving coordination between other state agencies involved in the administration of health-related programs, namely the Department of Human Services (DHS) and the Department of Public Health and Environment (DPHE). This commitment to improving interdepartmental coordination is being executed by quarterly meetings involving the executive teams from all three agencies, which began in August 2011. This is the first time such an effort has been attempted.

The first quarterly meeting took place in August 2011 as a retreat and included 32 employees from the three agencies, including all three executive directors. These employees are considered leaders within the departments but aren't all deputy directors. Executive team members are key leaders in each department's financial planning, policy development, and legislative arenas. Because of similarities between the functions of the Department, DHS, and DPHE, bringing individuals together who share similar responsibilities at their respective agencies will enhance knowledge and understanding from sharing experiences and eliminating unnecessary overlap and duplicative efforts between agencies.

During the first meeting, three areas of shared concern were identified and project groups consisting of members from each agency were formed. These groups are focused on these areas: 1) Long-Term Care, 2) Mental Health and Substance Abuse, and 3) Oral Health. Each group has compiled a list of potential projects pertinent to its area of concentration, and the projects are all intended to be short-term with measurable outcomes. To ensure the success of each project, executive team members will coordinate with subject matter experts from each agency to improve communication and streamline implementation. The executive team anticipates the current projects lists are simply a starting point and will evolve over time as new opportunities emerge.

Long-Term Care

As the baby-boomer generation ages, long-term care is becoming an increasing concern for health care providers, both in terms of services offered and how to pay for these services. The list of projects relating to long-term care includes: compiling mortality data and rates by facility or hospice, redesigning managed care organizations, improving resource utilization, kicking off the Advanced Illness Management (AIM) campaign, strengthening home- and community-based services (HCBS) programs, establishing a living will registry, consolidating all developmental disability (DD) programs under one department, and consolidating Medicaid waiver programs.

Mental Health and Substance Abuse

Under the umbrellas of mental health and substance abuse exists a significant amount of overlap, which provides an opportunity for the Department and its sister agencies DHS and DPHE to gain efficiencies through more frequent and effective collaboration. The list of potential projects includes: meeting of Transformation Council to gain a consensus on a direction for the future, incorporating mental health screening into home visitation programs, developing a program for adolescent behavioral health beyond youth corrections and child welfare, volume purchasing of psychotropic drugs, identifying access and capacity issues within Employee Benefit Programs (EBPs), reaching out to colleges and universities for training and development opportunities regarding EBPs, facilitating interdepartmental

discussions on prevention and early intervention in child mental health, and concentrating efforts on a unified public awareness campaign.

Oral Health

Recent studies link gum disease to serious health conditions, such as heart disease, stroke, and diabetes. Without question, oral health is an important, and often overlooked, element in preventive care. Because of this, the oral health group has proposed a number of projects, including: coordinating public service announcements, engaging communities without fluoridated water, establishing a global payment for oral health, reimbursing dentists based on providing sealants to patients at specific stages, examining licensing requirements for hygienists, and aligning oral health projects.

V. WORKLOAD REPORTS

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) [5] is a nationally recognized survey that measures client satisfaction within a given health plan and may be used to compare satisfaction across health plans. The goal of the CAHPS surveys is to effectively and efficiently obtain client information.

The Department requires Medicaid physical health plans to conduct client satisfaction surveys to ascertain whether clients are satisfied with their care, as well as to ascertain differences among clients enrolled in Medicaid managed care, the Primary Care Physician Program, and Medicaid fee-for-service. As part of a comprehensive quality improvement effort, the Department required physical health plans to conduct the CAHPS 4.0H Survey of Adults and 4.0H Survey of Children with Medicaid clients that had been continuously enrolled in a managed care plan for at least five of the last six months of calendar year 2009. The survey period for this questionnaire was July through December 2009, and the data was collected between February and May 2010. National averages for 2009 (the most recent comparative data available) are included.

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

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

FY 2010-11 CAHPS Results				
	Fee-For-Service	**Primary Care Physician Program**	**Denver Health Medical Plan**	**Rocky Mountain Health Plan**
Adult Medicaid				
Global Ratings				
Rating of Health Plan	★★	★★★	★	★★★
Rating of All Health Care	★	★★★★	★	★★★★
Rating of Personal Doctor	★★★	★★★★★	★★★★	★★★★
Rating of Specialist Seen Most Often	★★★	★★★★	★	★★★
Composite Measures				
Getting Needed Care	★★★	★★★★	★	★★★★★
Getting Care Quickly	★★	★★★★	★	★★★★★
How Well Doctors Communicate	★★	★★★★	★★	★★★★★
Customer Service	NA	NA	NA	NA
Shared Decision Making	★	★★★★★	★	★★★★★
★★★★★90th Percentile or Above ★★★★75th-89th Percentiles ★★★50th-74th Percentiles				
★★25th-49th Percentiles ★Below 25th Percentile **NA** Not Applicable				
	Fee-For-Service	**Primary Care Physician Program**	**Denver Health MP**	**Rocky Mountain Health Plan**
Child Medicaid				
Global Ratings				
Rating of Health Plan	★★	★★★	★★★★	★★★
Rating of All Health Care	★★★	★★★	★★★★	★★★
Rating of Personal Doctor	★★★	★★★★	★★★★★	★★★
Rating of Specialist Seen Most Often	NA	★★★★	★★★	NA
Composite Measures				
Getting Needed Care	★★	★★★	★	★★★
Getting Care Quickly	★★	★★★	★	★★★
How Well Doctors Communicate	★★★	★★★★	★★	★★★★
Customer Service	NA	NA	★	NA
Shared Decision Making	★★★	★★★★★	★★	★★★★★
★★★★★80th Percentile or Above ★★★★60th-79th Percentiles ★★★40th-59th Percentiles				
★★20th-39th Percentiles ★Below 20th Percentile **NA** Not Applicable				

Health Effectiveness Data and Information Set (HEDIS)

The Health Effectiveness Data and Information Set (HEDIS®)[6] is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans. The performance measures address many significant health care issues such as access to care, effectiveness of care, and use of services. Each year, different HEDIS measures are selected that relate to quality initiatives outlined in the State Quality Improvement Work Plan. Since different measures are selected annually, variations may occur in data presentation and reported level of detail.

The Department requires Medicaid health plans to report HEDIS measure rates each year. The Department uses this information to track the health plans' performance in providing care and services to Medicaid clients and to identify and prioritize improvement efforts. As part of a comprehensive quality initiative, the Department required health plans to report rates on HEDIS measures for adults and children. The data presented in the following tables shows performance rates on measures ranging from child immunization rates to cholesterol management. The 2011 rates reflect services provided January 1, 2010, through December 31, 2010.

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

2011 HEDIS Colorado Medicaid (CY 2010 Data Collection) HEDIS Rates for All Medicaid Health Plans								
HEDIS Measure	**Rocky Mountain Health Plans**	**Denver Health**	**Primary Care Physician Program (PCPP)**	**Fee-for-Service (FFS)**	**HMO Weighted Average[1]**	**PCPP & FFS Weighted Average[2]**	**Colorado Medicaid Weighted Average**	**2010 HEDIS National Medicaid Average**
Childhood Immunization Status (H) (Percent of children with immunization)								
Combination 2	82.20%	86.10%	81.80%	67.60%	85.10%	68.00%	70.10%	74.30%
Combination 3	78.60%	85.60%	80.80%	64.50%	83.80%	64.90%	67.20%	69.40%
4 Diptheria, Tetanus, Pertussis	86.60%	86.90%	86.40%	73.20%	86.80%	73.60%	75.20%	79.60%
3 Polio Virus immunizations	95.40%	95.90%	95.60%	85.20%	95.70%	85.40%	86.70%	89.00%
1 Measles, Mumps, and Rubella	93.90%	93.70%	94.20%	84.70%	93.70%	84.90%	86.00%	91.20%
3 Haemophilus Influenza Type b	95.10%	95.40%	97.30%	86.90%	95.30%	87.10%	88.10%	93.70%
3 Hepatitis B immunizations	95.40%	96.80%	93.70%	87.60%	96.50%	87.80%	88.80%	89.10%
1 VZV (Chicken Pox) vaccine	93.90%	92.70%	95.40%	85.90%	93.00%	86.10%	87.00%	90.60%
4 Pneumococcal Conjugate	84.90%	89.50%	93.20%	75.20%	88.30%	75.70%	77.20%	77.60%
Percent of Children with Well-Child Visits in the First 15 Months of Life (H)								
0 visits (lower indicates better performance)	0.90%	1.00%	1.30%	2.20%	1.00%	2.20%	2.10%	2.30%
6 or more	81.20%	67.70%	57.10%	65.50%	71.20%	65.40%	65.90%	59.40%
Percent of Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	68.10%	68.40%	70.10%	61.10%	68.30%	61.40%	62.20%	71.60%
Percent of Adolescents Receiving a Well-Care Visit	49.90%	49.10%	47.70%	41.80%	49.40%	42.20%	42.90%	47.70%
Percent of Children/Adolescents Receiving Weight Assessment and Counseling for Nutrition and Physical Activity (H)								
BMI Assessment - Ages 3-11	64.80%	78.60%	48.30%	31.60%	74.30%	32.30%	37.20%	30.40%
Nutrition Counseling - Ages 3-11	61.50%	79.20%	56.60%	47.00%	73.70%	47.40%	50.50%	43.80%
Physical Activity Counseling - Ages 3-11	48.00%	55.30%	45.50%	28.10%	53.00%	28.80%	31.70%	31.80%
BMI Assessment - Ages 12 to 17	56.10%	75.50%	44.40%	25.40%	69.00%	26.60%	31.50%	30.10%
Nutrition Counseling - Ages 12 to 17	54.20%	66.30%	44.40%	30.20%	62.30%	31.10%	34.70%	38.10%
Physical Activity Counseling - Ages 12 to 17	55.10%	57.10%	45.00%	31.70%	56.50%	32.60%	35.40%	34.20%
BMI Assessment - Total	62.50%	77.90%	46.70%	29.70%	73.00%	30.50%	35.50%	30.30%
Nutrition Counseling - Total	59.60%	76.20%	51.60%	41.80%	70.90%	42.30%	45.70%	41.90%
Physical Activity Counseling - Total	49.90%	55.70%	45.30%	29.20%	53.90%	30.00%	32.80%	32.50%

2011 HEDIS Colorado Medicaid (CY 2010 Data Collection) HEDIS Rates for All Medicaid Health Plans								
HEDIS Measure	**Rocky Mountain Health Plans**	**Denver Health**	**Primary Care Physician Program (PCPP)**	**Fee-for-Service (FFS)**	**HMO Weighted Average[1]**	**PCPP & FFS Weighted Average[2]**	**Colorado Medicaid Weighted Average**	**2010 HEDIS National Medicaid Average**
Prenatal and Postpartum Care (H)								
Percent receiving timely prenatal care	97.00%	82.90%	84.00%	73.70%	89.70%	73.90%	75.40%	83.40%
Percent receiving timely postpartum care	77.40%	61.00%	70.30%	53.50%	69.00%	53.90%	55.30%	64.10%
Percent of Children and Adolescents' Accessing Primary Care Practitioner								
Ages 12 to 24 Months	99.30%	93.90%	96.90%	95.50%	95.50%	95.60%	95.60%	95.20%
Ages 25 Months to 6 Years	90.00%	80.00%	88.40%	83.50%	82.70%	83.60%	83.50%	88.30%
Ages 7 to 11 Years	92.40%	81.50%	90.40%	85.30%	84.30%	85.50%	85.40%	90.30%
Ages 12 to 19 Years	93.40%	85.30%	91.70%	84.80%	87.70%	85.30%	85.50%	87.90%
Percent of Adults Accessing Preventive/Ambulatory Care								
Ages 20 to 44 Years	87.70%	73.20%	83.60%	78.00%	78.00%	78.30%	78.20%	80.50%
Ages 45 to 64 Years	91.80%	78.70%	88.00%	81.30%	82.40%	82.00%	82.00%	85.30%
Ages 65 Years and Older	96.10%	70.20%	86.00%	75.50%	78.30%	76.40%	76.60%	84.70%
Percent of Clients on Persistent Medications Receiving Annual Monitoring								
ACE inhibitors or ARBs	86.00%	88.50%	89.50%	87.70%	88.00%	87.90%	87.90%	85.90%
Anticonvulsants	69.20%	61.70%	70.60%	67.60%	64.30%	68.20%	67.60%	68.70%
Digoxin	N/A	N/A	N/A	89.10%	88.70%	87.40%	87.70%	88.90%
Diuretics	89.40%	87.00%	87.40%	88.30%	87.60%	88.20%	88.10%	85.40%
Percent of Clients With No Imaging Studies Initially Done for Low Back Pain (higher score indicates appropriate treatment)	66.90%	75.50%	71.10%	71.60%	72.40%	71.50%	71.60%	76.10%
Percent of Clients Whose High Blood Pressure was Controlled (H)	80.10%	66.20%	43.30%	43.60%	69.80%	43.50%	47.80%	55.30%
Percent of Clients with COPD Exacerbations Receiving Appropriate Pharmacotherapy Management								
Bronchodilator	65.90%	71.00%	75.00%	67.30%	69.10%	68.10%	68.20%	80.70%
Systemic Corticosteroid	39.00%	60.90%	62.50%	54.70%	52.70%	55.50%	55.10%	61.80%
Percent of Adults With Acute Bronchitis Where Antibiotic Treatment was Avoided	48.60%	44.40%	40.10%	25.60%	47.20%	27.00%	28.30%	25.60%

2011 HEDIS Colorado Medicaid (CY 2010 Data Collection) HEDIS Rates for All Medicaid Health Plans								
HEDIS Measure	**Rocky Mountain Health Plans**	**Denver Health**	**Primary Care Physician Program (PCPP)**	**Fee-for-Service (FFS)**	**HMO Weighted Average[1]**	**PCPP & FFS Weighted Average[2]**	**Colorado Medicaid Weighted Average**	**2010 HEDIS National Medicaid Average**
Percent of Women Receiving Chlamydia Screening								
Ages 16 to 20 Years	47.40%	73.10%	30.50%	53.70%	64.50%	52.80%	54.00%	54.40%
Ages 21 to 24 Years	46.50%	72.80%	27.70%	57.80%	63.30%	57.00%	57.60%	61.60%
Percent of Adults Receiving BMI Assessment	60.10%	82.20%	35.50%	40.10%	75.00%	39.70%	43.40%	34.60%
Inpatient Utilization								
Discharges/1,000 Member Months	11.6	9.9	11.5	12.2	10.4	12.1	11.9	8.9
Days/1,000 Member Months	33.8	37.2	56.4	54.6	36.2	54.7	52.6	37.5
Average Length of Stay	2.9	3.7	4.9	4.5	3.5	4.5	4.4	3.9
Number of Ambulatory Care Visits/1,000 Member Months								
Outpatient Visits	437.8	264.5	410	353.4	313.7	356.3	351.4	367.2
ED Visits	56.9	47.3	63.9	64.7	50	64.7	63	67.4
Antibiotic Utilization								
Average Number of Prescriptions PMPY for Antibiotics	1.1	0.5	1.2	0.9	0.7	1	0.9	1.1
Average Days Supplied Per Antibiotic Prescription	9.9	9.9	10.6	9.6	9.9	9.6	9.7	9.2
Average Number of Prescriptions PMPY for Antibiotics of Concern	0.4	0.1	0.5	0.4	0.2	0.4	0.3	0.5
Percent of Antibiotics of Concern of All Antibiotic Prescriptions	36.70%	25.80%	37.90%	37.50%	30.90%	37.60%	37.00%	41.10%

1 HMO Weighted Averages were derived from the rates of Rocky Mountain Health Plans and Denver Health.

2 Colorado Medicaid Weighted Average were derived from the rates of Rocky Mountain Health Plans, Denver Health, Primary Care Physician Program, and fee-for-service.

Demographics and Expenditures

Demographic statistics provide valuable insight on the demand for medical care within each region. More populated areas tend to have a greater demand for medical care. Therefore, a region that is more populated is likely to have higher medical expenditures and caseloads. Likewise, as Colorado's population increases, the demand for medical care will also increase. The Department is reporting county level data from the 2000 United States census as well as 2011 demographic data from the Colorado Department of Local Affairs.

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

Medicaid

Using the Department's decision support system database, FY 2010-11 Medicaid data was collected for the following statistics and reported for the State in the following table, and reported by county:

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

Please note that monthly expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System. The decision support system extracts data on a different time span and from a different source (i.e., Medicaid Management Information System) than the Colorado Financial Reporting System. Therefore, total expenditures presented in this document will not reconcile with the actual medical services expenditures reported in Exhibit M in the November 1, 2011 FY 2012-13 Budget Request.

Children's Basic Health Plan

Using FY 2010-11 expenditures and caseload data for the Children's Basic Health Plan (CHP+), the Department compiled the following data and reported it by county in the following table:

- Average Number of Children per Month;

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

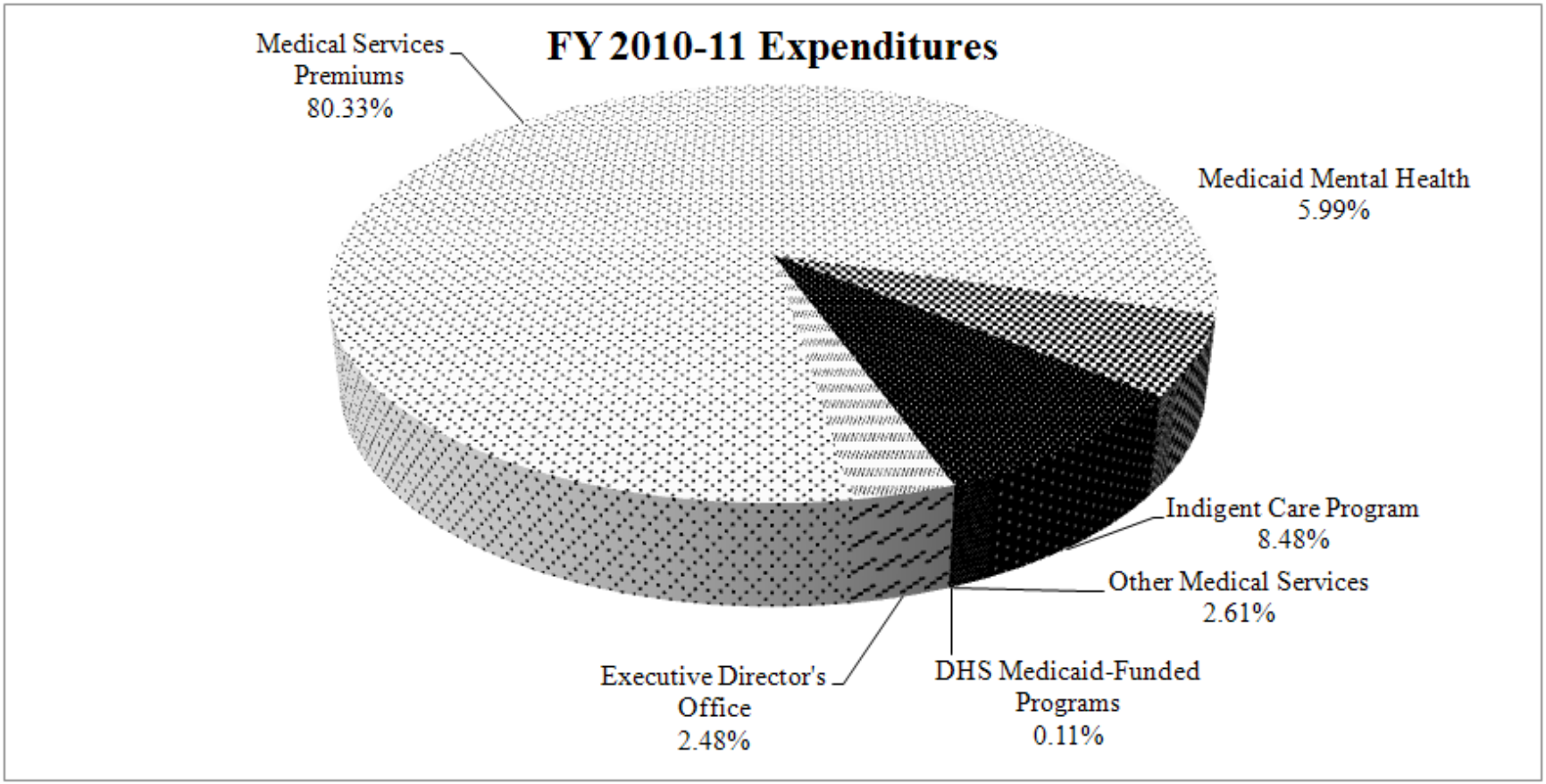
CHP+ provides medical and dental services to children under age 19, and provides prenatal care and delivery for adult pregnant women who are at or below 250% of the federal poverty level. The total CHP+ expenditures presented in the statewide table below include Children's Basic Health Plan Premium Costs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

Please note that all data included in prior Budget Submissions were aggregated at the Health Insurance Portability and Accountability Act (HIPAA) region level. HIPAA requires that the Department release client information in a larger aggregation in order to maintain client confidentiality and anonymity in smaller counties. To do this, twenty "HIPAA Regions" were developed for the provision of Department information. However, beginning with the FY 2011-12 Budget Submission, the Department will be reporting data at the county level, and suppressing data for small counties. For data at the HIPAA region level, please contact Jennifer St. Peter at 303-866-3982.

Colorado's Demographics, Medicaid, CHP+, and CICP – A Statewide View	
Characteristics	**Statewide**
Demographic Characteristics	
Colorado Population Estimate (2011)[1]	5,328,910
Percent of Population in the Labor Force (2000)[2]	70.99%
Percent of Homes where Non-English is Spoken (2000)[2]	15.10%
Percent of Families Below Poverty (2000)[2]	7.80%
Percent of Female Headed Households (2000)[2]	9.65%
Medicaid Characteristics, FY 2010-11	
Average Number of Medicaid Clients per Month	560,758
Percent of State Population that are Medicaid Clients	10.52%
Medicaid Expenditures	$3,278,085,686
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11	
Average Number of CHP+ Clients per Month	68,716
Percent of State Population that are CHP+ Clients	1.29%
CHP+ Expenditures	$161,093,534
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10	
Unduplicated Client Count	217,946
Number of CICP Providers	67
Colorado Indigent Care Program Expenditures	$310,879,968

1) 2011 Population Forecast - TABLE 3C. PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2010 – 2020
http://dola.colorado.gov/demog/population/forecasts/counties1yr.pdf

2) 2000 Census Data - Table DP-1. Profile of General Demographic Characteristics: 2000
https://dola.colorado.gov/dlg/demog/census_profiles.html
http://dola.colorado.gov/dlg/demog/2010censusdata.html



Source: November 1, 2011 FY 2012-13 Budget Request, Schedule 3.

Medicaid and the Children's Basic Health Plan

The following table provides insight on the variations of Medicaid and the Children's Basic Health Plan (CHP+) usage across counties. Some important caveats must be mentioned concerning the Medicaid and CHP+ data presented in the county table. Overall, Medicaid and CHP+ expenditure figures by county will not equal the year-to-date FY 2010-11 appropriated or actual amounts. This is due to several factors:

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

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

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

4. Expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System, whereas the Decision Support System database extracts its data from the Medicaid Management Information System (MMIS). Therefore, total Medicaid and CHP+ expenditures presented in the table below will not exactly reconcile with the numbers for actual medical services reported in the June 2011 Premiums, Caseload, and Expenditure Report to the Joint Budget Committee. Some Medicaid expenditures are not linked to an eligibility type or to a unique client identification number for the following reasons:

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

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

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

6. Data have been suppressed for select counties with smaller populations per the Department's threshold rule to comply with HIPAA regulations.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Adams**	**Alamosa**	**Arapahoe**	**Archuleta**
Demographic Characteristic				
Colorado Population Estimate (2011)[1]	465,693	16,709	593,964	14,663
Percent of Total Colorado Population (2011)[1]	8.74%	0.31%	11.15%	0.28%
Colorado Population (2000)[2]	363,857	14,966	487,967	9,898
Percent of Population in the Labor Force (2000)[2]	70.57%	66.29%	73.27%	63.22%
Percent of Homes where Non-English is Spoken (2000)[2]	21.64%	28.34%	15.51%	11.95%
Percent of Families Below Poverty (2000)[2]	6.46%	15.56%	4.18%	9.05%
Percent of Female Headed Households (2000)[2]	12.11%	11.65%	10.64%	8.17%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	64,472	3,848	60,706	1,301
Percent of Regional Population that are Medicaid Clients	13.84%	23.03%	10.22%	8.87%
Medicaid Expenditures	$341,390,246	$20,937,934	$353,687,463	$5,829,859
Percent of Total Medicaid Expenditures	10.41%	0.64%	10.79%	0.18%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	9,361	421	7,702	280
Percent of Regional Population that are CHP+ Clients	2.01%	2.52%	1.30%	1.91%
CHP+ Expenditures	$21,073,052	$950,728	$17,717,052	$733,329
Percent of Total CHP+ Expenditures	13.08%	0.59%	11.00%	0.46%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	18,305	684	0	0
Number of CICP Providers	2	2	2	0
CICP Expenditures	$38,120,146	$3,730,929	$7,404,196	$0
Percent of Total CICP Expenditures	12.26%	1.20%	2.38%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Baca**	**Bent**	**Boulder**	**Broomfield**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	4,065	5,754	306,381	59,425
Percent of Total Colorado Population (2011)[1]	0.08%	0.11%	5.75%	1.12%
Colorado Population (2000)[2]	4,517	5,998	291,288	-
Percent of Population in the Labor Force (2000)[2]	57.64%	48.60%	73.36%	-
Percent of Homes where Non-English is Spoken (2000)[2]	5.81%	16.83%	13.62%	-
Percent of Families Below Poverty (2000)[2]	12.89%	16.58%	4.59%	-
Percent of Female Headed Households (2000)[2]	7.51%	11.43%	7.70%	-
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	632	1,034	21,263	2,745
Percent of Regional Population that are Medicaid Clients	15.55%	17.97%	6.94%	4.62%
Medicaid Expenditures	$5,351,414	$6,677,904	$131,545,474	$20,001,029
Percent of Total Medicaid Expenditures	0.16%	0.20%	4.01%	0.61%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	100	103	2,792	591
Percent of Regional Population that are CHP+ Clients	2.45%	1.78%	0.91%	0.99%
CHP+ Expenditures	$234,249	$226,379	$6,090,160	$1,307,920
Percent of Total CHP+ Expenditures	0.15%	0.14%	3.78%	0.81%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	227	0	11,293	0
Number of CICP Providers	1	0	3	0
CICP Expenditures	$145,494	$0	$15,610,083	$0
Percent of Total CICP Expenditures	0.05%	0.00%	5.02%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Chaffee**	**Cheyenne**	**Clear Creek**	**Conejos**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	17,845	1,920	9,967	8,495
Percent of Total Colorado Population (2011)[1]	0.33%	0.04%	0.19%	0.16%
Colorado Population (2000)[2]	16,242	2,231	9,322	8,400
Percent of Population in the Labor Force (2000)[2]	52.97%	63.45%	77.30%	55.11%
Percent of Homes where Non-English is Spoken (2000)[2]	8.70%	7.61%	3.51%	42.11%
Percent of Families Below Poverty (2000)[2]	7.37%	8.72%	2.99%	18.64%
Percent of Female Headed Households (2000)[2]	6.85%	5.68%	6.89%	12.68%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	1,531	188	620	2,063
Percent of Regional Population that are Medicaid Clients	8.58%	9.79%	6.22%	24.28%
Medicaid Expenditures	$10,461,202	$1,287,790	$3,073,737	$9,862,285
Percent of Total Medicaid Expenditures	0.32%	0.04%	0.09%	0.30%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	382	46	96	354
Percent of Regional Population that are CHP+ Clients	2.14%	2.39%	0.96%	4.17%
CHP+ Expenditures	$1,014,052	$148,519	$228,832	$802,117
Percent of Total CHP+ Expenditures	0.63%	0.09%	0.14%	0.50%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	513	0	0	344
Number of CICP Providers	1	0	0	1
CICP Expenditures	$726,223	$0	$0	$430,741
Percent of Total CICP Expenditures	0.23%	0.00%	0.00%	0.14%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Costilla**	**Crowley**	**Custer**	**Delta**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	3,580	8,610	4,708	34,472
Percent of Total Colorado Population (2011)[1]	0.07%	0.16%	0.09%	0.65%
Colorado Population (2000)[2]	3,663	5,518	3,503	27,834
Percent of Population in the Labor Force (2000)[2]	45.67%	31.92%	56.27%	54.87%
Percent of Homes where Non-English is Spoken (2000)[2]	59.47%	14.65%	3.65%	10.32%
Percent of Families Below Poverty (2000)[2]	21.26%	15.20%	9.76%	8.55%
Percent of Female Headed Households (2000)[2]	11.31%	11.05%	5.41%	7.87%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	1,018	853	456	4,083
Percent of Regional Population that are Medicaid Clients	28.44%	9.91%	9.69%	11.84%
Medicaid Expenditures	$4,279,383	$4,902,282	$1,165,432	$20,335,700
Percent of Total Medicaid Expenditures	0.13%	0.15%	0.04%	0.62%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	83	53	56	590
Percent of Regional Population that are CHP+ Clients	2.32%	0.61%	1.19%	1.71%
CHP+ Expenditures	$195,584	$106,248	$126,218	$1,327,506
Percent of Total CHP+ Expenditures	0.12%	0.07%	0.08%	0.82%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	0	0	138	679
Number of CICP Providers	0	0	1	1
CICP Expenditures	$0	$0	$34,499	$2,139,235
Percent of Total CICP Expenditures	0.00%	0.00%	0.01%	0.69%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.
Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency.
4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Denver**	**Dolores**	**Douglas**	**Eagle**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	626,973	2,030	313,583	59,945
Percent of Total Colorado Population (2011)[1]	11.77%	0.04%	5.88%	1.12%
Colorado Population (2000)[2]	554,636	1,844	175,766	41,659
Percent of Population in the Labor Force (2000)[2]	67.65%	58.03%	79.01%	80.90%
Percent of Homes where Non-English is Spoken (2000)[2]	26.96%	5.71%	7.20%	24.68%
Percent of Families Below Poverty (2000)[2]	10.63%	10.22%	1.62%	3.94%
Percent of Female Headed Households (2000)[2]	10.84%	8.54%	5.74%	5.55%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	97,162	229	8,553	2,926
Percent of Regional Population that are Medicaid Clients	15.50%	11.28%	2.73%	4.88%
Medicaid Expenditures	$538,823,058	$960,092	$55,612,491	$8,915,970
Percent of Total Medicaid Expenditures	16.44%	0.03%	1.70%	0.27%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	8,464	43	1,560	457
Percent of Regional Population that are CHP+ Clients	1.35%	2.13%	0.50%	0.76%
CHP+ Expenditures	$18,589,254	$97,971	$3,844,184	$1,048,929
Percent of Total CHP+ Expenditures	11.54%	0.06%	2.39%	0.65%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	43,775	1,352	0	0
Number of CICP Providers	5	1	0	0
CICP Expenditures	$95,338,750	$839,564	$0	$0
Percent of Total CICP Expenditures	30.67%	0.27%	0.00%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Elbert**	**El Paso**	**Fremont**	**Garfield**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	24,236	643,785	51,178	69,998
Percent of Total Colorado Population (2011)[1]	0.45%	12.08%	0.96%	1.31%
Colorado Population (2000)[2]	19,872	516,929	46,145	43,791
Percent of Population in the Labor Force (2000)[2]	75.45%	71.94%	45.07%	71.05%
Percent of Homes where Non-English is Spoken (2000)[2]	4.79%	11.36%	7.37%	15.46%
Percent of Families Below Poverty (2000)[2]	2.54%	5.69%	8.35%	4.60%
Percent of Female Headed Households (2000)[2]	5.66%	10.22%	9.18%	7.79%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	1,261	66,405	6,433	5,925
Percent of Regional Population that are Medicaid Clients	5.20%	10.31%	12.57%	8.46%
Medicaid Expenditures	$6,362,880	$387,804,769	$45,258,244	$31,524,587
Percent of Total Medicaid Expenditures	0.19%	11.83%	1.38%	0.96%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	6,505	193	662	1,050
Percent of Regional Population that are CHP+ Clients	26.84%	0.03%	1.29%	1.50%
CHP+ Expenditures	$413,716	$16,988,787	$1,443,833	$2,466,361
Percent of Total CHP+ Expenditures	0.26%	10.54%	0.90%	1.53%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	0	35,553	0	7,842
Number of CICP Providers	0	3	1	3
CICP Expenditures	$0	$41,187,611	$2,761,457	$3,211,778
Percent of Total CICP Expenditures	0.00%	13.25%	0.89%	1.03%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Gilpin**	**Grand**	**Gunnison**	**Hinsdale**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	5,438	15,764	15,757	920
Percent of Total Colorado Population (2011)[1]	0.10%	0.30%	0.30%	0.02%
Colorado Population (2000)[2]	4,757	12,442	13,956	790
Percent of Population in the Labor Force (2000)[2]	81.33%	77.09%	73.36%	70.51%
Percent of Homes where Non-English is Spoken (2000)[2]	4.73%	6.11%	6.60%	4.85%
Percent of Families Below Poverty (2000)[2]	1.00%	5.39%	6.01%	4.45%
Percent of Female Headed Households (2000)[2]	5.73%	5.20%	5.42%	4.74%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	344	773	989	53
Percent of Regional Population that are Medicaid Clients	6.33%	4.90%	6.28%	5.76%
Medicaid Expenditures	$1,737,798	$3,138,869	$5,282,575	$160,974
Percent of Total Medicaid Expenditures	0.05%	0.10%	0.16%	0.00%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	62	201	222	N/A
Percent of Regional Population that are CHP+ Clients	1.14%	1.27%	1.41%	2.16%
CHP+ Expenditures	$145,425	$521,174	$577,887	$60,805
Percent of Total CHP+ Expenditures	0.09%	0.32%	0.36%	0.04%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	0	50	113	0
Number of CICP Providers	0	1	1	0
CICP Expenditures	$0	$52,762	$64,401	$0
Percent of Total CICP Expenditures	0.00%	0.02%	0.02%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Huerfano**	**Jackson**	**Jefferson**	**Kiowa**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	8,489	1,490	555,757	1,438
Percent of Total Colorado Population (2011)[1]	0.16%	0.03%	10.43%	0.03%
Colorado Population (2000)[2]	7,862	1,577	527,056	1,622
Percent of Population in the Labor Force (2000)[2]	48.81%	66.75%	73.43%	60.63%
Percent of Homes where Non-English is Spoken (2000)[2]	18.17%	3.83%	9.23%	3.54%
Percent of Families Below Poverty (2000)[2]	14.10%	10.27%	3.35%	9.64%
Percent of Female Headed Households (2000)[2]	10.35%	7.87%	9.13%	6.62%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	1,563	126	39,742	197
Percent of Regional Population that are Medicaid Clients	18.41%	8.46%	7.15%	13.70%
Medicaid Expenditures	$10,915,303	$301,995	$326,779,491	$1,482,122
Percent of Total Medicaid Expenditures	0.33%	0.01%	9.97%	0.05%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	109	41	5,278	N/A
Percent of Regional Population that are CHP+ Clients	1.28%	2.73%	0.95%	1.99%
CHP+ Expenditures	$236,976	$84,852	$12,691,759	$62,666
Percent of Total CHP+ Expenditures	0.15%	0.05%	7.88%	0.04%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	6,989	0	0	0
Number of CICP Providers	2	0	0	0
CICP Expenditures	$11,259,177	$0	$0	$0
Percent of Total CICP Expenditures	3.62%	0.00%	0.00%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Kit Carson**	**Lake**	**La Plata**	**Larimer**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	8,219	11,131	52,755	312,256
Percent of Total Colorado Population (2011)[1]	0.15%	0.21%	0.99%	5.86%
Colorado Population (2000)[2]	8,011	7,812	43,941	251,494
Percent of Population in the Labor Force (2000)[2]	60.98%	72.65%	69.04%	71.92%
Percent of Homes where Non-English is Spoken (2000)[2]	13.22%	26.35%	9.45%	8.47%
Percent of Families Below Poverty (2000)[2]	9.39%	9.52%	6.65%	4.26%
Percent of Female Headed Households (2000)[2]	6.29%	8.40%	8.66%	7.87%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	949	1,008	4,247	26,024
Percent of Regional Population that are Medicaid Clients	11.55%	9.06%	8.05%	8.33%
Medicaid Expenditures	$5,439,366	$4,304,010	$21,732,564	$150,475,602
Percent of Total Medicaid Expenditures	0.17%	0.13%	0.66%	4.59%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	289	832	175	3,388
Percent of Regional Population that are CHP+ Clients	3.52%	7.48%	0.33%	1.09%
CHP+ Expenditures	$701,086	$429,133	$2,083,861	$8,655,640
Percent of Total CHP+ Expenditures	0.44%	0.27%	1.29%	5.37%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	0	1,036	0	26,908
Number of CICP Providers	0	1	1	5
CICP Expenditures	$0	$123,920	$2,524,231	$26,413,091
Percent of Total CICP Expenditures	0.00%	0.04%	0.81%	8.50%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Las Animas**	**Lincoln**	**Logan**	**Mesa**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	17,724	5,774	23,466	156,653
Percent of Total Colorado Population (2011)[1]	0.33%	0.11%	0.44%	2.94%
Colorado Population (2000)[2]	15,207	6,087	20,504	116,255
Percent of Population in the Labor Force (2000)[2]	54.67%	52.43%	60.75%	64.20%
Percent of Homes where Non-English is Spoken (2000)[2]	20.79%	6.89%	8.21%	7.97%
Percent of Families Below Poverty (2000)[2]	14.00%	8.15%	8.99%	7.03%
Percent of Female Headed Households (2000)[2]	11.65%	8.36%	8.56%	9.78%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	2,981	631	2,662	19,381
Percent of Regional Population that are Medicaid Clients	16.82%	10.93%	11.34%	12.37%
Medicaid Expenditures	$24,949,130	$4,304,359	$17,815,683	$105,779,055
Percent of Total Medicaid Expenditures	0.76%	0.13%	0.54%	3.23%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	264	81	368	2,703
Percent of Regional Population that are CHP+ Clients	1.49%	1.40%	1.57%	1.73%
CHP+ Expenditures	$629,026	$184,682	$783,783	$6,580,860
Percent of Total CHP+ Expenditures	0.39%	0.11%	0.49%	4.08%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	3,170	1,161	0	6,802
Number of CICP Providers	1	1	1	3
CICP Expenditures	$634,672	$232,021	$2,745,588	$8,053,556
Percent of Total CICP Expenditures	0.20%	0.07%	0.88%	2.59%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Mineral**	**Moffat**	**Montezuma**	**Montrose**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	1,061	19,695	27,171	46,349
Percent of Total Colorado Population (2011)[1]	0.02%	0.37%	0.51%	0.87%
Colorado Population (2000)[2]	831	13,184	23,830	33,432
Percent of Population in the Labor Force (2000)[2]	62.30%	69.27%	63.35%	62.60%
Percent of Homes where Non-English is Spoken (2000)[2]	1.89%	8.37%	13.34%	11.57%
Percent of Families Below Poverty (2000)[2]	9.30%	6.89%	13.12%	8.88%
Percent of Female Headed Households (2000)[2]	5.84%	8.17%	10.56%	8.69%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	47	1,790	4,182	6,454
Percent of Regional Population that are Medicaid Clients	4.43%	9.09%	15.39%	13.92%
Medicaid Expenditures	$238,131	$8,872,288	$24,295,382	$29,018,277
Percent of Total Medicaid Expenditures	0.01%	0.27%	0.74%	0.89%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	N/A	258	625	1,333
Percent of Regional Population that are CHP+ Clients	0.52%	1.31%	2.30%	2.88%
CHP+ Expenditures	$36,399	$704,037	$1,429,772	$3,164,035
Percent of Total CHP+ Expenditures	0.02%	0.44%	0.89%	1.96%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	0	313	301	1,705
Number of CICP Providers	0	2	1	2
CICP Expenditures	$0	$180,277	$786,257	$2,395,182
Percent of Total CICP Expenditures	0.00%	0.06%	0.25%	0.77%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Morgan**	**Otero**	**Ouray**	**Park**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	29,379	19,169	5,005	19,691
Percent of Total Colorado Population (2011)[1]	0.55%	0.36%	0.09%	0.37%
Colorado Population (2000)[2]	27,171	20,311	3,742	14,523
Percent of Population in the Labor Force (2000)[2]	62.41%	58.35%	62.98%	70.30%
Percent of Homes where Non-English is Spoken (2000)[2]	25.64%	21.90%	5.70%	4.24%
Percent of Families Below Poverty (2000)[2]	8.50%	14.20%	6.03%	3.36%
Percent of Female Headed Households (2000)[2]	8.97%	11.96%	6.54%	4.45%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	4,369	4,457	288	982
Percent of Regional Population that are Medicaid Clients	14.87%	23.25%	5.75%	4.99%
Medicaid Expenditures	$25,195,894	$28,441,633	$897,186	$4,160,226
Percent of Total Medicaid Expenditures	0.77%	0.87%	0.03%	0.13%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	506	396	97	205
Percent of Regional Population that are CHP+ Clients	1.72%	2.07%	1.93%	1.04%
CHP+ Expenditures	$1,206,819	$829,935	$244,012	$459,671
Percent of Total CHP+ Expenditures	0.75%	0.52%	0.15%	0.29%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	1,571	1,253	0	0
Number of CICP Providers	2	1	0	0
CICP Expenditures	$1,405,644	$2,157,619	$0	$0
Percent of Total CICP Expenditures	0.45%	0.69%	0.00%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Phillips**	**Pitkin**	**Prowers**	**Pueblo**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	4,622	17,514	13,280	167,584
Percent of Total Colorado Population (2011)[1]	0.09%	0.33%	0.25%	3.14%
Colorado Population (2000)[2]	4,480	14,872	14,483	141,472
Percent of Population in the Labor Force (2000)[2]	59.65%	79.92%	65.42%	58.31%
Percent of Homes where Non-English is Spoken (2000)[2]	10.94%	12.10%	24.37%	16.13%
Percent of Families Below Poverty (2000)[2]	8.81%	3.03%	14.46%	11.18%
Percent of Female Headed Households (2000)[2]	5.56%	5.32%	10.95%	13.33%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	518	281	2,870	32,932
Percent of Regional Population that are Medicaid Clients	11.21%	1.60%	21.61%	19.65%
Medicaid Expenditures	$3,143,065	$1,313,501	$15,310,247	$212,743,329
Percent of Total Medicaid Expenditures	0.10%	0.04%	0.47%	6.49%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	97	69	369	2,239
Percent of Regional Population that are CHP+ Clients	2.09%	0.39%	2.78%	1.34%
CHP+ Expenditures	$205,061	$155,411	$795,209	$4,929,532
Percent of Total CHP+ Expenditures	0.13%	0.10%	0.49%	3.06%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	128	215	1,841	10,210
Number of CICP Providers	0	1	2	2
CICP Expenditures	$0	$822,331	$1,785,707	$15,080,331
Percent of Total CICP Expenditures	0.00%	0.26%	0.57%	4.85%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Rio Blanco**	**Rio Grande**	**Routt**	**Saguache**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	12,277	12,646	25,405	7,314
Percent of Total Colorado Population (2011)[1]	0.23%	0.24%	0.48%	0.14%
Colorado Population (2000)[2]	5,986	12,413	19,690	5,917
Percent of Population in the Labor Force (2000)[2]	67.58%	61.50%	80.39%	59.84%
Percent of Homes where Non-English is Spoken (2000)[2]	6.58%	27.57%	6.10%	36.48%
Percent of Families Below Poverty (2000)[2]	6.74%	11.26%	2.77%	18.73%
Percent of Female Headed Households (2000)[2]	7.81%	11.17%	5.78%	11.00%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	653	2,785	1,190	1,188
Percent of Regional Population that are Medicaid Clients	5.32%	22.02%	4.68%	16.24%
Medicaid Expenditures	$3,226,823	$14,856,103	$7,603,959	$4,764,751
Percent of Total Medicaid Expenditures	0.10%	0.45%	0.23%	0.15%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	116	411	364	179
Percent of Regional Population that are CHP+ Clients	0.94%	3.25%	1.43%	2.45%
CHP+ Expenditures	$262,551	$933,009	$929,591	$392,327
Percent of Total CHP+ Expenditures	0.16%	0.58%	0.58%	0.24%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	0	439	525	0
Number of CICP Providers	0	1	1	0
CICP Expenditures	$0	$258,975	$758,659	$0
Percent of Total CICP Expenditures	0.00%	0.08%	0.24%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**San Juan**	**San Miguel**	**Sedgwick**	**Summit**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	562	8,746	2,499	31,846
Percent of Total Colorado Population (2011)[1]	0.01%	0.16%	0.05%	0.60%
Colorado Population (2000)[2]	558	6,594	2,747	23,548
Percent of Population in the Labor Force (2000)[2]	69.56%	83.76%	60.88%	86.09%
Percent of Homes where Non-English is Spoken (2000)[2]	9.02%	10.85%	9.33%	13.58%
Percent of Families Below Poverty (2000)[2]	13.46%	6.59%	7.80%	3.09%
Percent of Female Headed Households (2000)[2]	8.92%	5.44%	6.61%	4.36%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	78	409	310	1,261
Percent of Regional Population that are Medicaid Clients	13.88%	4.68%	12.40%	3.96%
Medicaid Expenditures	$262,655	$900,721	$2,592,543	$4,277,314
Percent of Total Medicaid Expenditures	0.01%	0.03%	0.08%	0.13%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	N/A	125	61	335
Percent of Regional Population that are CHP+ Clients	3.96%	1.43%	2.46%	1.05%
CHP+ Expenditures	$33,577	$282,127	$121,819	$846,976
Percent of Total CHP+ Expenditures	0.02%	0.18%	0.08%	0.53%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	0	418	106	0
Number of CICP Providers	0	1	1	0
CICP Expenditures	$0	$159,785	$70,101	$0
Percent of Total CICP Expenditures	0.00%	0.05%	0.02%	0.00%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

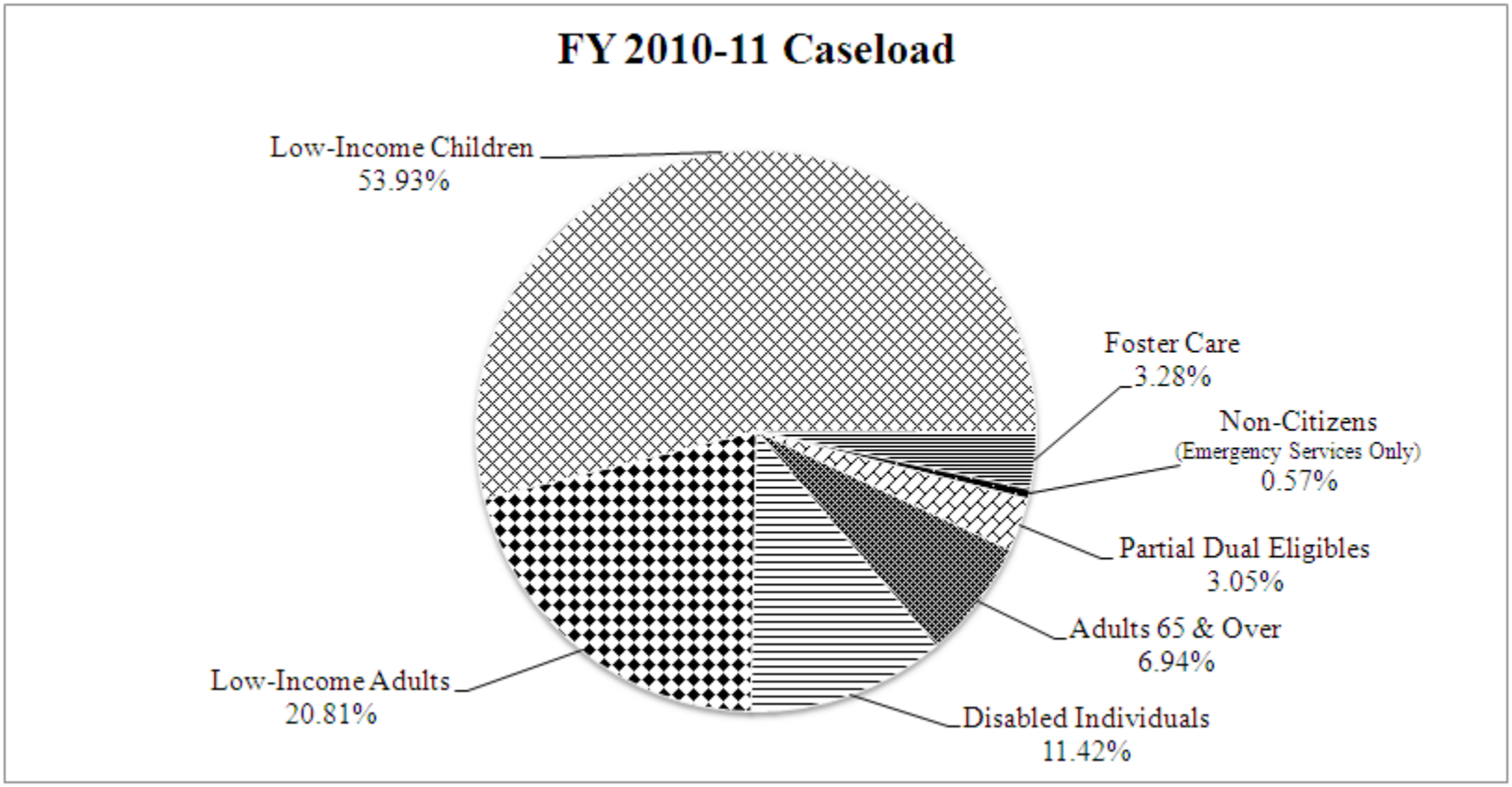
County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Teller**	**Washington**	**Weld**	**Yuma**
Demographic Characteristics				
Colorado Population Estimate (2011)[1]	24,671	4,773	276,475	10,166
Percent of Total Colorado Population (2011)[1]	0.46%	0.09%	5.19%	0.19%
Colorado Population (2000)[2]	20,555	4,926	180,936	9,841
Percent of Population in the Labor Force (2000)[2]	72.36%	62.84%	68.61%	66.20%
Percent of Homes where Non-English is Spoken (2000)[2]	4.00%	5.24%	20.25%	11.47%
Percent of Families Below Poverty (2000)[2]	3.40%	8.58%	8.04%	8.83%
Percent of Female Headed Households (2000)[2]	6.56%	6.44%	9.42%	6.76%
Medicaid Characteristics, FY 2010-11				
Average Number of Medicaid Clients per Month	1,962	491	32,425	1,459
Percent of Regional Population that are Medicaid Clients	7.95%	10.29%	11.73%	14.35%
Medicaid Expenditures	$9,526,234	$2,693,439	$164,957,853	$8,144,008
Percent of Total Medicaid Expenditures	0.29%	0.08%	5.03%	0.25%
Children's Basic Health Plan (CHP+) Characteristics, FY 2010-11				
Average Number of CHP+ Clients per Month	317	107	4,256	222
Percent of Regional Population that are CHP+ Clients	1.28%	2.23%	1.54%	2.18%
CHP+ Expenditures	$793,656	$246,380	$10,036,197	$450,839
Percent of Total CHP+ Expenditures	0.49%	0.15%	6.23%	0.28%
Colorado Indigent Care Program (CICP) Characteristics, FY 2009-10				
Unduplicated Client Count	268	0	31,034	685
Number of CICP Providers	1	0	3	2
CICP Expenditures	$343,795	$0	$20,170,168	$721,012
Percent of Total CICP Expenditures	0.11%	0.00%	6.49%	0.23%

Sources: TOAD for Data Analysis queries for caseload and expenditures (last updated July 2011); Colorado State Demography Website for population and demographic numbers.

Notes: 1) Average Number of Medicaid/CHP+ Clients per month is eligibility based and the expenditures are claims based. 2) Expenditures are by region in which the client lived in FY 2010-11. 3) Demographic data was updated since the 2000 Census for some counties. Data from the 2000 Census was used for all counties for consistency. 4) Number of Colorado Indigent Care Providers (CICP) by Region includes CICP hospitals and clinics. 5) Medicaid Expenditures excludes drug rebates, Single Entry Point, Supplemental Medicare Insurance Beneficiaries, and Supplemental Payments, and Other Adjustments.

Medicaid Caseload

Medicaid caseload trends are influenced by a number of factors including: population trends, in-State migration, age of the population, length of stay, economic conditions, and State and federal policy changes. Projecting annual caseload is complicated by the fact that each of these factors can contribute to categorical changes, some of which may be contradictory. For example, the State may enact legislation that removes clients from a Medicaid category who are aged 65 and older, while the population of adults aged 65 and older is increasing. The chart below shows Medicaid caseload by category as a percentage of the overall caseload for FY 2010-11.[4]



[4] Source: November 1, 2010 FY 2012-13 Budget Request, Exhibit B, "Medicaid Caseload Forecast."

A. Clients

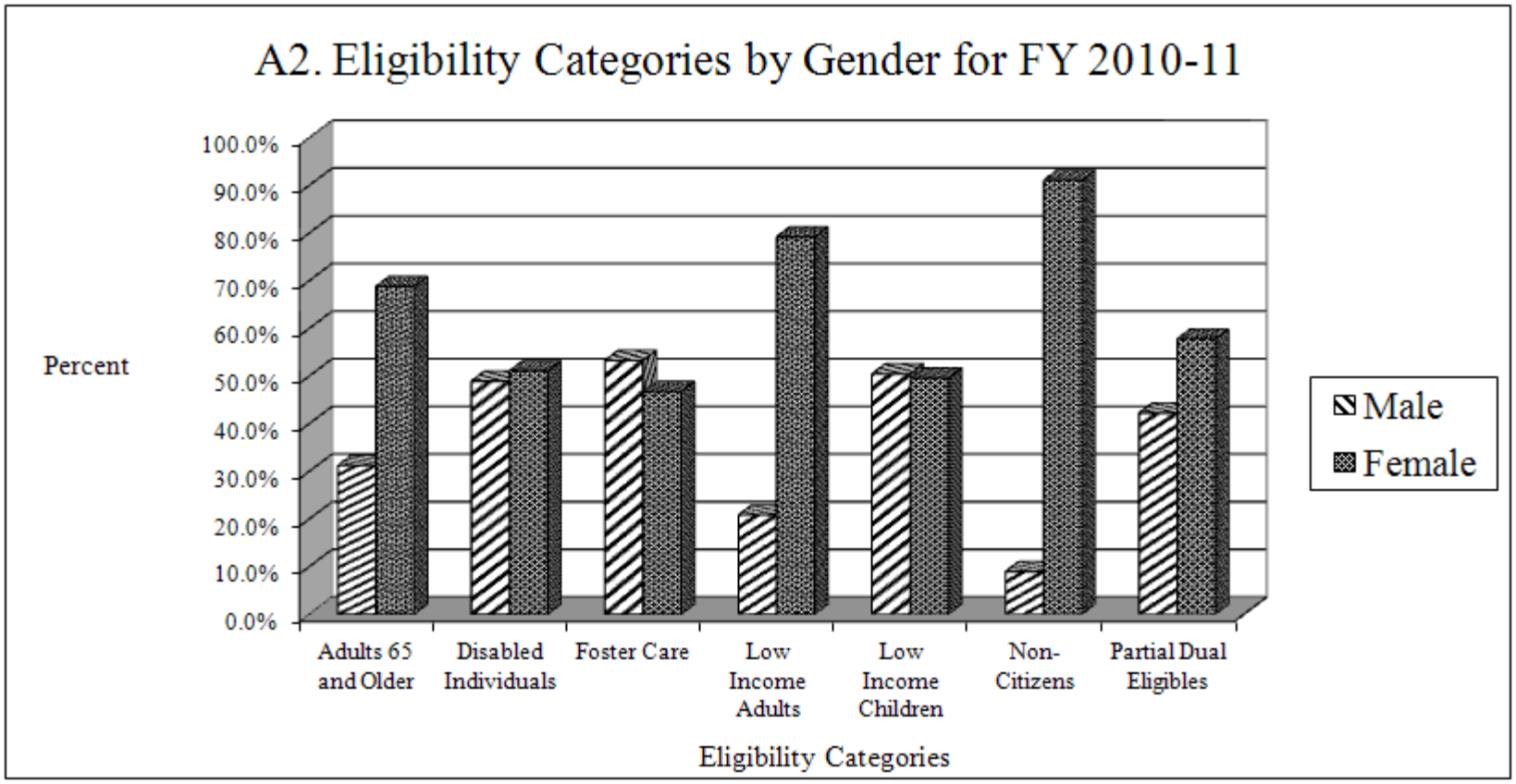
A1. 2011 Federal Poverty Levels

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

Federal Poverty Guidelines for Annual Income									
Family Size	**100%**	**120%**	**133%**	**150%**	**175%**	**185%**	**190%**	**200%**	**250%**
1	$10,890	$13,068	$14,520	$16,335	$19,058	$20,147	$20,691	$21,780	$27,225
2	$14,710	$17,652	$19,613	$22,065	$25,743	$27,214	$27,949	$29,420	$36,775
3	$18,530	$22,236	$24,707	$27,795	$32,428	$34,281	$35,207	$37,060	$46,325
4	$22,350	$26,820	$29,800	$33,525	$39,113	$41,348	$42,465	$44,700	$55,875
5	$26,170	$31,404	$34,893	$39,255	$45,798	$48,415	$49,723	$52,340	$65,425
6	$29,990	$35,988	$39,987	$44,985	$52,483	$55,482	$56,981	$59,980	$74,975
7	$33,810	$40,572	$45,080	$50,715	$59,168	$62,549	$64,239	$67,620	$84,525
8	$37,630	$45,156	$50,173	$56,445	$65,853	$69,616	$71,497	$75,260	$94,075

Source: Federal Register, Vol. 76, No. 13, Thursday, January 20, 2011, Notices, page 3638.

A2. Eligibility Categories by Gender for FY 2010-11[5]



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

A3. Medicaid Enrollment by Type of Managed Care Provider

The following table shows the breakdown by client count for FY 2006-07 through FY 2010-11 for clients enrolled in health maintenance organizations, prepaid inpatient health plan, Primary Care Physician Program, and unassigned fee-for-service. Health maintenance organizations, prepaid inpatient health plan and Primary Care Physician Program enrollment figures were subtracted from total caseload numbers (without retroactivity) to calculate the fee-for-service enrollment figures, and as a result may cause the fee-for-service counts to be underrepresented.[6]

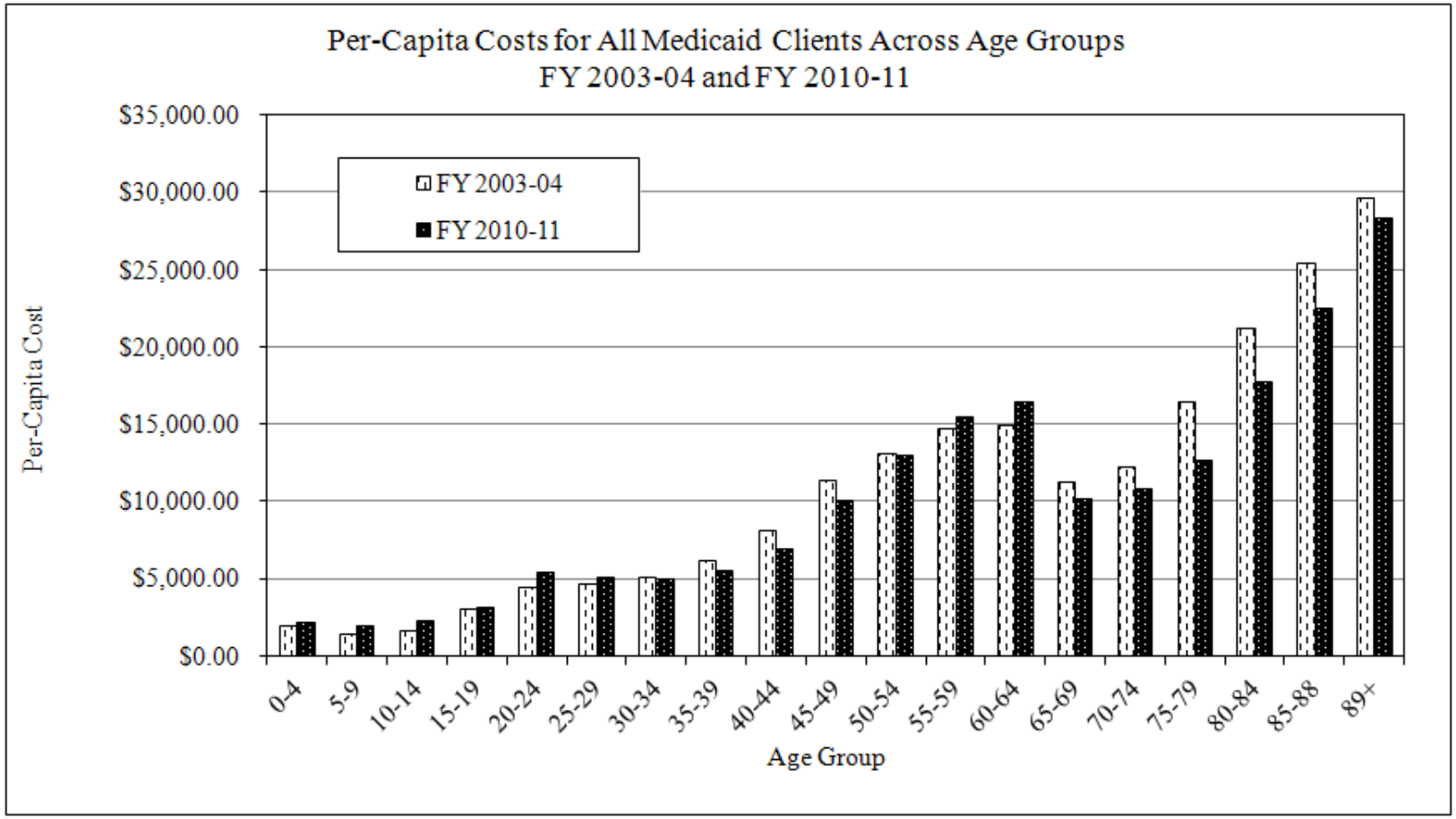
Average Medicaid Enrollment for FY 2006-07 through FY 2010-11					
Membership Category	**FY 2006-07**	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**
HMOs and Prepaid Inpatient Health Plans	35,985	36,701	54,510	61,047	59,923
Primary Care Physician Program	29,243	25,875	22,717	23,240	21,307
Fee-for-Service	327,849	325,492	359,585	413,902	479,492
TOTAL	**393,077**	**388,068**	**436,812**	**498,189**	**560,722**

[6] Department of Health Care Policy and Financing June 2011 Premiums, Caseload, and Expenditures Report (JBC Monthly Report).
Fee-for-service enrollment is derived by the total enrollment minus enrollment in administrative service organizations, health maintenance organizations, and the Primary Care Physician Program.
Note: The Department developed a new caseload report in FY 2007-08 that it believes measures caseload more accurately. Because of the differences between the methodologies used in the original and new caseload reports, the Department restated historical Medicaid caseload through FY 2002-03. The numbers above through FY 2007-08 are based on the old methodologies and will not match restated caseload totals because the Department does not have a methodology for restating caseload by provider type.

B. Services

B1. Paid Medical Services Per Capita Costs (from all claims) Across Age Groups[7]

The graph below represents Medicaid per capita costs by client age as of first date of service as reported on his or her most recent claim in FY 2010-11. The graph also contains all clients in the following caseload categories:



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

B2. FY 2010-11 Services by County

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

Acute Care, including:

Federal Qualified Health Centers

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

Prescription Drugs

Inpatient Hospital

Outpatient Hospital

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

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

Home- and Community-Based Services (HCBS)

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

Home Health

Nursing Facilities

B4. FY 2010-11 Deliveries

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

Deliveries by County

Delivery Types

Age Group of Mother

Low Birthweight, Preterm, and Neonatal Intensive Care Unit

Neonatal Intensive Care Unit

B5. FY 2010-11 Top Tens

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

Inpatient Hospital

Outpatient Hospital

Federal Qualified Health Centers

Rural Health Centers

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

Dental

Laboratory

Durable Medical Equipment and Supplies

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

The following should be noted:

- Clients with no county designation are not included.
- The Department's decision support system (MMIS-DSS), extracts data on a different time span and from a different source (i.e., the MMIS) than the Colorado Financial Reporting System. This decision support system contains a full extract of all county level data in the MMIS.
- The Department administers the following Home- and Community-Based Services waivers: Elderly, Blind and Disabled; Persons with Mental Illness; Persons Living with AIDS; Persons with Brain Injury; Children's; Children with Autism and Consumer Directed Care for the Elderly.
- The Department of Human Services administers the following Home- and Community-Based Services waivers: Developmentally Disabled, Supported Living Services, Children's Extensive Support, and Children's Habilitation Residential Program.

- The inpatient diagnosis related groups (DRGs) were categorized to improve the interpretation and evaluation of services (tables B5a and B5b). Research and reasonableness were used to determine the DRG categories. The naming of DRG categories was completed through consultation of the ICD-10 (International Classification of Diseases). There is a group called Non-Specific Symptoms, Disorders or Procedures which was created to minimize the number of DRG categories. Since the DRG descriptions were sometimes referring to diseases and sometimes to procedures, the term 'Disorders or Procedures' was often included in the names of categories, or groups.
- The tables exhibit the top 10 client counts, top 10 service utilizations, and top 10 expenditures by types of commonly used medical services. It should be noted that sometimes the ranking of top client counts and service utilizations are the same, but the expenditures rankings differ.
- The outpatient diagnosis groupings are based on the first three digits of the ICD-9 codes.
- For the top ten prescription drug tables, the number of prescriptions filled was used instead of the number of prescriptions because it provides better insight on the frequency of pharmacy Medicaid payments. In addition, claims where the payment was zero were excluded from the analysis.
- The totals at the bottom of each of the top ten tables reflect the sum of unique client count/count of services/expenditures for the top ten groupings only. These sums should not be mistaken for the totals of clients, services and expenditures for a type of medical service.

B2a: FY 2010-11 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	22,539	53,644	41,389	6,289	31,633
Alamosa	2,958	2,827	2,856	310	1,802
Arapahoe	10,063	52,332	39,383	5,709	29,524
Archuleta	*	907	818	119	598
Baca	62	339	380	49	253
Bent	593	760	818	59	481
Boulder	9,658	15,600	12,803	1,890	9,526
Broomfield	732	2,321	1,856	246	1,255
Chaffee	37	1,097	994	137	665
Cheyenne	24	103	136	*	78
Clear Creek	159	521	454	58	241
Conejos	1,103	1,418	1,623	139	936
Costilla	632	515	597	57	352
Crowley	301	646	664	66	415
Custer	*	279	300	*	151
Delta	*	2,104	1,496	134	969
Denver	29,401	50,629	38,167	7,023	28,674
Dolores	107	175	135	*	99
Douglas	409	8,002	6,160	764	3,622
Eagle	214	2,859	1,701	349	975
Elbert	324	1,075	900	99	551
El Paso	27,801	53,365	46,809	5,922	34,244
Fremont	331	4,680	4,869	466	3,026
Garfield	1,762	4,554	3,741	625	2,778
Gilpin	212	255	264	*	149
Grand	*	723	558	65	262
Gunnison	*	937	671	97	413
Hinsdale	*	*	*	*	*
Huerfano	73	1,158	975	100	718
Jackson	*	87	71	*	38
Jefferson	6,164	33,162	26,493	3,431	17,408
Kiowa	66	95	141	*	87
Kit Carson	169	631	627	85	440
Lake	*	1,029	789	99	516
La Plata	74	3,856	2,829	369	2,047

B2a: FY 2010-11 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Larimer	7,783	21,944	17,714	2,271	11,879
Las Animas	97	2,097	2,069	220	1,574
Lincoln	412	438	474	68	265
Logan	1,027	1,921	1,995	213	1,381
Mesa	73	8,145	5,558	497	3,427
Mineral	*	*	*	*	*
Moffat	535	1,551	1,324	168	892
Montezuma	422	3,135	2,936	341	2,059
Montrose	172	2,746	1,824	199	1,132
Morgan	1,489	3,446	3,076	464	2,261
Otero	2,058	3,521	3,225	376	2,225
Ouray	*	159	113	*	42
Park	67	867	675	72	294
Phillips	108	316	353	33	216
Pitkin	96	209	157	40	111
Prowers	1,720	2,197	2,260	226	1,585
Pueblo	9,096	27,457	24,518	2,685	17,132
Rio Blanco	*	343	335	35	228
Rio Grande	1,717	1,998	1,979	233	1,280
Routt	59	1,154	835	110	504
Saguache	914	774	771	103	497
San Juan	*	*	*	*	*
San Miguel	142	243	157	*	68
Sedgwick	35	193	241	*	144
Summit	*	1,350	827	176	437
Teller	1,042	1,530	1,469	170	1,110
Washington	104	316	365	45	192
Weld	14,263	26,950	22,382	3,144	15,372
Yuma	238	1,085	973	128	647
Suppressed Counties	136	136	102	183	69
STATEWIDE	**159,773**	**418,906**	**341,174**	**46,956**	**241,949**

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

B2b: FY 2010-11 Expenditures for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$12,153,867	$35,661,097	$28,771,315	$44,531,680	$30,464,670
Alamosa	$1,841,747	$1,584,732	$1,819,487	$1,998,600	$1,193,440
Arapahoe	$4,794,888	$35,422,271	$29,714,506	$41,140,445	$28,808,962
Archuleta	*	$442,424	$350,250	$893,315	$352,984
Baca	$18,967	$159,168	$441,537	$294,461	$192,508
Bent	$323,176	$338,930	$1,075,405	$344,041	$317,734
Boulder	$5,128,834	$10,028,379	$11,195,878	$11,421,807	$8,559,420
Broomfield	$14,830	$778,802	$1,135,926	$1,145,496	$685,077
Chaffee	$7,768	$46,376	$113,636	*	$65,880
Cheyenne	$81,466	$370,581	$444,772	$468,968	$271,452
Clear Creek	$580,987	$709,946	$1,079,114	$1,069,609	$838,692
Conejos	$372,318	$304,297	$432,938	$430,544	$268,263
Costilla	$162,428	$331,096	$825,290	$429,731	$266,165
Crowley	*	$142,080	$131,004	*	$99,452
Custer	*	$785,187	$758,032	$1,091,111	$637,630
Delta	$15,747,518	$32,215,303	$28,050,974	$63,382,588	$28,133,411
Denver	$51,160	$81,724	$97,320	*	$83,776
Dolores	$160,683	$6,159,549	$5,746,291	$5,644,699	$3,688,814
Douglas	$120,446	$1,541,896	$962,394	$2,364,817	$1,065,267
Eagle	$138,100	$835,584	$855,746	$694,825	$701,323
Elbert	$16,824,519	$35,928,008	$39,908,782	$35,273,825	$33,217,014
El Paso	$143,598	$2,740,924	$4,589,733	$2,986,586	$2,073,045
Fremont	$981,138	$2,194,801	$2,085,107	$3,366,302	$2,401,522
Garfield	$105,474	$263,333	$233,601	*	$144,768
Gilpin	*	$397,804	$393,686	$458,657	$349,194
Grand	*	$448,401	$277,233	$556,882	$497,036
Gunnison	$0	*	*	*	*
Hinsdale	$53,813	$751,451	$1,261,146	$621,555	$638,631
Huerfano	*	$41,106	$57,977	*	$23,767
Jackson	$3,135,886	$24,642,104	$25,446,963	$24,293,426	$18,109,485
Jefferson	$28,705	$44,527	$176,312	*	$62,534
Kiowa	$66,356	$336,821	$372,272	$772,930	$458,645
Kit Carson	*	$620,861	$611,020	$874,429	$512,442
Lake	$21,525	$2,331,751	$1,953,991	$2,315,741	$1,514,310
La Plata	$3,493,952	$13,724,018	$15,769,227	$13,467,659	$9,892,596

B2b: FY 2010-11 Expenditures for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Larimer	$42,742	$1,357,169	$1,987,735	$1,737,221	$1,398,694
Las Animas	$183,580	$307,694	$461,617	$463,725	$358,810
Lincoln	$554,009	$796,959	$1,742,094	$1,287,347	$1,004,475
Logan	$21,998	$3,076,285	$1,823,328	$3,724,585	$2,658,359
Mesa	*	*	*	*	*
Mineral	$274,576	$850,849	$785,169	$973,088	$888,199
Moffat	$136,998	$1,624,118	$2,073,122	$2,095,963	$1,639,116
Montezuma	$59,505	$1,012,030	$614,731	$1,246,466	$759,329
Montrose	$747,638	$1,976,837	$2,068,023	$2,701,890	$2,473,393
Morgan	$1,098,574	$2,047,563	$2,994,359	$2,500,220	$1,608,967
Otero	*	$44,818	$73,491	*	$26,026
Ouray	$30,943	$569,435	$610,762	$751,392	$338,093
Park	$40,392	$112,720	$219,970	$144,554	$208,538
Phillips	$49,503	$109,102	$87,290	$293,060	$165,936
Pitkin	$862,232	$862,109	$1,599,365	$1,209,856	$1,300,402
Prowers	$6,046,558	$18,424,211	$25,294,820	$18,923,636	$13,649,043
Pueblo	*	$121,383	$176,607	$199,955	$264,492
Rio Blanco	$911,614	$1,112,548	$1,183,817	$1,710,298	$974,889
Rio Grande	$23,172	$686,933	$532,387	$1,032,180	$537,638
Routt	$568,547	$445,486	$455,571	$918,092	$368,549
Saguache	$0	*	*	*	*
San Juan	$57,732	$97,448	$155,777	*	$44,202
San Miguel	$13,290	$58,113	$302,068	*	$111,451
Sedgwick	*	$883,909	$532,396	$959,944	$379,550
Summit	$569,458	$929,409	$1,265,779	$1,097,863	$824,329
Teller	$34,198	$128,613	$242,363	$223,937	$159,779
Washington	$7,705,019	$17,459,129	$18,523,626	$23,732,358	$14,094,667
Weld	$76,469	$492,116	$812,053	$715,234	$761,777
Yuma	$384,362	$1,442,163	$1,665,953	$1,400,883	$1,274,264
Suppressed Counties	$45,242	$73,682	$109,079	$1,303,420	$122,432
STATEWIDE	**$87,092,500**	**$269,508,162**	**$275,532,215**	**$333,681,895**	**$224,985,314**

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

B2c: FY 2010-11 Average Cost per Client for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$539	$665	$695	$7,081	$963
Alamosa	$623	$561	$637	$6,447	$662
Arapahoe	$476	$677	$755	$7,206	$976
Archuleta	$540	$488	$428	$7,507	$590
Baca	$306	$470	$1,162	$6,009	$761
Bent	$545	$446	$1,315	$5,831	$661
Boulder	$531	$643	$874	$6,043	$899
Broomfield	$401	$710	$1,143	$8,361	$1,030
Chaffee	$324	$450	$836	$14,088	$845
Cheyenne	$512	$711	$980	$8,086	$1,126
Clear Creek	$527	$501	$665	$7,695	$896
Conejos	$589	$591	$725	$7,553	$762
Costilla	$540	$513	$1,243	$6,511	$641
Crowley	$566	$509	$437	$6,411	$659
Custer	$326	$373	$507	$8,143	$658
Delta	$536	$636	$735	$9,025	$981
Denver	$478	$467	$721	$5,787	$846
Dolores	$393	$770	$933	$7,388	$1,018
Douglas	$563	$539	$566	$6,776	$1,093
Eagle	$426	$777	$951	$7,018	$1,273
Elbert	$605	$673	$853	$5,956	$970
El Paso	$434	$586	$943	$6,409	$685
Fremont	$557	$482	$557	$5,386	$864
Garfield	$498	$1,033	$885	$7,927	$972
Gilpin	$286	$550	$706	$7,056	$1,333
Grand	$401	$479	$413	$5,741	$1,203
Gunnison	*	$473	$941	$17,986	$1,642
Hinsdale	$737	$649	$1,293	$6,216	$889
Huerfano	$335	$472	$817	$6,673	$625
Jackson	$509	$743	$961	$7,081	$1,040
Jefferson	$435	$469	$1,250	$7,273	$719
Kiowa	$393	$534	$594	$9,093	$1,042
Kit Carson	$162	$603	$774	$8,833	$993
Lake	$291	$605	$691	$6,276	$740
La Plata	$449	$625	$890	$5,930	$833

B2c: FY 2010-11 Average Cost per Client for Selected Acute Care Service Categories by County					
County	**Federally Qualified Health Centers**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Larimer	$441	$647	$961	$7,896	$889
Las Animas	$446	$702	$974	$6,819	$1,354
Lincoln	$539	$415	$873	$6,044	$727
Logan	$301	$378	$328	$7,494	$776
Mesa	$360	$693	$1,539	$9,217	$2,554
Mineral	$513	$549	$593	$5,792	$996
Moffat	$325	$518	$706	$6,147	$796
Montezuma	$346	$369	$337	$6,264	$671
Montrose	$502	$574	$672	$5,823	$1,094
Morgan	$534	$582	$928	$6,650	$723
Otero	$181	$282	$650	$10,043	$620
Ouray	$462	$657	$905	$10,436	$1,150
Park	$374	$357	$623	$4,380	$965
Phillips	$516	$522	$556	$7,327	$1,495
Pitkin	$501	$392	$708	$5,353	$820
Prowers	$665	$671	$1,032	$7,048	$797
Pueblo	$287	$354	$527	$5,713	$1,160
Rio Blanco	$531	$557	$598	$7,340	$762
Rio Grande	$393	$595	$638	$9,383	$1,067
Routt	$622	$576	$591	$8,914	$742
Saguache	*	$478	$847	$7,836	$1,303
San Juan	$407	$401	$992	$3,996	$650
San Miguel	$380	$301	$1,253	$3,892	$774
Sedgwick	$182	$655	$644	$5,454	$869
Summit	$547	$607	$862	$6,458	$743
Teller	$329	$407	$664	$4,976	$832
Washington	$540	$648	$828	$7,548	$917
Weld	$321	$454	$835	$5,588	$1,177
Yuma	$525	$621	$898	$5,695	$1,015
STATEWIDE	**$561**	**$664**	**$833**	**$7,146**	**$950**

B3a: FY 2010-11 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Adams	1,677	787	367	1,062	1,266
Alamosa	337	62		166	121
Arapahoe	2,362	1,080	369	1,177	1,142
Archuleta	83	*		*	54
Baca	79	*		*	74
Bent	84	*		32	55
Boulder	1,119	480	*	574	691
Broomfield	184	68		74	144
Chaffee	120	45		62	82
Cheyenne	*	*		*	*
Clear Creek	57	*		*	*
Conejos	181	*		79	58
Costilla	157	*		56	*
Crowley	88	*		*	31
Custer	*			*	
Delta	288	60	96	147	124
Denver	3,909	774	635	1,484	1,807
Dolores	*	*		*	*
Douglas	494	182	*	205	177
Eagle	43	*		*	*
Elbert	49	*	*	*	*
El Paso	2,210	920	123	1,533	1,336
Fremont	574	108		171	401
Garfield	261	101		*	199
Gilpin	31	*		*	*
Grand	52	*		*	*
Gunnison	59	*		*	42
Hinsdale	*			0	
Huerfano	143	36		42	109
Jackson	*			*	
Jefferson	2,067	989	465	982	1,532
Kiowa	*			*	*
Kit Carson	52	*		*	*
Lake	*	*		*	*
La Plata	331	63		103	107

B3a: FY 2010-11 Unduplicated Client Count for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Larimer	1,287	502	*	689	882
Las Animas	400	69		49	120
Lincoln	64	*		*	35
Logan	205	91		30	114
Mesa	1,487	408	*	293	489
Mineral	*	*		*	
Moffat	76	32		*	51
Montezuma	347	38		122	167
Montrose	327	126	131	138	188
Morgan	254	55		72	209
Otero	362	91		154	174
Ouray	*	*		*	*
Park	35	*		*	*
Phillips	44	*		*	44
Pitkin	*			*	*
Prowers	172	54		44	85
Pueblo	1,799	588	88	1,172	785
Rio Blanco	51	*		*	38
Rio Grande	192	*		113	128
Routt	45	33		*	54
Saguache	123	*		69	*
San Juan	*			0	*
San Miguel	*	*		*	*
Sedgwick	31	*		*	*
Summit	*	*		*	*
Teller	96	*		37	44
Washington	34	*		*	*
Weld	1,164	390	*	806	617
Yuma	151	*		*	87
Suppressed Counties	185	285	*	346	191
STATEWIDE	**25,118**	**8,114**	**2,214**	**11,859**	**13,685**

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

B3b: FY 2010-11 Expenditures for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Adams	$13,811,365	$28,052,474	$12,487,666	$14,926,037	$44,958,965
Alamosa	$2,079,500	$2,790,547		$472,180	$3,179,401
Arapahoe	$24,260,218	$42,456,099	$12,139,540	$17,244,822	$40,508,927
Archuleta	$957,149	*		*	$1,491,768
Baca	$186,503	*		*	$2,955,745
Bent	$274,586	*		$138,627	$1,942,288
Boulder	$9,529,180	$19,480,621	*	$6,450,026	$24,219,891
Broomfield	$1,661,014	$2,502,723		$1,243,626	$4,530,661
Chaffee	$570,204	$1,495,878		$474,932	$2,187,406
Cheyenne	*	*		*	*
Clear Creek	$315,735	*		*	$10,441
Conejos	$1,350,121	*		$207,560	$1,682,358
Costilla	$981,330	*		$171,529	*
Crowley	$406,035	*		*	$1,158,632
Custer	*		*	*	
Delta	$2,403,922	$1,738,793	$3,134,279	$1,235,035	$4,200,684
Denver	$46,426,955	$23,125,899	$22,453,630	$17,625,614	$69,740,494
Dolores	*	*		*	*
Douglas	$4,823,700	$5,397,344	*	$4,037,279	$6,857,792
Eagle	$205,102	*		*	*
Elbert	$470,967	*	*	*	*
El Paso	$25,393,291	$32,430,484	$4,265,327	$37,512,437	$49,892,133
Fremont	$4,564,493	$4,851,160		$1,790,694	$12,392,038
Garfield	$1,525,427	$4,933,189		*	$7,893,054
Gilpin	$235,489	*		*	*
Grand	$477,368	*		*	*
Gunnison	$411,772	*		*	$1,904,132
Hinsdale	*				
Huerfano	$1,434,126	$1,130,387		$108,864	$2,973,250
Jackson	*			*	
Jefferson	$22,041,963	$35,657,580	$15,725,605	$17,295,616	$60,455,153
Kiowa	*			*	$555,375
Kit Carson	$325,610	*		*	$1,005,245
Lake	*	*		*	*
La Plata	$2,909,134	$2,111,896		$735,500	$3,439,815

B3b: FY 2010-11 Expenditures for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Larimer	$8,340,225	$20,974,738	*	$7,254,731	$29,896,396
Las Animas	$6,726,963	$2,221,760		$250,212	$4,758,837
Lincoln	$472,820	*		*	$1,356,430
Logan	$1,513,662	$3,994,090		$460,848	$3,182,602
Mesa	$17,895,232	$28,579,129	*	$2,806,226	$14,618,558
Mineral	*	*		*	
Moffat	$436,601	*		*	$1,498,044
Montezuma	$3,726,222	$1,125,723		$1,391,087	$4,963,761
Montrose	$1,764,762	$4,520,499	$4,208,281	$1,837,500	$6,212,097
Morgan	$1,639,875	$1,761,220		$221,081	$6,904,522
Otero	$1,687,442	$4,097,121		$2,040,384	$5,369,272
Ouray	*	*		*	*
Park	*	*		*	*
Phillips	$274,401	*		*	$1,398,613
Pitkin	*			*	*
Prowers	$713,820	$1,815,272		$163,211	$3,214,439
Pueblo	$15,005,783	$32,196,055	$2,264,352	$16,803,127	$24,245,590
Rio Blanco	$199,129	*		*	$1,562,171
Rio Grande	$885,910	*		$277,917	$4,220,307
Routt	$185,438	$1,414,147		*	$2,088,379
Saguache	$609,770	*		*	$21,323
San Juan	*				*
San Miguel	*	*		*	*
Sedgwick	$231,354	*		*	$671,044
Summit	$210,152	*		*	*
Teller	$846,102	*		$571,023	$1,212,923
Washington	$128,417	*		*	*
Weld	$10,641,863	$14,523,736	*	$8,414,392	$19,832,529
Yuma	$862,570	*		*	$2,514,609
Suppressed Counties	$1,726,984	$7,981,379	*	$2,085,397	$4,641,836
STATEWIDE	**$246,757,758**	**$333,359,944**	**$76,752,387**	**$166,247,515**	**$494,519,927**

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

B3c: FY 2010-11 Average Cost per Client for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Adams	$8,236	$35,645	$34,026	$14,055	$35,513
Alamosa	$6,171	$45,009	$0	$2,844	$26,276
Arapahoe	$10,271	$39,311	$32,898	$14,652	$35,472
Archuleta	$11,532	$16,672	$0	$8,871	$27,625
Baca	$2,361	$12,662	$0	$9,346	$39,942
Bent	$3,269	$43,224	$0	$4,332	$35,314
Boulder	$8,516	$40,585	$3,537	$11,237	$35,050
Broomfield	$9,027	$36,805		$16,806	$31,463
Chaffee	$4,752	$33,242	$0	$7,660	$26,676
Cheyenne	$2,733	$10,700	$0	$2,661	$36,892
Clear Creek	$5,539	$13,041	$0	$3,723	$5,221
Conejos	$7,459	$14,471	$0	$2,627	$29,006
Costilla	$6,251	$23,025	$0	$3,063	$11,534
Crowley	$4,614	$11,697	$0	$7,474	$37,375
Custer	$8,207	$0	$0	$8,842	$0
Delta	$8,347	$28,980	$32,649	$8,402	$33,876
Denver	$11,877	$29,878	$35,360	$11,877	$38,595
Dolores	$21,971	$371	$0	$4,932	$4,142
Douglas	$9,765	$29,656	$10,612	$19,694	$38,745
Eagle	$4,770	$25,146	$3,537	$1,321	$919
Elbert	$9,612	$9,615	$0	$14,463	$37,188
El Paso	$11,490	$35,251	$34,677	$24,470	$37,344
Fremont	$7,952	$44,918	$0	$10,472	$30,903
Garfield	$5,845	$48,843	$0	$6,238	$39,664
Gilpin	$7,596	$10,936	$0	$7,322	$7,530
Grand	$9,180	$10,159	$0	$4,844	$31,452
Gunnison	$6,979	$25,935	$0	$2,898	$45,336
Hinsdale	$883	$0	$0	$0	$0
Huerfano	$10,029	$31,400	$0	$2,592	$27,278
Jackson	$497	$0	$0	$237	$0
Jefferson	$10,664	$36,054	$33,819	$17,613	$39,462
Kiowa	$5,412	$0	$0	$3,306	$32,669
Kit Carson	$6,262	$38,508	$0	$1,213	$35,902
Lake	$2,488	$8,609	$0	$2,483	$40,018
La Plata	$8,789	$33,522	$0	$7,141	$32,148

B3c: FY 2010-11 Average Cost per Client for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Larimer	$6,480	$41,782	$28,299	$10,529	$33,896
Las Animas	$16,817	$32,199	$0	$5,106	$39,657
Lincoln	$7,388	$40,336	$0	$3,707	$38,755
Logan	$7,384	$43,891	$0	$15,362	$27,918
Mesa	$12,034	$70,047	$3,537	$9,578	$29,895
Mineral	$4,709	$5,208	$0	$207	$0
Moffat	$5,745	$47,494	$0	$5,501	$29,373
Montezuma	$10,738	$29,624	$0	$11,402	$29,723
Montrose	$5,397	$35,877	$32,124	$13,315	$33,043
Morgan	$6,456	$32,022	$0	$3,071	$33,036
Otero	$4,661	$45,023	$0	$13,249	$30,858
Ouray	$8,606	$6,848	$0	$26,231	$17,805
Park	$4,110	$40,820	$0	$13,433	$7,790
Phillips	$6,236	$8,249	$0	$37,575	$31,787
Pitkin	$14,183	$0	$0	$1,810	$23,730
Prowers	$4,150	$33,616	$0	$3,709	$37,817
Pueblo	$8,341	$54,755	$25,731	$14,337	$30,886
Rio Blanco	$3,904	$9,360	$0	$2,160	$41,110
Rio Grande	$4,614	$31,594	$0	$2,459	$32,971
Routt	$4,121	$42,853	$0	$676	$38,674
Saguache	$4,957	$55,093	$0	$2,023	$7,108
San Juan	$3,860	$0	$0	$0	$13,549
San Miguel	$8,151	$10,667	$0	$22,818	$6,918
Sedgwick	$7,463	$46,328	$0	$504	$26,842
Summit	$9,137	$26,976	$0	$1,947	$29,090
Teller	$8,814	$13,666	$0	$15,433	$27,566
Washington	$3,777	$41,593	$0	$3,377	$30,420
Weld	$9,142	$37,240	$2,960	$10,440	$32,143
Yuma	$5,712	$22,748	$0	$1,833	$28,904
STATEWIDE	**$7,288**	**$29,824**	**$22,412**	**$8,411**	**$29,297**

B3d: HCBS Waiver Programs Administered by the Department of Health Care Policy and Financing (HCPF)								
Fiscal Year	**Elderly Blind and Disabled; and Consumer Directed Care for the Elderly***	**Children's Home and Community-Based Services**	**Persons with Brain Injury**	**Persons with Mental Illness**	**Persons Living with AIDS**	**Children with Autism**	**Pediatric Hospice**	**Total HCPF**
FY 2005-06	16,415	1,049	297	1,948	58	0	0	**19,534**
FY 2006-07	17,019	1,254	306	2,160	62	17	0	**20,553**
FY 2007-08	17,627	1,360	264	2,312	71	73	0	**21,522**
FY 2008-09	18,618	1,334	264	2,489	71	89	42	**22,756**
FY 2009-10	19,848	1,314	253	2,641	67	113	84	**24,163**
FY 2010-11	20,890	1,285	249	2,786	60	108	120	**25,118**

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

B3e: HCBS Waiver Programs Administered by Department of Human Services (DHS)					
Fiscal Year	**Children's Habilitation Residential Program**	**Supported Living Services**	**Developmentally Disabled**	**Children's Extensive Support**	**Total DHS**
FY 2005-06	191	3,092	3,690	375	**7,212**
FY 2006-07	165	2,982	4,112	381	**7,521**
FY 2007-08	149	3,057	4,207	430	**7,692**
FY 2008-09	156	3,285	4,379	423	**8,053**
FY 2009-10	165	3,270	4,482	431	**8,223**
FY 2010-11	150	3,235	4,395	422	**8,114**

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

B3f: Long-Term Care Programs Administered by Department of Health Care Policy and Financing					
Fiscal Year	**Home Health**	**Program for All-Inclusive Care for the Elderly**	**Class I Nursing Facilities**	**Class II Nursing Facilities**	**Total Nursing Facilities (Classes I and II)**
FY 2005-06	9,430	1,271	14,287	20	14,299
FY 2006-07	10,161	1,376	14,045	21	14,066
FY 2007-08	10,272	1,501	13,886	21	13,907
FY 2008-09	10,902	1,794	13,614	22	13,636
FY 2009-10	10,982	2,013	13,583	38	13,621
FY 2010-11	11,859	2,214	13,650	35	13,685

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

B4a: FY 2010-11 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County of Residence on Delivery Date			
County	**Unique Deliveries**	**Total Payments**	**Average Payment**
Adams	3,578	$25,207,159	$7,045
Alamosa	171	$1,216,727	$7,115
Arapahoe	3,160	$22,790,907	$7,212
Archuleta	78	$507,378	$6,505
Baca	*	*	$7,198
Bent	37	$322,148	$8,707
Boulder	977	$6,491,010	$6,644
Broomfield	129	$934,787	$7,246
Chaffee	72	$524,440	$7,284
Cheyenne	*	*	$8,981
Clear Creek	*	*	$6,452
Conejos	68	$504,814	$7,424
Costilla	*	*	$7,270
Crowley	*	*	$9,868
Custer	*	*	$5,678
Delta	58	$230,142	$3,968
Denver	3,784	$27,035,419	$7,145
Dolores	*	*	$6,255
Douglas	405	$3,036,641	$7,498
Eagle	285	$1,584,978	$5,561
Elbert	3,069	$23,874,651	$7,779
El Paso	42	$291,025	$6,929
Fremont	224	$1,649,990	$7,366
Garfield	415	$2,853,400	$6,876
Gilpin	*	*	$7,311
Grand	36	$223,264	$6,202
Gunnison	59	$368,876	$6,252
Hinsdale	*	*	$8,664
Huerfano	37	$302,425	$8,174
Jackson	*	*	$6,631
Jefferson	1,682	$12,362,651	$7,350
Kiowa	*	*	$11,009
Kit Carson	49	$332,291	$6,781
Lake	224	$1,575,178	$7,032
La Plata	59	$482,350	$8,175

B4a: FY 2010-11 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County of Residence on Delivery Date			
County	**Unique Deliveries**	**Total Payments**	**Average Payment**
Larimer	1,172	$7,831,698	$6,682
Las Animas	94	$804,070	$8,554
Lincoln	37	$298,014	$8,054
Logan	105	$922,138	$8,782
Mesa	457	$1,590,083	$3,479
Mineral	*	*	$3,041
Moffat	100	$729,907	$7,299
Montezuma	177	$1,506,434	$8,511
Montrose	119	$640,804	$5,385
Morgan	272	$1,867,969	$6,868
Otero	167	$1,555,360	$9,314
Ouray	*	*	$5,570
Park	39	$259,465	$6,653
Phillips	*	*	$5,935
Pitkin	*	*	$5,218
Prowers	110	$859,975	$7,818
Pueblo	1,171	$9,542,262	$8,149
Rio Blanco	*	*	$7,495
Rio Grande	95	$773,752	$8,145
Routt	75	$581,139	$7,749
Saguache	46	$455,601	$9,904
San Juan	*	*	$4,970
San Miguel	*	*	$4,703
Sedgwick	*	*	$8,736
Summit	130	$710,734	$5,467
Teller	77	$567,342	$7,368
Washington	*	*	$7,550
Weld	1,566	$11,206,570	$7,156
Yuma	76	$512,713	$6,746
Suppressed Counties	312	$2,175,966	$6,974
STATEWIDE	**25,095**	**$180,094,643**	**$7,177**

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

B4b: FY 2010-11 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Type			
Delivery Type	**Unique Deliveries**	**Total Payments**	**Average Payment**
Caesarian	5,488	$57,750,986	$10,523
Vaginal	18,562	$119,180,495	$6,421
Unknown	1,045	$3,163,162	$3,027
TOTAL	**25,095**	**$180,094,643**	**$7,177**

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

B4c: FY 2010-11 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Age on Delivery Date			
Age Group	**Unique Deliveries**	**Total Payments**	**Average Payment**
<=14	61	$501,267	$8,217
15-19	3,783	$26,642,776	$7,043
20	1,783	$13,201,981	$7,404
21-24	6,728	$48,893,971	$7,267
25-34	10,534	$74,458,732	$7,068
35+	2,206	$16,395,915	$7,432
Total	**25,095**	**$180,094,643**	**$7,177**

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

B4d: FY 2010-11 Clients and Costs Associated with Low Birthweight, Preterm, and Neonatal Intensive Care Unit (NICU) Claims by Severity of Condition and Needy Newborn Status							
	Most Severe Classification*	**Unique Clients**	**Unique Clients: Not Needy Newborn**	**Unique Clients: Needy Newborn**	**Total LBW/ Preterm/NICU Payments**	**Payment: Not Needy Newborn**	**Payments: Needy Newborn**
Low-Birthweight Infants							
	Extremely Low BW (<1000 grams)	314	126	188	$9,243,434	$1,465,173	$7,778,261
	Very Low BW (1000 - 1499 grams)	315	79	236	$5,340,569	$305,110	$5,035,459
	Low BW (1500-2499 grams)	2,394	615	1,779	$9,206,246	$1,153,824	$8,052,422
	All LBW Clients	3,023	820	2,203	$23,790,249	$2,924,107	$20,866,142
Preterm Infants Not Classified as Low Birthweight							
	Very Preterm (<32 weeks gestation)	469	185	284	$3,887,013	$920,098	$2,966,915
	Moderately Preterm (32 to 36 weeks gestation)	531	120	411	$1,236,454	$194,086	$1,042,368
	All Preterm Infants not identified via LBW	1,000	305	695	$5,123,466	$1,114,183	$4,009,283
Infants Treated in the NICU Not Due to LBW or Preterm							
	NICU - Other, Including Normal Birthweight	1,189	89	1,100	$3,448,036	$239,842	$3,208,194
TOTAL		**5,212**	**1,214**	**3,998**	**$32,361,751**	**$4,278,132**	**$28,083,618**

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

B4e: FY 2010-11 Clients and Costs Associated with Neonatal Intensive Care Unit Claims		
DRG Description	**Unique Clients with DRG***	**NICU Payments**
Neonates, Died Or Transferred To Another Facility	27	$71,569
Full Term Neonate With Major Problems	714	$3,024,201
Neonate With Other Significant Problems	1,172	$2,509,708
Neonates < 1,000 grams	82	$5,165,301
Neonates 1,000 - 1,499 grams	155	$3,948,446
Neonates 1500 - 1,999 grams	352	$4,143,154
Neonates > 2,000 grams With RDS	218	$3,325,630
Neonates > 2,000 grams, Premature with Major Problems	235	$1,398,791
Neonates Low Birthweight Diagnosis, Over 28 Days	NR	$95,417
Total NICU Payments		**$23,682,217**

B5a: FY 2010-11 Top 10 Major Diagnostic Categories (Inpatient) Ranked by Expenditures					
Rank	**MDC**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	14	Pregnancy, childbirth and the puerperium	$90,700,839	23,882	$3,798
2	4	Respiratory system	$31,706,567	5,035	$6,297
3	15	Conditions of newborns	$24,039,723	3,530	$6,810
4	8	Musculoskeletal system and connective tissue	$21,463,487	2,137	$10,044
5	5	Circulatory system	$21,202,561	1,659	$12,780
6		Pre-MDC Other	$21,153,278	255	$82,954
7	6	Digestive system	$20,580,836	2,934	$7,015
8	1	Nervous System	$17,475,314	1,923	$9,088
9	11	Kidney and urinary tract	$13,829,359	1,323	$10,453
10	18	Infectious & parasitic diseases	$11,522,889	1,226	$9,399
		Top Ten Totals	**$273,674,853**	**43,904**	**$6,233**

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

B5b: FY 2010-11 Top 10 Inpatient Hospital Diagnosis Related Groups Ranked by Expenditures					
Rank	**DRG**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	373	Vaginal Delivery without Complicating Diagnoses	$38,746,319	14,177	$2,733
2	371	Cesarean Sections without Complicating Diagnoses	$16,395,465	3,116	$5,262
3	370	Cesarean Section with Complicating Diagnoses	$15,330,075	2,175	$7,048
4	541	Tracheotomy with Mechanical Ventilator with Major Operating Room Procedure	$12,289,924	130	$94,538
5	372	Vaginal Delivery with Complicating Diagnoses	$10,996,083	3,061	$3,592
6	898	Bronchitis and Asthma, Age <17 with Complicating Diagnoses	$6,085,505	1,641	$3,708
7	317	Admit for Renal Dialysis	$5,696,805	50	$113,936
8	801	Neonates < 1,000 Grams	$5,097,127	81	$62,927
9	542	Tracheotomy with Mechanical Ventilator without Major Operating Room Procedure	$4,780,323	85	$56,239
10	565	Respiratory System Diagnosis with Ventilator Support 96+ Hours	$4,305,607	118	$36,488
		Top Ten Totals	**$119,723,234**	**24,634**	**$4,860**

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

B5c: FY 2010-11 Top 10 Outpatient Hospital Principal Diagnosis Categories Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	789	Other Symptoms Involving Abdomen and Pelvis	$12,762,879	18,331	$696
2	521	Diseases of Hard Tissues of Teeth	$8,300,577	4,924	$1,686
3	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$7,941,732	15,776	$503
4	780	General Symptoms	$6,370,991	16,201	$393
5	V58	Other and Unspecified Aftercare	$4,223,980	3,304	$1,278
6	784	Symptoms Involving Head and Neck	$3,895,603	8,192	$476
7	474	Chronic Disease of Tonsils and Adenoids	$3,710,271	2,755	$1,347
8	585	Chronic Renal Failure	$3,674,239	361	$10,178
9	787	Symptoms Involving Digestive System	$3,583,012	12,094	$296
10	V57	Care Involving Use of Rehabilitation Procedures	$3,240,991	10,401	$312
		Top Ten Totals	**$57,704,273**	**92,339**	**$625**

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

B5d: FY 2010-11 Top 10 Outpatient Surgical Procedures Ranked by Expenditures					
Rank	**Surgical Procedure Code**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	23.41	Application of crown	$1,673,500	658	$2,543
2	28.3	Tonsillectomy with adenoidectomy	$1,600,014	609	$2,627
3	96.54	Dental scaling, polishing, and debridement	$1,214,719	448	$2,711
4	23.09	Extraction of other tooth	$1,168,852	432	$2,706
5	89.17	Polysomnogram	$1,120,270	692	$1,619
6	37.23	Combined right and left heart cardiac catheterization	$912,872	71	$12,857
7	23.70	Root canal, not otherwise specified	$799,137	300	$2,664
8	93.54	Application of splint	$722,804	2,241	$323
9	45.16	Esophagogastroduodenoscopy [EGD] with closed biopsy	$554,141	477	$1,162
10	86.59	Closure of skin and subcutaneous tissue of other sites	$527,368	1,741	$303
		Top Ten Totals	**$10,293,677**	**7,669**	**$1,342**

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

B5e: FY 2010-11 Top 10 Federally Qualified Health Center (FQHC) Principal Diagnosis Categories Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	V20	Health Supervision of Infant or Child	$15,063,603	58,789	$256
2	V72	Special Investigations and Examinations*	$12,226,416	39,480	$310
3	V22	Normal Pregnancy	$6,749,184	7,910	$853
4	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$3,282,193	16,486	$199
5	V04	Need For Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	$1,536,513	11,046	$139
6	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$1,460,462	7,417	$197
7	V25	Encounter For Contraceptive Management	$1,405,107	5,118	$275
8	382	Suppurative and Unspecified Otitis Media	$1,379,053	6,579	$210
9	250	Diabetes Mellitus	$1,319,053	3,374	$391
10	724	Other and Unspecified Disorders of Back	$1,270,769	4,598	$276
		Top Ten Totals	**$45,692,353**	**160,797**	**$284**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.
* Diagnosis V72 - Special Investigations and Examinations - may include a substantial amount of dental claims.

B5f: FY 2010-11 Top 10 Rural Health Center (RHC) Principal Diagnosis Categories Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	V20	Health Supervision of Infant or Child	$985,819	5,341	$185
2	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$475,606	2,977	$160
3	382	Suppurative and Unspecified Otitis Media	$396,449	2,181	$182
4	V72	Special Investigations and Examinations	$358,587	933	$384
5	462	Acute Pharyngitis	$267,466	2,074	$129
6	V22	Normal Pregnancy	$253,014	440	$575
7	034	Streptococcal Sore Throat and Scarlet Fever	$211,719	1,364	$155
8	780	General Symptoms	$208,019	1,505	$138
9	724	Other and Unspecified Disorders of Back	$192,980	971	$199
10	466	Acute Bronchitis and Bronchiolitis	$187,667	1,252	$150
		Top Ten Totals	**$3,537,327**	**19,038**	**$186**

Source: Medicaid paid claims from MMIS-DSS. Notes: To prevent expenditures and unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to 45 days after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only.
* Diagnosis V72 - Special Investigations and Examinations - may include a substantial amount of dental claims.

B5g: FY 2010-11 Top 10 Physician and Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program Principal Diagnosis Categories, Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	V20	Health Supervision of Infant or Child	$17,652,799	105,734	$167
2	650	Normal Delivery	$8,522,275	11,961	$713
3	315	Specific Delays in Development	$8,049,978	5,045	$1,596
4	V25	Encounter For Contraceptive Management	$7,405,568	22,062	$336
5	789	Other Symptoms Involving Abdomen and Pelvis	$6,505,240	38,212	$170
6	367	Disorders of Refraction and Accommodation	$6,401,985	50,568	$127
7	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$5,547,398	54,305	$102
8	780	General Symptoms	$5,459,487	43,382	$126
9	783	Symptoms Concerning Nutrition, Metabolism, and Development	$4,043,829	9,856	$410
10	784	Symptoms Involving Head and Neck	$3,854,609	22,566	$171
		Top Ten Totals	**$73,443,167**	**363,691**	**$202**

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

B5h: FY 2010-11 Top 10 Dental Procedures Ranked by Expenditures					
Rank	**Procedure Code**	**Procedure Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	D8090	Comprehensive Ortho Adult Dentition	$8,031,376	2,697	$2,978
2	D2930	Prefab Stainless Steel Crown Primary	$6,551,955	21,744	$301
3	D1120	Prophylaxis Child	$5,393,459	140,549	$38
4	D1330	Oral Hygiene Instructions	$4,494,510	145,531	$31
5	D2391	Resin Based Comp One Surface Posterior	$3,845,829	32,706	$118
6	D7140	Extraction Erupted Tooth/Exposed Root	$3,750,579	27,858	$135
7	D8080	Comprehensive Ortho Adolescent Dentition	$3,614,650	1,350	$2,678
8	D0120	Periodic oral evaluation	$3,356,081	120,196	$28
9	D2392	Resin Based Comp Two Surfaces Posterior	$3,335,415	23,956	$139
10	D2150	Amalgam Two Surfaces Permanent	$3,025,465	21,591	$140
		Top Ten Totals	**$45,399,318**	**538,178**	**$84**

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

B5i: FY 2010-11 Top 10 Laboratory Procedures Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	87491	Chlamydia Tracholmatis, DNA, Amplified Probe Technique	$2,349,542	39,668	$59
2	87591	Nisseria Gonorrhea, DNA, Amplified Probe Technique	$2,314,420	39,246	$59
3	80101	Drug Screen, Single	$2,057,940	11,007	$187
4	85025	Complete Blood Count with Automated White Blood Cells Differential	$1,448,464	85,598	$17
5	80053	Comprehensive Metabolic Panel	$1,300,914	58,632	$22
6	84443	Thyroid Stimulus Hormone	$1,116,130	41,456	$27
7	80050	General Health Panel	$860,603	18,111	$48
8	83914	Mutation ident ola/sbce/aspe	$818,068	2,909	$281
9	87086	Urine Culture/Colony Count	$735,068	49,371	$15
10	80061	Lipid Panel	$697,994	33,740	$21
		Top Ten Totals	**$13,699,142**	**379,738**	**$36**

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

B5j: FY 2010-11 Top 10 Durable Medical Equipment and Supplies Procedures Ranked by Expenditures					
Rank	**Principal Diagnosis Group Number**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	E1390	Oxygen concentrator	$12,278,653	12,454	$986
2	S8121	O2 contents liquid lb	$8,032,854	5,564	$1,444
3	B4160	Enteral Formula for Pediatrics, Calorie Dense	$4,252,470	1,421	$2,993
4	B4161	EF pediatric hydrolyzed/amino acid	$2,167,950	454	$4,775
5	T4527	Adult Large Sized Disposable Incontinence Product	$2,076,023	2,893	$718
6	A4253	Blood glucose/reagent strips	$1,990,128	7,606	$262
7	E0434	Portable Liquid Oxygen	$1,938,757	4,732	$410
8	B4035	Enteral feed supp pump per day	$1,909,621	1,054	$1,812
9	T4526	Adult Medium Sized Disposable Incontinence Product	$1,651,741	3,100	$533
10	A4554	Disposable liner/shield/pad	$1,628,048	6,517	$250
		Top Ten Totals	**$37,926,246**	**45,795**	**$828**

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

B5k: FY 2010-11 Top 10 Prescription Drugs Ranked by Expenditures					
Rank	**Drug Name**	**Therapeutic Class**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	Abilify	Antipsychotic	$15,765,892	5,236	$3,011
2	Seroquel	Antipsychotic	$13,714,019	5,284	$2,595
3	Zyprexa	Antipsychotic	$9,195,876	1,975	$4,656
4	Synagis	Monoclonal Antibody (prevention/treatment of respiratory virus in infants)	$8,967,398	822	$10,909
5	Oxycodone	Analgesic	$6,906,806	38,892	$178
6	Singulair	Leukotreine Receptor Antagonist	$5,440,799	11,132	$489
7	Norditropin	Anabolic Steroid	$5,066,769	264	$19,192
8	Advair	Bronchodilator and Corticosteroid	$5,017,913	7,024	$714
9	Aciphex	Proton Pump Inhibitor	$4,817,891	4,952	$973
10	Concerta	Treatment for Attention Deficit-Hyperactivity(ADHD) and Narcolepsy	$4,576,425	4,614	$992
		Top Ten Total	**$79,469,788**	**80,195**	**$991**

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

B5l: FY 2010-11 Top 10 Prescription Drugs Ranked by Number of Prescriptions Filled					
Rank	**Drug Name**	**Therapeutic Class**	**Total Prescriptions Filled**	**Expenditures**	**Average Cost**
1	Oxycodone	Analgesic	222,962	$6,906,806	$31
2	Hydrocodone	Analgesic	295,650	$4,391,056	$15
3	Amoxicillin	Antibiotic	116,892	$1,010,372	$9
4	Azithromycin	Macrolide	62,985	$1,527,262	$24
5	Lorazepam	Anti-Anxiety Drug	58,426	$493,977	$8
6	Proair	Beta-Adrenergic Agent	55,689	$2,510,286	$45
7	Lisinopril	ACE Inhibitor	54,312	$378,959	$7
8	Levothyroxine	Thyroid Hormone	52,344	$404,708	$8
9	Clonazepam	Anti-Convulsant	51,245	$447,493	$9
10	Ibuprofen	NSAID	50,744	$302,338	$6
		Top Ten Total	**1,021,249**	**$18,373,256**	**$18**

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