Colorado Department of Health Care Policy and Financing
FY 2013-14 Budget Request
November 1, 2012

Schedule 1 – Budget Request Table of Contents

	Tab Title	Pages starting at:
Volume I		
A.	Schedule 1 – Budget Request Table of Contents	A–1
B.	Department Description	B–1
C.	Strategic Plan	C–1
D.	Schedule 10 – Summary of Change Requests	D–1
D.	Requests	D See Index at Schedule 10
D.	Non-Prioritized Items	D See Index at Schedule 10
E.	Exhibits for Medical Services Premiums	E See Index at Tab E
F.	Exhibits for Medicaid Mental Health Programs	F See Index at Tab F
	Medicaid Caseload	
Volume II		
G.	Schedule 1 – Budget Request Table of Contents	G–1
H.	Line Item Description	H–1
I.	Reconciliation	I–1
J.	Schedule 2 – Summary by Long Bill Group	J–1
K.	Schedule 3 – Summary	K.0–1
K.	Schedule 3 – (1) Executive Director's Office	K.1–1
K.	Schedule 3 – (2) Medical Services Premiums	K.2–1
K.	Schedule 3 – (3) Medicaid Mental Health Community Programs	K.3–1
K.	Schedule 3 – (4) Indigent Care Programs	K.4–1
K.	Schedule 3 – (5) Other Medical Services	K.5–1
K.	Schedule 3 – (6) DHS Medicaid-Funded Programs	K.6–1
L.	Schedule 5 – Line Item to Statute	L–1
M.	Schedule 6 – Special Bills Summary	M–1
N.	Schedule 7 – Supplemental Bills Summary	N–1
O.	Schedule 9 – Cash Funds Reports	O–1
P.	Schedule 14 – Position and Object Code Detail Report	P–1
Q.	Health Care Affordability Act Update	Q-1
R.	Tobacco Tax Update	R-1
S.	Glossary and Acronyms	S–1

** The Schedule 4 has been incorporated into the Schedule 3 and is no longer a standalone document **

Department of Health Care Policy and Financing

Department Description

FY 2013-14 Budget Request

November 1, 2012

TABLE OF CONTENTS

I. ORGANIZATIONAL CHART ... 3

II. BACKGROUND INFORMATION ... 4

Executive Director's Office ... 4
Health Programs Office ... 4
Administration and Innovation Office ... 5
Audits and Compliance Division ... 7
Finance Office ... 7
Clinical Services Office ... 11
Policy and Communications Office ... 12
Client Services, Eligibility, and Enrollment Office ... 12
Community Partnerships Office ... 13

III. PRIOR-YEAR LEGISLATION ... 14

IV. HOT ISSUES ... 16

Customer Focus ... 16
- Accountable Care Collaborative ... 16
- Long-Term Services and Supports Redesign ... 18
- Office of Community Living ... 21
- Integration of Behavioral Health ... 22
- Health, Wellness, and Prevention ... 22
- Payment Reform ... 23
- Hospital Provider Fee ... 26
- Affordable Care Act ... 30

Information Technology ... 33
- Medicaid Eligibility and Enrollment Modernization Project ... 33
- MMIS Reprocurement ... 34
- Health Information Technology ... 35

Enhanced Department Operations: People and Processes ... 36
- LEAN ... 36

Hiring and Retaining Staff 38

V. WORKLOAD REPORTS 39

Consumer Assessment of Healthcare Providers and Systems (CAHPS) 39
Health Effectiveness Data and Information Set (HEDIS) 41
Medicaid Caseload 66
A. Clients 67
B. Services 70

I. ORGANIZATIONAL CHART

State of Colorado

The mission of the Department of Health Care Policy and Financing is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Executive Director's Office
Susan Birch
3.3 FTE $341,103

Health Programs Office
Suzanne Brennan
56.8 FTE $3,870,613

Administration and Innovation Office
Vacant
13.5 FTE $1,006,238

Audits and Compliance Division
Donna Kellow
27.2 FTE $1,918,045

Finance Office
John Bartholomew
132.7 FTE $9,072,665

Clinical Services Office
Judy Zerzan
14.6 FTE $1,147,303

Policy and Communications Office
Tom Massey
10.5 FTE $737,452

Client Services, Eligibility, and Enrollment Office
Vacant
47.7 FTE $3,005,643

Community Partnerships Office
Lorez Meinhold
19.9 FTE $1,494,860

TOTAL:	**326.2 FTE**	**$22,593,922**	
General Fund	Cash Funds	Reappropriated Funds	Federal Funds
$7,971,021	$2,038,599	$1,176,645	$11,407,657

II. BACKGROUND INFORMATION

The Department of Health Care Policy and Financing (the Department) receives federal funding as the single state agency responsible for administering the Medicaid program (Title XIX) and the 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 is approximately 65% federally funded.

Executive Director's Office

Susan 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 Office of Community Living was created in July 2012 pursuant to an Executive Order by the Governor to meet the growing need for long-term services and supports by aging adults and people with disabilities. The goal of the Office of Community Living is to provide strategic direction on the redesign of all aspects of the long-term services and supports delivery system, including service models, payment structures, and data systems to create efficient and person-centered community-based care.

Health Programs Office

The Health Programs Office designs, implements, and administers Medicaid, Children's Basic Health Plan (CHP+), 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. The office is comprised of the Health Programs Services and Supports Division and the Long-Term Services and Supports Division.

Health Programs Services and Supports Division

The Health Programs Services and Supports Division is responsible for the administration and performance of Medicaid fee-for-service and managed-care services and programs, as well as CHP+. The division also seeks to maximize the health, functioning, and self-sufficiency of all Medicaid and CHP+ 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 and CHP+ program performance.

Long-Term Services and Supports Division

The Long Term Care Services and Supports 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.

Administration and Innovation Office

The Administration and Innovation (A&I) Office aims to create a culture of innovation and engagement throughout the Department's workforce. This office includes the Strategy Section, Workforce Development Section, and Human Resources (HR) Section. The A&I Office also represents the Department in human resources collaboration efforts with the Department of Public Health and Environment (DPHE) and the Department of Human Services (DHS).

Strategy Section

The Strategy Section develops and enriches the Department's strategic management process. Its goal is to create understanding, value, and line-of-sight from individual staff roles to attainment of the Department's vision, mission, and goals. The Strategy Section guides the Department through the annual strategic-management process, from formulation activities to implementation and

evaluation. It collaborates with staff across the Department to achieve integration of various initiatives, including health reform, and develops strategies to leverage resources. Overall, this Section provides structure and cohesion for implementing and prioritizing projects that align with the Department's strategic direction. The Strategy Section has three areas of focus: Research and Planning, Innovation and Grants, and Process Improvement.

Workforce Development Section

The purpose of the Workforce Development Section is to sustain and improve the Department's ability to achieve its on-going mission and capacity to innovate. The Workforce Development Section will develop and implement a plan to integrate its talent-management processes to ensure that the A&I Office is effectively developing, managing, and improving programs to improve quality of the Department's workforce. The section is responsible for strategic human resources planning including the acquisition of software to support on-going and future human resources programs. The Workforce Development Section will participate in the evaluation of human resources functions that can be included in the scope of human resources collaboration with the Department of Public Health and Environment (DPHE) and the Department of Human Services (DHS).

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 and selection
- Classification
- Salary administration
- Rules interpretation
- Dispute resolution
- Personnel performance management
- Annual compensation/benefits
- Employee/manager counseling
- Corrective and disciplinary actions
- Workforce turnover/retention analysis
- Maintaining personnel records

This section also provides guidance, counseling, and technical assistance to Department managers and staff on the application of the State personnel system. The Human Resources Section has assumed responsibility of the reception area and has been delegated the security function 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. The Human Resources Section is responsible for training all Department staff on Executive Orders such as sexual harassment, violence in the workplace, and maintaining a respectful workplace.

The Human Resources Section also oversees the building Reception Unit, which provides identification badges to all department visitors, to ensure compliance with Health Insurance Portability and Accountability Act (HIPAA) in accordance with the State Procurement rules the Department's supply purchases are made.

Audits and Compliance Division

The Audits and Compliance Division consists of the Program Integrity Section and the Internal 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 then 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.

Internal Audits Section

The Internal 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 the Medicaid Eligibility Quality Control Unit, County Audits, Payment Error Rate Measurement (PERM) Program, Internal Audits/Review, and Department Audit Coordination.

Finance Office

The Finance Office consists of the Budget Division, the Controller Division, the Rates and Analysis Division, and the Safety Net Programs Section. The Finance Office also houses the Provider Operations Division, which includes the Claims Systems and Operations Division and the Purchasing and Contracting Services Section.

Budget Division

The Budget Division's 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.

The Budget Division includes the Financing and Indigent Care Unit, the Medical Premiums Unit, and the Personal Services and Other Agencies Unit.

Controller Division

The Controller 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).

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.

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.

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.

Provider Operations Division

The Provider Operations Division is composed of the Purchasing and Contracting Services Section and the Claims Systems and Operations Division, which is made up of the Fiscal Operations Section, the Program Management Unit, and the Claims System 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.

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, and is responsible for addressing escalated billing and provider enrollment issues that require state approval.

The Program Management Unit (PMU) assists in developing and implementing large projects such as the MMIS reprocurement 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.

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, this section proposes 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.

Clinical Services Office

The new Clinical Services Office provides clinical expertise across the Department. This Office focuses on preventing the onset of disease and helping the Department's clients to manage chronic diseases in such a way that their health improves. Staff in the Office advise clinically on medical services provided by the Medicaid agency, assist in policy development, program planning, quality improvement, provide clinical input on member and provider grievances and appeals, and act as liaisons with the provider community and other State agencies as needed. This Office includes Pharmacy, Strategic Projects and the Quality and Health Improvement units.

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.

Quality and Health Improvement Unit

The Quality and Health Improvement 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 Medicaid managed care and 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.

Policy and Communications Office

The Policy and Communications Office was created in September 2012, and includes the Director of Government Affairs, Legislative Liaison, Legislative Analyst, the Public Information Officer and other communications staff, the Policy and Federal Rules professionals, and the State Board Coordinator. The Office bears responsibility for management of the functions associated with government affairs and communication and media relations. The Policy and Communications Office is responsible for providing leadership and advice to the Department to optimize internal and external communication and enhance internal and external relations. The staff represents the Department before a wide variety of external stakeholders, including but not limited to policy makers, county partners, advocates/stakeholders, and the press. Staff are responsible for working with Department managers on high-profile matters to make certain they are handled in a manner that is most beneficial to the citizens of Colorado and to the Department. The Office bears responsibility for developing a broad-scale communications plan, proactively addressing both internal and external audiences' needs. The Policy and Communications Office is responsible for crafting messages to policy makers, clients, and stakeholders that are accurate and that reflect the overall mission and accomplishments of the Department and programs. The Office creates the Department's legislative agenda and advocates for successful passage of Department initiatives, and creates and maintains positive relationships with all legislators and regularly communicates with legislators about the Department's initiatives.

Client Services, Eligibility, and Enrollment Office

The Client Services, Eligibility, and Enrollment Office 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 Client Services, Eligibility, and Enrollment Office identifies ways to improve communication to further the goals of transparency and accountability.

<u>Eligibility Division</u>
The Eligibility Division 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 the Office of Information Technology.

Client Services Division

The Client Services Division 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.

Community Partnerships Office

The Community Partnerships Office builds and manages community partnerships and relationships and assists with aligning the Department's strategy and activities with statewide and national health reform initiatives. The Office includes the Legal Division and coordinates relationships between the Department and partners of the Department, including advocacy organizations, providers, and other units of government.

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 2011-12, the Benefits Coordination Section collected $45.1 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 11.4% over the FY 2010-11 recoveries.

III. PRIOR-YEAR LEGISLATION

The following is a summary of major legislation enacted in 2012 that affects Department policies and procedures.

HB 12-1054 (Fields, Boyd) Simplify Procurement for HCPF Providers
This bill simplifies the procurement process by exempting the Department and health care providers from certain state fiscal-rule requirements concerning standard state contracts and commitment vouchers when the Department has regulatory authority over the program and when the provider has already signed a provider agreement.

HB 12-1202 (Levy, Lambert) Allow HCPF Appropriations for Quitline Matching Funds
This bill authorizes the General Assembly to appropriate moneys from the Tobacco Education Programs Fund to the Department in order to allow the Department to obtain federal matching funds for the Colorado Quitline program.

HB 12-1246 (Becker, Hodge) Reverse Payday Shift State Employees Paid Bi-Weekly
This bill reverses the payday shift enacted by Senate Bill 03-197 for state employees who are paid on a bi-weekly basis so that such employees will be paid in June in accordance with their regular two-week payment schedule.

HB 12-1281 (Young and Gerou, Steadman and Roberts) Medicaid Payment Reform Pilot
This bill creates the Medicaid Payment Reform and Innovation Pilot Program within the structure of the existing coordinated care system to foster the use of new payment projects. The Department is directed to create a process for interested contractors to submit payment projects for consideration under the pilot program.

HB 12-1288 (Murray, Bacon) Administration of IT Projects in State Government
This bill requires the Office of Information Technology (OIT) to develop a comprehensive risk-assessment that will be applied to every new information technology (IT) project to assess risk levels related to the project and determine whether the project should be classified as a major IT project. The bill also requires OIT to establish project budgets for projects of all sizes, including major IT projects.

SB 12-023 (Boyd, Summers, and Kerr A.) Improve Eligible Persons Access to PACE Program
This bill allows providers for the Program of All-inclusive Care for the Elderly (PACE) to contract with an enrollment broker to include the PACE program in its marketing materials to eligible long-term care clients.

SB 12-060 (Roberts, Gerou) Improve Medicaid Fraud Prosecution
This bill allows counties to keep the state share of any funds recovered from client fraud. It also requires the Attorney General to prepare annual reports on client and provider fraud, respectively.

SB 12-074 (Aguilar, Gardner B.) Consumer-Directed Care Designee Service Provider
This bill allows a guardian to also be a client's direct service provider under the Consumer Directed Attendant Support Services (CDASS) program.

SB 12-127 (Newell, Summers) Medicaid Health Homes Long-Term Care Providers
This bill requires, to the extent permitted under federal law, the Department to include providers of long-term care services and supports as health homes or as part of health homes in the Medicaid program.

SB 12-128 (Roberts, Summers) Alternative Care Facility Reimbursement Pilot
This bill allows the Department to create an enhanced reimbursement program in which an alternative care facility will receive a temporary increase in the Medicaid per-diem reimbursement rate for a client discharged from a nursing facility.

SB 12-159 (Hudak, Kerr J.) Evaluation Children with Autism Waiver
This bill clarifies the frequency and content of evaluations for children receiving Medicaid Home and Community-Based Services (HCBS) through the Children with Autism (CWA) waiver program. The Department is directed to annually review the fund balance of the Colorado Autism Treatment Fund to determine whether additional eligible children may be enrolled in the program. The bill also prioritizes getting children who are determined to have an imminent need for services on the waiver first if approved by the Centers for Medicare and Medicaid Services (CMS).

IV. HOT ISSUES

Customer Focus

Customer focus includes all activities and initiatives that improve health outcomes, client experience, and lower per capita costs. For years, both the public and private sectors in Colorado have been working toward the Triple Aim: achieving better care, better health, and lower cost, while keeping people and patients at the center of reform efforts. The Department acknowledges the current cost trajectory of health care is unsustainable, and the Department is working to make Coloradans healthier while getting the most value for every health care dollar spent. Colorado already has the framework for health system transformation in place, including an All-Payer Claims Database, Medicaid's Accountable Care Collaborative, and new initiatives like the Comprehensive Primary Care Initiative. The Department's State Health Care Innovation Plan touches on several innovative initiatives and broadly outlines a plan to build upon what is working to further reform Colorado's health care delivery and payment systems to achieve more value for every health care dollar spent.

Many collaborative payment and delivery system reform efforts are already underway among State agencies, providers, health plans, private payers, and stakeholders representing clients and families. Colorado has a unique culture that allows for innovations in health care at the local, regional, and State level. That collaboration must continue and grow in order to transform the health system. Many of the strategies in the State Health Care Innovation Plan include building upon the successes of previous and ongoing initiatives, while supporting innovations at the local levels to meet the health care needs of Colorado's diverse population and improving statewide infrastructure as the backbone of a transformed health system.

Accountable Care Collaborative

The Accountable Care Collaborative (ACC) Program is designed to transform the Medicaid Program into an integrated system of better care for all its members and to lower costs for the State of Colorado. The program is an innovative approach that neither returns to the fully capitated managed-care program of the 1990s, nor does it promulgate regular fee-for-service without counterbalancing adverse incentives.

The Department has outlined four goals to guide its efforts moving forward with the ACC Program. The program will:

- ensure access to a focal point of care or medical home;
- coordinate medical care and non-medical care;
- improve member and provider experiences; and
- provide the necessary data to support these goals.

The ACC Program is both a short-term solution to improving care and reducing costs, as well as a long-term investment in better health futures and savings for the Colorado population. The program design includes an immediate focus on reduction of specific key performance indicators that measure member utilization of services. In addition, better coordination of care will enhance client engagement, as well as prevention and wellness promotion. This increased focus on proactively managing care is expected to result in better health and reduced costs across the lifespan of current members. Reduced costs are achieved through the reduction of avoidable, duplicative, variable, and inappropriate use of health care resources.

The three core components of the ACC Program include the:

- Regional Care Collaborative Organizations (RCCOs), to ensure cost and quality outcomes for their Medicaid members;
- Primary Care Medical Providers (PCMPs), to serve as the focal point of care for each member; and
- Statewide Data and Analytics Contractor (SDAC), which provides actionable data at both the population and client level.

The State is geographically distributed into seven regions, each with a single RCCO. Each client is a member of the RCCO, based on residence in that region, and each client should have a designated PCMP. The SDAC provides an online dashboard of client data to each RCCO and all participating PCMPs to help manage their clients in the program.

The ACC Program currently has over 128,000 Medicaid clients enrolled, and approximately 135 Primary Care Medical Providers (PCMPs) are participating in the program, which includes 1,700 rendering providers. Program performance is currently being measured by tracking hospital readmissions, emergency room utilization, and high-cost imaging services. Additional measures are being developed to more broadly examine the program's impact.

The ACC Program is the platform through which the Department will implement future reform efforts, including:

- State Demonstration to Integrate Care for Dual Eligible Individuals (for individuals dually eligible for both Medicare and Medicaid);
- Comprehensive Primary Care Initiative (a federally funded initiative through the Center for Medicare & Medicaid Innovation to support enhanced primary care);
- ACC Payment Reform Initiative (H.B. 12-1281); and
- Behavioral health integration efforts.

The Department will submit a formal report to the legislature, to include initial program results on utilization and cost containment on November 1, 2012.

Long-Term Services and Supports Redesign

- **Colorado Choice Transitions**

Colorado Choice Transitions (CCT) is Colorado's Money Follows the Person (MFP) Rebalancing Demonstration program. The Department of Health Care Policy and Financing (the Department) was awarded $22 million over five years from the Centers of Medicare and Medicaid Services (CMS). CCT has two primary goals for Coloradans: 1) transition Medicaid clients out of long-term care facilities into community living using traditional waiver services and enhanced home- and community-based services, or demonstration services, and 2) to support efforts to reform the long-term care delivery system for people of all ages with long-term care needs using rebalancing funds created through an enhanced federal match.

The Long-Term Services and Supports 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, and/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). The division is also responsible for managing consumer-directed attendant support services which allow qualifying individual clients to direct their own in-home care.

Colorado has 12 waiver programs serving a variety of populations. 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.

Colorado Choice Transitions (CCT) 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 program is designed to provide enhanced transition services to clients currently living in nursing and other long-term care facilities in order to transition and sustain them in the community for up to 365 days. Medicaid-eligible clients residing in long-term care facilities for 90 days or more and are willing to move to CCT qualified housing are eligible for the program and can receive CCT services. The Department anticipates 100 clients per year will transition and receive services in a community setting.

With the ability to provide additional services through the grant program, the Department intends to improve clients' quality of life and realize savings as clients move from long-term care 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 and can continue to successfully transition into the community.

- **Long-term Care Advisory Committee**

In September 2011 the Long-term Care Advisory Committee (LTCAC) was reconstituted by Sue Birch, Executive Director of the Department of Health Care Policy and Financing (the Department), to be the primary planning and implementation channel for long-term services and supports (LTSS) redesign. The LTCAC was reconstituted to include members from all segments of the LTSS system to begin crafting a roadmap for the redesign of the LTSS system. Beginning in November 2011 and continuing through April 2012, both Sue Birch and Reggie Bicha, Executive Director of the Department of Human Services (DHS), led a series of community forums and meetings to gather stakeholder input on streamlining the administration of the two departments to reduce duplicate efforts with regard to rules, planning, and other administrative functions.

By April 2012, the LTCAC had conducted a strategic planning session, which included review and consideration of the recommendations found in Senate Bill 05-173 (2005), House Bill 07-1374 (2007), and the Olmstead Report (2010). The strategic planning session resulted in the identification of four strategic priorities and the development of four subcommittees of stakeholders and staff to work on those priorities. These four strategic priorities are Medicaid Entry and Eligibility, Waiver Modernization, Care Coordination, and Consumer Direction. Each of these subcommittees is discussed below.

- Medicaid Entry and Eligibility: The Centers for Medicare and Medicaid Services (CMS) through the Affordable Care Act has incentivized states to create more efficient, person-centered single entry point systems. While Colorado is not eligible for these incentives, it can use the manual created by CMS that outlines best practices for assessment and service planning processes, expectations for conflict-free case management and a suggested framework for entry point design. The entry point design work is based on the Aging and Disability Resource Center (ADRC) initiative that CMS and the Administration on Community Living have been promoting nationally over the last decade. The intent of this initiative is to streamline access to long-term services and supports regardless of payer. The ADRC initiative has generated multiple documents on best practices by state, and defines the functions of an entry point system.

- Waiver Modernization: To improve how Colorado serves clients and reduces the overall administrative burden and inefficiencies by having 12 Home- and Community-Based Services waivers, the Department is examining how HCBS waivers can be modernized by consolidating the number of waivers at the same time that the choice of services is expanded. As part of this process, the Department will be examining how it can create efficiencies in assessment and service planning processes and improve the allocation of services so that clients only receive the services they need when they need them. This specific work will be informed by the CMS manual mentioned earlier, which discusses best practices in assessment and service planning processes. It also lists all of the tools currently in use to assess the functional capacity of clients. The Department is in the process of securing a contractor who will research other states to examine lessons learned and the success of the consolidation efforts. In addition, the Department is in close contact with CMS to discuss the tools, timing and any technical assistance resources they may be able to provide as new waivers are submitted for federal approval.
- Care Coordination: Wisconsin and Massachusetts have generally been considered leaders in care coordination/case management for HCBS clients and particularly for individuals who are dual eligible for Medicare and Medicaid (i.e. 'the Duals'). The AARP Policy Institute has published several reports on best practices in case management, which can be used as reference material as the case management infrastructure is redesigned. The Department has convened a workgroup examining care coordination to map the various entities doing case management/care coordination in the state for the Medicaid population. Based on this analysis, the Department will be working to identify areas where certain functions can be consolidated and areas to create more efficient hand-offs. The LTCAC will use this information to develop recommendations for a standard set of activities for care coordination.
- Consumer Direction: Both departments are committed to improving the client's experience when contact is necessary with government systems. This means that services are developed to provide the right services at the right time in the right amount. One strategy for getting the right services at the right time is to maximize consumer choice and direction in the provision of services. The Department is currently engaged in a number of projects related to consumer direction, such as the development of the Community First Choice Council, the Participant Director Policy and Procedures Committee and now the Consumer Direction subcommittee of the LTCAC. These groups will be working closely together to expand consumer directed options in all aspects of the LTSS system.

- **Community-First Choice**

As part of the Affordable Care Act (ACA), the Community-First Choice (CFC) option allows states the option to provide person-centered home- and community-based attendant services and supports under the Medicaid State Plan, which is an agreement between the State and federal government that defines each state's Medicaid program. CFC is intended to

provide home- and community-based attendant services and supports for elderly individuals and people living with disabilities.

Currently, the Department is creating a Community-First Choice Council (CFC Council) to explore possible implementation of a CFC program in Colorado. The CFC Council will have 20 members, consisting of ten people either with disabilities or elderly and their representatives, six state staff with expertise on Medicaid infrastructure, and four at-large members.

The Department has grant funding designated to help the CFC Council conduct a thorough analysis of the cost and programmatic structure of CFC in order to develop potentially viable options for the State.

Office of Community Living

The Office of Community Living was created in July 2012 pursuant to an Executive Order by the Governor to meet the growing need for long-term services and supports by aging adults and people with disabilities. By 2021, the number of Colorado adults 65 and older is expected to increase by 54 percent. The Office of Community Living will align services and supports so individuals and their families will not have to navigate a complicated or fragmented system.

The goal of the Office of Community Living is to provide strategic direction on the redesign of all aspects of the long-term services and supports delivery system, including service models, payment structures, and data systems to create efficient and person-centered community-based care. Through the Office of Community Living, the Department aims to:

- provide services in a timely manner with respect and dignity;
- strengthen consumer choice in service provision;
- incorporate best practices in service delivery;
- encourage integrated home- and community-based service delivery;
- involve stakeholders in planning and processes; and
- incorporate supportive housing.

State agencies and divisions will work collaboratively with the Office of Community Living. Such agencies and divisions include but are not limited to:

- Department of Local Affairs;
- Division of Housing;
- Department of Transportation;

- Department of Public Health and Environment; and
- Department of Human Services.

As part of the redesign process, an advisory group will consider and recommend changes to the long-term services and supports delivery system. The advisory group will meet regularly through September 2014. The advisory group will work closely with the Long-Term Care Advisory Committee, the Colorado Commission on Aging, and other planning groups to carry out this work and build on previous discussions and recommendations.

Integration of Behavioral Health

Colorado is divided into five mental health service areas. In each area, a Behavioral Health Organization (BHO) arranges for or provides medically necessary mental health services for Medicaid clients. The Department is beginning its process to rebid behavioral health services for 2014, which provides an opportunity to continue greater integration of care and to align systems of care.

Some Regional Care Collaborative Organizations (RCCOs) in the Accountable Care Collaborative (ACC) are already partnering with BHOs to better serve clients with behavioral health needs. Activities such as co-location between providers, limited data sharing, and client-focused collaboration are some of the innovative ways employed to address the needs of Medicaid clients. Colorado’s State Health Care Innovation Plan will further advance the department’s efforts to integrate physical and behavioral health services..

Planning for behavioral health integration efforts is already underway for individuals eligible for both Medicare and Medicaid and long-term care populations in Colorado. A newly-created Office of Community Living, the Dual Eligible Demonstration Project, and the Colorado provider group participating in the Centers for Medicare and Medicaid Services’ Pioneer Accountable Care Organization all have processes to support integration of behavioral and physical health for Coloradans.

Health, Wellness, and Prevention

The Department’s commitment to improving the health and wellness of Colorado Medicaid clients and communities extends from infant development to adult aging. Two years ago, the Department of began working on the Healthy Living Initiatives, addressing issues of health promotion and disease prevention for the Medicaid and Children's Basic Health Plan (CHP+) populations. In this, the Department identified four priority areas for health promotion: oral health, behavioral health (with a

focus on depression), nutrition and fitness (with a focus on obesity), and tobacco cessation. The top ten innovations are as follows:

- Medicaid has improved and expanded the tobacco cessation benefit for adults who want to quit.
- Federal matching funds now provide support to the Colorado QuitLine for Medicaid clients.
- Medicaid now offers annual depression screening for youth ages 11 to 20 years.
- The Oral Health Tool Kit outlines preventive oral health services available to children in the primary care setting.
- The Obesity Tool Kit outlines guidance for billing and reimbursement on addressing obesity in primary care through an extended visit with Body Mass Index (BMI) screening.
- The Healthy Living leadership team collaborates extensively with prevention partners statewide.
- The Healthy Living website provides information on trends in population health and outlines performance indicators for tracking changes in the health of individuals served by the Medicaid program.
- The Demographic Profile of Medicaid Clients provides information on Medicaid participants in Colorado in terms of income level, geographic distribution, age, gender, and ethnicity, which informs population health planning.
- An emphasis has been placed on evidence-based prevention programming for Medicaid clients, including chronic disease self-management classes and early-childhood nurse home-visitation through the Nurse Family Partnership program.
- An improved and expanded client engagement process has begun at the Department in order to more effectively involve clients and families in their own health, as well as engage clients as advisors to the Department.

Payment Reform

The Department is developing a broader vision for payment reform within the ACC Program and integration across the various delivery systems and will have a robust stakeholder process as this larger vision is developed. In this, the Department will support the design and testing of innovative, transformational health programs that generate savings and improve care, with an emphasis on multi-payer payment and service delivery models as well as build upon the ACC framework to integrate behavioral health and substance abuse into the ACC model.

- **Gainsharing**

  The Department's FY 2012-13 approved "Medicaid Fee-for-Service Reform" budget request (R-5) included three separate gainsharing initiatives: Behavioral Health Organization (BHO) gainsharing, Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) gainsharing, and Accountable Care Collaborative (ACC) gainsharing. In this

request, BHO gainsharing was designed to measure and share savings with BHOs associated with reducing psychotropic drug utilization. FQHC and RHC gainsharing proposed sharing savings associated with reducing costs for specific hospital and pharmaceutical metrics. ACC gainsharing was less defined and only specified that savings above and beyond the administrative costs of the ACC program would be shared between the Department, the Regional Care Collaborative Organizations (RCCOs), and the Care Medical Providers (PCMPs).

Through a collaborative stakeholder process following the approval of this budget request, the Department is working with stakeholders to evaluate the feasibility of combining BHO and FQHC/RHC gainsharing into the ACC program. That is, only costs associated with clients enrolled in the ACC would be measured for the purposes of sharing savings. Furthermore, instead of specific metrics, savings would be measured on a total cost of care basis, along with quality metrics to ensure that care is not compromised. Aligning all three gainsharing initiatives has several benefits to the Department and to stakeholders. This would support the Department's ACC program and its future, leverage existing infrastructure and resources of the ACC program and the Statewide Data and Analytics Contractor (SDAC) vendor, encourage the integration of physical and behavioral health care, combine delivery system reform with payment reform, and simplify and streamline the Department's several payment reform initiatives.

Discussions with stakeholders to determine an equitable distribution of savings between the RCCOs and the providers, including FQHCs, RHCs, PCMPs, and the BHOs are ongoing, and will result in a draft methodology during the month of November.

- **ACC Pay-For-Performance Incentives**

Beginning in July 2012, the Department is withholding one dollar of the per-member per-month (PMPM) capitation being paid to the Accountable Care Collaborative (ACC) Regional Care Collaborative Organizations (RCCOs) and Primary Care Medical Providers (PCMPs) for a pay-for-performance incentive plan. This pay-for-performance incentive plan was in the Request for Proposals for the RCCOs, which went through a lengthy stakeholder process. The RCCOs and PCMPs may recover this dollar if certain thresholds are achieved as measured by the three Key Performance Indicators (KPIs):

1. Hospital All-Cause Thirty (30) Day Readmissions;
2. Emergency Room (ER) Visits; and
3. High Cost Imaging Services.

Each KPI calculation is based on service utilization by the population enrolled in the ACC. Performance will be measured as a percentage point improvement from the base period. To account for regional variation, each RCCO will be compared to the performance of its region during the base year. Improvement is measured by subtracting the program year-to-date performance from the regionally adjusted base year performance. There are two levels of performance achievement:

1. Level 1 savings indicate a 1-5% reduction in a particular KPI from the base period; and
2. Level 2 savings indicate a greater than 5% reduction in a particular KPI relative to the base period.

A reduction greater than 5% for each KPI results in a PMPM incentive payment of $0.33, for a total incentive payment of one dollar if all three KPIs meet the Level 1 savings. Similarly, a reduction between 1-5% for each KPI results in a PMPM incentive payment equal to 66% of $0.33, or $0.22. Incentive payments for each member are calculated based on performance of the region in which the member lives. PCMPs that have enrolled members from multiple regions could receive varying incentive payments based on the regional performance of their members' regions.

- **HB 12-1281 Payment Reform Pilots**

The Department is preparing to begin implementing a payment reform pilot authorized by HB 12-1281, which permits the Department to accept proposals for innovative payment reforms that will demonstrate new ways of paying for improved client outcomes while reducing costs. The first step in this process was to publish an invitation for pilot project abstracts. Interested parties were required to work directly with the Accountable Care Collaborative's (ACC) Regional Care Collaborative Organizations (RCCOs) on the abstract and subsequent payment reform proposals. Abstracts were received and reviewed by Department staff in September 2012.

The Department is currently developing a formal process for requesting, receiving, evaluating, and selecting proposals. Evaluation criteria will be based partly on the ideas submitted in the abstracts as well as on alignment with Department goals and technical feasibility. Opportunities for stakeholder input are being offered through the Department's ACC Payment Reform Subcommittee, and public comment on the proposal criteria will be solicited before the criteria are finalized.

Proposals selection(s) will be made by June 2013.

Hospital Provider Fee

On April 21, 2009, Governor Ritter signed Colorado House Bill 09-1293 "Health Care Affordability Act" into law. 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. Once fully implemented, the legislation will provide health care coverage for uninsured Coloradans, reduce uncompensated care costs, and benefit the state as a whole.

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 additional funding through a hospital provider fee and draw down 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.

The Department successfully launched three Medicaid expansion populations within the last year: the Buy-In Program for Working Adults with Disabilities in March 2012, the Adults without Dependent Children program in May 2012, and the Buy-In Program for Disabled Children in July 2012. While the Adults without Dependent Children (AwDC) program currently covers only individuals with income up to 10% of the federal poverty level with an enrollment cap of 10,000 clients, the Department will continually monitor and analyze the costs of the existing clients around December 2012 to recommend whether more individuals can be covered under the Section 1115 Medicaid Demonstration Waiver. This is contingent upon the costs of the current caseload as well as the ability to generate additional provider fee revenue under the FFY 2012-13 hospital provider fee model, if necessary.

As of September 30, 2012, the approximate caseloads for the expansion populations funded under the hospital provider fee are:

- 39,700 Medicaid Parents, of which 17,900 were newly eligible for Medicaid;
- 15,300 CHP+ children, of which 9,100 were newly eligible for CHP+;
- 490 CHP+ pregnant women, of which 450 were newly eligible for CHP+;
- 10,000 Adults without Dependent Children, of which 8,000 were newly eligible for public assistance; and

- 540 Disabled Individuals in the Working Adults and Children's Buy-in. Of the 440 Working Adults, 190 were previously enrolled in regular Medicaid and now have gainful employment[4].

In FY 2011-12, the Department collected approximately $584 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 beginning in FY 2009-10:

Payment Type	FY 2009-10	FY 2010-11	FY 2011-12
Supplemental Hospital Payments	$590,238,707	$745,237,426	$896,654,478
Department Administration	$2,938,743	$5,743,900	$15,824,778
Expansion Populations	$3,241,896	$90,099,056	$134,338,939
General Fund Offset	$46,329,410	$61,343,993	$65,700,000
Total Expenditures	**$642,748,756**	**$902,424,375**	**$1,112,518,195**

Through this financing mechanism, Colorado was able to draw down and distribute $528 million in additional federal dollars in FY 2011-12. The net gain to hospitals in federal fiscal year 2011-12 from supplemental payments was an estimated $122.5 million. These net gains represent the reduction in uncompensated costs incurred by hospitals.

CHCAA reduces the need for hospital providers to shift uncompensated care costs to private payers by providing higher reimbursement for patients covered by public health care programs and reducing the number of uninsured Coloradans. By raising the rates paid to hospital providers, the need to shift costs is reduced. CHCAA increases reimbursement paid for inpatient and outpatient care for Medicaid clients as well as rates paid for the Colorado Indigent Care Program (CICP). Fewer uninsured Coloradans leads to lower uncompensated costs by creating a funding source for these clients. In the first year, the hospital provider fee increased eligibility for parents of Medicaid covered children and children and pregnant women covered by CHP+.

CHCAA was implemented following federal approval in April 2010; therefore, changes to cost to payment ratios due to CHCAA are captured with the CY 2010 data. The following table and graph display the difference between total payments and total costs on a per patient basis for Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other payer groups.

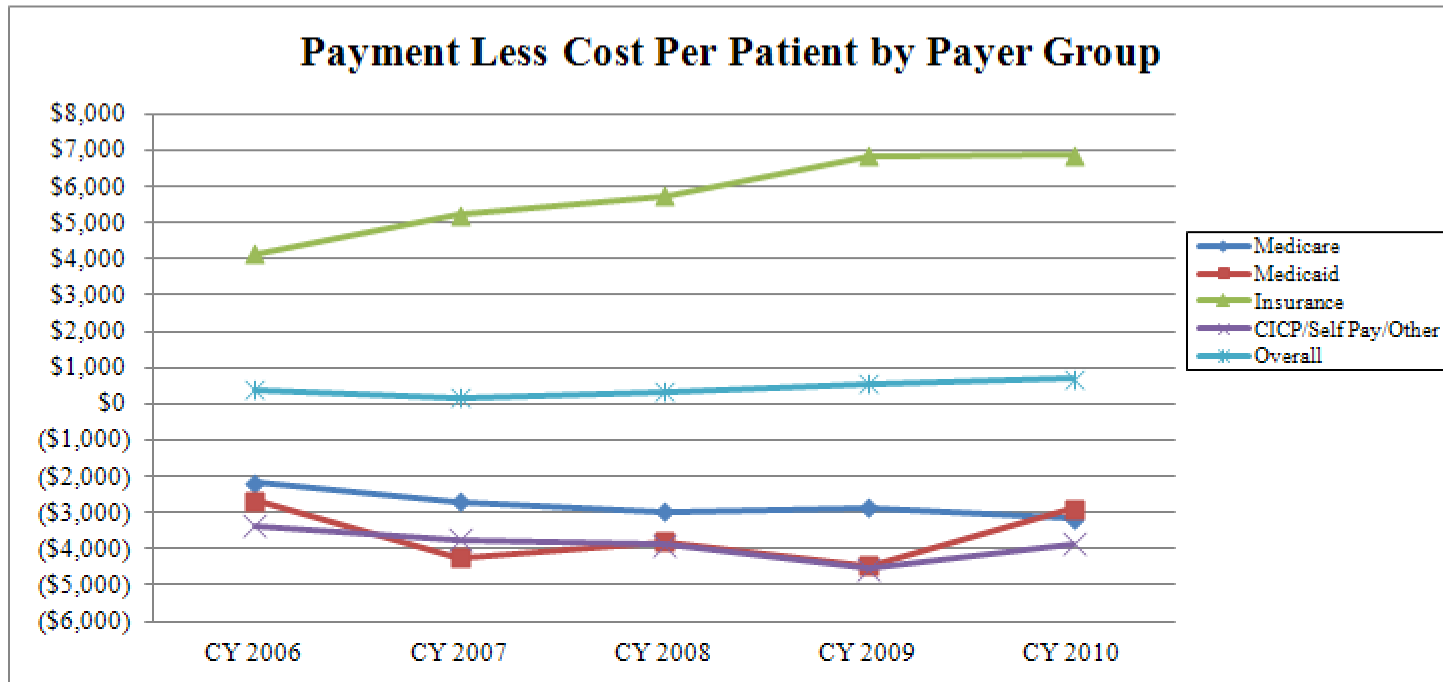
[4] For the purposes of this analysis, "newly eligible for public assistance" and "previously enrolled in Medicaid" are measured relative to enrollment in October 2007.

Negative values indicate that costs exceed payments. This is the case for Medicare, Medicaid, and the CICP/Self Pay/Other payer groups and indicates hospitals are undercompensated for care provided to these clients.

Positive values indicate that payments exceed costs. This is the case for the private sector insurance group, where there is overcompensation relative to costs. This is the essence of cost shift as publicly insured and uninsured care is paid under cost and private payers pay more to cover those costs.

The data show that following the implementation of the CHCAA in July 2009, overcompensation by the private sector insurance was flat in CY 2010 – increasing less than 1% over CY 2009. The average rate of growth of private sector overcompensation was more than 18% per year for the previous three years. At the same time, the undercompensation for the Medicaid and CICP/Self Pay/Other payer groups sharply decreased in CY 2010.

Payment Less Cost Per Patient by Payer Group					
	CY 2006	**CY 2007**	**CY 2008**	**CY 2009**	**CY 2010**
Medicare	($2,172)	($2,691)	($2,969)	($2,872)	($3,166)
Medicaid	($2,682)	($4,239)	($3,807)	($4,468)	($2,906)
Private Sector Insurance	$4,148	$5,221	$5,749	$6,838	$6,881
CICP/Self Pay/Other	($3,370)	($3,754)	($3,874)	($4,561)	($3,848)
Overall	$377	$182	$328	$551	$690



The Taxpayer's Bill of Rights (TABOR) – Article X, Section 20 of the Colorado Constitution – limits the State's revenue growth to the sum of inflation plus population growth in the previous calendar year. Under the provisions of TABOR, revenue collected above the TABOR limit must be returned to taxpayers, unless voters decide the State can retain the revenue. In November 2005, voters approved Referendum C, which set a new cap on revenue starting in FY 2010-11. According to the Office of State Planning and Budgeting September 2012 economic forecast, TABOR revenue is projected to be about $1 billion below the Referendum C cap through FY 2014-15. Because the Hospital Provider Fee is cash fund revenue subject to TABOR, the Department monitors the increase in the forecasted fee collection in this light and provides updated projections of fee revenue to the Office of State Planning and Budgeting and Legislative Council for inclusion in economic forecasts that are updated quarterly. While the amount of provider fee needed to fund expansion populations will decrease if the State receives the ACA enhanced federal financial participation for a partial expansion, which thus reduces the amount of TABOR revenue collected, the State is still awaiting federal guidance on this issue.

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 if the State opts to expand eligibility to 133% FPL for all individuals. 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. If the State receives the enhanced federal financial participation available through ACA for a partial expansion beginning in January 2014 for expansion populations included in CHCAA (see Hot Issue below), the additional federal funds will help ensure the viability of the Hospital Provider Fee.

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.

Affordable Care Act

The passage of the Affordable Care Act (ACA) provides unprecedented opportunities to increase the value spent on health care, create a culture supporting healthy living and wellness, and expand access to affordable care. Signed into law on March 23, 2010, the ACA seeks to improve the quality of health of all Americans by providing increased options, more ownership over health decisions, and lowering costs, while ensuring more accountability and transparency from insurance companies. Beginning immediately and continuing through 2014, a myriad of changes to existing polices and implementation of new ones will result in the most comprehensive health reform effort in history. The ACA is wide-ranging in its attempt to achieve greater health outcomes and complex in its approach. Among the provisions of the ACA are:

- Coverage requirements: Require most U.S. citizens and legal residents to have health insurance, and require employers with more than 50 employees to offer health coverage by 2014 to avoid penalties.
- Expansion and reform of public programs:
  - Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% of the federal poverty level (FPL) based on modified adjusted gross income (as, under current law, undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges. To finance coverage for the newly eligible (those who were not previously eligible for at least benchmark equivalent coverage, those who were eligible for a capped program but were not enrolled, or those

who were enrolled in state-funded programs), states will receive 100% federal medical assistance percentage (FMAP) for 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% for 2020 and subsequent years.

  - Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019, and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Provide states with the option to provide CHIP coverage to children of State employees who are eligible for health benefits if certain conditions are met. Beginning in FFY 2015, states will receive a 23 percentage-point increase in the CHIP FMAP.
  - Increase Medicaid payments in fee-for-service and managed care for primary-care services provided by primary care doctors (family medicine, general internal medicine, or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014; States will receive 100% FMAP for the increased payment rates.
  - Creation of new State Plan options to permit Medicaid enrollees with chronic conditions to designate a provider as a health home, with 90% FMAP for two years for home health-related services, including care management, care coordination, and health promotion; and provide states that offer Medicaid coverage of and remove cost-sharing for recommended preventive services and immunizations with a one percentage-point increase in the FMAP for these services.
  - Creation of new demonstration projects, including those to pay bundled payments for episodes of care that include hospitalizations; to make global capitated payments to safety net hospital systems; to allow pediatric medical providers organized as accountable care organizations to share in cost-savings; and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition.
  - Long-term care improvements, including extending the Medicaid Money Follows the Person Rebalancing Demonstration program; providing states with new options for offering home- and community-based services (HCBS) through a Medicaid State Plan rather than through a waiver, including a provision to all full Medicaid benefits to individuals receiving HCBS; establishing the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care with a six percentage-point increase in the FMAP for reimbursable expenses in the program.
  - Reduce Medicaid disproportionate share hospital (DSH) allotments in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for 1115 waivers.
  - Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
- Health insurance exchanges: Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133-400% FPL and create separate Exchanges through which small businesses can purchase coverage. All plans sold in the health insurance exchange must include the state-selected essential health benefits.

- Insurance market reform: Provide dependent coverage for children up to age 26 for all individual and group policies; prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage, and prohibit insurers from rescinding coverage except in cases of fraud; prohibit pre-existing condition exclusions for children; beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage; and require guarantee issue and renewability and allow rating variation based only on age, premium rating area, family composition, and tobacco use in the individual and the small group market and the Exchange.
- Other provisions: Promote health and wellness programs through grants to small employers; permit employers to offer employees rewards for participating in a wellness program and meeting certain health-related standards; establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program); and promoting the health workforce supply through increased Graduate Medical Education (GME) training positions, State grants to providers in medically underserved areas, and scholarships, loan-repayment programs and retention grants.

On the last day of the 2011-2012 Term, the United States Supreme Court issued its long-anticipated opinion about the ACA. In a case known as *National Federation of Independent Business v. Sebelius*, the Court agreed to consider the constitutionality of two major provisions of the ACA: the individual mandate and the Medicaid expansion. A majority of the Court upheld the individual mandate, and, while the Court found the Medicaid expansion unconstitutionally coercive of states because states did not have adequate notice to voluntarily consent and the Secretary could potentially withhold all of a state's existing federal Medicaid funds for non-compliance, a majority of the Court found that this issue was appropriately remedied by circumscribing the Secretary's enforcement authority, thus leaving the Medicaid expansion intact in the ACA but in effect making the expansion to 133% FPL optional.

The Department is in the process of developing a fiscal analysis of the impact of increasing Medicaid eligibility to 133% FPL. This analysis is extremely complex due to the interaction of many provisions of the ACA, including the individual mandate, the transition to the use of modified adjusted gross income (MAGI) to determine eligibility for public programs and the Exchange, the optional enrollment of newly eligible Medicaid enrollees in a benchmark benefit offering the State's essential health benefits, and the interplay between the provisions of the Colorado Health Care Affordability Act (CHCAA, see above) and the ACA. In the development of this analysis, the Department is collaborating with many entities – including the Governor's Office, the Colorado Health Institute, and the Colorado Center on Law and Policy – to ensure all assumptions included in the analysis are thoroughly vetted and reasonable. In addition, the Department is awaiting federal guidance, particularly related to the applicability of the enhanced FMAP for partial Medicaid expansions (e.g., to 100% FPL). Under the ACA, Colorado was slated to receive the enhanced FMAP for the Medicaid Parents from 61-100% FPL and the Adults without

Dependent Children to 100% FPL populations beginning in 2014, as these expansions were implemented after the passage of the ACA.

On September 28, 2012, Colorado submitted its recommendation for an Essential Health Benefits (EHB) Benchmark plan. The selection process was facilitated jointly by the Governor's Office, the Division of Insurance, and the Colorado Health Benefit Exchange, and the benefits in the benchmark plan will be used as a template for Colorado insurance carriers to use when designing EHB-compliant benefit plans in 2014 and 2015. Colorado selected its largest small group plan, which is offered by Kaiser Permanente. The Department is currently working with the Governor's Office and Kaiser Permanente to complete a comparison of the benchmark plan to the existing Medicaid benefit package and to estimate the cost of applying the benchmark plan to newly eligible Medicaid enrollees. In addition, the Department will evaluate the cost-effectiveness of purchasing health insurance through the Exchange for optional Medicaid populations, specifically enrollees in the Breast and Cervical Cancer Treatment program and pregnant women with income above 133% FPL, rather than offering Medicaid coverage. This requires a comparison of health benefits offered to ensure enrollees receive necessary services, an analysis of the cost of such enrollees under the EHB, and a comparison of the federal fund under Medicaid to the premium and cost-sharing credits available under the Exchange.

Information Technology

Medicaid Eligibility and Enrollment Modernization Project

On December 30, 2011 the Department received approval of a Planning Advanced Planning Document from the Centers for Medicare and Medicaid Services (CMS) to secure staff and consulting resources to research, analyze, and plan the Department's implementation of the Affordable Care Act (ACA) and collaboration with Colorado's Health Benefit Exchange (COHBE). In addition, the Department used the funding to examine options to modify and utilize as necessary the Colorado Benefits Management System (CBMS) to meet the CMS Seven Standards and Conditions and to comport with the ACA.

In June 2012, the Department submitted an Implementation Advanced Planning Document (IAPD) to CMS to obtain enhanced federal funding to modernize the Department's eligibility system and processes to facilitate efficient, effective, and elegant enrollment into medical assistance programs through an integrated system and to ensure seamless and minimal interoperability with COHBE. This funding will be used to implement necessary changes to CBMS to comport with the ACA and to ensure that the system meets the CMS Seven Standards and Conditions, which exist to "foster better collaboration with states, reduce unnecessary paperwork, and focus attention on the key elements of success for modern and flexible systems development and employment."

The Department is collaborating closely and partnering with the Governor's Office, Office of Information Technology (OIT), Department of Human Services (DHS), Colorado Counties, COHBE, Department of Education (CDE), and Department of Public Health and Environment (CDPHE) to provide an eligibility and enrollment process which works for Coloradans. In developing this Implementation Advanced Planning Document (IAPD), the Department worked in collaboration with its partners and stakeholders.

The Department adopts the national vision for health care reform to provide consumers and users with a World Class Experience of real-time online eligibility determination and has developed a comprehensive vision and coherent phased strategy to leverage federal, state and other funding, as it becomes available, to improve systems and business processes across multiple programs and agencies. Implementation of this strategy will streamline assistance processes, decrease ongoing administrative costs, and greatly enhance client service and satisfaction.

The Department received conditional approval of this IAPD in August 2012, along with written instruction from CMS to proceed with the initiation of the project.

MMIS Reprocurement

The Medicaid Management Information System (MMIS) is the hardware, software, and business process workflows designed to meet the criteria for a "mechanized claim processing and information retrieval system" required by federal law to participate in the Medicaid program. The MMIS's core function is to adjudicate and process the Department's medical claims and capitations for payment; it also provides other important functions including provider enrollment and management, certain client management functions, and analytics and reporting. Since the MMIS electronically processes approximately 97% of the Department's claims, its capabilities and limitations play a pivotal role in how the Department administers the Medicaid program.

The current MMIS and Fiscal Agent services contract has been with Affiliated Computer Services, Inc. (ACS), now Xerox, since December 1998. During this period, the MMIS and Fiscal Agent services contract was competitively bid and reprocured once, in which the incumbent vendor won the bid. The current contract's operational phase began in July 2007, using the same MMIS software as the prior contract, and it expires June 30, 2015, at which time it will be an eight-year-old contract. After eight years, CMS has historically required the MMIS and Fiscal Agent services contract to be competitively bid and reprocured; therefore, the Department must reprocure the MMIS and Fiscal Agent services by the end of the current contract to satisfy federal requirements and maintain enhanced federal matching rate for Design, Development, and Implementation (DDI)

and operational costs. Before the current vendor, Blue Cross Blue Shield was the MMIS and Fiscal Agent services vendor for 12 years, using the same MMIS currently utilized by the Department.

The current MMIS is highly outdated, as it is over 20 years old (with some components being over 30 years old) and is based on a 1970s general mainframe design. Several of these components were modern when first designed (e.g., the MMIS is accessible by Department users through a Windows interface), but most interactions with outside parties (including providers) are now performed through outdated and difficult-to-configure processes. While the current MMIS is sufficient to process a high volume of claims, it lacks the enhanced capabilities of modern solutions. For example, modern MMIS solutions allow for system changes through configurable technology rather than long and costly programming efforts, allow for more effective web-based interfaces rather than mainframe file exchanges, and allow for alternative health benefit packages and provider reimbursement methodologies. Since the MMIS is central to administering the Medicaid program, the manual processes and workarounds that the Department has developed around these limitations create significant operating inefficiencies and restrictions to policy changes.

To best meet the federal requirements to competitively bid and reprocure the MMIS and Fiscal Agent services contract and to address the substantial difficulties, inefficiencies, and risks posed by the current MMIS, the Department is requesting funding in this budget submission to acquire a new, modern replacement MMIS. This proposed solution consists of a competitive bid and procurement for the MMIS and Fiscal Agent services to meet federal reprocurement deadlines, and replacing the current MMIS software with a modern MMIS, transferred and modified for use in Colorado, to address the current and future needs of the Department.

Health Information Technology

The Department has led innovations and adoption of Health Information Technology (HIT) for many years and has invested significantly in strategies to maintain its place in the forefront, putting technology and information systems to work to support a transformed health care system that provides better value and higher quality care.

Without comprehensive payment reform and financial incentives to provider better quality, more efficient care, health care providers have been slow to make significant investments in HIT. Although national standards are in place for electronic health records (EHRs), including vocabulary, content, and transport standards, many EHRs may not fully meet Meaningful Use standards. Additionally, every version of a particular EHR can be developed, implemented, and utilized by providers differently, causing difficulty and expense in custom interfaces and development where standards should provide for

scalability. This custom work requires intensive work with EHR vendor staff as well as additional costs to health care providers.

To incentivize health care providers and organizations to adopt and utilize HIT, the Department will continue to develop reformed payment strategies and structures that reward investment in providing better value and higher quality care. The Department will also pursue direct health plan support of HIT efforts; particularly HIE, in keeping with the understanding that savings achieved through better value care often accrue to the payer instead of the provider or consumer.

Enhanced Department Operations: People and Processes

The Department is currently implementing initiatives and processes to enhance operations and maximize Department resources, both human and capital. As part of this, the Department is undergoing an iterative revitalization process allowing the Department to make changes to enable the improvement of processes and functions. The Department is now in Phase III of its Revitalization Process. Based on feedback from a staff survey, input from the Department's Executive Committee, and observations made by the Executive Director, the Department added the following offices: Clinical Services; Administration and Innovation; Policy and Communications; and Community Partnerships.

LEAN

In June and August 2012, the Department began two LEAN process improvement plans using LEAN coaching and training resources available from the Governor's Office of State Planning and Budgeting. The June project focused on reducing the time to hire new employees and the August project focused on streamlining the service plan development process for Long Term Care waivers. These projects are described as follows:

Reduce Time to Hire

Key objectives of the "Reduce Time to Hire" project are to:

1. Streamline the hiring process to reduce the number of internal approvals, hand-offs; and days to hire
2. Improve the quality of hire (select 'best-fit' candidates), and collaboration between hiring managers and human resources
3. Fully utilize the capabilities of existing electronic systems (NEOGOV, SharePoint) to reduce the amount of paper and transactional processes

The result of the "Reduce Time to Hire" project was a process improvement plan to achieve an effective, fair, fast and user-friendly hiring process based on the following operational definitions: It will be effective by reducing the number of days to fill a vacancy and increasing the likelihood of hiring the top candidates; it will be fair by maintaining compliance with State rules; it will be *fast* by eliminating duplicative and non-value added steps; and it will be user-friendly by creating partnerships between human resource analysts and hiring managers.

The "Reduce Time to Hire" process improvement plan estimates implementation will achieve the following measurable improvements in FY 2012-13:

- A reduction in the number of hand-offs of hiring documents from 65 to 13.
- A reduction in the number of approvals to hire new staff from 36 to 7.
- A reduction in the average total time to hire from 142 business days to 65 business days.

LTC Waivers: Service Plan Development Process

An effort to LEAN the Department's Long-Term Care (LTC) service plan development process was undertaken in August 2012. The purpose was to streamline the process and decrease variability between and across waivers and case management agencies with the goal of improving quality and consistency of services available to all Medicaid clients. Targeted outcomes of the "LTC Waivers" LEAN project are:

- Developing a uniform standardized case management review process that can be communicated to providers and improve initial case reviews
- Reducing the number of judgments against the Department
- Improving client and case manager experience with the Department

The result of the "LTC Waivers" project was a process improvement plan to provide clients a fair, transparent and uniform case management review process that accommodates client's individual needs, and to take advantage of available technology to deliver an improved customer experience, move to electronic process and achieve a green "paperless" process. The Department will equip staff and case management agencies with the guidelines, training, tools and technology necessary to improve efficiency and the overall customer experience.

The "LTC Waivers" process improvement plan estimates its implementation will achieve the following measurable improvements in FY 2012-13:

- Reduce the number of faxes and paper used (by moving to an electronic process)
- Move home health case management reviews to a third-party vendor

- Move adult case management reviews greater than $250/day to a third-party vendor

The Department's Strategy Section produces a monthly newsletter providing updates on all active and upcoming LEAN projects and soliciting suggestions for new projects.

Hiring and Retaining Staff

Like other employers, the Department has also had to adapt to a new, 21st century workforce. This workforce is mobile, and does not typically stay within State employment for more than a few years. This creates an acute problem for the Department, because the sheer complexity of the Medicaid program and its regulations mean that employees take a full year to train to be effective at an operational level, and several years to fully train to be effective at a policy or strategic level. The Department has experienced turnover rates higher than the state average, and the Department expects the turnover rate to increase with an improving economy.

Within the Administration and Innovation Office, the Department has created the Workforce Development Section. This Section will develop and implement a plan to integrate its talent-management processes to ensure that the Office is effectively developing, managing, and improving programs to improve quality of the Department's workforce. The section is responsible for strategic human resources planning including the acquisition of software to support on-going and future human resources programs. The Department believes that providing the opportunity for staff to develop their professional skills in their current positions not only benefits the Department through a stronger workforce, but also encourages internal promotional opportunities for staff that allow the Department to retain institutional knowledge and experience.

In addition to these changes currently being implemented, the Department is also requesting funding to hire additional employees to enable the Department to meet its objectives and restore core functionality as the administrator of the State's medical assistance programs and authority on health care. The Department's inadequate FTE level is impairing its ability to execute its mission to improve health care access and outcomes for the people it serves while demonstrating sound stewardship of financial resources. As discussed in FY 2013-14 R-6 "Additional FTE to Restore Functionality," the Department is committed to improving external relations, providing timelier responses, and presenting more information with better data. This agency wide request will support senior Department staff, enabling timely, better informed interactions with stakeholders, legislators, and other partners.

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 2010. The survey period for this questionnaire was July through December 2010, and the data was collected between February and May 2011. National averages for 2010 (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 (NA). 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 to 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 in case-mix differences.

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

FY 2011-12 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	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 antibiotic utilization. The 2012 rates reflect services provided January 1, 2011, through December 31, 2011.

HEDIS Measure	Rocky Mountain Health Plan	Denver Health	Primary Care Physician Program (PCPP)	Fee-for-Service (FFS)	HMO Weighted Average[1]	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average[2]	2011 HEDIS National Medicaid Average
Childhood Immunization Status (H) (Percent of children with immunization)								
Combination 2	78.2%	84.2%	76.6%	70.6%	82.3%	70.7%	72.0%	74.1%
Combination 3	76.2%	83.7%	76.1%	66.7%	81.3%	66.9%	68.5%	69.9%
Combination 4	12.7%	51.6%	53.3%	27.5%	39.4%	28.1%	29.4%	31.6%
Combination 5	63.4%	70.3%	58.3%	49.1%	68.2%	49.4%	51.5%	47.2%
Combination 6	52.1%	73.2%	38.3%	42.1%	66.6%	42.0%	44.8%	36.4%
Combination 7	11.3%	45.3%	41.2%	20.7%	34.6%	21.2%	22.7%	23.8%
Combination 8	9.0%	47.0%	27.8%	17.8%	35.1%	18.0%	19.9%	19.0%
Combination 9	44.9%	62.0%	31.2%	33.1%	56.7%	33.0%	35.7%	27.8%
Combination 10	8.1%	41.1%	22.6%	13.4%	30.8%	13.6%	15.5%	15.2%
4 Diptheria, Tetanus, Pertussis	85.4%	84.7%	79.5%	75.9%	84.9%	76.0%	77.0%	80.2%
3 Polio Virus immunizations	94.7%	93.4%	94.2%	88.8%	93.8%	88.9%	89.5%	90.8%
1 Measles, Mumps, and Rubella	92.4%	92.5%	93.2%	87.8%	92.4%	88.0%	88.5%	90.6%

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

HEDIS Measure	Rocky Mountain Health Plan	Denver Health	Primary Care Physician Program (PCPP)	Fee-for-Service (FFS)	HMO Weighted Average[1]	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average[2]	2011 HEDIS National Medicaid Average
3 Haemophilus Influenza Type b	95.8%	93.2%	94.2%	91.2%	94.0%	91.3%	91.6%	90.3%
3 Hepatitis B immunizations	91.4%	94.2%	93.7%	89.1%	93.3%	89.2%	89.6%	90.1%
1 VZV (Chicken Pox) vaccine	91.2%	92.2%	93.7%	86.6%	91.9%	86.8%	87.4%	90.0%
4 Pneumococcal Conjugate	86.3%	85.6%	88.7%	77.6%	85.9%	77.9%	78.8%	79.4%
2 Hepatitis A	13.2%	52.8%	55.6%	32.4%	40.4%	32.9%	33.7%	36.5%
Required Number of Rotavirus	73.4%	72.7%	64.6%	61.3%	72.9%	61.4%	62.7%	57.6%
2 Influenza	55.6%	79.1%	43.6%	49.9%	71.7%	49.7%	52.2%	43.6%
Immunizations for Adolescents (A)[3] (Percent of children with immunization)								
Combination 1	47.9%	82.3%	64.2%	52.5%	71.6%	53.1%	55.2%	52.2%
1 Meningococcal	50.7%	83.1%	66.7%	54.1%	73.0%	54.7%	56.8%	56.3%
1 Tdap/Td	83.6%	84.2%	80.5%	73.9%	84.0%	74.3%	75.4%	67.8%
Percent of Children with Well-Child Visits in the First 15 Months of Life (H) (fewer visits indicates better performance)								
0 visits	0.2%	1.0%	1.1%	2.2%	0.7%	2.2%	2.1%	2.2%
6 or more	82.6%	51.3%	61.4%	62.5%	62.7%	62.5%	62.5%	60.2%
Percent of Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (A)[3]	64.9%	68.6%	59.1%	60.5%	67.4%	60.5%	61.3%	71.9%
Percent of Adolescents Receiving a Well-Care Visit (H)	42.8%	51.1%	47.9%	38.9%	48.4%	39.3%	40.3%	48.1%
Percent of Children/Adolescents Receiving Weight Assessment and Counseling for Nutrition and Physical Activity (H)								
BMI Assessment - 3-11 Years	73.4%	84.6%	58.7%	44.6%	80.9%	45.0%	49.2%	37.5%
Nutrition Counseling - 3-11 Years	65.1%	80.3%	63.2%	52.7%	75.3%	53.1%	55.6%	47.4%
Physical Activity Counseling - 3-11 Yrs	55.6%	57.1%	55.8%	37.8%	56.6%	38.4%	40.5%	35.6%
BMI Assessment - 12-17 Years	65.6%	87.0%	49.3%	50.4%	79.5%	50.4%	53.6%	36.8%
Nutrition Counseling - 12-17 Years	57.8%	80.4%	40.1%	47.0%	72.6%	46.7%	49.5%	41.3%
Physical Activity Counseling - 12-17 Yr	59.4%	76.1%	42.3%	47.0%	70.3%	46.8%	49.4%	38.5%
BMI Assessment - Total	71.1%	85.2%	55.5%	46.2%	80.4%	46.6%	50.5%	37.3%
Nutrition Counseling - Total	63.0%	80.3%	55.2%	51.1%	74.5%	51.3%	53.9%	45.6%
Physical Activity Counseling - Total	56.7%	61.3%	51.1%	40.4%	59.8%	40.8%	43.0%	36.7%
Annual Dental Visit								
Total	NB	NB	70.7%	65.7%	NB	65.9%	65.9%	47.8%
Ages 2 to 3 Years	NB	NB	56.4%	55.9%	NB	55.9%	55.9%	30.8%
Ages 4 to 6 Years	NB	NB	72.5%	70.4%	NB	70.4%	70.4%	54.3%

HEDIS Measure	Rocky Mountain Health Plan	Denver Health	Primary Care Physician Program (PCPP)	Fee-for-Service (FFS)	HMO Weighted Average[1]	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average[2]	2011 HEDIS National Medicaid Average
Ages 7 to 10 Years	NB	NB	80.7%	73.5%	NB	73.8%	73.8%	58.5%
Ages 11 to 14 Years	NB	NB	73.5%	67.7%	NB	68.0%	68.0%	53.2%
Ages 15 to 18 Years	NB	NB	63.8%	59.0%	NB	59.3%	59.3%	44.9%
Ages 19 to 21 Years	NB	NB	39.9%	36.1%	NB	36.2%	36.2%	33.2%
Prenatal and Postpartum Care (H)								
Percent receiving timely prenatal care	97.0%	83.5%	80.3%	76.2%	90.1%	76.2%	77.5%	83.7%
Percent receiving timely postpartum care	77.4%	59.6%	69.6%	60.3%	68.4%	60.5%	61.3%	64.4%
Percent of Children and Adolescents' Accessing Primary Care Practitioner								
Ages 12 to 24 Months	98.5%	95.0%	97.0%	95.4%	96.1%	95.4%	95.5%	96.1%
Ages 25 Months to 6 Years	89.0%	81.2%	85.8%	84.4%	83.6%	84.5%	84.4%	88.3%
Ages 7 to 11 Years	92.1%	84.0%	90.2%	86.6%	86.2%	86.7%	86.6%	90.2%
Ages 12 to 19 Years	91.6%	85.2%	90.0%	86.3%	87.2%	86.5%	86.5%	88.1%
Percent of Adults Accessing Preventive Care								
Total	89.8%	73.5%	83.9%	78.1%	78.9%	78.4%	78.5%	83.0%
Ages 20 to 44 Years	86.9%	71.1%	81.7%	77.6%	76.9%	77.8%	77.7%	81.2%
Ages 45 to 64 Years	91.5%	78.0%	86.0%	81.3%	81.8%	81.6%	81.6%	86.0%
Ages 65 Years and Older	96.4%	72.6%	84.5%	75.8%	80.1%	76.5%	76.8%	83.7%
Use of Appropriate Medications for People With Asthma								
Total	86.6%	81.6%	90.6%	89.7%	83.3%	89.8%	89.2%	88.4%[4]
Ages 5-11 Years	96.4%	96.3%	90.2%	92.1%	96.4%	92.0%	92.3%	91.8%
Ages 12-18 Years	84.4%	89.4%	91.5%	89.3%	87.5%	89.5%	89.3%	—
Ages 19-50 Years	82.5%	67.2%	88.1%	84.9%	72.6%	85.1%	84.0%	—
Ages 51 to 64 Years	NA	50.8%	93.2%	92.3%	54.8%	92.4%	89.1%	—
Comprehensive Diabetes Care (H)								
HbA1c Testing	92.2%	84.9%	65.7%	66.4%	87.2%	66.4%	68.8%	82.0%
HbA1c Poor Control (>9.0%)*	19.2%	37.7%	63.7%	65.0%	32.0%	64.9%	61.0%	44.0%
HbA1c Control (<8.0%)	72.2%	46.7%	32.6%	30.9%	54.7%	31.0%	33.8%	46.9%
Eye Exam	60.8%	56.2%	45.7%	40.6%	57.6%	41.0%	43.0%	53.1%
LDL-C Screening	74.6%	75.4%	56.4%	57.2%	75.2%	57.1%	59.3%	74.7%
LDL-C Level <100 mg/dL	47.7%	54.0%	25.3%	19.5%	52.1%	19.9%	23.7%	34.6%
Medical Attention for Nephropathy	75.9%	79.3%	68.1%	73.0%	78.2%	72.6%	73.3%	77.7%
Blood Pressure Cont. <140/80 mm Hg	61.5%	55.5%	27.7%	30.9%	57.4%	30.6%	33.8%	38.7%
Blood Pressure Cont. <140/90 mm Hg	79.9%	71.0%	40.9%	46.5%	73.8%	46.0%	49.3%	60.4%

HEDIS Measure	Rocky Mountain Health Plan	Denver Health	Primary Care Physician Program (PCPP)	Fee-for-Service (FFS)	HMO Weighted Average[1]	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average[2]	2011 HEDIS National Medicaid Average
Percent of Clients With Low Back Pain Who Did Not Have an Imaging Study within 28 Days of Diagnosis	74.0%	80.0%	74.7%	73.4%	77.6%	73.5%	73.8%	75.5%
Percent of Clients on Persistent Medications Receiving Annual Monitoring								
Total	85.0%	86.0%	71.9%	83.5%	85.8%	82.4%	83.1%	83.9%
ACE inhibitors or ARBs	86.1%	90.1%	76.0%	86.7%	89.3%	85.9%	86.6%	86.0%
Anticonvulsants	74.9%	61.0%	62.2%	67.3%	65.6%	66.5%	66.4%	67.7%
Digoxin	NA	NA	NA	91.5%	91.9%	89.2%	89.7%	89.7%
Diuretics	89.9%	88.8%	76.6%	86.8%	89.0%	85.9%	86.6%	85.5%
Percent of Clients with COPD Exacerbations Receiving Appropriate Pharmacotherapy Management								
Bronchodilator	43.4%	65.9%	72.2%	64.7%	55.1%	65.3%	62.7%	82.1%
Systemic Corticosteroid	28.9%	56.1%	61.1%	47.4%	43.0%	48.5%	47.1%	65.3%
Percent of Women Receiving Chlamydia Screening								
Total	45.4%	67.8%	26.1%	55.9%	58.5%	55.1%	55.4%	57.5%
Ages 16 to 20 Years	42.3%	67.8%	29.9%	52.9%	58.1%	52.1%	52.7%	54.6%
Ages 21 to 24 Years	48.2%	67.8%	21.1%	58.6%	59.0%	57.7%	57.8%	62.3%
Percent of Adults Receiving BMI Assessment (H)	69.9%	84.9%	50.9%	52.1%	79.8%	52.0%	55.2%	42.2%
Inpatient Utilization								
Discharges/1,000 Member Months (Total Inpatient)	10.6	10.9	10.2	10.8	10.8	10.8	10.8	8.1
Days/1,000 Member Months (Total Inpatient)	31.1	36.4	51.5	48.8	34.8	48.9	47.3	29.8
Average Length of Stay (Total Inpatient)	2.9	3.4	5.0	4.5	3.2	4.5	4.4	3.6
Number of Ambulatory Care Visits/1,000 Member Months								
Outpatient Visits	436.6	289.6	379.5	346.6	334.3	348.0	346.5	357.2
ED Visits	62.9	40.5	55.5	60.4	47.3	60.2	58.7	62.0

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 2006-2010 American Community Survey conducted by the United States Census Bureau as well as 2012 demographic forecasts from the Colorado Department of Local Affairs (DOLA).

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 2011-12 Medicaid data was collected for the following statistics and reported in the following table for the State by county:

- Medicaid Clients;
- Medicaid Expenditures; and
- Percentage Share of Medicaid Expenditures.

Please note monthly expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System (COFRS). The decision support system extracts data on a different time span and from a different source (i.e., Medicaid Management Information System – MMIS) than COFRS. In addition, Medicaid expenditures reported include those for Medical Services Premiums, Medicaid Mental Health, and certain claims-based costs for Medicaid-funded programs administered by the Department of Human Services. Therefore, total expenditures presented in this document will not reconcile with the actual medical services expenditures reported in Exhibit M in the November 1, 2012 FY 2013-14 Budget Request.

Children's Basic Health Plan

Using FY 2011-12 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:

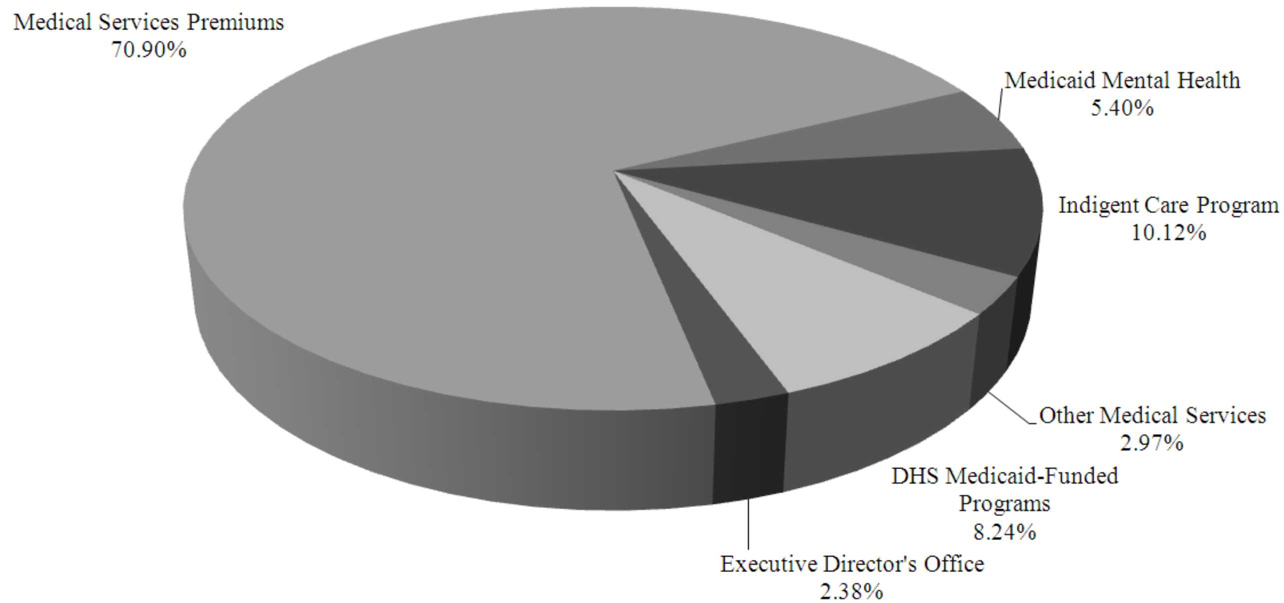
- Average Number of Children per Month;
- Percent of Population Enrolled in CHP+; and
- Children's Basic Health Plan Expenditures.

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 all data included in prior Budget Submissions were aggregated at the Health Insurance Portability and Accountability Act (HIPAA) region level. HIPAA requires the Department release client information in a larger aggregation in order to maintain client confidentiality and anonymity in smaller counties. To do this, 20 "HIPAA Regions" were developed for the provision of Department information. However, beginning with the FY 2011-12 Budget Submission, the Department began reporting data at the county level and suppressed data for small counties. For data at the HIPAA-region level, please contact the Department's Budget Division at 303-866-6077.

Colorado's Demographics, Medicaid, CHP+, and CICP – A Statewide View	
Characteristics	**Colorado**
Demographic Characteristics	
Population (2012) [1]	5,196,177
Population (2006-10) [2]	4,887,061
Percent of Population 16+ in Labor Force (2006-10) [2]	69.81%
Percent of Population 5+ Where Non-English is Spoken at Home (2006-10) [2]	16.79%
Percent of Households with Income Below the Poverty Level in Past 12 Months (2006-10) [2]	8.60%
Percent of Female-Headed Households (2006-10) [2]	9.88%
Medicaid Characteristics (FY 2011-12)	
Average Number of Medicaid Clients per Month	619,963
Percent of Population Who are Medicaid Clients	11.93%
Medicaid Expenditures	$3,478,430,739
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)	
Average Number of CHP+ Clients per Month [3]	76,190
Percent of Population Who are CHP+ Clients	1.47%
CHP+ Expenditures	$181,892,331
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)	
Unduplicated Client Count	225,906
Number of CICP Providers [4]	197
CICP Expenditures	$325,584,046

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics



Source: November 1, 2012 FY 2013-14 Budget Request, Schedule 2.

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 Colorado 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 2011-12 appropriated or actual amounts. This is due to several factors:

1. The Medicaid expenditure data were pulled from a different source than the rest of the Budget's exhibits to obtain county numbers. However, Medicaid caseload will match the official caseload count as reported in "Exhibit B – Medicaid Caseload Forecast." CHP+ caseload will not match the official caseload count as reported in "Exhibit C.8 – CHIP Federal Allotment

Forecast," as data reported here exclude enrollees in the CHP+ at Work program. Expenditures for the CHP+ at Work Program have been excluded from the data reported here.

2. County Medicaid expenditures represent actual fiscal year totals for Medical Services Premiums, Medicaid Mental Health, and certain claims-based costs for Medicaid-funded programs administered by the Department of Human Services.

3. Expenditures reported to the Joint Budget Committee are derived from the Colorado Financial Reporting System (COFRS), 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 reconcile with the numbers for actual medical services reported in the June 2012 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, and service organizations, such as cost settlements or lump sum payments; and

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

4. 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.

5. Data has 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 Characteristics				
Population (2012) [1]	460,846	15,899	590,675	12,908
Percent of Colorado Population (2012) [2]	8.87%	0.31%	11.37%	0.25%
Population (2006-10) [2]	425,330	15,293	552,860	12,136
Percent of Colorado Population (2006-10) [2]	8.70%	0.31%	11.31%	0.25%
Percent of Population 16+ in Labor Force (2006-10) [2]	71.90%	62.19%	72.15%	60.02%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	27.24%	25.76%	21.71%	7.55%
Percent of Population Living Below the Poverty Level (2006-10) [2]	11.20%	16.20%	9.00%	4.70%
Percent of Female-Headed Households (2006-10) [2]	12.22%	21.63%	19.87%	10.33%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	72,070	4,081	67,251	1,441
Percent of Population Who are Medicaid Clients	15.64%	25.67%	11.39%	11.16%
Medicaid Expenditures	$355,628,840	$22,092,081	$380,669,078	$6,533,463
Percent of Total Medicaid Expenditures	10.22%	0.64%	10.94%	0.19%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	10,016	432	8,926	286
Percent of Population Who are CHP+ Clients	2.17%	2.72%	1.51%	2.21%
CHP+ Expenditures	$23,457,170	$1,001,782	$21,625,830	$709,705
Percent of Total CHP+ Expenditures	12.90%	0.55%	11.89%	0.39%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	19,038	8,666	14,379	0
Number of CICP Providers [4]	9	6	10	0
CICP Expenditures	$43,503,362	$3,702,953	$7,799,726	$0
Percent of Total CICP Expenditures	13.36%	1.14%	2.40%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Baca**	**Bent**	**Boulder**	**Broomfield**
Demographic Characteristics				
Population (2012) [1]	3,786	6,563	300,823	58,999
Percent of Colorado Population (2012) [2]	0.07%	0.13%	5.79%	1.14%
Population (2006-10) [2]	3,833	6,125	290,177	52,872
Percent of Colorado Population (2006-10) [2]	0.08%	0.13%	5.94%	1.08%
Percent of Population 16+ in Labor Force (2006-10) [2]	59.71%	41.49%	69.56%	74.50%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	4.65%	18.80%	16.18%	12.44%
Percent of Population Living Below the Poverty Level (2006-10) [2]	11.10%	13.40%	6.50%	3.90%
Percent of Female-Headed Households (2006-10) [2]	7.91%	28.42%	12.50%	14.82%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	632	1,095	23,490	3,045
Percent of Population Who are Medicaid Clients	16.69%	16.69%	7.81%	5.16%
Medicaid Expenditures	$5,483,404	$7,207,020	$138,568,322	$22,372,632
Percent of Total Medicaid Expenditures	0.16%	0.21%	3.98%	0.64%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	104	104	3,124	618
Percent of Population Who are CHP+ Clients	2.76%	1.58%	1.04%	1.05%
CHP+ Expenditures	$249,829	$238,835	$7,458,691	$1,408,281
Percent of Total CHP+ Expenditures	0.14%	0.13%	4.10%	0.77%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	225	0	11,660	0
Number of CICP Providers [4]	1	0	6	0
CICP Expenditures	$217,120	$0	$14,700,968	$0
Percent of Total CICP Expenditures	0.07%	0.00%	4.52%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Chaffee**	**Cheyenne**	**Clear Creek**	**Conejos**
Demographic Characteristics				
Population (2012) [1]	18,426	1,861	9,294	8,476
Percent of Colorado Population (2012) [2]	0.35%	0.04%	0.18%	0.16%
Population (2006-10) [2]	17,540	2,194	9,088	8,220
Percent of Colorado Population (2006-10) [2]	0.36%	0.04%	0.19%	0.17%
Percent of Population 16+ in Labor Force (2006-10) [2]	56.39%	65.46%	75.17%	59.20%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	6.30%	7.41%	3.95%	39.57%
Percent of Population Living Below the Poverty Level (2006-10) [2]	8.80%	6.50%	4.20%	16.00%
Percent of Female-Headed Households (2006-10) [2]	11.83%	4.83%	11.17%	19.10%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	1,749	240	676	2,165
Percent of Population Who are Medicaid Clients	9.49%	12.90%	7.27%	25.54%
Medicaid Expenditures	$10,398,652	$1,328,203	$3,263,453	$11,187,291
Percent of Total Medicaid Expenditures	0.30%	0.04%	0.09%	0.32%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	417	51	91	376
Percent of Population Who are CHP+ Clients	2.26%	2.72%	0.98%	4.44%
CHP+ Expenditures	$981,671	$124,251	$219,964	$875,498
Percent of Total CHP+ Expenditures	0.54%	0.07%	0.12%	0.48%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	607	0	0	324
Number of CICP Providers [4]	3	0	0	4
CICP Expenditures	$869,921	$0	$0	$393,282
Percent of Total CICP Expenditures	0.27%	0.00%	0.00%	0.12%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Costilla**	**Crowley**	**Custer**	**Delta**
Demographic Characteristics				
Population (2012) [1]	3,604	6,026	4,470	32,739
Percent of Colorado Population (2012) [2]	0.07%	0.12%	0.09%	0.63%
Population (2006-10) [2]	3,536	5,897	3,899	30,533
Percent of Colorado Population (2006-10) [2]	0.07%	0.12%	0.08%	0.62%
Percent of Population 16+ in Labor Force (2006-10) [2]	49.00%	30.92%	54.88%	57.35%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	52.75%	13.69%	1.27%	11.11%
Percent of Population Living Below the Poverty Level (2006-10) [2]	20.40%	17.00%	11.70%	9.80%
Percent of Female-Headed Households (2006-10) [2]	11.83%	14.19%	11.14%	12.51%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	1,084	928	425	4,445
Percent of Population Who are Medicaid Clients	30.07%	15.40%	9.51%	13.58%
Medicaid Expenditures	$4,796,673	$5,173,435	$1,218,198	$20,345,163
Percent of Total Medicaid Expenditures	0.14%	0.15%	0.04%	0.58%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	85	61	61	635
Percent of Population Who are CHP+ Clients	2.36%	1.01%	1.36%	1.94%
CHP+ Expenditures	$197,485	$138,427	$153,144	$1,507,740
Percent of Total CHP+ Expenditures	0.11%	0.08%	0.08%	0.83%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	0	0	119	369
Number of CICP Providers [4]	1	0	1	1
CICP Expenditures	$0	$0	$18,932	$2,275,526
Percent of Total CICP Expenditures	0.00%	0.00%	0.01%	0.70%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Denver**	**Dolores**	**Douglas**	**Eagle**
Demographic Characteristics				
Population (2012) [1]	622,148	2,140	297,485	56,145
Percent of Colorado Population (2012) [2]	11.97%	0.04%	5.73%	1.08%
Population (2006-10) [2]	578,087	2,027	273,440	50,793
Percent of Colorado Population (2006-10) [2]	11.83%	0.04%	5.60%	1.04%
Percent of Population 16+ in Labor Force (2006-10) [2]	70.48%	61.50%	76.46%	82.09%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	27.72%	3.48%	9.09%	30.70%
Percent of Population Living Below the Poverty Level (2006-10) [2]	14.80%	10.70%	1.90%	5.80%
Percent of Female-Headed Households (2006-10) [2]	16.02%	8.89%	10.58%	13.66%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	107,003	236	9,777	3,106
Percent of Population Who are Medicaid Clients	17.20%	11.03%	3.29%	5.53%
Medicaid Expenditures	$575,631,372	$851,005	$60,456,276	$9,936,129
Percent of Total Medicaid Expenditures	16.55%	0.02%	1.74%	0.29%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	9,404	63	1,850	598
Percent of Population Who are CHP+ Clients	1.51%	2.94%	0.62%	1.07%
CHP+ Expenditures	$22,248,989	$150,801	$4,394,185	$1,376,383
Percent of Total CHP+ Expenditures	12.23%	0.08%	2.42%	0.76%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	46,334	1,029	0	0
Number of CICP Providers [4]	15	1	0	0
CICP Expenditures	$98,598,071	$86,962	$0	$0
Percent of Total CICP Expenditures	30.28%	0.03%	0.00%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Elbert**	**El Paso**	**Fremont**	**Garfield**
Demographic Characteristics				
Population (2012) [1]	24,124	642,538	48,266	59,192
Percent of Colorado Population (2012) [2]	0.46%	12.37%	0.93%	1.14%
Population (2006-10) [2]	22,712	599,988	46,941	54,761
Percent of Colorado Population (2006-10) [2]	0.46%	12.28%	0.96%	1.12%
Percent of Population 16+ in Labor Force (2006-10) [2]	73.02%	70.23%	37.62%	76.06%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	4.66%	11.55%	14.34%	24.73%
Percent of Population Living Below the Poverty Level (2006-10) [2]	2.30%	8.10%	9.80%	6.60%
Percent of Female-Headed Households (2006-10) [2]	9.44%	18.21%	11.52%	13.83%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	1,379	74,490	7,018	6,702
Percent of Population Who are Medicaid Clients	5.72%	11.59%	14.54%	11.32%
Medicaid Expenditures	$7,396,176	$412,005,388	$48,047,524	$35,106,353
Percent of Total Medicaid Expenditures	0.21%	11.84%	1.38%	1.01%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	207	7,437	632	1,177
Percent of Population Who are CHP+ Clients	0.86%	1.16%	1.31%	1.99%
CHP+ Expenditures	$471,111	$18,205,659	$1,470,328	$2,830,717
Percent of Total CHP+ Expenditures	0.26%	10.01%	0.81%	1.56%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	0	34,689	2,399	3,083
Number of CICP Providers [4]	0	22	2	6
CICP Expenditures	$0	$41,219,396	$2,963,981	$3,997,402
Percent of Total CICP Expenditures	0.00%	12.66%	0.91%	1.23%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Gilpin**	**Grand**	**Gunnison**	**Hinsdale**
Demographic Characteristics				
Population (2012) [1]	5,654	15,576	15,596	866
Percent of Colorado Population (2012) [2]	0.11%	0.30%	0.30%	0.02%
Population (2006-10) [2]	5,126	14,526	15,136	489
Percent of Colorado Population (2006-10) [2]	0.10%	0.30%	0.31%	0.01%
Percent of Population 16+ in Labor Force (2006-10) [2]	76.15%	75.52%	74.91%	57.34%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	6.76%	9.45%	10.02%	13.22%
Percent of Population Living Below the Poverty Level (2006-10) [2]	7.10%	5.10%	1.60%	6.50%
Percent of Female-Headed Households (2006-10) [2]	11.15%	10.51%	5.52%	3.53%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	404	853	1,110	62
Percent of Population Who are Medicaid Clients	7.15%	5.48%	7.12%	7.16%
Medicaid Expenditures	$2,058,114	$3,825,133	$5,512,607	$138,792
Percent of Total Medicaid Expenditures	0.06%	0.11%	0.16%	0.00%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	58	252	261	N/A
Percent of Population Who are CHP+ Clients	1.03%	1.61%	1.67%	2.14%
CHP+ Expenditures	$149,625	$647,411	$617,700	$55,305
Percent of Total CHP+ Expenditures	0.08%	0.36%	0.34%	0.03%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	0	94	206	0
Number of CICP Providers [4]	1	4	1	0
CICP Expenditures	$0	$89,042	$98,559	$0
Percent of Total CICP Expenditures	0.00%	0.03%	0.03%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Huerfano**	**Jackson**	**Jefferson**	**Kiowa**
Demographic Characteristics				
Population (2012) [1]	6,800	1,455	539,973	1,416
Percent of Colorado Population (2012) [2]	0.13%	0.03%	10.39%	0.03%
Population (2006-10) [2]	6,948	1,464	528,614	1,643
Percent of Colorado Population (2006-10) [2]	0.14%	0.03%	10.82%	0.03%
Percent of Population 16+ in Labor Force (2006-10) [2]	49.13%	68.90%	70.97%	64.84%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	18.39%	4.21%	10.77%	2.69%
Percent of Population Living Below the Poverty Level (2006-10) [2]	20.20%	13.50%	5.60%	10.20%
Percent of Female-Headed Households (2006-10) [2]	13.79%	13.04%	16.02%	18.98%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	1,602	150	44,343	196
Percent of Population Who are Medicaid Clients	23.56%	10.31%	8.21%	13.84%
Medicaid Expenditures	$10,714,083	$552,206	$341,906,619	$1,401,074
Percent of Total Medicaid Expenditures	0.31%	0.02%	9.83%	0.04%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	101	40	5,920	43
Percent of Population Who are CHP+ Clients	1.48%	2.76%	1.10%	3.04%
CHP+ Expenditures	$231,480	$95,003	$14,434,776	$101,030
Percent of Total CHP+ Expenditures	0.13%	0.05%	7.94%	0.06%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	87	0	0	0
Number of CICP Providers [4]	2	1	9	0
CICP Expenditures	$543,980	$0	$0	$0
Percent of Total CICP Expenditures	0.17%	0.00%	0.00%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Kit Carson**	**Lake**	**La Plata**	**Larimer**
Demographic Characteristics				
Population (2012) [1]	8,480	7,733	53,474	308,439
Percent of Colorado Population (2012) [2]	0.16%	0.15%	1.03%	5.94%
Population (2006-10) [2]	8,156	7,039	50,149	291,162
Percent of Colorado Population (2006-10) [2]	0.17%	0.14%	1.03%	5.96%
Percent of Population 16+ in Labor Force (2006-10) [2]	64.36%	74.34%	70.71%	69.76%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	14.87%	29.90%	9.85%	8.66%
Percent of Population Living Below the Poverty Level (2006-10) [2]	6.20%	18.60%	5.70%	6.90%
Percent of Female-Headed Households (2006-10) [2]	15.28%	18.09%	14.16%	12.86%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	1,041	1,016	4,833	28,842
Percent of Population Who are Medicaid Clients	12.28%	13.14%	9.04%	9.35%
Medicaid Expenditures	$5,606,319	$4,093,480	$23,504,618	$163,180,057
Percent of Total Medicaid Expenditures	0.16%	0.12%	0.68%	4.69%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	281	165	938	3,985
Percent of Population Who are CHP+ Clients	3.31%	2.14%	1.75%	1.29%
CHP+ Expenditures	$651,105	$380,187	$2,334,636	$9,681,513
Percent of Total CHP+ Expenditures	0.36%	0.21%	1.28%	5.32%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	0	N/A	396	15,352
Number of CICP Providers [4]	1	1	1	9
CICP Expenditures	$0	$134,561	$2,685,569	$27,673,827
Percent of Total CICP Expenditures	0.00%	0.04%	0.82%	8.50%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Las Animas**	**Lincoln**	**Logan**	**Mesa**
Demographic Characteristics				
Population (2012) [1]	16,095	5,590	23,050	151,539
Percent of Colorado Population (2012) [2]	0.31%	0.11%	0.44%	2.92%
Population (2006-10) [2]	15,675	5,476	22,278	142,284
Percent of Colorado Population (2006-10) [2]	0.32%	0.11%	0.46%	2.91%
Percent of Population 16+ in Labor Force (2006-10) [2]	56.92%	53.68%	63.38%	65.05%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	14.90%	8.23%	9.11%	9.07%
Percent of Population Living Below the Poverty Level (2006-10) [2]	13.00%	8.30%	10.40%	7.90%
Percent of Female-Headed Households (2006-10) [2]	13.35%	10.73%	23.80%	14.42%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	3,058	669	2,823	21,300
Percent of Population Who are Medicaid Clients	19.00%	11.97%	12.25%	14.06%
Medicaid Expenditures	$25,383,229	$3,789,223	$18,624,123	$111,079,805
Percent of Total Medicaid Expenditures	0.73%	0.11%	0.54%	3.19%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	268	75	372	2,789
Percent of Population Who are CHP+ Clients	1.67%	1.34%	1.61%	1.84%
CHP+ Expenditures	$635,602	$200,297	$850,322	$6,875,198
Percent of Total CHP+ Expenditures	0.35%	0.11%	0.47%	3.78%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	1,393	1,317	955	6,419
Number of CICP Providers [4]	3	1	2	6
CICP Expenditures	$951,685	$184,743	$2,465,130	$8,065,976
Percent of Total CICP Expenditures	0.29%	0.06%	0.76%	2.48%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.

2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) CHP+ caseload does not include "CHP+ at Work" clients

4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Mineral**	**Moffat**	**Montezuma**	**Montrose**
Demographic Characteristics				
Population (2012) [1]	748	14,329	26,439	43,546
Percent of Colorado Population (2012) [2]	0.01%	0.28%	0.51%	0.84%
Population (2006-10) [2]	1,020	13,519	25,279	40,266
Percent of Colorado Population (2006-10) [2]	0.02%	0.28%	0.52%	0.82%
Percent of Population 16+ in Labor Force (2006-10) [2]	55.70%	71.97%	64.74%	63.62%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	3.43%	11.01%	13.43%	13.64%
Percent of Population Living Below the Poverty Level (2006-10) [2]	2.60%	10.80%	14.20%	8.10%
Percent of Female-Headed Households (2006-10) [2]	0.45%	17.01%	20.11%	15.26%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	53	1,915	4,524	7,052
Percent of Population Who are Medicaid Clients	7.09%	13.36%	17.11%	16.19%
Medicaid Expenditures	$233,554	$9,747,204	$25,319,497	$30,249,965
Percent of Total Medicaid Expenditures	0.01%	0.28%	0.73%	0.87%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	N/A	292	674	1,267
Percent of Population Who are CHP+ Clients	0.95%	2.04%	2.55%	2.91%
CHP+ Expenditures	$24,640	$717,323	$1,585,189	$2,958,564
Percent of Total CHP+ Expenditures	0.01%	0.39%	0.87%	1.63%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	0	634	284	1,790
Number of CICP Providers [4]	0	3	7	3
CICP Expenditures	$0	$919,094	$778,018	$3,237,425
Percent of Total CICP Expenditures	0.00%	0.28%	0.24%	0.99%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Morgan**	**Otero**	**Ouray**	**Park**
Demographic Characteristics				
Population (2012) [1]	28,625	19,123	4,748	17,185
Percent of Colorado Population (2012) [2]	0.55%	0.37%	0.09%	0.33%
Population (2006-10) [2]	27,911	18,830	4,319	16,286
Percent of Colorado Population (2006-10) [2]	0.57%	0.39%	0.09%	0.33%
Percent of Population 16+ in Labor Force (2006-10) [2]	66.66%	55.98%	65.56%	68.69%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	25.87%	19.26%	6.60%	4.44%
Percent of Population Living Below the Poverty Level (2006-10) [2]	12.80%	16.00%	5.00%	4.20%
Percent of Female-Headed Households (2006-10) [2]	19.97%	21.68%	5.52%	9.56%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	4,729	4,790	353	1,162
Percent of Population Who are Medicaid Clients	16.52%	25.05%	7.44%	6.76%
Medicaid Expenditures	$26,101,186	$29,241,205	$1,085,293	$5,015,301
Percent of Total Medicaid Expenditures	0.75%	0.84%	0.03%	0.14%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	607	393	98	217
Percent of Population Who are CHP+ Clients	2.12%	2.05%	2.07%	1.26%
CHP+ Expenditures	$1,427,619	$909,083	$224,079	$497,432
Percent of Total CHP+ Expenditures	0.78%	0.50%	0.12%	0.27%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	2,143	1,195	0	0
Number of CICP Providers [4]	3	3	0	0
CICP Expenditures	$1,812,461	$1,741,291	$0	$0
Percent of Total CICP Expenditures	0.56%	0.53%	0.00%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	Phillips	Pitkin	Prowers	Pueblo
Demographic Characteristics				
Population (2012) [1]	4,473	17,932	12,707	163,590
Percent of Colorado Population (2012) [2]	0.09%	0.35%	0.24%	3.15%
Population (2006-10) [2]	4,394	16,389	12,734	156,244
Percent of Colorado Population (2006-10) [2]	0.09%	0.34%	0.26%	3.20%
Percent of Population 16+ in Labor Force (2006-10) [2]	64.84%	77.25%	66.62%	59.60%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	16.08%	16.23%	24.64%	14.09%
Percent of Population Living Below the Poverty Level (2006-10) [2]	3.70%	4.80%	18.70%	13.60%
Percent of Female-Headed Households (2006-10) [2]	10.55%	5.96%	21.12%	22.03%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	567	346	3,057	35,509
Percent of Population Who are Medicaid Clients	12.68%	1.93%	24.06%	21.71%
Medicaid Expenditures	$3,069,606	$1,487,436	$16,593,361	$224,960,476
Percent of Total Medicaid Expenditures	0.09%	0.04%	0.48%	6.47%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	104	77	397	2,530
Percent of Population Who are CHP+ Clients	2.32%	0.43%	3.12%	1.55%
CHP+ Expenditures	$236,264	$174,761	$883,279	$5,948,516
Percent of Total CHP+ Expenditures	0.13%	0.10%	0.49%	3.27%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	131	222	2,087	14,766
Number of CICP Providers [4]	2	2	6	12
CICP Expenditures	$124,230	$1,057,289	$2,075,841	$26,318,891
Percent of Total CICP Expenditures	0.04%	0.32%	0.64%	8.08%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Rio Blanco**	**Rio Grande**	**Routt**	**Saguache**
Demographic Characteristics				
Population (2012) [1]	7,206	12,216	24,030	6,132
Percent of Colorado Population (2012) [2]	0.14%	0.24%	0.46%	0.12%
Population (2006-10) [2]	6,494	11,926	22,924	6,161
Percent of Colorado Population (2006-10) [2]	0.13%	0.24%	0.47%	0.13%
Percent of Population 16+ in Labor Force (2006-10) [2]	66.90%	54.02%	78.63%	64.03%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	8.22%	26.92%	6.05%	35.78%
Percent of Population Living Below the Poverty Level (2006-10) [2]	1.60%	10.30%	4.70%	20.20%
Percent of Female-Headed Households (2006-10) [2]	11.14%	14.90%	9.56%	15.61%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	744	2,944	1,430	1,432
Percent of Population Who are Medicaid Clients	10.33%	24.10%	5.95%	23.35%
Medicaid Expenditures	$3,331,965	$15,259,822	$8,435,120	$5,460,516
Percent of Total Medicaid Expenditures	0.10%	0.44%	0.24%	0.16%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	103	420	460	171
Percent of Population Who are CHP+ Clients	1.43%	3.43%	1.91%	2.79%
CHP+ Expenditures	$234,137	$989,560	$1,069,048	$396,406
Percent of Total CHP+ Expenditures	0.13%	0.54%	0.59%	0.22%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	0	448	554	0
Number of CICP Providers [4]	0	5	1	0
CICP Expenditures	$0	$220,292	$1,490,453	$0
Percent of Total CICP Expenditures	0.00%	0.07%	0.46%	0.00%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**San Juan**	**San Miguel**	**Sedgwick**	**Summit**
Demographic Characteristics				
Population (2012) [1]	735	7,899	2,448	29,387
Percent of Colorado Population (2012) [2]	0.01%	0.15%	0.05%	0.57%
Population (2006-10) [2]	752	7,299	2,412	27,105
Percent of Colorado Population (2006-10) [2]	0.02%	0.15%	0.05%	0.55%
Percent of Population 16+ in Labor Force (2006-10) [2]	82.10%	85.47%	56.03%	83.44%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	4.58%	10.62%	7.33%	15.28%
Percent of Population Living Below the Poverty Level (2006-10) [2]	0.00%	7.00%	8.80%	3.10%
Percent of Female-Headed Households (2006-10) [2]	10.46%	11.86%	9.24%	7.57%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	86	548	370	1,517
Percent of Population Who are Medicaid Clients	11.70%	6.94%	15.11%	5.16%
Medicaid Expenditures	$218,101	$1,104,681	$2,982,619	$5,454,617
Percent of Total Medicaid Expenditures	0.01%	0.03%	0.09%	0.16%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	N/A	111	56	394
Percent of Population Who are CHP+ Clients	2.87%	1.41%	2.28%	1.34%
CHP+ Expenditures	$44,841	$268,529	$118,926	$940,733
Percent of Total CHP+ Expenditures	0.02%	0.15%	0.07%	0.52%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	0	287	209	0
Number of CICP Providers [4]	0	1	2	1
CICP Expenditures	$0	$134,407	$83,963	$0
Percent of Total CICP Expenditures	0.00%	0.04%	0.03%	0.00%

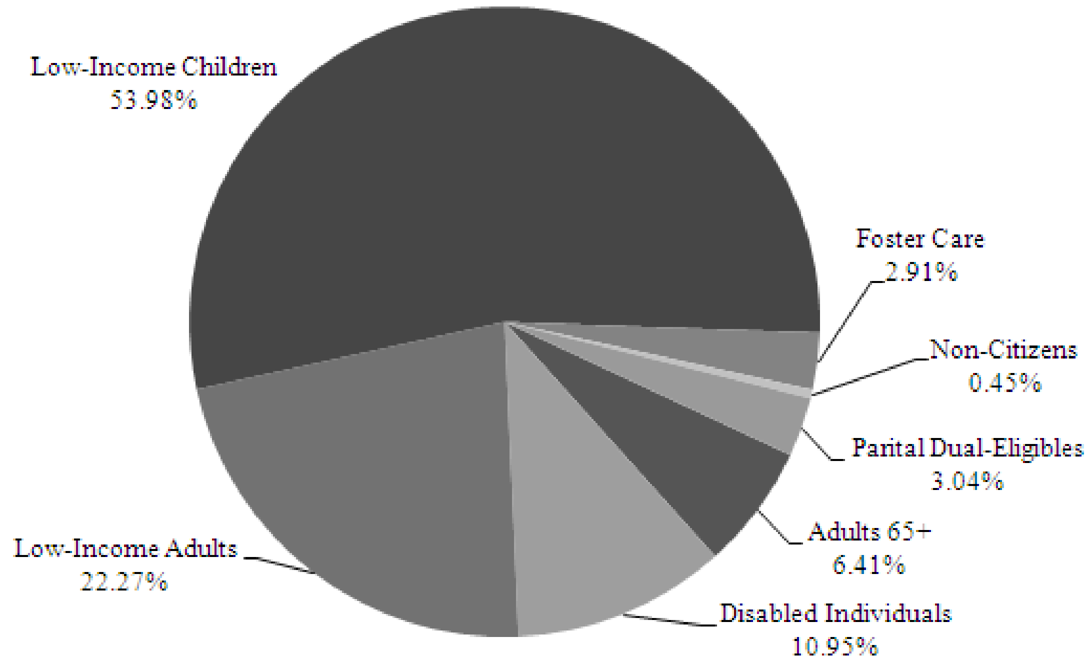
1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Teller**	**Washington**	**Weld**	**Yuma**
Demographic Characteristics				
Population (2012) [1]	23,934	4,885	264,528	10,164
Percent of Colorado Population (2012) [2]	0.46%	0.09%	5.09%	0.20%
Population (2006-10) [2]	22,821	4,773	242,860	9,896
Percent of Colorado Population (2006-10) [2]	0.47%	0.10%	4.97%	0.20%
Percent of Population 16+ in Labor Force (2006-10) [2]	66.83%	66.48%	69.65%	65.44%
Percent of Homes Where Non-English is Spoken (2006-10) [2]	5.32%	6.21%	18.88%	15.50%
Percent of Population Living Below the Poverty Level (2006-10) [2]	5.40%	12.20%	9.80%	6.00%
Percent of Female-Headed Households (2006-10) [2]	13.27%	9.56%	15.81%	9.79%
Medicaid Characteristics (FY 2011-12)				
Average Number of Medicaid Clients per Month	2,230	539	35,737	1,499
Percent of Population Who are Medicaid Clients	9.32%	11.03%	13.51%	14.75%
Medicaid Expenditures	$11,077,550	$3,376,230	$172,679,426	$8,880,394
Percent of Total Medicaid Expenditures	0.32%	0.10%	4.96%	0.26%
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12)				
Average Number of CHP+ Clients per Month [3]	327	119	4,797	233
Percent of Population Who are CHP+ Clients	1.37%	2.43%	1.81%	2.29%
CHP+ Expenditures	$742,823	$278,097	$11,265,236	$519,582
Percent of Total CHP+ Expenditures	0.41%	0.15%	6.19%	0.29%
Colorado Indigent Care Program (CICP) Characteristics (FY 2010-11)				
Unduplicated Client Count	435	0	30,900	652
Number of CICP Providers [4]	2	1	9	4
CICP Expenditures	$376,585	$0	$21,326,707	$646,425
Percent of Total CICP Expenditures	0.12%	0.00%	6.55%	0.20%

1) Source: Department of Local Affairs, Population Forecasts - years (2000 to 2040), 1-year Increments, TABLE III - C-1, PRELIMINARY POPULATION FORECASTS FOR COLORADO COUNTIES, 2000-2040.
2) Source: 2006-2010 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) CHP+ caseload does not include "CHP+ at Work" clients
4) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics

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 2011-12.[7]



[7] Source: November 1, 2012 FY 2013-14 Budget Request, Exhibit B, "Medicaid Caseload Forecast"

A. Clients

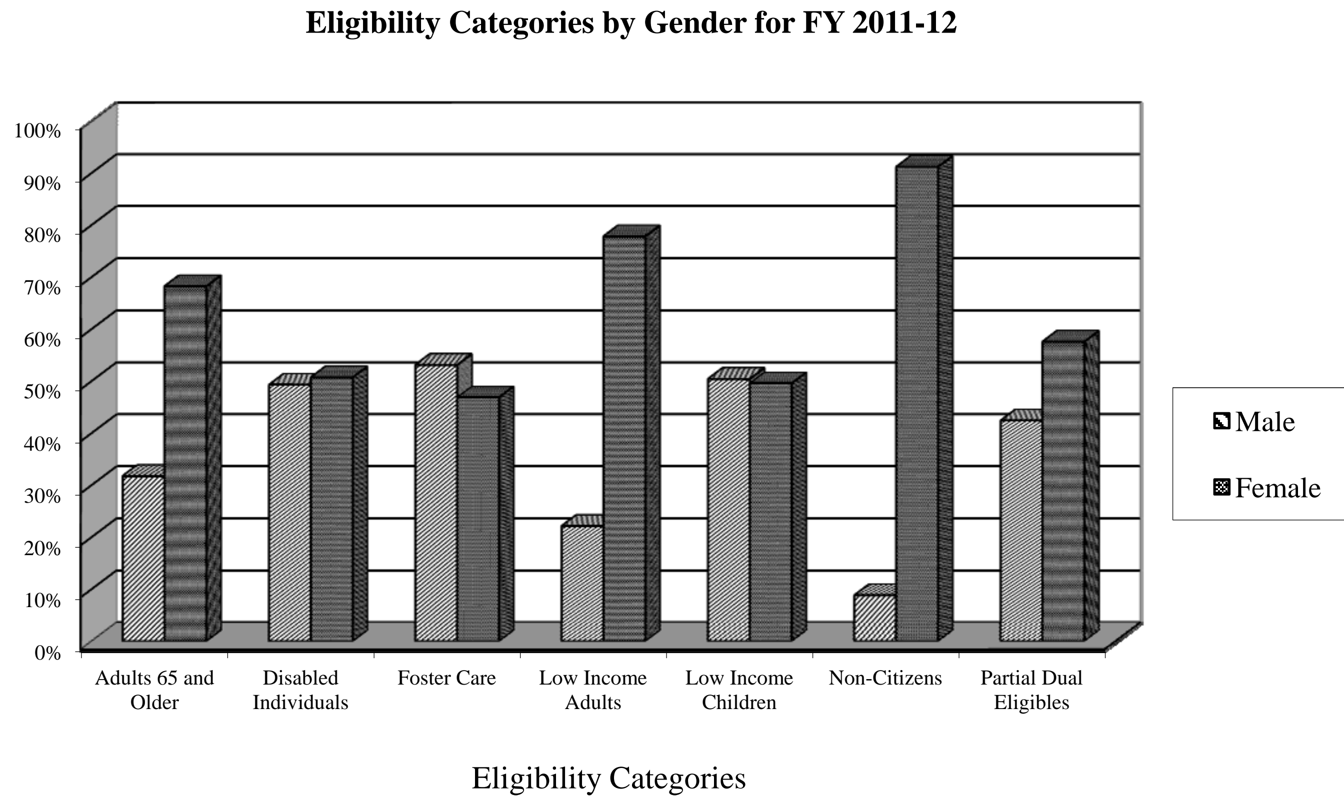
A1. 2012 Federal Poverty Levels

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 $3,960 for each additional family member.

Federal Poverty Guidelines for Annual Income									
Family Size	**100%**	**120%**	**133%**	**150%**	**175%**	**185%**	**190%**	**200%**	**250%**
1	$11,170	$13,404	$14,893	$16,755	$19,548	$20,665	$21,223	$22,340	$27,925
2	$15,130	$18,156	$20,173	$22,695	$26,478	$27,991	$28,747	$30,260	$37,825
3	$19,090	$22,908	$25,453	$28,635	$33,408	$35,317	$36,271	$38,180	$47,725
4	$23,050	$27,660	$30,733	$34,575	$40,338	$42,643	$43,795	$46,100	$57,625
5	$27,010	$32,412	$36,013	$40,515	$47,268	$49,969	$51,319	$54,020	$67,525
6	$30,970	$37,164	$41,293	$46,455	$54,198	$57,295	$58,843	$61,940	$77,425
7	$34,930	$41,916	$46,573	$52,395	$61,128	$64,621	$66,367	$69,860	$87,325
8	$38,890	$46,668	$51,853	$58,335	$68,058	$71,947	$73,891	$77,780	$97,225

Source: Federal Register, Vol. 77, No. 17, Thursday, January 26, 2012, Notices, page 4035

A2. Eligibility Categories by Gender for FY 2011-12[8]



[8] Source: The Department's decision support system (MMIS-DSS)
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

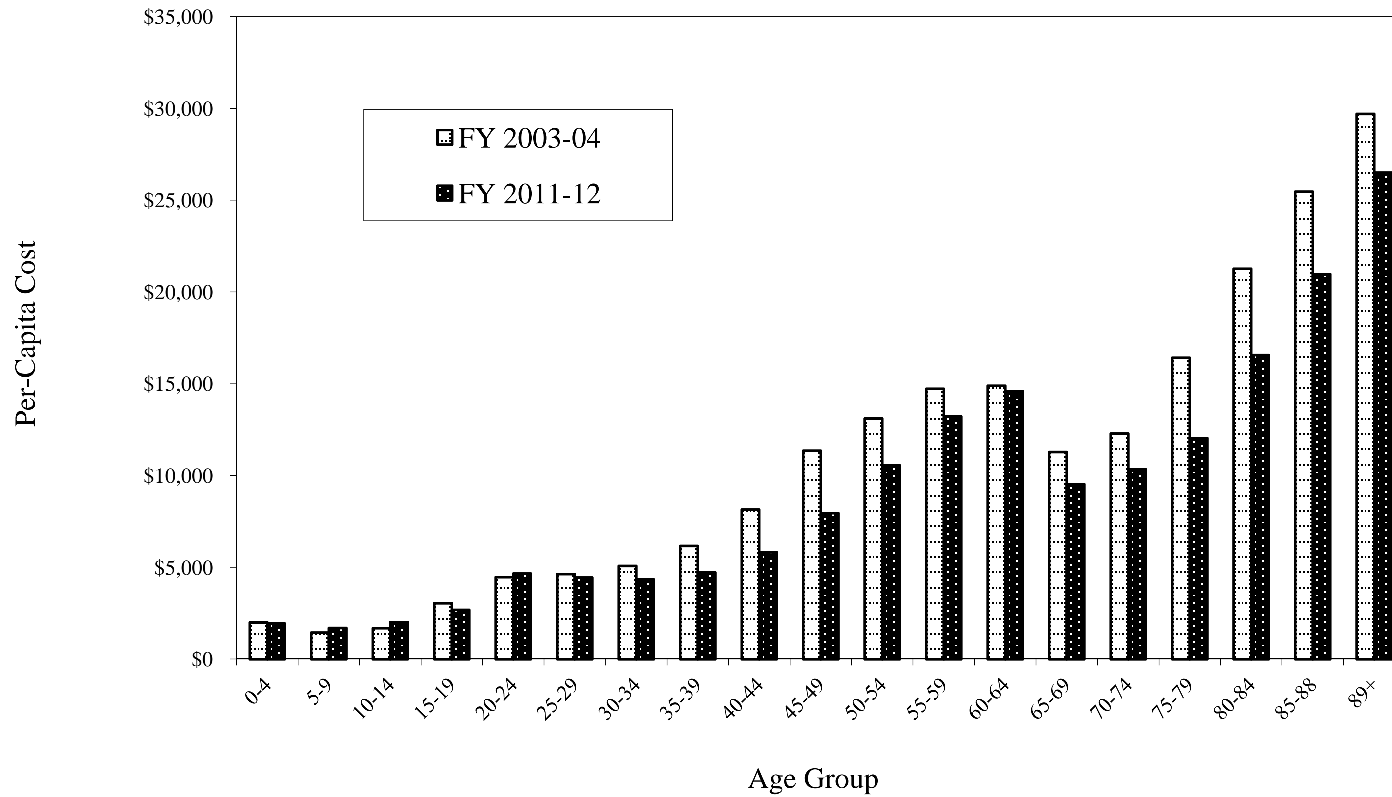
The following table shows the breakdown by client count for FY 2007-08 through FY 2011-12 for clients enrolled in health maintenance organizations, prepaid inpatient health plan, Primary Care Physician Program, and unassigned fee-for-service. Health maintenance organizations, prepaid inpatient health plan and Primary Care Physician Program enrollment figures were subtracted from total caseload numbers (without retroactivity) to calculate the fee-for-service enrollment figures, and as a result may cause the fee-for-service counts to be underrepresented.[9]

Average Medicaid Enrollment for FY 2007-08 through FY 2011-12					
Membership Category	**FY 2007-08**	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**
HMOs and Prepaid Inpatient Health Plans	36,701	54,510	61,047	66,477	70,351
Primary Care Physician Program	25,875	22,717	23,240	23,380	23,264
Fee-for-Service	325,492	359,585	413,902	470,865	526,349
TOTAL	**388,068**	**436,812**	**498,189**	**560,722**	**619,964**

[9] Department of Health Care Policy and Financing June 2012 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[10]



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

B2. FY 2011-12 Services by County

Exhibits B2a and 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 (FTE) client.

Acute Care, including:

- Federal Qualified Health Centers (FQHCs)
- 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 though 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 2011-12 Deliveries

Exhibit B4a through 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 2011-12 Top Tens

Exhibits B5a through B5j show expenditure and utilization for the top 10 diagnoses and procedures for the following:

Inpatient Hospital

Outpatient Hospital

Federal Qualified Health Centers (FQHCs)

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 Medicaid Management Information System, or 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; Pediatric Hospice Waiver; and Spinal Cord Injury (effective July 2012).
- 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 10 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-10 tables reflect the sum of unique client count/count of services/expenditures for the top-10 groupings only. These sums should not be mistaken for the totals of clients, services and expenditures for a type of medical service.

This page intentionally left blank

B2a: FY 2011-12 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	23,982	57,652	44,331	6,095	33,366
Alamosa	2,905	2,925	2,853	312	1,797
Arapahoe	10,513	56,086	41,745	5,742	31,115
Archuleta	*	993	886	97	616
Baca	70	364	379	48	248
Bent	634	727	834	78	532
Boulder	9,744	17,042	13,763	1,866	10,044
Broomfield	746	2,546	1,957	258	1,401
Chaffee	42	1,257	1,122	130	737
Cheyenne	33	141	160	*	109
Clear Creek	171	526	456	52	246
Conejos	1,080	1,450	1,615	167	952
Costilla	659	543	623	56	350
Crowley	288	640	679	66	423
Custer	*	257	247	*	123
Delta	*	2,077	1,331	138	937
Denver	30,638	53,569	40,699	6,734	30,614
Dolores	106	184	161	*	99
Douglas	394	8,951	6,905	859	4,200
Eagle	301	2,970	1,819	356	1,105
Elbert	363	1,073	987	126	580
El Paso	30,997	57,413	49,651	5,853	37,208
Fremont	464	5,060	5,015	453	3,333
Garfield	2,483	4,870	4,121	601	3,008
Gilpin	173	315	274	*	158
Grand	*	786	592	76	372
Gunnison	*	981	640	88	453
Hinsdale	*	35	*	*	*
Huerfano	85	1,103	981	98	696
Jackson	*	97	85	*	50
Jefferson	6,815	35,687	28,130	3,398	18,883
Kiowa	55	101	149	*	76
Kit Carson	208	755	706	85	457
Lake	*	1,036	738	95	568
La Plata	67	4,256	3,086	358	2,231

B2a: FY 2011-12 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Larimer	8,102	23,835	19,311	2,198	12,638
Las Animas	110	2,159	2,097	201	1,609
Lincoln	388	459	497	50	284
Logan	963	1,957	2,042	232	1,432
Mesa	59	7,930	4,916	465	3,216
Mineral	*	47	*	*	*
Moffat	524	1,590	1,331	138	906
Montezuma	377	3,413	3,006	319	2,103
Montrose	149	2,556	1,556	183	1,069
Morgan	1,680	3,656	3,248	423	2,322
Otero	2,091	3,724	3,380	385	2,425
Ouray	*	173	92	*	52
Park	72	983	777	90	371
Phillips	100	334	354	38	282
Pitkin	128	231	194	36	122
Prowers	1,774	2,190	2,316	224	1,520
Pueblo	9,750	28,774	25,116	2,565	18,112
Rio Blanco	*	374	381	32	265
Rio Grande	1,741	2,004	2,005	185	1,251
Routt	63	1,373	984	97	593
Saguache	1,029	900	873	104	564
San Juan	*	87	*	*	*
San Miguel	175	255	181	*	77
Sedgwick	44	247	260	*	173
Summit	*	1,524	900	178	490
Teller	1,146	1,654	1,537	138	1,168
Washington	88	349	345	34	206
Weld	15,434	29,468	23,836	3,021	16,514
Yuma	169	1,183	980	129	681
Suppressed Counties	169	-	93	190	74
STATEWIDE	**166,987**	**434,057**	**350,327**	**45,606**	**251,864**

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 Counties" category.

B2b: FY 2011-12 Expenditures for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$13,135,864	$37,506,986	$33,055,309	$42,759,654	$32,847,067
Alamosa	$1,867,627	$1,620,436	$2,134,850	$1,696,642	$1,258,635
Arapahoe	$5,351,985	$36,097,624	$35,141,813	$42,455,331	$29,915,687
Archuleta	*	$520,289	$372,581	$759,346	$527,752
Baca	$26,110	$154,738	$465,204	$277,228	$208,330
Bent	$343,073	$360,479	$1,193,950	$587,414	$338,992
Boulder	$5,133,034	$10,806,195	$12,561,666	$12,993,531	$8,829,156
Broomfield	$379,154	$1,633,073	$2,150,083	$1,872,634	$1,559,957
Chaffee	$12,147	$869,123	$1,096,270	$963,477	$769,588
Cheyenne	$8,589	$57,080	$167,104	*	$89,264
Clear Creek	$88,385	$376,350	$497,208	$469,918	$304,910
Conejos	$565,335	$775,013	$1,142,660	$916,692	$978,171
Costilla	$420,823	$310,506	$608,333	$371,877	$393,504
Crowley	$125,132	$354,688	$826,255	$510,965	$279,980
Custer	*	$116,793	$127,379	*	$121,489
Delta	*	$689,416	$627,872	$706,159	$650,957
Denver	$16,422,290	$34,305,624	$31,542,843	$61,950,282	$30,711,566
Dolores	$50,121	$76,169	$74,233	*	$77,474
Douglas	$160,257	$6,332,724	$7,182,475	$5,503,272	$4,354,217
Eagle	$181,201	$1,527,427	$1,233,537	$2,532,185	$1,183,493
Elbert	$156,720	$888,983	$972,112	$1,220,358	$733,640
El Paso	$19,069,987	$38,749,611	$46,433,056	$35,082,105	$31,342,136
Fremont	$204,033	$3,093,829	$5,328,145	$3,151,023	$2,506,396
Garfield	$1,406,730	$2,337,008	$2,622,637	$3,833,451	$3,170,662
Gilpin	$84,903	$289,364	$383,608	*	$171,010
Grand	*	$442,607	$714,042	$487,169	$636,630
Gunnison	*	$546,697	$270,751	$829,149	$422,797
Hinsdale	*	$10,374	*	*	*
Huerfano	$81,308	$649,666	$1,518,725	$521,060	$608,652
Jackson	*	$60,978	$101,722	*	$83,269
Jefferson	$3,624,947	$25,458,789	$29,944,175	$25,047,172	$20,047,820
Kiowa	$26,071	$40,403	$199,389	*	$96,534
Kit Carson	$70,265	$339,046	$483,908	$547,579	$556,723
Lake	*	$542,355	$577,831	$684,996	$546,983
La Plata	$22,421	$2,634,531	$2,154,716	$2,693,531	$1,813,705

B2b: FY 2011-12 Expenditures for Selected Acute Care Service Categories by County

County	FQHCs	Physician and EPSDT	Pharmacy Prescriptions	Inpatient Hospital	Outpatient Hospital
Larimer	$3,795,876	$14,779,530	$18,924,097	$14,684,287	$11,318,150
Las Animas	$54,770	$1,343,924	$1,981,457	$1,605,756	$1,551,985
Lincoln	$197,439	$255,387	$430,113	$298,589	$309,222
Logan	$580,416	$947,177	$1,981,109	$1,655,478	$1,137,469
Mesa	$16,666	$2,817,438	$1,906,733	$3,670,507	$2,839,795
Mineral	*	$21,068	*	*	*
Moffat	$232,717	$861,058	$926,472	$1,023,612	$1,255,348
Montezuma	$123,032	$1,685,256	$2,435,859	$2,264,260	$1,771,407
Montrose	$47,740	$827,923	$524,354	$1,134,533	$814,446
Morgan	$934,559	$1,901,574	$2,476,709	$2,657,247	$2,339,576
Otero	$1,074,473	$1,824,893	$3,345,363	$2,589,678	$1,570,633
Ouray	*	$43,879	$78,685	*	$25,613
Park	$36,708	$607,709	$864,033	$712,706	$507,166
Phillips	$45,031	$130,379	$275,854	$242,139	$255,160
Pitkin	$82,571	$100,213	$118,526	$174,032	$145,184
Prowers	$920,061	$795,919	$1,797,534	$1,606,526	$1,242,638
Pueblo	$6,821,946	$19,549,258	$28,044,261	$17,543,178	$16,228,713
Rio Blanco	*	$122,416	$255,079	$131,905	$345,617
Rio Grande	$1,030,049	$1,036,409	$1,573,970	$1,239,176	$968,989
Routt	$26,561	$725,899	$1,064,086	$682,589	$701,720
Saguache	$631,907	$469,851	$621,858	$786,346	$424,587
San Juan	*	$30,430	*	*	*
San Miguel	$76,112	$97,517	$133,573	*	$76,845
Sedgwick	$15,935	$81,049	$293,395	*	$174,813
Summit	*	$998,906	$881,030	$1,408,641	$453,866
Teller	$642,537	$869,246	$1,703,926	$908,580	$841,700
Washington	$36,985	$153,542	$304,531	$409,845	$227,434
Weld	$8,333,836	$17,970,446	$20,423,733	$20,353,480	$14,857,023
Yuma	$61,528	$550,824	$966,066	$935,031	$1,033,713
Suppressed Counties	$68,430	$0	$138,678	$1,196,313	$70,498
STATEWIDE	**$94,906,395**	**$282,174,095**	**$318,377,525**	**$331,338,635**	**$241,626,458**

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 Counties" category.

B2c: FY 2011-12 Average Cost Per Client for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$548	$651	$746	$7,016	$984
Alamosa	$643	$554	$748	$5,438	$700
Arapahoe	$509	$644	$842	$7,394	$961
Archuleta	$605	$524	$421	$7,828	$857
Baca	$373	$425	$1,227	$5,776	$840
Bent	$541	$496	$1,432	$7,531	$637
Boulder	$527	$634	$913	$6,963	$879
Broomfield	$508	$641	$1,099	$7,258	$1,113
Chaffee	$289	$691	$977	$7,411	$1,044
Cheyenne	$260	$405	$1,044	$8,451	$819
Clear Creek	$517	$715	$1,090	$9,037	$1,239
Conejos	$523	$534	$708	$5,489	$1,027
Costilla	$639	$572	$976	$6,641	$1,124
Crowley	$434	$554	$1,217	$7,742	$662
Custer	$459	$454	$516	$7,638	$988
Delta	$444	$332	$472	$5,117	$695
Denver	$536	$640	$775	$9,200	$1,003
Dolores	$473	$414	$461	$3,080	$783
Douglas	$407	$707	$1,040	$6,407	$1,037
Eagle	$602	$514	$678	$7,113	$1,071
Elbert	$432	$829	$985	$9,685	$1,265
El Paso	$615	$675	$935	$5,994	$842
Fremont	$440	$611	$1,062	$6,956	$752
Garfield	$567	$480	$636	$6,378	$1,054
Gilpin	$491	$919	$1,400	$8,686	$1,082
Grand	$470	$563	$1,206	$6,410	$1,711
Gunnison	$410	$557	$423	$9,422	$933
Hinsdale	*	$296	$1,170	$3,648	$488
Huerfano	$957	$589	$1,548	$5,317	$874
Jackson	$160	$629	$1,197	$10,826	$1,665
Jefferson	$532	$713	$1,064	$7,371	$1,062
Kiowa	$474	$400	$1,338	$4,146	$1,270
Kit Carson	$338	$449	$685	$6,442	$1,218
Lake	$217	$524	$783	$7,210	$963
La Plata	$335	$619	$698	$7,524	$813

B2c: FY 2011-12 Average Cost Per Client for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Larimer	$469	$620	$980	$6,681	$896
Las Animas	$498	$622	$945	$7,989	$965
Lincoln	$509	$556	$865	$5,972	$1,089
Logan	$603	$484	$970	$7,136	$794
Mesa	$282	$355	$388	$7,894	$883
Mineral	$492	$448	$1,599	$2,787	$1,420
Moffat	$444	$542	$696	$7,417	$1,386
Montezuma	$326	$494	$810	$7,098	$842
Montrose	$320	$324	$337	$6,200	$762
Morgan	$556	$520	$763	$6,282	$1,008
Otero	$514	$490	$990	$6,726	$648
Ouray	$294	$254	$855	$4,907	$493
Park	$510	$618	$1,112	$7,919	$1,367
Phillips	$450	$390	$779	$6,372	$905
Pitkin	$645	$434	$611	$4,834	$1,190
Prowers	$519	$363	$776	$7,172	$818
Pueblo	$700	$679	$1,117	$6,839	$896
Rio Blanco	$316	$327	$669	$4,122	$1,304
Rio Grande	$592	$517	$785	$6,698	$775
Routt	$422	$529	$1,081	$7,037	$1,183
Saguache	$614	$522	$712	$7,561	$753
San Juan	$209	$350	$1,576	$4,027	$831
San Miguel	$435	$382	$738	$4,680	$998
Sedgwick	$362	$328	$1,128	$4,893	$1,010
Summit	$454	$655	$979	$7,914	$926
Teller	$561	$526	$1,109	$6,584	$721
Washington	$420	$440	$883	$12,054	$1,104
Weld	$540	$610	$857	$6,737	$900
Yuma	$364	$466	$986	$7,248	$1,518
STATEWIDE	**$568**	**$650**	**$909**	**$7,265**	**$959**

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 Counties" category.

B3a: FY 2011-12 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	1,888	789	433	1,127	1,238
Alamosa	422	56	0	160	117
Arapahoe	2,772	1,094	441	1,155	1,267
Archuleta	106	*	0	*	57
Baca	81	*	0	*	77
Bent	94	*	0	42	53
Boulder	1,279	472	*	543	688
Broomfield	208	76	*	82	160
Chaffee	131	46	0	59	74
Cheyenne	*	*	0	*	*
Clear Creek	73	*	*	*	0
Conejos	198	*	0	68	62
Costilla	178	*	0	57	*
Crowley	112	*	0	*	41
Custer	*	0	0	*	*
Delta	308	59	119	131	130
Denver	4,323	778	817	1,528	1,966
Dolores	*	0	0	*	*
Douglas	582	187	*	217	194
Eagle	51	*	0	*	*
Elbert	55	*	*	*	*
El Paso	2,760	943	176	1,629	1,460
Fremont	580	111	0	178	395
Garfield	331	106	0	34	206
Gilpin	50	*	0	*	0
Grand	60	*	0	*	*
Gunnison	60	*	0	*	41
Hinsdale	*	0	0	*	0
Huerfano	161	37	0	38	80
Jackson	*	0	0		*
Jefferson	2,303	976	176	988	1,607
Kiowa	*	0	0	*	*
Kit Carson	51	*	0	*	34
Lake	*	*	0	*	*
La Plata	371	59	0	93	108

B3a: FY 2011-12 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	1,523	497	*	776	919
Las Animas	538	69	0	43	121
Lincoln	71	*	0	*	*
Logan	221	88	0	40	113
Mesa	1,639	406	*	324	511
Mineral	*	*	0	0	*
Moffat	96	31	0	*	51
Montezuma	424	36	0	136	175
Montrose	338	117	157	120	173
Morgan	298	53	*	82	213
Otero	437	82	0	152	192
Ouray	*	*	0	*	*
Park	47	*	0	*	*
Phillips	43	*	0	*	38
Pitkin	36	0	0	*	*
Prowers	218	47	0	49	97
Pueblo	1,971	586	155	1,187	782
Rio Blanco	53	*	0	*	41
Rio Grande	195	*	0	88	129
Routt	53	35	0	*	46
Saguache	155	*	0	57	*
San Juan	*	0	0	*	*
San Miguel	*	*	0	*	*
Sedgwick	35	*	0	0	*
Summit	35	*	*	*	*
Teller	133	*	0	52	52
Washington	39	*	*	*	41
Weld	1,501	391	*	779	652
Yuma	167	*	0	*	89
Suppressed Counties	150	244	*	339	176
STATEWIDE	**30,004**	**8,471**	**2,489**	**12,353**	**14,666**

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 Counties" category.

B3b: FY 2011-12 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	$15,372,414	$28,550,819	$13,185,866	$15,197,416	$44,776,585
Alamosa	$2,294,041	$2,569,939	$0	$358,990	$3,744,529
Arapahoe	$27,611,404	$44,327,228	$12,821,396	$17,791,045	$48,041,457
Archuleta	$980,079	*	$0	*	$1,894,264
Baca	$212,411	*	$0	*	$3,025,000
Bent	$368,286	*	$0	$214,072	$1,760,711
Boulder	$10,020,929	$18,103,700	*	$6,507,721	$24,345,568
Broomfield	$1,823,972	$2,503,571	*	$1,240,223	$4,778,364
Chaffee	$578,235	$1,539,830	$0	$447,987	$2,103,175
Cheyenne	*	*	$0	*	*
Clear Creek	$368,042	*	*	*	$0
Conejos	$1,236,248	*	$0	$142,995	$2,761,906
Costilla	$1,201,425	*	$0	$152,279	$33,742
Crowley	$508,849	*	$0	*	$1,113,966
Custer	*	$0	$0	*	*
Delta	$2,550,423	$1,783,318	$3,777,772	$1,172,596	$4,121,606
Denver	$49,154,356	$23,529,789	$25,741,178	$17,843,672	$74,121,037
Dolores	*	$0	$0	*	*
Douglas	$5,542,229	$5,387,567	*	$4,019,606	$7,501,511
Eagle	$392,981	*	$0	*	*
Elbert	$442,460	*	*	*	*
El Paso	$28,542,015	$33,583,501	$5,356,278	$37,764,844	$53,879,410
Fremont	$4,465,310	$4,851,800	$0	$1,917,363	$13,120,809
Garfield	$1,797,937	$5,015,977	$0	$183,095	$8,440,932
Gilpin	$294,313	*	$0	*	$0
Grand	$412,371	*	$0	*	*
Gunnison	$514,296	*	$0	*	$1,658,161
Hinsdale	*	$0	$0	*	
Huerfano	$1,449,802	$1,182,705	$0	$96,110	$2,447,752
Jackson	*	$0	$0	$0	*
Jefferson	$22,384,672	$35,905,438	$15,031,819	$16,723,152	$63,561,834
Kiowa	$82,349	$0	$0	*	*
Kit Carson	$384,258	*	$0	*	$1,026,145
Lake	*	*	$0	*	*
La Plata	$3,177,935	$2,061,220	$0	$680,402	$3,598,144

B3b: FY 2011-12 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	$8,792,935	$20,638,372	*	$7,734,491	$30,918,598
Las Animas	$6,721,239	$2,081,817	$0	$219,714	$4,846,606
Lincoln	$502,445	*	$0	*	*
Logan	$1,448,113	$3,924,617	$0	$407,809	$3,176,954
Mesa	$18,654,377	$27,958,958	*	$2,902,481	$16,692,932
Mineral	*	*	$0		*
Moffat	$441,373	$1,446,889	$0	*	$1,730,546
Montezuma	$3,956,357	$1,119,449	$0	$1,170,166	$5,081,170
Montrose	$2,285,649	$4,296,717	$5,117,834	$1,761,419	$6,227,225
Morgan	$1,810,580	$1,738,693	*	$226,446	$7,103,966
Otero	$2,051,900	$3,825,093	$0	$1,888,184	$5,856,125
Ouray	*	*	$0	*	*
Park	$258,180	*	$0	*	*
Phillips	$255,606	*	$0	*	$1,116,725
Pitkin	$525,160	$0	$0	*	*
Prowers	$916,875	$1,673,670	$0	$163,182	$3,546,768
Pueblo	$14,980,543	$32,513,767	$4,069,538	$17,752,330	$24,891,800
Rio Blanco	$212,122	*	$0	*	$1,517,130
Rio Grande	$984,328	*	$0	$265,567	$4,259,317
Routt	$176,169	$1,419,549	$0	*	$2,360,355
Saguache	$884,799	*	$0	$115,094	*
San Juan	*	$0	$0	*	*
San Miguel	*	*	$0	*	*
Sedgwick	$254,692	*	$0		*
Summit	$254,441	*	*	*	*
Teller	$1,105,185	*	$0	$820,797	$1,311,021
Washington	$115,084	*	*	*	$1,076,613
Weld	$12,026,235	$15,199,613	*	$8,171,569	$21,636,596
Yuma	$931,709	$176,540	$0	*	$2,533,005
Suppressed Counties	$843,196	$6,513,447	$261,082	$1,697,392	$5,282,857
STATEWIDE	**$265,553,329**	**$335,423,591**	**$85,366,242**	**$167,779,141**	**$523,022,914**

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 Counties" category.

B3c: FY 2011-12 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	$8,142	$36,186	$30,452	$13,485	$36,168
Alamosa	$5,436	$45,892	$0	$2,244	$32,005
Arapahoe	$9,961	$40,518	$29,073	$15,404	$37,917
Archuleta	$9,246	$15,204	$0	$5,811	$33,233
Baca	$2,622	$17,890	$0	$23,115	$39,286
Bent	$3,918	$40,378	$0	$5,097	$33,221
Boulder	$7,835	$38,355	$19,136	$11,985	$35,386
Broomfield	$8,769	$32,942	$22,615	$15,125	$29,865
Chaffee	$4,414	$33,475	$0	$7,593	$28,421
Cheyenne	$1,623	$5,013	$0	$3,025	$41,317
Clear Creek	$5,042	$12,752	$6,958	$8,606	$0
Conejos	$6,244	$12,308	$0	$2,103	$44,547
Costilla	$6,750	$13,744	$0	$2,672	$6,748
Crowley	$4,543	$26,863	$0	$4,950	$27,170
Custer	$6,254	$0	$0	$7,290	$3,065
Delta	$8,281	$30,226	$31,746	$8,951	$31,705
Denver	$11,370	$30,244	$31,507	$11,678	$37,701
Dolores	$16,921	$0	$0	$3,042	$54,029
Douglas	$9,523	$28,811	$19,136	$18,524	$38,668
Eagle	$7,706	$20,914	$0	$1,400	$15,871
Elbert	$8,045	$15,416	$3,479	$15,210	$37,722
El Paso	$10,341	$35,613	$30,433	$23,183	$36,904
Fremont	$7,699	$43,710	$0	$10,772	$33,217
Garfield	$5,432	$47,321	$0	$5,385	$40,975
Gilpin	$5,886	$11,354	$0	$7,122	$0
Grand	$6,873	$13,980	$0	$2,034	$25,506
Gunnison	$8,572	$25,760	$0	$3,129	$40,443
Hinsdale	$1,431	$0	$0	$960	$0
Huerfano	$9,005	$31,965	$0	$2,529	$30,597
Jackson	$530	$0	$0	$0	$10,911
Jefferson	$9,720	$36,788	$85,408	$16,926	$39,553
Kiowa	$3,580	$0	$0	$2,638	$27,750
Kit Carson	$7,534	$39,771	$0	$649	$30,181
Lake	$3,751	$7,726	$0	$2,853	$32,711
La Plata	$8,566	$34,936	$0	$7,316	$33,316

B3c: FY 2011-12 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	$5,773	$41,526	$3,479	$9,967	$33,644
Las Animas	$12,493	$30,171	$0	$5,110	$40,055
Lincoln	$7,077	$45,029	$0	$11,787	$41,199
Logan	$6,553	$44,598	$0	$10,195	$28,115
Mesa	$11,382	$68,864	$41,751	$8,958	$32,667
Mineral	$383	$13,776	$0	$0	$36,804
Moffat	$4,598	$46,674	$0	$3,599	$33,932
Montezuma	$9,331	$31,096	$0	$8,604	$29,035
Montrose	$6,762	$36,724	$32,598	$14,678	$35,996
Morgan	$6,076	$32,806	$11,772	$2,762	$33,352
Otero	$4,695	$46,647	$0	$12,422	$30,501
Ouray	$8,495	$10,469	$0	$11,870	$28,602
Park	$5,493	$39,782	$0	$9,488	$0
Phillips	$5,944	$11,515	$0	$16,074	$29,387
Pitkin	$14,588	$0	$0	$243	$8,765
Prowers	$4,206	$35,610	$0	$3,330	$36,565
Pueblo	$7,600	$55,484	$26,255	$14,956	$31,831
Rio Blanco	$4,002	$6,150	$0	$1,224	$37,003
Rio Grande	$5,048	$42,346	$0	$3,018	$33,018
Routt	$3,324	$40,559	$0	$2,125	$51,312
Saguache	$5,708	$53,702	$0	$2,019	$10,422
San Juan	$1,624	$0	$0	$187	$3,264
San Miguel	$12,655	$5,946	$0	$7,933	$18,635
Sedgwick	$7,277	$52,131	$0	$0	$28,511
Summit	$7,270	$31,960	$9,244	$2,231	$24,346
Teller	$8,310	$20,968	$0	$15,785	$25,212
Washington	$2,951	$40,162	$13,917	$1,321	$26,259
Weld	$8,012	$38,874	$26,094	$10,490	$33,185
Yuma	$5,579	$17,654	$0	$1,702	$28,461
STATEWIDE	**$6,793**	**$31,005**	**$25,003**	**$7,621**	**$30,936**

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.

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 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**
FY 2011-12	22,385	1,179	255	2,966	57	99	151	**26,901**

*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 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**
FY 2011-12	120	3,307	4,371	399	**8,136**

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 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
FY 2011-12	12,079	2,665	13,939	20	13,959

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.

This page intentionally left blank

B4a: FY 2011-12 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Adams	3,314	$23,004,105	$7,024
Alamosa	157	$1,189,299	$7,575
Arapahoe	2,948	$21,273,608	$7,303
Archuleta	70	$466,847	$6,669
Baca	*	*	$6,818
Bent	36	$265,480	$7,374
Boulder	994	$6,827,053	$6,889
Broomfield	119	$843,898	$7,092
Chaffee	66	$479,088	$7,259
Cheyenne	*	*	$8,589
Clear Creek	33	$256,153	$8,005
Conejos	81	$632,188	$7,805
Costilla	*	*	$8,830
Crowley	*	*	$7,276
Custer	*	*	$6,703
Delta	63	$306,865	$4,871
Denver	3,920	$25,309,125	$7,495
Dolores	*	*	$6,502
Douglas	389	$2,720,235	$7,011
Eagle	285	$2,010,410	$7,104
Elbert	47	$334,483	$7,117
El Paso	2,989	$22,083,493	$7,391
Fremont	219	$1,663,850	$7,597
Garfield	376	$2,685,339	$7,142
Gilpin	*	*	$6,075
Grand	41	$273,418	$6,669
Gunnison	60	$398,505	$6,642
Hinsdale	*	*	$5,898
Huerfano	45	$373,099	$8,291
Jackson	*	*	$8,340
Jefferson	1,666	$11,946,418	$7,316
Kiowa	*	*	$6,826
Kit Carson	48	$403,295	$8,402
Lake	46	$293,703	$6,385
La Plata	200	$1,371,290	$6,891

B4a: FY 2011-12 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date

County Name	Unique Deliveries	Total Payments	Average Payment
Larimer	1,174	$7,469,752	$6,363
Las Animas	92	$692,123	$7,523
Lincoln	*	*	$7,238
Logan	122	$1,147,918	$9,409
Mesa	385	$1,298,272	$3,372
Mineral	*	*	$5,155
Moffat	76	$612,997	$8,066
Montezuma	165	$1,276,397	$7,736
Montrose	98	$453,328	$4,626
Morgan	245	$1,887,747	$7,705
Otero	171	$1,194,583	$6,986
Ouray	*	*	$5,104
Park	43	$342,065	$7,955
Phillips	35	$244,688	$6,991
Pitkin	30	$165,541	$5,518
Prowers	134	$1,055,305	$7,875
Pueblo	1,156	$9,314,393	$8,057
Rio Blanco	*	*	$5,809
Rio Grande	82	$629,529	$7,677
Routt	62	$439,103	$7,082
Saguache	60	$512,212	$8,537
San Juan	*	*	$9,471
San Miguel	*	*	$5,316
Sedgwick	*	*	$6,964
Summit	127	$756,044	$5,953
Teller	56	$416,391	$7,436
Washington	*	*	$8,819
Weld	1,582	$11,531,018	$7,289
Yuma	75	$460,127	$6,135
Suppressed Counties	276	$1,907,001	$6,909
STATEWIDE	**24,458**	**$173,294,077**	**$7,085**

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. *Denotes county included in "Suppressed Counties" category.

B4b: FY 2011-12 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Delivery Type			
Vaginal or C-Section	**Unique Deliveries**	**Total Payments**	**Average Payment**
Caesarian	5,292	$50,208,037	$9,488
Vaginal	17,645	$118,149,244	$6,696
Unknown/No Delivery Information	1,521	$4,936,797	$3,246
Total	**24,458**	**$173,294,077**	**$7,085**

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 2011-12 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Age on Delivery Date			
Age Group	**Unique Deliveries**	**Total Payments**	**Average Payment**
<=14	*	*	$6,353
15-19	3,399	$22,998,150	$6,766
20	1,643	$11,476,881	$6,985
21-24	6,450	$46,714,778	$7,243
25-34	10,570	$75,019,095	$7,097
35+	2,357	$16,848,884	$7,148
Unknown	*	*	$5,310
Total	**24,458**	**$173,294,077**	**$7,085**

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. *Denotes data is suppressed.

B4d: FY 2011-12 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's Eligibility Type on Delivery Date

Eligibility Type	Unique Deliveries	Total Payments	Average Payment
Disabled Individuals to 59	281	$3,448,999	$12,274
Low-Income and Expansion Adults	9,001	$70,763,237	$7,862
Eligible Children	1,648	$11,528,079	$14,051
Foster Care	115	$1,138,778	$9,902
Baby Care Adults	8,435	$61,302,396	$14,662
Non-Citizens	4,964	$25,055,507	$5,047
Other Medicaid Eligibility Types	14	$57,081	$4,077
Total Medicaid	**24,458**	**$173,294,077**	**$7,085**

B4e: FY 2011-12 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	Payments: Not Needy Newborn	Payments: Needy Newborn
Low Birthweight Infants						
Extremely Low BW (<1000 grams)	320	150	170	$8,414,938	$1,889,297	$6,525,642
Very Low BW (1000 - 1499 grams)	337	73	264	$6,064,485	$508,021	$5,556,464
Low BW (1500-2499 grams)	2,480	583	1,897	$8,915,475	$713,773	$8,201,702
All LBW Clients	**3,137**	**806**	**2,331**	**$23,394,899**	**$3,111,090**	**$20,283,809**
Preterm Infants Not Classified as Low Birthweight						
Very Preterm (<32 weeks gestation)	452	186	266	$3,264,259	$788,456	$2,475,803
Moderately Preterm (32 to 36 weeks gestation)	588	92	496	$1,438,760	$148,551	$1,290,208
All Preterm Infants not identified via LBW	**1,040**	**278**	**762**	**$4,703,019**	**$937,007**	**$3,766,011**
Infants Treated in the NICU Not Due to LBW or Preterm						
NICU - Other, Including Normal Birthweight	1,169	87	1,082	$3,704,042	$214,366	$3,489,676
TOTAL	**5,346**	**1,171**	**4,175**	**$31,801,960**	**$4,262,464**	**$27,539,496**

*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.

B4f: FY 2011-12 Clients and Costs Associated with Neonatal Intensive Care Unit Claims		
DRG Description	**Unique Clients with DRG***	**NICU Payments**
Neonates, Died or Transferred to Another	NR	$86,391
Full-Term Neonate with Major Problems	682	$3,253,256
Neonate with Other Significant Problems	1,217	$2,612,038
Neonates < 1,000 grams	75	$5,154,976
Neonates 1,000-1,499 grams	163	$4,418,987
Neonates 1500-1,999 grams	345	$4,248,044
Neonates > 2,000 grams with RDS	167	$2,433,146
Neonates > 2,000 grams, Premature with Major Problems	281	$1,779,902
Neonate, Low Birthweight Diagnosis, Over 28 Days	NR	$164,404
TOTAL NICU Payments		**$24,151,144**

*Clients may have claims for more than one NICU DRG. 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.

B5a: FY 2011-12 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	$82,291,762	22,722	$3,622
2	4	Respiratory System	$29,316,249	4,695	$6,244
3	15	Conditions of Newborns	$24,891,301	3,706	$6,716
4		Pre-MDC Other	$24,304,116	285	$85,278
5	8	Musculoskeletal System and Connective tissue	$23,653,518	2,201	$10,747
6	5	Circulatory System	$20,752,504	1,658	$12,517
7	6	Digestive System	$20,751,896	2,973	$6,980
8	1	Nervous System	$19,276,874	2,086	$9,241
9	18	Infectious and Parasitic Diseases	$15,197,658	1,456	$10,438
10	11	Kidney and Urinary Tract	$14,160,596	1,323	$10,703
		Top Ten Totals	**$274,596,472**	**43,105**	**$6,370**

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 2011-12 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	$37,227,588	13,397	$2,779
2	370	Cesarean Section with Complicating Diagnoses	$15,009,580	2,137	$7,024
3	541	Tracheotomy with Mechanical Ventilator with Major Operating Room Procedure	$12,821,130	138	$92,907
4	372	Vaginal Delivery with Complicating Diagnoses	$11,056,240	2,941	$3,759
5	371	Cesarean Sections without Complicating Diagnoses	$10,170,819	2,923	$3,480
6	898	Bronchitis and Asthma, Age <17 with Complicating Diagnoses	$6,067,597	1,604	$3,783
7	576	Septicemia without Mechanical Ventilator, 96+ hours, age >17	$5,420,418	696	$7,788
8	317	Admit for Renal Dialysis	$5,406,453	55	$98,299
9	542	Tracheotomy with Mechanical Ventilator without Major Operating Room Procedure	$5,274,754	103	$51,211
10	801	Neonates < 1,000 Grams	$5,154,976	75	$68,733
		Top Ten Totals	**$113,609,556**	**24,069**	**$4,720**

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 2011-12 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	$14,086,817	20,571	$685
2	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$8,933,898	17,115	$522
3	521	Diseases of Hard Tissues of Teeth	$8,329,336	5,525	$1,508
4	780	General Symptoms	$6,815,393	16,995	$401
5	V58	Other and Unspecified Aftercare	$5,613,078	3,816	$1,471
6	474	Chronic Disease of Tonsils and Adenoids	$4,258,330	2,724	$1,563
7	784	Symptoms Involving Head and Neck	$4,220,403	8,653	$488
8	787	Symptoms Involving Digestive System	$4,080,506	12,661	$322
9	V57	Care Involving Use of Rehabilitation Procedures	$3,903,030	12,227	$319
10	585	Chronic Renal Failure	$3,687,960	384	$9,604
		Top Ten Totals	**$63,928,752**	**100,671**	**$635**

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 2011-12 Top 10 Outpatient Surgical Procedures Ranked by Expenditures					
Rank	**Surgical Procedure Code**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	96.54	Dental Scaling, Polishing, and Debridement	$769,352	310	$2,482
2	28.3	Tonsillectomy with Adenoidectomy	$764,293	290	$2,635
3	99.29	Injection or Infusion of Other Therapeutic or Prophylactic Substance	$555,892	623	$892
4	23.09	Extraction of Other Tooth	$551,777	237	$2,328
5	89.17	Polysomnogram	$482,255	357	$1,351
6	23.41	Application of Crown	$415,348	200	$2,077
7	23.70	Root Canal, Not Otherwise Specified	$385,965	156	$2,474
8	37.23	Combined Right and Left Heart Cardiac Catheterization	$352,928	35	$10,084
9	93.54	Application of Splint	$319,182	1,023	$312
10	47.01	Laparoscopic Appendectomy	$299,683	74	$4,050
		Top Ten Totals	**$4,896,674**	**3,305**	**$1,482**

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 2011-12 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	$16,264,177	62,472	$260
2	V72	Special Investigations and Examinations*	$14,280,016	46,836	$305
3	V22	Normal Pregnancy	$6,963,698	7,963	$875
4	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$3,198,722	15,755	$203
5	V04	Need For Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	$1,755,215	11,826	$148
6	724	Other and Unspecified Disorders of Back	$1,608,457	5,559	$289
7	V25	Encounter For Contraceptive Management	$1,557,999	5,699	$273
8	250	Diabetes Mellitus	$1,543,493	3,878	$398
9	382	Suppurative and Unspecified Otitis Media	$1,489,810	6,834	$218
10	780	General Symptoms	$1,365,306	6,680	$204
		Top Ten Totals	**$50,026,894**	**173,502**	**$288**

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 2011-12 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	$1,034,093	5,616	$184
2	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$443,582	2,716	$163
3	V72	Special Investigations and Examinations*	$372,604	962	$387
4	382	Suppurative and Unspecified Otitis Media	$348,257	1,937	$180
5	462	Acute Pharyngitis	$259,990	1,902	$137
6	724	Other and Unspecified Disorders of Back	$237,934	1,122	$212
7	789	Other Symptoms Involving Abdomen and Pelvis	$215,908	1,288	$168
8	780	General Symptoms	$210,374	1,459	$144
9	V22	Normal Pregnancy	$195,267	449	$435
10	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$195,234	1,372	$142
		Top Ten Totals	**$3,513,241**	**18,823**	**$187**

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 2011-12 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	$17,737,263	113,212	$157
2	315	Specific Delays in Development	$10,048,656	5,965	$1,685
3	650	Normal Delivery	$8,424,846	11,657	$723
4	367	Disorders of Refraction and Accommodation	$7,943,280	56,529	$141
5	V25	Encounter For Contraceptive Management	$7,375,653	22,809	$323
6	789	Other Symptoms Involving Abdomen and Pelvis	$6,984,967	42,553	$164
7	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$5,548,741	54,482	$102
8	780	General Symptoms	$5,344,007	43,302	$123
9	784	Symptoms Involving Head and Neck	$4,411,839	24,651	$179
10	783	Symptoms Concerning Nutrition, Metabolism, and Development	$3,681,774	10,417	$353
		Top Ten Totals	**$63,618,371**	**294,931**	**$216**

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 2011-12 Top 10 Dental Procedures Ranked by Expenditures					
Rank	**Procedure Code**	**Procedure Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	D2930	Prefab Stainless Steel Crown Primary	$7,210,156	24,252	$297
2	D8090	Comprehensive Ortho Adult Dentition	$6,137,243	2,095	$2,929
3	D1120	Prophylaxis Child	$5,860,170	153,032	$38
4	D7140	Extraction Erupted Tooth/Exposed Root	$4,180,383	30,712	$136
5	D8080	Comprehensive Ortho Adolescent Dentition	$3,879,493	1,465	$2,648
6	D0120	Periodic Oral Evaluation	$3,868,640	139,151	$28
7	D2391	Resin Based Comp One Surface Posterior	$3,553,932	31,985	$111
8	D2392	Resin Based Comp Two Surfaces Posterior	$3,373,961	24,153	$140
9	D2150	Amalgam Two Surfaces Permanent	$3,275,506	23,473	$140
10	D7210	Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap	$3,154,940	13,047	$242
		Top Ten Totals	**$44,494,423**	**443,365**	**$100**

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 2011-12 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	$2,591,344	43,771	$59
2	87591	Nisseria Gonorrhea, DNA, Amplified Probe Technique	$2,553,027	43,299	$59
3	80101	Drug Screen, Single	$1,900,936	9,932	$191
4	85025	Complete Blood Count with Automated White Blood Cells Differential	$1,489,179	89,248	$17
5	80053	Comprehensive Metabolic Panel	$1,437,014	64,675	$22
6	84443	Thyroid Stimulus Hormone	$1,187,061	44,677	$27
7	83914	Mutation Identification by Enzymatic Ligation or Primer Extension	$973,599	2,893	$337
8	80050	General Health Panel	$958,908	20,592	$47
9	83901	Molecular Diagnostics; Amplification	$832,408	2,891	$288
10	87086	Urine Culture/Colony Count	$771,758	52,609	$15
		Top Ten Totals	**$14,695,235**	**374,587**	**$39**

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 2011-12 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	$13,336,632	13,196	$1,011
2	E0442	Stationary Oxygen, Liquid	$4,889,112	4,430	$1,104
3	B4160	Enteral Formula for Pediatrics, Calorie Dense	$4,024,481	1,362	$2,955
4	B4161	Enteral Formula for Pediatrics, Hydrolyzed/Amino Acid	$2,412,288	529	$4,560
5	T4527	Adult Disposable Diaper, Large	$2,214,788	3,180	$696
6	B4035	Enteral Feed Supplement, Pump, per day	$2,106,637	1,157	$1,821
7	T4526	Adult Disposable Diaper, Medium	$1,867,536	3,334	$560
8	A4554	Disposable Underpads	$1,842,403	7,217	$255
9	T4535	Disposable Liner/Shield/Pad	$1,708,673	5,075	$337
10	E0441	Stationary Oxygen, Gas	$1,613,984	1,812	$891
		Top Ten Totals	**$36,016,534**	**41,292**	**$872**

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 2011-12 Top 10 Prescription Drugs Ranked by Expenditures					
Rank	**Drug Name**	**Therapeutic Class**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	Abilify	Antipsychotics	$18,401,495	5,597	$3,288
2	Seroquel	Antipsychotics	$14,251,278	5,059	$2,817
3	Singulair	Leukotreine Receptor Antagonist	$7,126,255	12,110	$588
4	Synagis	Monoclonal Antibody (prevention/treatment of respiratory virus in infants)	$6,386,937	607	$10,522
5	Aciphex	Proton Pump Inhibitors	$6,114,723	5,001	$1,223
6	Norditropin	Anabolic Steroid	$5,856,715	296	$19,786
7	Advair	Beta-Adrenergics and Glucocort	$5,447,010	6,743	$808
8	Olanzapine	Antipsychotics	$5,229,786	1,688	$3,098
9	Oxycontin	Analgesics	$4,878,634	1,179	$4,138
10	Oxycodone	Analgesics	$4,582,797	44,146	$104
		Top Ten Total	**$78,275,629**	**82,426**	**$950**
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 45 day of the end of the fiscal year.					

B5l: FY 2011-12 Top 10 Prescription Drugs Ranked by Number of Prescriptions Filled					
Rank	**Drug Name**	**Therapeutic Class**	**Total Prescriptions Filled**	**Expenditures**	**Average Cost**
1	Oxycodone	Analgesic	147,566	$4,582,797	$31
2	Hydrocodone	Analgesic	145,419	$2,057,681	$14
3	Amoxicillin	Antibiotics	107,462	$1,117,672	$10
4	Lorazepam	Anti-anxiety Drugs	62,586	$514,746	$8
5	Azithromycin	Macrolides	59,587	$1,643,667	$28
6	Lisinopril	ACE Inhibitor	58,151	$416,299	$7
7	Proair	Beta-adrenergic agents	57,918	$2,815,214	$49
8	Clonazepam	Anti-Convulsants	57,472	$496,935	$9
9	Levothyroxine	Thyroid Hormone	56,498	$519,886	$9
10	Ibuprofen	NSAID	55,767	$394,230	$7
		Top Ten Total	**808,426**	**$14,559,127**	**$18**
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 45 day of the end of the fiscal year.					

Colorado Department of Health Care Policy and Financing
FY 2013-14 Budget Request
November 1, 2012

Schedule 1 – Budget Request Table of Contents

	Tab Title	Pages starting at:
Volume I		
A.	Schedule 1 – Budget Request Table of Contents	A–1
B.	Department Description	B–1
C.	Strategic Plan	C–1
D.	Schedule 10 – Summary of Change Requests	D–1
D.	Requests	D See Index at Schedule 10
D.	Non-Prioritized Items	D See Index at Schedule 10
E.	Exhibits for Medical Services Premiums	E See Index at Tab E
F.	Exhibits for Medicaid Mental Health Programs	F See Index at Tab F
	Medicaid Caseload	
Volume II		
G.	Schedule 1 – Budget Request Table of Contents	G–1
H.	Line Item Description	H–1
I.	Reconciliation	I–1
J.	Schedule 2 – Summary by Long Bill Group	J–1
K.	Schedule 3 – Summary	K.0–1
K.	Schedule 3 – (1) Executive Director's Office	K.1–1
K.	Schedule 3 – (2) Medical Services Premiums	K.2–1
K.	Schedule 3 – (3) Medicaid Mental Health Community Programs	K.3–1
K.	Schedule 3 – (4) Indigent Care Programs	K.4–1
K.	Schedule 3 – (5) Other Medical Services	K.5–1
K.	Schedule 3 – (6) DHS Medicaid-Funded Programs	K.6–1
L.	Schedule 5 – Line Item to Statute	L–1
M.	Schedule 6 – Special Bills Summary	M–1
N.	Schedule 7 – Supplemental Bills Summary	N–1
O.	Schedule 9 – Cash Funds Reports	O–1
P.	Schedule 14 – Position and Object Code Detail Report	P–1
Q.	Health Care Affordability Act Update	Q-1
R.	Tobacco Tax Update	R-1
S.	Glossary and Acronyms	S–1

Department of Health Care Policy and Financing
Line Item Description
FY 2013-14 Budget Request

November 1, 2012

(1) EXECUTIVE DIRECTOR'S OFFICE ***6***

(A) GENERAL ADMINISTRATION ***6***

PERSONAL SERVICES 6
HEALTH, LIFE, AND DENTAL 6
SHORT-TERM DISABILITY 6
AMORTIZATION EQUALIZATION DISBURSEMENT 6
SUPPLEMENTAL AMORTIZATION EQUALIZATION DISBURSEMENT 7
SALARY SURVEY AND SENIOR EXECUTIVE SERVICE 7
MERIT PAY 7
WORKERS' COMPENSATION 8
OPERATING EXPENSES 8
LEGAL SERVICES 8
ADMINISTRATIVE LAW JUDGE SERVICES 8
PURCHASES OF SERVICES FROM COMPUTER CENTER 8
MULTIUSE NETWORK PAYMENTS 8
MANAGEMENT AND ADMINISTRATION OF OIT 9
COFRS MODERNIZATION 9
PAYMENT TO RISK MANAGEMENT AND PROPERTY FUNDS 9
LEASED SPACE 9
CAPITOL COMPLEX LEASED SPACE 9
GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS 9

(B) TRANSFERS TO OTHER DEPARTMENTS ***10***

TRANSFER TO DPHE FOR FACILITY SURVEY AND CERTIFICATION 10
TRANSFER TO DEPT OF PUBLIC SAFETY FOR LIFE SAFETY CODE INSPECTIONS FOR HEALTH FACILITIES .. 10
TRANSFER TO DPHE FOR NURSE HOME VISITOR PROGRAM 11
TRANSFER TO DPHE FOR PRENATAL STATISTICAL INFORMATION 12
TRANSFER TO DPHE FOR ENHANCED PRENATAL CARE TRAINING AND TECHNICAL ASSISTANCE 12
TRANSFER TO DORA FOR NURSE-AIDE CERTIFICATION 13
TRANSFER TO DORA FOR REVIEWS 14
TRANSFER TO DEPARTMENT OF EDUCATION FOR PUBLIC SCHOOL HEALTH SERVICES ADMINISTRATION 14

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS ***14***

INFORMATION TECHNOLOGY CONTRACTS 14

MEDICAID MANAGEMENT INFORMATION SYSTEM CONTRACT 15
PROVIDER WEB PORTAL 16
FRAUD DETECTION SOFTWARE CONTRACT 16
CENTRALIZED ELIGIBILITY VENDOR CONTRACT PROJECT 16

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES 17

MEDICAL IDENTIFICATION CARDS 17
CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS 17
DISABILITY DETERMINATION SERVICES 18
NURSING HOME PREADMISSION AND RESIDENT ASSESSMENTS 18
HOSPITAL OUTSTATIONING 19
COUNTY ADMINISTRATION 19
HOSPITAL PROVIDER FEE COUNTY ADMINISTRATION 20
ADMINISTRATIVE CASE MANAGEMENT 20
CUSTOMER OUTREACH 21
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM 21
ENROLLMENT BROKER 22

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS 22

PROFESSIONAL SERVICES CONTRACTS 22
ACUTE CARE UTILIZATION REVIEW 22
LONG-TERM CARE UTILIZATION REVIEW 23
EXTERNAL QUALITY REVIEW 24
MENTAL HEALTH EXTERNAL QUALITY REVIEW 24
DRUG UTILIZATION REVIEW 25

(F) PROVIDER AUDITS AND SERVICES 26

PROFESSIONAL AUDIT CONTRACTS 26
NURSING FACILITY AUDITS 27
HOSPITAL AND FEDERALLY QUALIFIED HEALTH CENTERS AUDITS 27
SINGLE ENTRY POINT AUDITS 27
PAYMENT ERROR RATE MEASUREMENT PROJECT CONTRACT 27
NURSING FACILITY APPRAISALS 28
COLORADO INDIGENT CARE PROGRAM AUDITOR 28
DISPROPORTIONATE SHARE HOSPITAL AUDITS 29

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS ***29***

ESTATE RECOVERY 29

(H) NURSING FACILITY PENALTY CASH FUND, NURSING FACILITY CULTURE CHANGE ***29***

NURSING FACILITY PENALTY CASH FUND, NURSING FACILITY CULTURE CHANGE 29

(2) MEDICAL SERVICES PREMIUMS ***31***

(3) MEDICAID MENTAL HEALTH ***32***

MENTAL HEALTH CAPITATION PAYMENTS 32
MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS 32

(4) INDIGENT CARE PROGRAM ***33***

SAFETY NET PROVIDER PAYMENTS 35
THE CHILDREN'S HOSPITAL, CLINIC-BASED INDIGENT CARE 36
HEALTH CARE SERVICES FUND PROGRAMS 37
PEDIATRIC SPECIALITY HOSPITAL 37
APPROPRIATION FROM THE GENERAL FUND TO PEDIATRIC SPECIALITY HOSPITAL FUND 37
APPROPRIATION FROM TOBACCO TAX CASH FUND TO THE GENERAL FUND 38
PRIMARY CARE FUND PROGRAM 38
PRIMARY CARE GRANT PROGRAM SPECIAL DISTRIBUTION 38
COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANTS PROGRAM 38

CHILDREN'S BASIC HEALTH PLAN ***39***

CHILDREN'S BASIC HEALTH PLAN TRUST 40
CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION 41
CHILDREN'S BASIC HEALTH PLAN PREMIUM COSTS 42
CHILDREN'S BASIC HEALTH PLAN DENTAL BENEFIT COSTS 42
CHILDREN'S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS 42

(5) OTHER MEDICAL SERVICES ***43***

SERVICES FOR OLD AGE PENSION STATE MEDICAL PROGRAM CLIENTS 43
SUPPLEMENTAL OLD AGE PENSION MEDICAL CARE FUND 43
COMMISSION ON FAMILY MEDICINE RESIDENCY TRAINING PROGRAMS 44
STATE UNIVERSITY TEACHING HOSPITALS, DENVER HEALTH AND HOSPITAL AUTHORITY 44
STATE UNIVERSITY TEACHING HOSPITALS, UNIVERSITY OF COLORADO HOSPITAL AUTHORITY 44

MEDICARE MODERNIZATION ACT OF 2003 STATE CONTRIBUTION PAYMENT 45
PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION 45
PUBLIC SCHOOL HEALTH SERVICES 46

(6) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS 47

(A) EXECUTIVE DIRECTOR'S OFFICE 47

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996........ 49

(B) OFFICE OF INFORMATION TECHNOLOGY SERVICES – MEDICAID FUNDING 50

COLORADO BENEFITS MANAGEMENT SYSTEM 50
COLORADO BENEFITS MANAGEMENT SYSTEM, HCPF-ONLY........ 51
CBMS SAS-70 AUDIT 52
COLORADO BENEFITS MANAGEMENT SYSTEM CLIENT SERVICES IMPROVEMENT PROJECT........ 53
OTHER OFFICE OF INFORMATION TECHNOLOGY SERVICES LINE ITEMS 53

(C) OFFICE OF OPERATIONS – MEDICAID FUNDING 54

(D) DIVISION OF CHILD WELFARE-MEDICAID FUNDING........ 55

ADMINISTRATION 55
CHILD WELFARE SERVICES........ 56

(E) OFFICE OF SELF SUFFICIENCY – MEDICAID FUNDING 59

SYSTEMATIC ALIEN VERIFICATION FOR ELIGIBILITY 59

(F) MENTAL HEALTH AND ALCOHOL AND DRUG ABUSE SERVICES-MEDICAID FUNDING........ 59

ADMINISTRATION 59
RESIDENTIAL TREATMENT FOR YOUTH........ 60
MENTAL HEALTH INSTITUTES 61
ALCOHOL AND DRUG ABUSE DIVISION, ADMINISTRATION 62
ALCOHOL AND DRUG ABUSE DIVISION, HIGH-RISK PREGNANT WOMEN PROGRAM 63

(G) SERVICES FOR PEOPLE WITH DISABILITIES-MEDICAID FUNDING 64

COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, ADMINISTRATION 64
COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, PROGRAM COSTS 64
REGIONAL CENTERS 67
REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS 67

(H) ADULT ASSISTANCE PROGRAMS; COMMUNITY SERVICES FOR THE ELDERLY – MEDICAID FUNDING..... 68
(I) DIVISION OF YOUTH CORRECTIONS – MEDICAID FUNDING 68
(J) OTHER CONTRACTUAL SERVICES 70
FEDERAL MEDICAID INDIRECT COST REIMBURSEMENT FOR DHS PROGRAMS.. 70

(1) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office section of the Department's budget contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determination, client and provider services, utilization and quality review, and information technology contacts. This division is divided into seven subdivisions.

(A) GENERAL ADMINISTRATION

This subdivision contains the appropriations for the Department's FTE, personal services, employee-related expenses and benefits, and operating expenses. This subdivision also contains funding for all of the centrally appropriated line items in the Department. A description of each line item is presented below.

PERSONAL SERVICES
This line item funds the Department's expenditures for FTE, temporary staff, and some of its contractors. All allocated POTS for Salary Survey, Performance Achievement Pay, Health, Life, Dental, Short-Term Disability, and Amortization Equalization Disbursement are paid through this line item. Supplemental Amortization Equalization Disbursement, however, is not included in this total, as it is already included as part of the Salary Survey amount.

HEALTH, LIFE, AND DENTAL
This line item funds the Department's insurance benefits, and is part of the POTS component paid jointly by the State and state employees on a predetermined ratio, based on the type of package that each employee selects (e.g., Employee, Employee plus Dependant, Employee plus Spouse, etc.). Since FY 2005-06, the State has been increasing its portion of the costs for this benefit. For FY 2010-11 and FY 2011-12, due to an economic downturn, the reimbursement rate for the Health portion stayed at 90% of the market average; however the dental benefit was reduced to 85% of market average. For FY 2012-13, the reimbursement was increased to 100% of the market average.

SHORT-TERM DISABILITY
This line item, a component of POTS, provides partial payment of an employee's salary in the event that an individual becomes disabled and cannot perform his or her work duties. The yearly estimated rate is set by the Department of Personnel and Administration (DPA), and is based on the sum of base salaries, Salary Survey, range adjustments, and Performance Achievement Pay.

AMORTIZATION EQUALIZATION DISBURSEMENT
This line item funds the increased employer contribution to the Public Employees' Retirement Association (PERA) Trust Fund to amortize the unfunded liability in the Trust Fund beginning January 2006. The rate is provided by the Department of Personnel and

Administration and is calculated using the sum of base salaries, Salary Survey, and range adjustments. During the 2005 legislative session, the General Assembly created a single Amortization Equalization Disbursement line item in all departments to fund these expenses. The Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

SUPPLEMENTAL AMORTIZATION EQUALIZATION DISBURSEMENT

The Supplemental Amortization Equalization Disbursement increases the employee's contribution to the PERA Trust Fund to amortize the unfunded liability beginning January 2008. It is similar to the Amortization Equalization Disbursement discussed above, however, this line is funded through a reduction of the proposed Salary Survey increases for the upcoming fiscal year. This amount is ultimately paid through the Personal Services line item, through a defined percentage of the employee's raise. The rate is provided by the Department of Personnel and Administration, and is calculated using the sum of base salaries, Salary Survey, and range adjustments. During the 2006 legislative session, the General Assembly passed SB 06-235, which created the Supplemental Amortization Equalization Disbursement as a sub-line of the Salary Survey and Senior Executive Services line item in all departments to fund these expenses. The Supplemental Amortization Equalization Disbursement is calculated using the same methodology as the PERA contribution calculation and includes all employees eligible for State retirement benefits.

SALARY SURVEY AND SENIOR EXECUTIVE SERVICE

The Salary Survey and Senior Executive Services appropriation reflects the amounts appropriated to the Department to cover the cost of salary increases based on the job and wage classification survey performed annually by the Department of Personnel and Administration.

Each employee title or class is matched to an occupational group for a percentage increase. This percentage is then multiplied by the employee's estimated salary as of June to come up with the Salary Survey amount. In the Department, most of the employees fall into the following occupational groups: financial services, administrative support and related, or professional services. Applicable PERA and Medicare amounts are added into the Salary Survey calculations.

MERIT PAY

Formerly known as "Performance Achievement Pay," Merit Pay represents the annual amount appropriated for periodic salary increases for State employees based on demonstrated and documented ability of each employee to satisfy standards related to quantity and quality of work. Effective July 2001, the Department of Personnel and Administration implemented a performance management plan under authority of SB 00-211. This legislation required the State Personnel Director to submit a plan to the Joint Budget Committee for payouts to occur on July 1, 2001. Due to the State's depressed fiscal situation, the payout date was delayed to July 1, 2002. The performance management component of the new system began without associated payouts on July 1, 2001.

WORKERS' COMPENSATION

This line item provides funding for payments made to the Department of Personnel and Administration (DPA) to support the State's self-insured program. Workers' Compensation is a statewide allocation to each Department based upon historic usage. The cost basis is developed relative to estimated claim payouts, purchased professional services (actuarial and broker costs), and Common Policy adjustments. DPA's actuaries determine departmental allocations.

OPERATING EXPENSES

In addition to funding telephones, computers, office furniture, and employee supplies associated with the Department's staff, this line also supports a number of annual costs such as in- and out-of-state travel, building maintenance and repairs, storage of records, telephones and postage, costs for the Department's call center, and subscriptions to federal publications.

LEGAL SERVICES

This Common Policy line item funds the Department's expenditures for legal services provided by the Department of Law. The Department is billed based on a blended attorney/paralegal hourly rate developed by the Department of Law.

ADMINISTRATIVE LAW JUDGE SERVICES

This Common Policy line item includes funding for services typically provided by administrative law judges and paralegals from the Office of Administrative Courts. Departmental appropriations are based upon historical utilization of these services, by applying the prior year's billable hours to the estimated billable cost for the request year. Adjustments are made based on mid-year reviews by the Department of Personnel and Administration.

PURCHASES OF SERVICES FROM COMPUTER CENTER

This Common Policy line item is appropriated funding for the Department's use of centralized computer services. The Department of Personnel and Administration (DPA) operates a computer center as a service to other departments in state government. This computer center, formerly known as the General Government Computer Center, has the Medicaid Management Information System (MMIS) computer and long-term care computer and also incurs the printing costs associated with each. The total need to fund the General Government Computer Center is calculated by multiplying a prior year's usage ratio for each state department.

MULTIUSE NETWORK PAYMENTS

This Common Policy line item was created in FY 2010-11 due to the establishment of the Governor's Office of Information Technology and subsequent consolidation of Department Information Technology personnel into that organization. These payments are to cover the cost of managing the statewide multiuse network.

MANAGEMENT AND ADMINISTRATION OF OIT

SB 08-155 created the Governor's Office of Information Technology's (OIT) in an effort to enhance the effectiveness of Information Technology (IT) services available within State government and to provide value-driven outcomes in changing times. The objectives developed to support this mission included securing and protecting State IT assets, optimizing expenditures for IT programs, projects and technology, and to effectively manage IT project costs and improve service delivery through collaboration and innovation. SB 08-155 also created the mechanism for billing associated executive agencies beginning in FY 2008-09 in order to fund OIT. This Common Policy line item was created during FY 2008-09 to fund OIT's "back-office" expenses.

COFRS MODERNIZATION

This Common Policy line item resulted from the passage of HB 12-1335, the FY 2012-13 Long Appropriations Bill. It funds the first two phases of a five-phase project to replace the statewide accounting system used by the Office of the State Controller to record all state revenues and expenditures. The new system is needed to meet the State's fiduciary responsibilities, mitigate the risk of system failure, and upgrade functionality. The new system will be built in the cloud environment by a private vendor in collaboration with state personnel. The five-phase project incorporates all of the components necessary to replace COFRS.

PAYMENT TO RISK MANAGEMENT AND PROPERTY FUNDS

This Common Policy line item is an allocation appropriated to each department based on a shared statewide risk formula for two programs: the Liability Program and the Property Program. Prior to FY 2007-08, the Department did not participate in the Property Program. However, for FY 2007-08, the Department of Personnel and Administration adjusted its policy and began billing the Department for the Property Program portion.

LEASED SPACE

Previously called Commercial Leased Space, this line item was established in FY 2003-04 as part of the transfer of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and staff from the Department of Public Health and Environment to the Department via the Long Bill (SB 03-258). Funding is appropriated to this line item to pay for leased space required beyond the capacity of the Capitol Complex Leased Space.

CAPITOL COMPLEX LEASED SPACE

This Common Policy line item is appropriated based on usable square footage utilized by each State department. Currently, for the Department of Health Care Policy and Financing, this includes 31,512 square feet of space at 1570 Grant Street.

GENERAL PROFESSIONAL SERVICES AND SPECIAL PROJECTS

This line item was created in 2008 and is appropriated funding for special or temporary projects the General Assembly chooses to fund each year.

(B) TRANSFERS TO OTHER DEPARTMENTS

TRANSFER TO DPHE FOR FACILITY SURVEY AND CERTIFICATION

The Department of Public Health and Environment (DPHE) is authorized to establish and enforce standards of operation for health facilities per 25-1.5-103, C.R.S. Federal statute 42 C.F.R. §488 authorizes and sets requirements for both Medicare and Medicaid surveys and certification of health facilities. This line item helps to fund the survey and certification of nursing facilities, hospices, home health agencies, and Home- and Community-Based Services agencies (including alternative care facilities, personal care/homemaking agencies, and adult day services) by paying the Medicaid share. The Department also pays DPHE to maintain and operate the Minimum Data Set resident assessment instrument, which is used for nursing facility case mix reimbursement methodology. However, the Minimum Data Set resident assessment instrument, from which the data is obtained, is not Medicaid funded. The Department contracts with DPHE through an interagency agreement for these functions. Federal financial participation is broken into two categories: 1) expenditures qualifying for a 75% enhanced federal financial participation rate for skilled professionals expenditures related to long-term care facilities, and 2) expenditures qualifying for a 50% federal financial participation rate to cover POTS and other Common Policies for the FTE that perform these services. While the DPHE FTE is working in the field to survey and inspect the facilities, that FTE qualifies for 75% federal financial participation. After the FTE returns to the office to complete the paperwork associated with the inspection, the FTE time in the office qualifies for 50% federal financial participation. The FTE uses a time reporting sheet that details how each hour of work is spent, so that Medicare and Medicaid funding can be claimed as applicable.

The federal Centers for Medicare and Medicaid Services (CMS) also requires that the State be in compliance with Medicare requirements for home health and licensure for hospice agencies. Facility surveys associated with compliance for these Medicare requirements are also performed by DPHE; however, they are Medicare funded rather than Medicaid funded.

The Health Facilities and Emergency Medical Services subdivision of DPHE receives funding from the Department to survey a variety of facilities that serve Medicaid patients. Based on the survey, DPHE makes a recommendation to the Department as to whether or not a facility or provider is in compliance with applicable regulations and should be Medicaid certified.

TRANSFER TO DEPT OF PUBLIC SAFETY FOR LIFE SAFETY CODE INSPECTIONS FOR HEALTH FACILITIES

This line item is new for FY 2013-14 and was created by HB 12-1268 "A Transfer of Functions Pertaining to Health Facility Compliance with Certain Building Safety Standards from the Department of Public Health and Environment to the Division of Fire Safety in the Office of Preparedness, Security, and Fire Safety within the Department of Public Safety." Historically, the Life Safety Code Inspections have been performed by the Department of Public Health and Environment (DPHE) as an adjunct function to the medical inspections that DPHE performs to survey and certify various types of medical facilities for Medicare and Medicaid. The Department provides part of the funding through Medicaid for the medical inspections of nursing facilities through the "Transfer to Department of Public Health and Environment Facility for Survey and Certification" line item, and the Department will continue with

the Survey and Certification Medicaid funding. Going forward, the Department will also provide a portion of the funding, through Medicaid, to the Department of Public Safety for continuation of the Life Safety Code Inspections for nursing facilities.

TRANSFER TO DPHE FOR NURSE HOME VISITOR PROGRAM

The Nurse Home Visitor Program was created by SB 00-071 with funding from the Tobacco Master Settlement Agreement. The program uses regular in-home, visiting nurse services for low-income (below 200% of the federal poverty level), first-time mothers with a baby less than one month old. The nurses offer services during the mother's pregnancy and up to the child's second birthday. The overall goal of the program is to serve all low-income, first-time mothers who want to participate.

The trained visiting nurses educate mothers on the importance of nutrition and avoiding alcohol and drugs (including nicotine) and to assist and educate mothers on providing general care for their children and to improve health outcomes for their children. In addition, visiting nurses may help mothers to locate assistance with educational achievement and employment. This type of service is sometimes referred to as "targeted case management," involving a coordinated, ongoing, and personalized strategy for clients with a variety of needs, both medical and non-medical. Each unit of service provided equals 15 minutes and is rated and billed based on that timeframe. The goals of the program are improvements in pregnancy outcomes and the health and development of their children, as well as long-term economic self-sufficiency of their families.

During FY 2010-11, the program served 2,590 total families. Data for FY 2011-12 will not be available until a report is finished near the end of calendar year 2012. Families who do not qualify for Medicaid are served entirely by funding from the Nurse Home Visitor Program Fund, managed by the Department of Public Health and Environment (DPHE), which does not have federal financial participation.

Nineteen grantee organizations have been contracted by DPHE to provide Nurse Home Visitor Program services in 52 counties in Colorado. Most providers serve Medicaid eligible clients, and often serve multiple counties. DPHE continues to explore ways to serve the other 12 counties in Colorado that are not yet participating in this program. The nurses providing these services work for various eligible grantees that are non-profit organizations, for-profit corporations, religious or charitable organizations, institutions of higher education, visiting nurse associations, other existing visiting nurse programs, local health departments, county departments of human/social services, or other governmental agencies.

The Colorado General Assembly passed SB 10-073 "Concerning the Nurse Home Visitor Program Duties of the Health Sciences Facility at the University of Colorado," which transferred the administration of the program from DPHE to the University of Colorado Health Sciences Center. The Health Sciences Center looks for ways to expand and enhance the program to reach more needy clients in additional counties. However, the financial management of the program remains with DPHE. The Department will continue to have an interagency agreement with DPHE to pay Medicaid claims for clients that are eligible through Medicaid.

In the Department's 2010 Figure Setting, the Joint Budget Committee (JBC) staff recommended that this line item be moved from the Department's (5) Other Medical Services Long Bill Group to the (1) Executive Director's Office, (B) Transfers to Other Departments subdivision in order to accurately reflect the nature of this appropriation (Figure Setting document dated March 16, 2010, page 185). The Committee approved this recommendation, and the line item was transferred in the FY 2010-11 Long Bill (HB 10-1376).

TRANSFER TO DPHE FOR PRENATAL STATISTICAL INFORMATION

The Department requires statistical data to evaluate the effectiveness of the Prenatal Plus program that used to be managed by DPHE but is now managed by the Department effective FY 2011-12. DPHE had been measuring the effectiveness of the program by using data supplied by the DPHE Vital Statistics office. The departments determined that it would be more cost-effective to continue to use the Vital Statistics data rather than to create a new tracking system for this purpose, so funding is allocated to reimburse DPHE for this purpose. This line item was newly established as a result of FY 2011-12 DI-8 "Prenatal Plus Administration Transfer." See the below line item for more information.

TRANSFER TO DPHE FOR ENHANCED PRENATAL CARE TRAINING AND TECHNICAL ASSISTANCE

The Enhanced Prenatal Care Training and Technical Assistance program provides funding for administrative activities for case management, nutrition, and mental health counseling to the Medicaid-eligible pregnant women in Colorado who are assessed to be at high risk for delivering low birth weight infants (5 pounds, 8 ounces or less). These services complement medical prenatal care by addressing the lifestyle, behavioral, and non-medical aspects of a woman's life likely to affect her pregnancy. The Enhanced Prenatal Care program, also known as Prenatal Plus, has been effective at increasing the number of women who stop smoking, gain an adequate amount of weight, resolve psychosocial problems, and has decreased the number of infants who are born at low birth weight. Regular medical services for Prenatal Plus clients are paid under the Department's line item for Medical Services Premiums.

The program provides services to slightly fewer than 2,000 women each year. Enhanced prenatal services are provided at county health departments, county nursing services, community health centers, and private non-profit agencies. This program is conducted by having the pregnant women visit the office sites for the services in contrast to the Nurse Home Visitor Program, in which the nurses visit the pregnant women and new mothers at the family home. The sites are visited by the Department of Public Health and Environment (DPHE) on a three-year rotation, with a mail-in audit chart required every other year. The sites are required to submit a plan addressing identified concerns to the program coordinator and correct any deficiencies.

The Department last implemented a rate change in Medicaid reimbursement for the Enhanced Prenatal Care Training and Technical Assistance services effective July 1, 2004. The Medicaid reimbursement structure – which has been in effect since the federal Centers for Medicare and Medicaid Services (CMS) approved the State Plan in 1996 – pays more for model care services that result in the best health outcomes for pregnant women and their infants. The reimbursement structure also encourages early enrollment of women to reduce pregnancy risk factors. There are four tiers in the reimbursement structure based on the number of visits by the pregnant woman: one to four visits; five to nine visits; ten visits; and, eleven or more visits. The more visits that occur, the more likely behavioral changes will occur to improve the outcome of the pregnancy. Total visits of 10 or more are considered to be model care.

Payment to the providers is made only after delivery of the baby or after the woman leaves the program for other reasons in order to determine the total number of visits. Payments for the visits are paid through the Department's Medical Services Premiums line item.

This program was managed by DPHE prior to FY 2011-12, within which the transferred funds were spread across a number of different lines, including Health Statistics and Vital Records, Information Technology Services, Prevention Services Division, and Women's Health.

The Department and DPHE discussed the possibility of transferring this program to the Department for oversight and management, as the program is operated entirely for Medicaid clients. The Department requested this action be taken in its FY 2011-12 DI-8 "Prenatal Plus Administration Transfer." Management of the program by the Department would no longer require that funding be transferred to another department, so the funding for the administration of the program was requested to be divided between the Department's Personal Services and Operating Expenses line items. The JBC approved this decision item as requested, which eliminated this line item effective FY 2011-12.

TRANSFER TO DORA FOR NURSE-AIDE CERTIFICATION

Federal law requires certification of nurse aides working in any medical facility with Medicaid or Medicare patients (42 C.F.R. §483.150(b)). The Department of Regulatory Agencies (DORA) administers the Nurse Aide Certification program under an interagency agreement with the Department and the Department of Public Health and Environment (DPHE). The Department provides Medicaid funding for the program and DPHE provides Medicare funding for the program. Pursuant to 12-38-101, C.R.S., the Colorado State Board of Nursing in DORA oversees regulation of certified nurse aides practicing in medical facilities throughout the state. The regulation of nurse aides is carried out under the Nurse Aide Certification program, which includes a nurse aide training program, followed by testing and application for certification as a nurse aide as well as enforcement functions. The Nurse Aide Certification program is administered by the Division of Registrations located in DORA and is directly overseen by the five-member Nurse Aide Advisory Committee.

DORA is required to administer the Nurse Aide Certification program using established standards for the training curriculum to ensure that nurse aides receive federally required training and that nurse aides are tested regularly to assure competency. DORA is also responsible for administering a nurse aide registry program that allows investigations into allegations of abuse by nurse aides, when necessary. The registry also tracks the mandatory criminal background check required for nurse aides per the passage of HB 95-1266.

State funding for this program is comprised of General Fund and fees collected directly from nurse aides. These fees are assessed as part of the required criminal background check. Federal regulations prohibit requiring nurse aides to pay for certification, but requiring non-certified nurse aides to pay the cost of the background check is a permissible exception to these regulations. Many nursing facilities reimburse the nurse aides for any fees paid as part of the pre-hiring requirements. The State funds, consisting of General Fund and reappropriated funds from DORA are used to draw down federal funds.

TRANSFER TO DORA FOR REVIEWS

The Office of Policy, Research, and Regulatory Reform in the Department of Regulatory Agencies (DORA) conducts sunset reviews as required by legislation passed by the Colorado General Assembly. The Departments affected by the legislation reimburse DORA for performance of such sunset reviews. Previously, when the Department had a law requiring a sunset review, a specific line item was established in the Long Bill with a line item name that referred to the short name of the legislation, which was subsequently eliminated upon completion of the review.

This line item was established in the FY 2009-10 Long Bill Add-Ons (SB 09-259), beginning with FY 2008-09. The line item name was created to accommodate the potential for multiple sunset reviews required by various laws across multiple Department programs and functions. Sunset reviews are a type of audit that are performed to provide information to the General Assembly on the effectiveness and efficiencies of particular programs. This information is used by the General Assembly to provide guidance on future legislation or modifications to current legislation. Statutory authority authorizing DORA to conduct these reviews comes from 24-34-104 (8) (a), C.R.S.

TRANSFER TO DEPARTMENT OF EDUCATION FOR PUBLIC SCHOOL HEALTH SERVICES ADMINISTRATION

This line item funds a portion of the administrative expenses of the Public School Health Services Program created in SB 97-101. The intent of the program is to use Medicaid funds to support local school health services, increase access to primary and preventive care to low-income, under- or uninsured children, and improve the coordination of care between schools and health care providers. Unlike most other programs administered by the Department, the State's contribution of funding to the program is derived from certification of public expenditures. This process allows participating school district providers to certify the expenditure of state funds on eligible services that can be matched by the federal government through Title XIX of the Social Security Act. Pursuant to 25.5-5-318 (8)(b), C.R.S., the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

The administration of the Public School Health Services program is split between the Department of Health Care Policy and Financing (the Department) and the Department of Education through an Interagency Agreement. This line funds the administrative expenses of the Colorado Department of Education, which provides technical assistance to medical staff at participating school districts, receives and reviews all local services plans, reviews annual reports, and pays for additional personnel. .

(C) INFORMATION TECHNOLOGY CONTRACTS AND PROJECTS

INFORMATION TECHNOLOGY CONTRACTS

Footnote 22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The two line items for Medicaid Management Information System (MMIS) Contract and HIPAA Web Portal Maintenance were combined into one line item titled "(C)

Information Technology Contracts and Projects: Information Technology Contracts" within Long Bill group (1) Executive Director's Office.

MEDICAID MANAGEMENT INFORMATION SYSTEM CONTRACT

Section 1903(r)(1) of the Social Security Act states that, to receive federal funding for use of automated data systems in administration of the Medicaid program, the State must have a mechanized claims processing and information retrieval system. The Centers for Medicare and Medicaid Services' (CMS) State Medicaid Manual states that for Medicaid purposes, the mechanized system is called the Medicaid Management Information System (MMIS). The MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. The system may be operated by either a state agency or a fiscal agent, which is a private contractor hired by the State.

CMS's State Medicaid Manual identifies the specific types of MMIS costs that are allowable for federal reimbursement. For activities related to the design, development, or installation of an MMIS, the Department may receive, with proper approval, 90% federal financial participation per 42 C.F.R. §433.15 (b)(3). Any costs related to the operations of MMIS for ongoing automated processing of claims, payments, and reports, the Department may receive 75% federal financial participation per 42 C.F.R. §433.15 (b)(4).

The Department has contracted with Affiliated Computer Systems (ACS) to perform as the fiscal agent for the operation and development of MMIS since December 1, 1998. The MMIS processes claims and capitations based on edits that determine payment or payment denial and performs prior authorization reviews for certain medical services and pharmacy prescriptions. Warrants are produced by the State based on the information electronically transmitted from MMIS. The MMIS Contract budget item covers costs for running claims through the processing system and for certain administrative functions.

The State must competitively bid the role of the fiscal agent for the operation of the MMIS once every eight years. During FY 2006-07, reprocurement of MMIS operational responsibilities was completed, and ACS was reselected as the fiscal agent. On July 1, 2007 a new MMIS contract began and remained in effect until June 30, 2010. Prior to the expiration of the current contract, the Department entered into negotiations with ACS for the extension of the MMIS contract. In June 2010 the Department completed negotiations with ACS and extended the MMIS contract until June 30, 2015. Later on July 14, 2010, CMS approved the Department's five-year contract extension in accordance with federal statute at 45 C.F.R. §95.611. The Department is requesting funding in FY 2013-14 to competitively bid and reprocure the MMIS when the current eight-year contract ends. Please note that ACS is now owned by Xerox.

Beginning March 1, 2004, the MMIS contract was converted to a fixed-price contract that covers all claims processing, provider enrollment and notification, and prior authorization reviews. Items that are not included in the fixed price portion include: postage, development costs associated with systems changes, preferred drug list maintenance, and Payment Error Rate Measurement (PERM) maintenance costs.

PROVIDER WEB PORTAL

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 included provisions to address the need for developing a consistent framework for electronic transactions and other administrative issues. Through subtitle F of title II of Public Law 104-191, Congress added to title XI of the Social Security Act a new Part C, titled Administrative Simplification. The purpose of this new part is to improve the efficiency and effectiveness of the Medicare and Medicaid programs by encouraging the development of standards and requirements to enable the electronic exchange of certain health information.

Under part C of title XI, section 1172 makes any standard adopted applicable to: 1) health plans; 2) health care clearinghouses; and, 3) health care providers who transmit any health information in electronic form in connection with a transaction covered by 45 C.F.R. Part 162. Based on this section of the Social Security Act, Colorado's Medicaid program is considered a covered health plan.

To comply with the provisions under HIPAA, the Department issued a request for proposals to design, develop, implement, monitor, and maintain a web portal application. The web portal became operational in 2003 and provides a web application front-end for providers to submit HIPAA-compliant electronic transactions to and from the Medicaid Management Information System (MMIS), Colorado Benefits Management System (CBMS), and Benefits Utilization System.

FRAUD DETECTION SOFTWARE CONTRACT

On January 23, 2008, the Department submitted BA-9 "Efficiencies in Medicaid Cost Avoidances and Provider Recoveries," requesting $1,250,000 in total funding to increase efficiencies in Medicaid cost avoidances and provider recoveries. The budget amendment allowed the Department to purchase fraud-detection software and also allowed the Department to implement improvements to the Medicaid provider re-enrollment process.

The fraud-detection software utilizes neural network and learning technology to detect fraud, abuse, or waste in the Medicaid program. It also supports such functions as compliance monitoring, provider referrals, and utilization review. Moreover, it provides support to the Department's Program Integrity Section by providing additional research on: potential fraud and abuse; receiving and accessing licensing board data to compare with provider data; looking for known abusive or fraudulent practices using target queries on procedure or diagnosis codes; and, tracking the progress of individual cases, including case hours, investigative cost, and travel expenses related to the Medicaid program.

CENTRALIZED ELIGIBILITY VENDOR CONTRACT PROJECT

This line item was created in the FY 2008-09 Long Bill (HB 08-1375) for the implementation and administration of a centralized eligibility vendor model. It was the result of the recommendation by The Blue Ribbon Commission for Health Care Reform (the "208 Commission") created to study and establish health care reform models for expanding coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents. Recommendation 10 in the Fifth Proposal suggested creating a single state-level entity for determining Medicaid and Children's Basic Health Plan eligibility.

The Centralized Eligibility Vendor streamlines navigation through the eligibility process of Medicaid and the Children's Basic Health Plan, creates expedited eligibility for medical only cases, and improves outreach and enrollment in both programs. These changes ensure easier, more reliable, and timely eligibility and enrollment processes, making the programs more efficient and effective in delivering important benefits to clients, providers, and enrollment staff. In addition, the entity modernizes the current eligibility determination process by providing technology that is not currently available in every county, such as an automated customer contact center and an electronic document and workflow management system. This provides a central repository for applications and related documents. The Centralized Eligibility Vendor also provides electronic systems that aid in managing the online application for benefits. This entity enhances and complements the current multiple county-level process.

This contract currently covers the following expansion populations from HB 09-1293, the Colorado Health Care Affordability Act of 2009: CHP+ to 250% of the federal poverty level, the Buy-In Programs for Individuals with Disabilities, and Adults without Dependent Children to 100% of the federal poverty level.

(D) ELIGIBILITY DETERMINATIONS AND CLIENT SERVICES

MEDICAL IDENTIFICATION CARDS

The purpose of Medicaid authorization cards is to provide proof of a client's Medicaid eligibility to service providers so that the client can receive medical services from the provider. Currently, if clients can not show proof of Medicaid eligibility, providers can, at times, refuse to provide services.

Under the medical ID card system, clients are issued plastic Medicaid authorization cards upon a determination of their eligibility for Medicaid. Prior to rendering Medicaid services, providers must verify Medicaid eligibility electronically after viewing the client's plastic card. In the event plastic cards are lost, replacement cards are issued when necessary. The plastic authorization cards have reduced the Department's liability from a one-month guarantee of eligibility to only the exact periods of eligibility. The new cards also allow clients to move on and off covered programs without receiving a new card each time.

Old Age Pension State Medical Program clients have always received Medicaid authorization cards, but, prior to FY 2003-04, there were no specific funds to pay for the production of these cards. Beginning in FY 2003-04, funding for authorization cards for the Old Age Pension State Medical Program's clients was added to the appropriation. Since these clients are not Medicaid eligible, no federal match is available for these funds.

CONTRACTS FOR SPECIAL ELIGIBILITY DETERMINATIONS

This line item provides funding for four three Department functions: Disability Determination Services, Nursing Facility Preadmission Screening and Resident Review, School District Eligibility Determinations, and Hospital Outstationing.

Prior to FY 2008-09, Disability Determination Services, Nursing Home Preadmission and Resident Assessments, and School District Eligibility Determinations were funded through their own separate line items within Long Bill group (1) Executive Director's Office. Footnote 22 of SB 07-239, the FY 2007-08 Long Bill, instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, HB 08-1375, the FY 2008-09 Long Bill consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The three budget items for Disability Determination Services, Nursing Facility Preadmission Screening and Resident Review, and School District Eligibility Determinations were combined into one line item titled "(D) Eligibility Determinations and Client Services: Contracts for Special Eligibility Determinations" within Long Bill group (1) Executive Director's Office. In FY 2009-10, School District Eligibility Determinations was eliminated pursuant to the Department's FY 2009-10 ES-3 "Department Administrative Reductions" and Hospital Outstationing was added as a result of the passage of HB 09-1293, "Colorado Health Care Affordability Act."

DISABILITY DETERMINATION SERVICES

Federal law mandates that disability determinations be conducted for clients who are eligible for Medicaid due to a disability. Prior to July 2004, the Disability Determination Services line provided Medicaid funding to the Department of Human Services (DHS) to conduct disability determinations for individuals waiting for eligibility determination of Supplemental Security Income or, if not financially eligible for Supplemental Security Income, were potentially eligible for Medicaid due to a disability. In July 2004, administration of disability determinations for Medicaid eligible persons was transferred from DHS to the Department of Health Care Policy and Financing.

NURSING HOME PREADMISSION AND RESIDENT ASSESSMENTS

This budget item funds screenings and reviews mandated by the federal Omnibus Budget Reconciliation Act of 1987 to determine the appropriateness of nursing facility placements for individuals with major mental illness or developmental disabilities. The federal financial participation rate for this program is 75%.

All admissions to nursing facilities with Medicaid certified beds, regardless of individual payer source, are subject to preadmission screening, and all current residents, regardless of individual payer source, are subject to an annual review. The purpose of these assessments is to ensure that residents receive appropriate care, that they remain in the nursing facility for the appropriate amount of time, and that the percentage of residents with a major mental illness or developmental disability does not exceed 50% of all patients in the facility. This is a federal requirement to receive Medicaid funds.

There are two levels of preadmission resident reviews. Level I pre-screening is comprised of a series of questions related to the diagnosis of a developmental disability or mental illness. For Medicaid clients, these questions are a part of the Uniform Long-Term Care 100.2 Form, an assessment completed by the Single Entry Point agencies to determine the level of care (see Long-Term Care Utilization Review). If the Level I screening identifies a mental illness or developmental disability with the need for specialized services, a referral is made to the community mental health center or the Division for Developmental Disabilities (DDD) for a Level

II Enhanced Evaluation. These Level I screenings are funded out the Long Term Care Utilization Review budget item, which is in Long Bill group (1) Executive Director's Office; (E) Utilization and Quality Review Contracts.

The purpose of the Level II enhanced evaluation is to confirm a diagnosis of a major mental illness (MMI) and/or mental retardation/developmental disability or related condition (MR/DD/RC) and to establish need for nursing facility-based specialized services. Upon diagnosis of a Level II MMI or MR/DD/RC, the Level II enhanced evaluation is sent to the State Mental Health Authority or the State Mental Retardation Authority at the Department of Human Services for review and to determine placement. These extensive evaluations also provide recommendations to assist the nursing facility in developing an appropriate plan of care for necessary services. They are coordinated by the nursing facility with a mental health and developmental disabilities service provider. A resident review must be conducted for residents of Medicaid-certified nursing facilities that have a MMI and/or MR/DD/RC diagnosis whenever there is a significant change in their medical and/or psychiatric condition. Level II enhanced evaluations, resident reviews, and depression diversion screenings by mental health centers are funded through the Preadmission Screening and Resident Review (PASRR) budget item.

In 2007, it was determined that training is needed to ensure that community-based PASRR providers understand and follow correct screening and review procedures and comply with all State and federal PASRR program requirements. The program administrator conducts trainings throughout the year using this funding. These trainings cover the entire PASRR process, preadmission screenings, Level II screenings, and resident reviews. The training is available to all PASRR providers which includes mental health centers, nursing facilities, Community Centered Boards, Single Entry Point agencies, and hospital and hospice discharge planners.

HOSPITAL OUTSTATIONING

This line item funds outstationing activities at hospitals in order for hospitals to provide certain on-site services to inform, educate, and assist qualifying clients in gaining enrollment into the State's medical assistance programs. Not every hospital is anticipated to participate in outstationing activities, but costs for these activities were based on 1.0 FTE at each hospital. This line item was created as a result of the passage of HB 09-1293, the "Colorado Health Care Affordability Act," to assist with the anticipated increase in caseload due to the bill.

COUNTY ADMINISTRATION

This line item provides for partial reimbursement to local county departments of human/social services for costs associated with performing Medicaid, Children's Basic Health Plan, and Old Age Pension State Medical Program eligibility determinations. Prior to July 1, 2006, this funding was included in the Department of Human Services (DHS) budget through an interagency transfer and was combined with the corresponding appropriation for non-Medicaid programs such as food stamps and cash assistance programs administered by DHS. However, with the passage of SB 06-219 beginning in FY 2006-07, oversight and funding for the Medicaid portion of county administration was transferred to the Department, thereby establishing a direct relationship between the Department and the counties performing these functions.

As part of the Department's fiscal note for SB 06-219, the Department and DHS agreed that the allocation and reimbursement methodology would remain the same as prior to July 1, 2006. This included: 1) using the existing federally-approved random moment sampling model performed by DHS to determine the allocation of expenditures between programs administered by the Department and those administered by DHS; 2) continuing the cost-sharing allocation of 50% federal funds, 30% State funds, and 20% local funds; 3) continuing to utilize the County Financial Management System for counties to have one-stop billing; and, 4) utilizing interagency transfers of State General Fund between the Department and DHS pursuant to 24-75-106, C.R.S. in order to maximize Medicaid reimbursement to the counties, thereby maximizing reimbursement of county expenditures.

HOSPITAL PROVIDER FEE COUNTY ADMINISTRATION

This line item provides for reimbursement to local county departments of human/social services for costs associated with performing Medicaid eligibility determinations for the "Expansion Adults to 100% Federal Poverty Level (FPL)" category funded under HB 09-1293, the "Colorado Health Care Affordability Act." This funding was included in the County Administration line item, showing up as Cash Funds and Federal Funds; however, the Department's FY 2012-13 S-7 "Hospital Provider Fee Administrative True-up," submitted with the January 3, 2012 Supplemental Budget Request, requested the separation of this funding, thereby establishing this line item to make the budget more transparent, allow for easier tracking of hospital provider fee funds, and to separate funding sources that are allocated based on differing methodologies.

While the County Administration line item reimburses county departments using a methodology including a random moment time study, a local funding match, and interagency transfers, this line item reimburses in a manner more reflective of the expansion of the Department's programs under HB 09-1293. These funds are distributed twice per state fiscal year based on total County Administration expenditures and each county's percentage of clients which fall into the "Expansion Adults to 100% FPL" expansion category funded by the Hospital Provider Fee relative to total Medicaid.

ADMINISTRATIVE CASE MANAGEMENT

This line item funds administrative case management activities related to the Child Welfare program administered by the Department of Human Services (DHS). Administrative Case Management was approved by the federal Centers for Medicare and Medicaid Services (CMS) for 50% federal financial participation in August 2005. With the passage of SB 06-219, the oversight of administrative case management was transferred from DHS, beginning July 1, 2006. Prior to FY 2006-07, Medicaid funding for these programs was transferred through interagency transfers, originating in the Department's Long Bill group (6) DHS – Medicaid Funded Programs appropriations.

Funding for administrative case management includes reimbursement for staff and operating costs associated with State supervision and county administration of programs that protect and care for children, including out-of-home placement, subsidized adoptions, child care, and burial reimbursements. Medicaid funding for these costs was identified through a contingency based contract held between the Governor's Office of State Planning and Budgeting and Public Consulting Group, Inc.

Similar to the County Administration appropriation narrated above, State appropriated funding for these services is allocated across all 64 counties. The Department and DHS agreed that the best allocation for this revenue was to base funding on the current allocation percentages used in the Child Welfare program administered by DHS. Also similar to the County Administration appropriation, DHS has agreed to provide additional General Fund spending authority if necessary, to maximize Medicaid reimbursement. This allows the State to maximize available matching federal funds. There is no county share associated with this funding.

CUSTOMER OUTREACH

This line item funds customer outreach services provided through two Department functions: the Early and Periodic Screening, Diagnosis, and Treatment Program and SB 97-05 Enrollment Broker. Prior to FY 2008-09, each of these functions was funded through its own separate line item within Long Bill group (1) Executive Director's Office. Footnote 22 of SB 07-239, the FY 2007-08 Long Bill, instructed the Department to submit a plan for restructuring its Executive Director's Office long bill group into a more programmatic format. As a result of HB 08-1375, the FY 2008-09 Long Bill, 46 line items were consolidated into 31 line items within Long Bill group (1) Executive Director's Office. Two of the consolidated budget items were the Early and Periodic Screening, Diagnosis, and Treatment Program and SB 97-05 Enrollment Broker, which were combined into one line item titled "(D) Eligibility Determinations and Client Services: Customer Outreach" within Long Bill group "(1) Executive Director's Office."

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM

The Department is required to ensure Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program outreach and case management services in a manner consistent with the federal regulations set forth at 42 CFR Sections 441.50-441.61. These outreach and case management services are aimed at the promotion of health, the prevention of disease, and improved access to health care services for children. The services include, but are not limited to:

- contacting eligible clients to provide in-depth explanation of the program and its importance within 60 days of eligibility being established;
- offering assistance and information to eligible clients and helping to overcome barriers which might impede access to services;
- clarifying the role of primary care providers, dentists, and the managed care/prepaid health plans;
- emphasizing the client's obligation to maintain the linkage between the child/youth and the primary care physician;
- maintaining periodic contact with the client to encourage the utilization of services needed or promoted by referrals and assisting with referrals as needed;
- initiating collaborative activities with other child-related health and social services agencies and resources within each county and referring EPSDT clients as needed to those agencies and resources;
- assisting clients with the program and managed care information process; and,
- referring applicants to the enrollment broker at the time of Medicaid application.

Only administrative and outreach services are funded by this budget item. Services funded by this budget item are contracted primarily by county health department staff but may include other local outreach providers such as hospitals and community-based

organizations. The funding for medical services provided through the EPSDT Program remain in the Department's Medical Services Premiums Long Bill group.

ENROLLMENT BROKER

Funding for a Medicaid managed care enrollment broker was appropriated to the Department through SB 97-05. The enrollment broker is charged with providing information on basic Medicaid benefits offered through all health plans. The Department's enrollment broker contract was awarded in 1998 to MAXIMUS, Inc.

MAXIMUS, Inc. contacts all newly eligible Medicaid clients to inform them of Medicaid plan choices. If a client chooses the Primary Care Physician Program or a health maintenance organization, MAXIMUS, Inc. will enroll the client in the plan. MAXIMUS, Inc. also enrolls and disenrolls clients from the managed care plans in accordance with Medicaid rules. MAXIMUS, Inc. does this work under the name of Health*Colorado*.

Effective July 1, 2013, the Department's contract with MAXIMUS, Inc. has been extended for two fiscal years. Additionally, per a sole source contract awarded by the Department effective January 1, 2013, MAXIMUS, Inc. will provide enrollment management services for the CHP+ program.

(E) UTILIZATION AND QUALITY REVIEW CONTRACTS

PROFESSIONAL SERVICES CONTRACTS

Footnote #22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The five budget items for Acute Care Utilization Review, Long-term Care Utilization Review, External Quality Review, Drug Utilization Review and Mental Health External Quality Review were combined into one line item titled "(E) Utilization and Quality Review Contracts: Professional Services Contracts" within Long Bill group (1) Executive Director's Office.

ACUTE CARE UTILIZATION REVIEW

Acute Care Utilization Review budget item includes the performance of prospective and retrospective reviews for specified services to ensure that requests for benefits are a covered benefit and that the service is medically necessary and appropriate. Prospective reviews are conducted prior to the delivery of services and include the following service categories: transplants; select procedures; out-of-state elective admissions; inpatient mental health services; inpatient substance abuse rehabilitation; durable medical equipment; select non-emergent medical transportation; Early and Periodic Screening, Diagnosis and Treatment home health service reviews; and, outpatient physical and occupational therapy requests. Retrospective reviews are conducted on inpatient stays after the hospital claims have been paid. By examining the paid claims against the medical records, the contractor ensures the care paid for was medically necessary, required an acute level of care, and was coded and billed correctly.

The Department contracts with an independent contractor to perform prospective and retrospective reviews. These reviews result in cost avoidance and recovery of provider payments should the provider or facility fail to provide the required documentation. Under Section 1903 (a)(3)(C)(i) of the Social Security Act and 42 C.F.R. §433.15 (6)(i), the Department is allowed to request enhanced federal financial participation of 75% for funds expended for the performance of medical and utilization review by a qualified improvement organization. The Department's acute care utilization review contractor qualifies as a quality improvement organization as defined under Section 1152 of the Social Security Act.

LONG-TERM CARE UTILIZATION REVIEW

Long-term care utilization reviews include performing prior authorization reviews for certain services to determine medical necessity, level of care, and target population determinations as well as periodic reevaluation of services. In addition, the Single Entry Point agencies (case management agencies and community centered boards) perform pre-admission screening for Medicaid clients seeking admittance to nursing facilities and home and community-based long-term care programs, as well as annual continued stay reviews of these clients. The Single Entry Point agencies and other contractors perform the following functions with funding from this budget item:

- Uniform Long-Term Care 100.2 Form (ULTC 100.2) assessments for needed level of care;
- Pre-Admission Screening and Resident Review (Level I) to identify clients who need Level II screening;
- administration of the Hospital Back-Up Program, which provides cost-effective alternatives for clients who have extended acute hospitalizations by permitting transfer to nursing facilities capable of providing care;
- assessments for the Children's Extensive Support waiver which provides Medicaid benefits, services and support for children with developmental disabilities or delays and require special services and provide an alternative to institutional placement;
- assessments for Private Duty Nursing which provides eligible clients with skilled nursing services in a home setting;
- data management; and,
- training for case managers.

Ascend Management Innovations, LLC is another contractor that maintains a long-term care database and performs prior authorization reviews for long-term care clients. The results of the prior authorization reviews are transmitted electronically to the Department's fiscal agent. Ascend Management Innovations also conducts reviews for the Level II Pre-Admission Screening and Resident Review Program. The Department's contract with Ascend Management Innovations, LLC ended June 30, 2012. Beginning July 1, 2012, the Department contracts with Masspro for these services.

Under Section 1903 (a)(2)(C) of the Social Security Act and 42 C.F.R. §433.15 (9), the Department is allowed to request enhanced federal financial participation of 75% for funds expended to conduct preadmission screening and resident review activities. If a contractor qualifies as a qualified improvement organization under Section 1152 of the Social Security Act, the Department may seek enhanced federal financial participation of 75% for the performance of medical and utilization review activities other than preadmission screening and resident review.

EXTERNAL QUALITY REVIEW

This budget item provides funding for the Department's contractor Health Services Advisory Group, Inc. to validate performance improvement projects and Healthcare Effectiveness Data and Information Set (HEDIS) measures for managed-care organizations, the Primary Care Physician Program, and fee-for-service providers. Health Services Advisory Group, Inc. also provides an annual report of activities and recommendations. The contractor is responsible for the day-to-day administration and management of a credentialing program for Medicaid providers. The process includes, but is not limited to:

- collection and verification of the status of licensure;
- validation of Drug Enforcement Agency or Controlled Dangerous Substances certification;
- verification of relevant training, experience, and board certification;
- maintenance of records on any past liability claims;
- tracking of U.S. Department of Health and Human Services, Medicare and Medicaid sanctions; and,
- verification of work history.

Through the credentialing process, the contractor verifies the credentials of approximately 33% of the primary care providers enrolled in the Primary Care Physician Program each year (up to 380 annually) and 20 primary care providers enrolled in the Self-Insured Network, plus new monthly enrollments. The credentialing process helps the Department identify quality of care issues, fraudulent representation, loss of privileges, and licensure revocation or illegal practices which require further investigation. If such actions from physician regulatory boards have been recommended, the Department staff suggests further actions that may include termination of Medicaid participation. Beginning in FY 2012-13, the Department's contract with Health Services Advisory Group is amended to include conducting survey administration, analysis, and reporting of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys (Children with Chronic Conditions-Plan Specific), for six CHP+ plans.

The Department is permitted to receive an enhanced federal financial participation rate of 75% for funds expended for performance of external quality review or related activities when they are conducted by an external quality review organization as defined in 42 C.F.R. §438.320 and 42 CFR §433.15 (b)(10).

MENTAL HEALTH EXTERNAL QUALITY REVIEW

This budget line item funds federally required, external quality-review activities that receive 75% federal financial participation when the activities are conducted by an external quality-review organization as defined in 42 C.F.R. §438.320 and 42 C.F.R. §433.15 (b)(10). Federal statute at 42 C.F.R. §456.1 requires a statewide utilization control program of all Medicaid services. Federal statute located at 42 C.F.R. §438.350 requires that either the State or an external quality-review organization validate the performance measures, performance improvement projects, and regulation compliance of all contracted managed care organizations and prepaid inpatient health plans. This budget item is specific to mental health services.

The Department's contractor Health Services Advisory Group, Inc. is responsible for five activities related to behavioral health, which include the following:

- Validate performance measures using the Centers for Medicare and Medicaid Services' protocol as a resource for validation methodology. The contractor reviews the validity of designated performance measures – which may include clinical outcomes from the Colorado Client Assessment Record – and satisfaction survey results from the Mental Health Statistics Improvement program and Youth Services Survey for Families or other internally developed performance measures. Performance measure validation for behavioral health organizations requires review of each behavioral health organization's Information Systems Capabilities Assessment Tool and site visits.
- Conduct compliance monitoring, which includes standards for access to services, structure, and operations, and quality measurement and improvement. The behavioral health organizations must meet the Department's Quality Strategy in order to promote safe and effective health care. The contractor uses no fewer than five main sources of information to determine compliance, which include document review, record review, secret shopper surveys, interviews with health plan personnel, and stakeholder/provider input.
- Validate no more than two performance-improvement projects conducted by each behavioral health organization each year. In order for such projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the performance-improvement projects must be designed, conducted, and reported in a methodologically sound manner as outlined in the Centers for Medicare and Medicaid Services' protocol.
- Conduct quality-of-care reviews that investigate individual potential quality concerns and assist the Department in addressing concerns or discovering issues that may require focused study. Medical records are the primary review source for individual case reviews.
- Deliver an annual report on each behavioral health organization.

The Department's responsibility for the Mental Health External Quality Review program began in FY 2004-05 with the passage of HB 04-1265. Prior to this time, the Department of Human Services managed Medicaid mental health programs, including the external quality review organization for mental health.

DRUG UTILIZATION REVIEW

This budget item funds the Department's drug utilization review program established pursuant to 42 C.F.R. §456.703. The purpose of the program is to ensure appropriate drug therapy while permitting sufficient professional prerogatives to allow for individualized drug therapy. The program consists of both prospective and retrospective reviews, the application of explicit predetermined standards, and an educational program. Pursuant to 25.5-5-506 (3) (b), C.R.S., the Department submits an annual report to the Health and Human Services Committees of the General Assembly that contains:

- information on the prospective and retrospective drug review program;
- the steps taken by the Department and Drug Use Review Board to ensure compliance with the requirements for predetermined standards;

- a summary of the educational interventions used and an assessment of the effect of these educational efforts on quality of care; and,
- an estimate of the cost savings generated as a result of the drug use review program.

The Department's drug utilization review program was implemented in six phases:

- Phase I, effective December 15, 2003, developed prior authorization reviews for certain sleeping agents, a non-steroid, anti-inflammatory, short-term pain medication, certain anti-migraine products, and certain anti-nausea products.
- Phase II, effective March 4, 2004, included certain atypical antipsychotics, two narcotic pain medications and COX-2 pain inhibitors.
- Phase III, effective February 2005, included two asthma treatment drugs and three skin infection treatment drugs for which less expensive alternative prescriptions existed.
- Phase IV, effective March 1, 2007, implemented prior authorizations for stimulant medications, Zantac liquid, Tramadol, narcotic analgesics containing acetaminophen, certain injectable medications, Methadone, Provigil, and Fentora.
- Phase V, effective February 1, 2008, implemented the Preferred Drug List (PDL) authorized by Executive Order D 004 07. The program provides needed medications to Medicaid clients while decreasing expenditures on pharmaceuticals. It also formed a Pharmacy and Therapeutics Committee which evaluates clinical data and evidence on all drugs under consideration for inclusion in the PDL. The Department also evaluated and pursued supplemental rebates to further facilitate providing pharmaceuticals for Medicaid clients at the lowest possible cost.
- Phase VI, effective FY 2008-09, continued the addition of drug classes to the PDL. The Department added 12 more drug classes by the end of FY 2008-09, and continues to add new drug classes annually.

(F) PROVIDER AUDITS AND SERVICES

PROFESSIONAL AUDIT CONTRACTS

This line item funds various audit contracts managed by the Department. Footnote #22 of the FY 2007-08 Long Bill (SB 07-239) instructed the Department to submit a plan for restructuring its Executive Director's Office Long Bill group into a more programmatic format. As a result, the FY 2008-09 Long Bill (HB 08-1375) consolidated 46 line items into 31 line items within Long Bill group (1) Executive Director's Office. The five budget items for Nursing Facility Audits, Hospital and Federally Qualified Health Clinics Audits, Single Entry Point Audits, Payment Error Rate Measurement Contract, and Nursing Facility Appraisals were combined into one line item titled "(F) Provider Audits and Services: Professional Audit Contracts" within Long Bill group (1) Executive Director's Office. The budget item Colorado Indigent Care Program Auditor was later added as a result of HB 09-1293 "Health Care Affordability Act," and the budget item Disproportionate Share Hospital (DSH) Audits was added as a result of the Department's FY 2010-11 DI-6 "Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures."

NURSING FACILITY AUDITS

This budget item funds statutorily required audits of costs reported by Medicaid nursing facilities for rate setting purposes. The Department contracts with an independent accounting firm to perform audits of nursing facility cost reports. The Medicaid "Financial and Statistical Report of Nursing Homes" (MED-13) determines which costs are reasonable, necessary, and patient-related to subsequently set rates based on those costs. The audited cost reports are the basis for setting nursing facility rates to cover the reasonable and necessary costs of providing care for Medicaid clients, in accordance with State and federal statutes.

HOSPITAL AND FEDERALLY QUALIFIED HEALTH CENTERS AUDITS

This budget item funds a Department contract with an independent certified public accounting firm to audit cost and rate data for hospitals, federally qualified health centers (FQHCs), and rural health centers that participate in the Medicaid program, and to establish reimbursement for extraordinary out-of-state services. Auditing of these facilities is federally mandated. Most of the hospital audits are completed from the Medicare cost report audit and are tailored to Medicaid requirements. The independent accounting firm provides the following services to the Department: contract review and reimbursement, final settlements, rebasing calculations, consultation and assistance on cost report interpretation, and participation in meetings with providers to resolve problems. The annual rates of reimbursement are based on the results of these audits and are set to cover the reasonable and necessary costs of an efficiently run hospital, FQHC, and rural health center, per federal and State law.

SINGLE ENTRY POINT AUDITS

This budget item funds annual audits of Single Entry Point agencies provided through a contractor. The scope of work has been limited to reviews of cost reports. To the extent that funds allowed, on-site audits are conducted for agencies that posed the highest risk. In FY 2006-07, the appropriation to this line was increased in order to increase the accuracy of SEP agency billing and potentially increase recovery of improper payments.

PAYMENT ERROR RATE MEASUREMENT PROJECT CONTRACT

This budget item funds the Payment Error Rate Measurement Project, which was established in response to the federal Improper Payments Information Act of 2002 and was the culmination of three separate federal pilot programs collectively referred to as the Payment Accuracy Measurement Projects. The federal Improper Payments Information Act of 2002 requires the Department to: conduct an annual review of those Medicaid services that may be susceptible to significant erroneous payments; estimate the amount of improper payments made; and, report on those estimates. The Improper Payments Information Act of 2002 defines an improper payment as "any payment made that should not have been made or that was made in an incorrect amount including overpayments and underpayments." The definition further states that these payments "include any payment to an ineligible recipient; any payment for an ineligible service; any duplicate payment; payments for services not received; and, any payment that does not account for credit for applicable discounts."

In August 2006, the Centers for Medicare and Medicaid Services (CMS) issued an interim final rule stating that federal contractors would be hired to calculate national error rates and review states' fee-for-service and managed care payments for Medicaid and State Children's Health Insurance Programs. Under the rule, each state is required to calculate its state-specific eligibility error rates and measure improper payments once every three years, so that all states are reviewed on a rotating basis, with 17 states reviewed per federal fiscal year. Due to the three-year cycle, Colorado completed the eligibility and payment error reviews in FY 2010-11 and will do so again in FY 2013-14.

Under the Payment Error Rate Measurement project, reviews are conducted in three areas: fee-for-service, managed care, and eligibility for both Medicaid and Children's Basic Health Plan. The claims review is conducted by federal contractors, whereas the eligibility review is conducted by the states. The results of these reviews are used to produce national program error rates as well as state-specific program error rates.

NURSING FACILITY APPRAISALS

This budget item funds nursing facility appraisals, which occur once every four years. The Department contracts with an independent firm to conduct these appraisals, with the underlying result being the determination of "fair rental value." Fair rental value, or appraised value, means the determination of the depreciated cost of replacement of a capital-related asset to its current owner. The fair rental (property) value determination is used in the process of rate setting, which is governed by statute at 25.5-6-201, C.R.S. The per-diem rate paid to nursing facilities is based in part on the fair rental value of the facility.

COLORADO INDIGENT CARE PROGRAM AUDITOR

This budget item funds an auditor for the Colorado Indigent Care Program due to the passage of HB 09-1293 "Heath Care Affordability Act." Prior to this passage of this bill, the providers were paid using certification of public expenditures in order to draw federal matching funds. The Department currently contracts with a certified public accounting firm to perform federally mandated cost and rate data audits for hospitals, federally qualified health clinics, and rural health centers that participate in Medicaid. The certified public accounting firm establishes reimbursement rates, reviews contracts, calculates final cost settlements, rebases calculations, consults and assists on cost report interpretations, and meets with providers to resolve discrepancies. Prior to the passage of HB 09-1293, the Department did not perform such audits for providers participating in the Colorado Indigent Care Program. However, due to HB 09-1293, reimbursements for providers participating in the program are to be increased to 100% of cost, requiring similar audits to be conducted for the Colorado Indigent Care Program providers.

Through this budget item, the Department will utilize two types of audits to ensure proper payment of hospital fee funds to Colorado Indigent Care Program providers. The first are desk audits to: analyze cost reports to determine the accuracy and reasonableness of financial data reported by providers; identify problem areas that warrant additional review; and, obtain information for use in planning

a site audit if deemed necessary. Second are on-site audits that will focus on specific payment issues that are potentially material in nature and a more detailed verification of data than the desk audit.

DISPROPORTIONATE SHARE HOSPITAL AUDITS

This budget item provides funding for Disproportionate Share Hospital (DSH) audits as a result of DI-6 "Funding for Federally Mandated Audit of Disproportionate Share Hospital Expenditures" (November 2, 2009 FY 2010-11 Budget Request). This funding is for a contractor that is responsible for auditing the Department's DSH expenditures on an annual basis, pursuant to reporting requirements mandated by the federal Centers for Medicare and Medicaid Services (CMS) in rule (CMS-2198-F). This rule, which went into effect on January 19, 2009, institutes new auditing requirements that will clarify allowable expenditures under the DSH program and help the Department prevent improper expenditure of DSH funds. The rule also requires states to submit an independent certified audit of their DSH expenditures on an annual basis to CMS, while specifying the data elements that need to be included in each submission.

DSH payments are intended to offset the uncompensated costs of providing medical services to uninsured and underinsured patients. These payments assist in securing the hospitals' financial viability and preserving access to care for Medicaid and low-income clients, while reducing the shift in costs to private payers. For more information regarding these types of payments, please see the Safety Net Provider Payments section of this document.

(G) RECOVERIES AND RECOUPMENT CONTRACT COSTS

ESTATE RECOVERY

The estate recovery program, established by HB 91S2-1030 and authorized in 25.5-4-302, C.R.S., is operated by a contractor under supervision of the Department. The contractor pursues recoveries on a contingency fee basis and recovers funds from estates and places liens on real property held by Medicaid clients in nursing facilities or clients who are over the age of 55. Since FY 2003-04, the contractor has charged a contingency fee of 10.9%, with the remainder of the recoveries acting as an offset to the Medical Services Premiums line.

(H) NURSING FACILITY PENALTY CASH FUND, NURSING FACILITY CULTURE CHANGE

NURSING FACILITY PENALTY CASH FUND, NURSING FACILITY CULTURE CHANGE

This line item was created due to the passage of HB 09-1196, "Nursing Facility Penalty Cash Fund." Funding from this line item is to be used to promote culture change in nursing facilities through training, consumer education, newsletter production, website development and maintenance, and other measures.

HB 09-1196 created a Nursing Facility Culture Change Accountability Board within the Department to make recommendations to the Department and the Department of Public Health and Environment regarding the distribution of funds. In addition, HB 09-1196 requires a new annual report to be submitted jointly by the Department and the Department of Public Health and Environment to the Governor and the Health and Human Services Committee beginning each October. The report details information regarding the amount of moneys expended for culture change, the recipients of the funds, and the effectiveness of the funds.

(2) MEDICAL SERVICES PREMIUMS

Medicaid was enacted by Title XIX of the Social Security Act as an entitlement program to provide health care services to eligible elders, the disabled, adults, and children. Medical services are grouped into the following categories, each of which include several programs: acute care, community-based long-term care, and long-term care. Additional expenditures are incurred for insurance, service management, and financing payments. For a program-level description of each of the aforementioned categories of services, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-1, "Request for Medical Services Premiums."

To calculate the funding need for the Medical Services Premiums Line, the Department must forecast Medicaid caseload. In past years, the caseload forecast was included in the Line-Item Description. This year, the caseload presentation is included in the budget request as a separate exhibit. For a detailed narrative of the caseload forecast, please see the "Medicaid Caseload" Section included in this budget submission.

(3) MEDICAID MENTAL HEALTH

MENTAL HEALTH CAPITATION PAYMENTS

The Mental Health Capitation Payments line item reflects the appropriation that funds Medicaid mental health services throughout Colorado through managed-care providers contracted by the Department. The behavioral health organizations are responsible for providing or arranging all medically necessary mental health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category. For further information, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-2, "Request for Medicaid Mental Health Community Services."

MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS

The Medicaid Mental Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a behavioral health organization to receive mental health services or enrolled Medicaid clients to receive mental health services not covered by the behavioral health organizations. For further information, including program and appropriation history, please see the detailed narrative accompanying the Department's request R-2, "Request for Medicaid Mental Health Community Services."

(4) INDIGENT CARE PROGRAM

The Indigent Care Program section of the Department budget consists of the Colorado Indigent Care Program, the Primary Care Fund Program, the Children's Basic Health Plan, and other Safety Net provider payments. These programs and payments are designed to serve Colorado's underinsured, uninsured, or otherwise medically indigent populations. A description of each program is presented below.

COLORADO INDIGENT CARE PROGRAM

The Colorado Indigent Care Program provides direct or indirect funding to hospitals and clinics that have uncompensated costs from treating underinsured or low-income uninsured Coloradans. It is neither an insurance program nor an entitlement program, but rather a financial vehicle for providers to recoup some of their costs for providing medical services to the medically indigent. In FY 2010-11, total payments to indigent care providers through the Colorado Indigent Care Program equaled $325,584,047 and 225,906 clients were served by the program, up 3.6% from 217,946 in FY 2009-10. As of FY 2012-13, the program consists of the following four line items: Safety-Net Provider Payments; The Children's Hospital Clinic Based Indigent Care; the Primary Care Fund Program; and, Pediatric Specialty Hospital. The Primary Care Fund program was suspended in FY 2010-11 and FY 2011-12, and Tobacco Tax revenues were redistributed to clinics through the Health Care Services Fund Program and General Fund relief. Pursuant to HB 10-1323 and effective July 1, 2010, the Comprehensive Primary and Preventive Care Program has been permanently eliminated. These line items allow providers to receive partial compensation for uncompensated costs due to services rendered to uninsured or underinsured low-income Colorado residents who are not eligible for Medicaid or the Children's Basic Health Plan (effective July 1, 2002). Clients can have third-party insurance, but this resource must be exhausted prior to the providers receiving any reimbursement from the program.

Established by the "Reform Act for the Provision of Health Care for the Medically Indigent" in 1983, the Colorado Indigent Care Program was created as a partial solution to the health care needs of Colorado's indigent citizens. The financial eligibility requirement for the program increased from 185% to 200% of the federal poverty level effective February 1, 2006 due to the expansion populations created under HB 05-1262 (Health Care Expansion Fund). On July 1, 2006, the financial eligibility requirement was further increased to 250% of the federal poverty level per SB 06-044. The program contracts directly with hospitals and community health clinics to provide specific services to eligible individuals. By statute, providers are required to prioritize care in the following order: 1) emergency care for the entire year; 2) additional medical care for those conditions determined to be the most serious threat to the health of indigent persons; and, 3) any other medical care as financing allows. Providers are required to provide on-site eligibility and co-payment determinations. To determine eligibility, providers assign a rating to applicants based on their total income and assets. Nearly all clients are required to pay a minimal annual co-payment, which varies according to services received and client rating. For all client ratings except the N-rating (0-40% of the federal poverty level), annual co-payments cannot exceed 10% of the family's total income and equity in assets. The annual co-payment for clients with an N-rating cannot exceed $120.

The majority of the program is supported by two sources of federal financial participation: Disproportionate Share Hospital (DSH) and Medicare Upper Payment Limit (UPL). Disproportionate Share Hospital funds are paid to qualifying hospitals that are eligible for federal matching funds at the same Medicaid rate paid for services to Medicaid clients. Upper Payment Limit funds are calculated by estimating the amount Medicare would have reimbursed hospital providers for providing Medicaid inpatient services. The State uses both General Fund and cash funds to draw down these federal funds, although the contribution of General Fund dollars to the state match is minimal relative to more innovative sources of state funds. Prior to FY 2009-10, the State utilized certification of public expenditures for all publicly-owned facilities (seen as cash funds in the budget) to draw down matching federal funds. Beginning in FY 2009-10, the use of certification has been replaced with fees assessed on hospital providers. Any provider who participates in the program is qualified to receive funding from the DSH Allotment and the Medicare UPL. See the "Safety-Net Provider Payments" line item for more detail about funding mechanisms.

The introduction of the Balanced Budget Act of 1997 established declining limits of the amount of federal funds available to states for Disproportionate Share Hospital payments. Although these limits were established for each state starting in federal fiscal year (FFY) 1998 based on their previous levels of payments, the impact of these limits was not truly felt until FFY 2003. Under this Act, federal fund limits for Colorado were set at the following: FFY 1997-98: $93 million, FFY 1998-99: $85 million, FFY 1999-00: $79 million and FFY 2000-01 and beyond: $74 million, with limits adjusted by a cost of living factor each year after FFY 2001-02. However, federal legislation enacted in December 2000 maintained the FFY 1999-00 allotment of $79 million for FFY 2000-01 and FFY 2001-02, plus increases tied to the Consumer Price Index for all Urban Consumers for those years. The new allotments for FFY 2000-01 and FFY 2001-02 were $81,765,000 and $83,890,890, respectively. Beginning in FFY 2002-03, the DSH limit reverted back to the Balanced Budget Act of 1997 legislation that indicated Colorado's allotment would regress back to $74 million plus an inflationary increase. This increase, determined to be 1.5% for FFY 2002-03, resulted in a final DSH limit of $75,110,000.

In late 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act. Included in this federal legislation was further fiscal relief for Disproportionate Share Hospitals beginning in FFY 2004. From FFY 2004 to FFY 2008, the State DSH annual limit is set to be $87,127,600 (or 16% growth over the FFY 2003 DSH limit). For FFY 2009 the DSH allotment was increased to $90,612,704, which translated to an allotment of $89,741,428 for the State FY 2008-09. On February 17, 2009, the President signed into law the American Recovery and Reinvestment Act of 2009 (ARRA). Among other things, this legislation authorized an increase in the DSH allotment of 2.5% each federal fiscal year through FFY 2010, after which the determination of each state's DSH allotment will proceed without regard to the increased DSH allotments received during the relevant ARRA period. In FFY 2009, the DSH cap for Department expenditures is equal to $93,235,244. Converting this to State FY 2009-10, the DSH allotment was equal to $94,619,485. The Department received a final DSH allotment of $92,189,191 for state fiscal year (SFY) 2010-11 and a preliminary allotment of $94,727,736 for SFY 2011-12.

As required by HB 04-1438, the Department must include in the annual Budget Request the number of Medicaid eligible inpatient days and the total number of inpatient days by provider each year. For calendar year 2009 data, this information can be found in

Exhibit K in the Department's November 1, 2012 FY 2013-14 Budget Request. This information will be available for calendar year 2010 in Exhibit K in the Department's February 15, 2013 FY 2013-14 Budget Request.

SAFETY NET PROVIDER PAYMENTS

The Safety Net Provider Payments line item was added to the Indigent Care Program Long Bill group following the passage of SB 03-258, the FY 2003-04 Long Bill. The Department's FY 2003-04 DI-6 "Change Methodology for Financing the Indigent Care Program and Disproportionate Share Hospital Through Proposed Safety Net Funding Allocation" submitted with the November 1, 2002 Budget Request requested the consolidation of the following line items into the new Safety Net Provider Payments line item: Denver Indigent Care Program, University Hospital Indigent Care Program, Out-state Indigent Care Program, Disproportionate Share Payments to Hospitals and Pre-Component 1 Disproportionate Share Payments to Hospitals. The primary goal in combining the line items was to create a more simplified system that could more easily be understood by Department staff, the General Assembly, and providers. Another goal in combining the line items was to create a system that distributed the available funds in a more equitable manner. With these added efficiencies, a more simplified payment system was achieved, providing increased overall payments to qualified providers.

Prior to FY 2009-10, the Safety Net Provider Payments line item was composed of four payments: Low-Income, Bad Debt, High-Volume, and Medicaid Shortfall. However, HB 09-1293 combined the Low-Income, Bad Debt, High Volume, and Medicaid Shortfall payments into two more broadly-based supplemental payments to CICP providers: the CICP Disproportionate Share Hospital Payment and the CICP Supplemental Medicaid Payment. A summary of the rules related to the reimbursement of Safety Net providers under these two payments is given in the following matrix.

Payment Type	Public Hospitals	Private Hospitals
CICP Disproportionate Share Hospital Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of available Disproportionate Share Hospital federal funds limit imposed by federal law. For federal fiscal year (FFY) 2010-11, the final DSH cap, after inclusion of ARRA, for Colorado was equal to $92,507,555. The federal limit is a projection based on information in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. For FFY 2012 this information is not yet known.	The State share of payments to public hospitals is from provider fees assessed on hospitals and is represented as cash funds in the Long Bill. The federal share of payments is from Disproportionate Share Hospital federal funds.	The State share of payments to private hospitals is from provider fees assessed on hospitals. The federal share of payment is from Disproportionate Share Hospital federal funds.

Payment Type	Public Hospitals	Private Hospitals
CICP Supplemental Medicaid Payment: Payable to Colorado Indigent Care Program eligible providers, this payment is an allocation of the available Upper Payment Limit for inpatient hospital services.	The State share of payments to public hospitals is from provider fees assessed on hospitals and is represented as cash funds in the Long Bill. The federal share is from the federal Medicaid matching rate for Colorado.	The State share of payments to private hospitals is from provider fees assessed on hospitals. The federal share is from the federal Medicaid matching rate for Colorado.

Under the distribution model, CICP hospital providers are reimbursed up to 100% of uncompensated costs associated with treating indigent clients funded in sum by two separate payment calculations (CICP Disproportionate Share Hospital Payment and CICP Supplemental Inpatient Hospital Medicaid Payment). Per federally funded program requirements, monies provided by federal match must be allocated as either Disproportionate Share Hospital or Upper Payment Limit for inpatient hospital services funds. Both of these allocation types have limits that restrict the amount of federal match available.

Under the Disproportionate Share Hospital payments, the total federal amount made available is a projection based on information in the Medicare Drug, Improvement, and Modernization Act of 2003. The CICP Disproportionate Share Hospital Payment is a payment of this type. Under the American Recovery and Reinvestment Act of 2009 (ARRA), DSH expenditures are not eligible for the enhanced federal financial participation granted for other payments to hospitals and client service providers. For state fiscal year (SFY) 2010-11, the Department received a final DSH allotment of $92,507,555. For SFY 2011-12, this figure increased 2.4% based on the Consumer Price Index for All Urban Consumers (CPI-U) to a preliminary $94,727,736.

The Upper Payment Limit for inpatient hospital services is determined on a hospital-by-hospital basis and aggregated by hospital type: state-owned public hospitals, non-state owned public hospitals, and private-owned hospitals. Total inpatient hospital expenditures cannot exceed the available aggregated Upper Payment Limit by type. The CICP Supplemental Inpatient Hospital Medicaid Payment is funded by assessed hospital provider fees and federal matching funds under the available Upper Payment Limit for inpatient hospital services.

Based upon the state's increased unemployment rate, ARRA authorized an enhanced federal financial participation rate beginning in FY 2008-09 that affected the fund splits for this line item. This enhanced rate did not affect the total funding to this line item, but it did provide more federal funds. This reduced the amount of state funds required to maintain the total appropriation level. The enhanced federal financial participation rate affected this line item beginning in the second half of FY 2008-09 and continued through FY 2010-11, after which the federal financial participation rate returned to 50%.

THE CHILDREN'S HOSPITAL, CLINIC-BASED INDIGENT CARE

The Children's Hospital, Clinic Based-Indigent Care line item was created in FY 2002-03 utilizing the Medicare Upper Payment Limit for inpatient hospital services. The Children's Hospital qualifies for this payment because the hospital is privately owned. Being

privately owned, the certification of public expenditures for uncompensated Medicaid costs is not allowed. Instead, General Fund is required to draw down the matching federal funds. From this appropriation, The Children's Hospital distributes all but $60,000 in total funds to participating clinics. The $60,000 is retained by The Children's Hospital as an administration fee to cover expenses associated with operating the program. Reimbursement to participating clinics is based on a percentage of uncompensated indigent care costs relative to uncompensated costs reported by all recipients as reported in the Colorado Indigent Care Program Annual Report, increased for two years using the Consumer Price Index, All Workers, Denver Medical Costs for July of the most recent year.

HEALTH CARE SERVICES FUND PROGRAMS

In 2006, SB 06-044 created the Health Care Services Fund to make funding available to Denver Health Medical Center (as the Community Health Clinic provider for the city and county of Denver), Community Health Clinics, and primary care clinics operated by Colorado Indigent Care Program Hospitals for the provision of primary care services to low-income adults. SB 06-044 required 18% of the available funding to be distributed to Denver Health and Hospital Authority (Denver Health) and the remaining 82% to be distributed to clinics. Of the 82% distributed to clinics, 18% must be distributed to clinics operated by licensed or certified health care facilities (hospitals), and the remaining 82% must be distributed to federally qualified health centers (FQHCs). The Health Care Services Fund Programs line item contains only the funding for Denver Health and the clinics operated by licensed or certified health care facilities. This line allows the Department to secure matching Title XIX funds for these programs using Upper Payment Limit financing. The Health Care Services Fund was funded by Referendum C General Fund moneys, which expired at the end of FY 2009-10. This line item was funded in HB 10-1378 and in FY 2011-12 through SB 11-219 with refinanced Tobacco Tax funding from the allocation to the Primary Care Fund.

PEDIATRIC SPECIALITY HOSPITAL

The creation of this line item was recommended during a Joint Budget Committee (JBC) meeting on March 24, 2005, to provide funding to the State's only pediatric specialty hospital, The Children's Hospital, in an effort to help offset the costs of providing care to large numbers of Medicaid and indigent care clients. Funding for the Pediatric Specialty Hospital line item originated from General Fund savings anticipated from the removal of the Medicaid Asset Test per HB 05-1262 (Tobacco Tax Bill). Payments are made using Upper Payment Limit financing. During Conference Committee for SB 09-259, the JBC recommended transferring funding of the Children's Hospital Kid's Street and Medical Day Treatment Programs from the Department's Medical Services Premiums line item to the Pediatric Specialty Hospital. This was recommended because these programs did not qualify for fee-for-service reimbursement under Medicaid but would qualify for a supplemental payment to Children's Hospital through the Colorado Indigent Care Program.

APPROPRIATION FROM THE GENERAL FUND TO PEDIATRIC SPECIALITY HOSPITAL FUND

In 2005, the General Assembly passed HB 05-1262, legislation that created rules to govern the allocation of the Tobacco Tax revenues. Section 24-22-117 (1)(c)(I)(A), C.R.S. states that of the 3% of all Tobacco Tax revenues appropriated into the Tobacco Tax Cash Fund, 20% of these funds should be appropriated to the General Fund. Pursuant to Section 24-22-117 (1)(c)(I)(B), C.R.S., 50% of these above mentioned revenues are to be appropriated by the General Assembly to the Pediatric Specialty Hospital Fund as General Fund Exempt. In 2011, SB 11-216 "Children's Basic Health Plan General Fund Appropriation" moved this revenue stream

from the Pediatric Specialty Hospital Fund to the Children's Basic Health Plan Trust Fund, eliminating this line item effective FY 2011-12.

APPROPRIATION FROM TOBACCO TAX CASH FUND TO THE GENERAL FUND

In 2005, the General Assembly passed HB 05-1262, legislation that created rules to govern the allocation of the Tobacco Tax revenues. Section 24-22-117 (1)(c)(I)(A), C.R.S. states that of the 3% of all Tobacco Tax revenues appropriated into the Tobacco Tax Cash Fund, 20% should be appropriated to the General Fund. Pursuant to Section 24-22-117 (1)(c)(I)(B), C.R.S., 50% of these above mentioned revenues are to be appropriated by the General Assembly to the General Fund.

PRIMARY CARE FUND PROGRAM

The Primary Care Fund supports payments to providers serving indigent clients. Each provider seeking assistance from the Primary Care Fund must submit an application and meet other Department criteria. The Fund was authorized under Section 24-22-117 (2)(b), C.R.S., and distributes funds generated from Amendment 35 (Tobacco Tax) to the providers based on the portion of medically indigent or uninsured patients they served relative to the total number of medically indigent or uninsured clients served by all qualified providers. To be a qualified provider, an entity must:

- accept all patients regardless of their ability to pay, using either a sliding fee schedule or providing benefits at no charge;
- serve a population that lacks adequate health care services;
- provide cost-effective care;
- provide comprehensive primary care for all ages;
- screen and report eligibility for the Medical Assistance Program, Children’s Basic Health Plan, and the Indigent Care Program; and,
- be a federally qualified health center per Section 330 of the federal Public Health Services Act **or** have a patient base that is at least 50% uninsured, medically indigent, a participant in Children’s Basic Health Plan, a participant in the Medical Assistance Program, or any combination thereof.

PRIMARY CARE GRANT PROGRAM SPECIAL DISTRIBUTION

The Primary Care Grant Program Special Distribution fund was created during the 2010 legislative session with the passage of HB 10-1321, establishing the fund pursuant to 25.5-3-112 (4)(a), C.R.S. This line item was created with the intent of minimizing losses to clinics that receive money from the Primary Care Fund, which was reallocated in FY 2009-10, FY 2010-11, and FY 2011-12 through HB 10-1321, HB 10-1378 and SB 11-219, respectively.

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANTS PROGRAM

The Comprehensive Primary and Preventive Care Grants Program was authorized by Sections 25.5-3-201 through 207, C.R.S. to provide funds in the form of grants to providers that expand primary and preventive health care services to low income, uninsured residents of Colorado. More specifically, the Comprehensive Primary and Preventive Care Grants Program aims to provide services

to Colorado families who are at or below 200% of the federal poverty level. The program and the services it provides do not replace or substitute for State Medicaid, the Colorado Indigent Care Program, or the Children's Basic Health Plan.

Funds from the Comprehensive Primary and Preventive Care Grants Program can be awarded to qualified providers that demonstrate the intention of using funds to expand services to indigent Colorado residents. Because of this, grant money issued through the program can be used in many ways, though its primary applications are expanding clinics or hiring additional staff and purchasing equipment. Grants are available for one to three years on a gradually declining basis, depending on the type of project being funded.

During the 2011 Legislative Session, the General Assembly passed SB 11-216 "Children's Basic Health Plan General Fund Appropriation." This legislation moved the Tobacco Master Settlement Agreement revenue for this program to the Children's Basic Health Plan Trust Fund beginning in FY 2011-12 and eliminated the Comprehensive Primary and Preventive Care Grants Program.

CHILDREN'S BASIC HEALTH PLAN

History and Background Information

In 1997, HB 97-1304 created the Colorado Children's Basic Health Plan. Title XXI of the Social Security Act created the State Children's Health Insurance Program through the Congressional Budget Reconciliation Act of 1997. The Children's Basic Health Plan was reauthorized at the federal level through the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). HB 98-1325 authorized Colorado to participate in Title XXI, and provided basic health insurance coverage for uninsured children of families with incomes below 185% of the federal poverty level (FPL). The Medical Services Board is the rule-making authority for the Plan. The General Assembly has specified that the Children's Basic Health Plan shall be 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. A dental benefit, offered in a capitated managed care environment, was added for children in February 2002. Under HB 02-1155, prenatal, delivery, and postpartum benefits were added for uninsured pregnant women with incomes under 185% FPL. To participate in the plan, families with incomes over 150% FPL (with the exception of pregnant women) pay a nominal annual enrollment fee, based on family size and income. All State expenditures for benefits are matched with 65% Title XXI federal funds up to the federal allocation available. Annual enrollment fees collected from families are deposited in the Children's Basic Health Plan Trust Fund. However, there is no federal financial participation on the annual enrollment fees collected from families. Based on a memorandum of understanding with the Centers for Medicare and Medicaid Services, Colorado's administrative expenditures are matched differently than the normal 65% federal financial participation rate for Title XXI, and may not exceed 10% of total expenditures.

Until FY 2010-11, the Children's Basic Health Plan consisted of several distinct line items in the Department's (4) Indigent Care Program Long Bill group. Effective in FY 2000-01, per Supplemental Bill SB 01-183, the line items and appropriations were moved from the (5) Other Medical Services Long Bill group to the (4) Indigent Care Program Long Bill group. In the Long Bill for FY 2003-04, the Children's Basic Health Plan Medical Premiums for children and the Prenatal and Delivery line created in HB 02-1155 for

pregnant women were combined into a single Long Bill line item titled Children's Basic Health Plan Premium Costs. In the FY 2010-11 Supplemental Bill (SB 11-139), the Children's Basic Health Plan Premium Costs line item was combined with the Children's Basic Health Plan Dental Benefit costs line item into a single line item titled Children's Basic Health Plan Medical and Dental Costs.

In November 2004, the voters of Colorado approved Amendment 35, which raised taxes on tobacco products and designated that 46% of this revenue go to the Health Care Expansion Fund administered by the Department. The Health Care Expansion Fund, which expanded the Children's Basic Health Plan and Medicaid, was implemented through HB 05-1262. The legislation provided funding to expand eligibility in the Children's Basic Health Plan to families with incomes up to 200% FPL effective July 1, 2005. The legislation also provided funding for cost-effective marketing, which began April 1, 2006. Funding was also provided to remove the Medicaid asset test, which became effective July 1, 2006.

In 2007, the Colorado Legislature passed SB 07-097, which expanded eligibility in the Children's Basic Health Plan to children and pregnant women with family incomes up to 205% FPL. Eligibility in the Children's Basic Health Plan was further expanded to 225% of the FPL in 2008 with the passage of SB 08-160. This eligibility expansion was suspended in SB 09-211 due to budget constraints.

Governor Ritter signed HB 09-1293, the Colorado Health Care Affordability Act on April 21, 2009. The Act authorizes the Department to collect a hospital provider fee to increase eligibility in Medicaid and the Children's Basic Health Plan, as well as increase hospital reimbursement. As part of the Act, eligibility in the Children's Basic Health Plan was increased to 250% FPL on May 1, 2010.

During the 2011 Legislative Session, two bills were passed that altered Medicaid eligibility for children and pregnant women and changed the structure of the Children's Basic Health Plan. SB 11-008 increases Medicaid eligibility for children aged 6 through 18 with family incomes up to 133% FPL beginning in January 2013. SB 11-250 implements a federal mandate to expand Medicaid eligibility for pregnant women with family incomes from 134% to 185% FPL beginning in January 2013. Although the children and pregnant women newly eligible for Medicaid will receive standard Medicaid benefits, the Department will continue to receive federal funding through Title XXI and the enhanced 65% federal financial participation rate for their expenditures. The Department is working with the Centers for Medicare and Medicaid Services to convert its separate Title XXI program into a combination program that will allow this funding.

CHILDREN'S BASIC HEALTH PLAN TRUST

This line item is for contributions to the Children's Basic Health Plan Trust Fund. The Trust Fund balance partially funds the State's share of the other line items for the Plan. By statute, at the end of any given fiscal year, unspent appropriations remain in the Trust Fund rather than revert to the General Fund. Moreover, funds in the Trust that are not appropriated to other lines also earn interest each year. Common sources of funding for appropriations to the Trust are General Fund and cash funds from the collection of annual enrollment fees from families. The Trust also receives an annual transfer from the Tobacco Litigation Settlement Trust Fund and a small amount of Tobacco Tax revenues.

The FY 2011-12 Long Bill (SB 11-209) did not include an appropriation to this line item. Given the recent insolvency of the Trust, which has required General Fund appropriations to this line, the Joint Budget Committee (JBC) staff recommended that these General Fund appropriations be made directly to the Children's Basic Health Plan Medical and Dental Costs line (FY 2011-12 Figure Setting document dated March 8, 2011, page 82). This effectively eliminated this line item as any other transfers to the Trust Fund are just transferred rather than appropriated to the Trust.

CHILDREN'S BASIC HEALTH PLAN ADMINISTRATION

This line item funds private contracts for administrative services associated with the operation of the Children's Basic Health Plan. Most administrative services are contracted out to a primary private vendor who provides enrollment and customer services to clients enrolled in the Children's Basic Health Plan. Auxiliary administrative functions are contracted out separately to various vendors for professional services such as actuarial analysis, claims audit, and quality assurance. The actuarial analysis is used to update capitation rates and project claims that are incurred but not yet reported. The claims audit is necessary to meet the State Auditor's evaluation requirements. Quality assurance services collect Health Plan Employer Data and Information Set (HEDIS) quality data. Beginning in FY 2012-13, the Department also administers, analyzes, and reports results from the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, as required by the Children's Health Insurance Program Reauthorization Act of 2009.

Under federal law, children eligible for Medicaid may not enroll in the Children's Basic Health Plan, yet many of the children who apply for the Children's Basic Health Plan are determined to be Medicaid-eligible. Thus, much of the costs of eligibility processing and enrollment functions provided by the Children's Basic Health Plan's primary administrative services contractor are attributable to the Medicaid Program. Based on a study that identified the portion of workload generated by Medicaid, the Department and the Centers for Medicare and Medicaid Services have agreed upon a cost allocation methodology for charging costs to the correct program. The following table illustrates Colorado's cost allocation matrix used for determining which federal funds related to administration of the Children's Basic Health Plan are reimbursed by Medicaid, Title XIX of the Social Security Act, and which are reimbursed by the State's Child Health Insurance Program, Title XXI of the Social Security Act. The federal financial participation for the Medicaid program is 50% and that for Title XXI is 65%. Note that while total federal funds are referenced in legislative appropriation clauses, the share of Title XXI and Title XIX is not.

Cost Allocation Plan for Federal Funds		
Administrative Function	**Share of Funds at Title XXI Federal Match**	**Share of Funds at Title XIX Federal Match**
Marketing and Outreach Component	77.3%	22.7%
Eligibility and Enrollment Component	12.0%	88.0%
Professional Services and Other Administration Component	100.0%	0.0%
Children's Basic Health Plan Prenatal and Delivery Components	100.0%	0.0%

CHILDREN’S BASIC HEALTH PLAN PREMIUM COSTS

This line item funds the costs of medical services provided to eligible children enrolled in the Children’s Basic Health Plan and medical premiums for prenatal and delivery services for pregnant women. The Department establishes annual enrollment projections. Each year the actuary contracted by the Department recommends a per-member-per-month rate for health maintenance organizations and the State’s self-insured network. This rate includes the expected costs of providing medical benefits to enrollees as well as medical management services such as case management. The Department uses the rates to develop estimated per capita costs. For children in the Plan, the per capita is a “blended” cost that is based on the ratio of the number of children expected to be enrolled in health maintenance organizations to the number of children in the Children’s Basic Health Plan’s self-insured network.

During the Department’s Supplemental Hearing on January 19, 2011, the Joint Budget Committee Staff (JBC) staff combined the Children's Basic Health Plan Premiums Costs and the Children's Basic Health Plan Dental Benefits Costs line items into one line called the Children's Basic Health Plan Medical and Dental Costs.

CHILDREN’S BASIC HEALTH PLAN DENTAL BENEFIT COSTS

In FY 2001-02, the Department issued a request for proposals to provide dental services for all children enrolled in the Children’s Basic Health Plan and selected the vendor who offered the most complete dental benefit package. The Department currently has a $600 yearly maximum benefit per client and a statewide network with several hundred participating dentists and contracts with Essential Community Providers.

During the Department’s Supplemental Hearing on January 19, 2011, the Joint Budget Committee (JBC) staff combined the Children's Basic Health Plan Premiums Costs and the Children's Basic Health Plan Dental Benefits Costs line items into one line called the Children's Basic Health Plan Medical and Dental Costs.

CHILDREN’S BASIC HEALTH PLAN MEDICAL AND DENTAL COSTS

This line item was created during the Department’s Supplemental Hearing on January 19, 2011, by the Joint Budget Committee (JBC) Staff as the combination of the Children's Basic Health Plan Premiums Costs and the Children's Basic Health Plan Dental Benefits Costs line items. The costs of medical and dental services provided to eligible children and medical premiums for prenatal and delivery services for pregnant women enrolled in the Children’s Basic Health Plan are funded through this line item beginning in FY 2010-11.

(5) OTHER MEDICAL SERVICES

The Other Medical Services section of the Department's budget contains funding for programs not administered by the Department through the Medicaid or Indigent Care programs. Some of the line items receive federal Medicaid funding but are administered by other departments, Commissions, or hospitals. This long bill group also contains funding for the Old Age Pension State Medical Program and the Medicare Modernization Act of 2003 State Contribution Payment. A description of each program is presented below.

SERVICES FOR OLD AGE PENSION STATE MEDICAL PROGRAM CLIENTS

The Services for Old Age Pension State Medical Program Clients line item, also known as the Old Age Pension Health and Medical Care Program, provides limited medical care for non-Medicaid-eligible individuals receiving Old Age Pension grants. This program is 100% State-funded and is not a federal entitlement. Eligible recipients are over the age of 60 and ineligible for Medicaid. The Old Age Pension State Medical Program is currently funded through the Old Age Pension Health and Medical Care Fund established in Article XXIV of the constitution and supplemental General Fund appropriations to ensure adequate funding.

The Old Age Pension was established in 1936 by an amendment to the State constitution, creating Article XXIV. This article was amended in 1956 to add the Old Age Pension Health and Medical Care Program and Fund in Section 7. Old Age Pension benefits specified in Article XXIV of the State constitution require that a health and medical program be provided to anyone who qualifies to receive an Old Age Pension cash payment and is not a patient in an institution for tuberculosis or mental disease. Specified sources of General Fund (primarily excise taxes) must be earmarked to cover the costs of Old Age Pension benefits.

Both the administration and appropriation of the Old Age Pension State Medical Program, created in section 25.5-2-101, C.R.S., was transferred to the Department from the Department of Human Services, effective July 1, 2003. Beginning in FY 2003-04, this line item was placed in the (5) "Other Medical Services" Long Bill group. The Other Medical Services Long Bill group is more suitable than Medical Services Premiums for three reasons: 1) the program is a non-Medicaid program; 2) the program is not subject to overexpenditure authority; and, 3) the program was not affected by the cash accounting changes authorized in SB 03-196 (however, the program moved to cash accounting on July 1, 2007). The Department of Human Services continues to have statutory authority to administer the Old Age Pension, the State Old Age Pension Fund, and the Old Age Pension Stabilization Fund.

SUPPLEMENTAL OLD AGE PENSION MEDICAL CARE FUND

In 2002, the General Assembly passed HB 02-1276, which created the Supplemental Old Age Pension Health and Medical Care Fund to supplement the Old Age Pension program, since the Colorado Constitution caps the revenue deposited into the Old Age Pension Health and Medical Care Fund at $10,000,000 annually. With the passage of Amendment 35 in November 2004, the State increased taxes on tobacco products. Amendment 35 allowed 3% of the new revenue to be allocated to the General Fund, the Old Age Pension Program, and to the cities and counties. With the passage of HB 05-1262 in 2005, the General Assembly allocated 50% of the 3% allocation to the Supplemental Old Age Pension Health and Medical Care Fund. Funding in this line contains was reappropriated to

the Services for Old Age Pension State Medical Program Clients line item to be used in addition to the cash funds appropriated to that line.

SB 11-210 "Phase-Out Supplemental OAP Health Fund" gradually eliminated funding to the Supplemental Old Age Pension Health Care Program and Fund. Beginning in FY 2011-12, the Amendment 35 revenues usually appropriated to the Supplemental Old Age Pension State Medical Fund and then transferred to this line item were used to fund medical cost for Old Age Pension clients served in Medicaid. The Supplemental Old Age Pension Medical Care line item and Fund were abolished in July 2012.

COMMISSION ON FAMILY MEDICINE RESIDENCY TRAINING PROGRAMS

The Commission on Family Medicine Residency Training Programs line item provides payments to nine hospitals to help offset their costs of participating in the Colorado Family Medicine Residency Training Program. The program is administered by the Advisory Commission on Family Medicine in the Department of Higher Education, Health Sciences Center. Before FY 1994-95, the program was funded entirely with General Fund appropriated to the Department of Higher Education. Beginning in FY 1994-95, however, the majority of the program's funding was financed with a federal financial participation rate of 50%. These new financial participation rates were due to federal regulations allowing federal financial participation for payments to hospitals enrolled in the program. Since federal Medicaid funds were involved, a line item appropriation to the Department was established.

STATE UNIVERSITY TEACHING HOSPITALS, DENVER HEALTH AND HOSPITAL AUTHORITY

This line item was created through SB 08-230 in order to clarify the status of Denver Health and Hospital Authority as a "Unit of Government" in its role as a provider of Graduate Medical Education. In addition, the reorganization implemented by the legislation allowed the Department to better identify the funding designated for medical education services recognized by a public university, namely the University of Colorado Health Sciences Center. The Department reimburses Denver Health and Hospital Authority for Graduate Medical Education in two ways. First, fee-for-service payments to Denver Health and Hospital Authority include a small portion identifiable as being due to the provision of Graduate Medical Education. Second, Denver Health and Hospital Authority also receives lump sum payments when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education. Costs incurred by Denver Health and Hospital Authority in the provision of graduate medical education that are eligible for Medicaid funds were formerly funded through the Department's Medical Services Premiums line item. Beginning with FY 2007-08, funding for this purpose was directly appropriated to the "(5) Other Medical Services; State University Teaching Hospitals, Denver Health and Hospital Authority" line item.

STATE UNIVERSITY TEACHING HOSPITALS, UNIVERSITY OF COLORADO HOSPITAL AUTHORITY

This line item was created through SB 08-230 in order to clarify the status of the University of Colorado Hospital Authority as a "Unit of Government" in its role as a provider of Graduate Medical Education. In addition, the reorganization implemented by the bill allowed the Department to better identify the funding designated for medical education services recognized by a public university, namely the University of Colorado Health Sciences Center. The Department reimburses the University of Colorado Hospital Authority for Graduate Medical Education in three ways. First, fee-for-service payments to University of Colorado Hospital

Authority include a small portion identifiable as being due to the provision of Graduate Medical Education. Second, lump sum payments are also received when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education. Third, the University of Colorado Hospital Authority receives funding for one of nine family medicine residency training programs administered by the Commission on Family Medicine, namely A.F. Williams Family Residency. Costs incurred by the University of Colorado Hospital Authority in the provision of graduate medical education that are eligible for Medicaid funds were formerly funded through the Department's Medical Services Premiums and Other Medical Services; University of Colorado Family Medicine Residency Training Programs line items. Beginning with FY 2007-08, funding for this purpose was directly appropriated to the "(5) Other Medical Services; State University Teaching Hospitals, University of Colorado Hospital Authority" line item.

MEDICARE MODERNIZATION ACT OF 2003 STATE CONTRIBUTION PAYMENT

On January 1, 2006, the Centers for Medicare and Medicaid Services assumed responsibility for the Part D prescription drug benefit, replacing Medicaid prescription drug coverage for clients dually eligible for both Medicare and Medicaid benefits. In lieu of the obligation of states to cover prescription drugs for this population, the Centers for Medicare and Medicaid Services began requiring states to pay a portion of what their anticipated dual eligible drug cost would have been had this cost shift not occurred. This is known as the "clawback" payment. For calendar year 2006, states were to pay 90% of the federal portion of their average dual eligible drug benefit from calendar year 2003, inflated to 2006 using the National Healthcare Expenditure average growth rate. As each calendar year passes, the 90% factor is reduced, or "phased down," by 1.67% each year, until it reaches 75% in 2015, where it will remain on a go-forward basis. The funding source for this line item is entirely state funds that do not receive federal matching funds.

PUBLIC SCHOOL HEALTH SERVICES CONTRACT ADMINISTRATION

This line item was created with the approval of the Department's S-9, BA-7 "Public School Health Services Administrative Claiming" during the FY 2010-11 budget cycle. The Public School Health Services Program uses Medicaid funds to support local school health services, increase access to primary and preventive care programs to low-income, under- or uninsured children, and improve the coordination of care between schools and health care providers.

The line item contains all administrative funding for the program excluding the Department's personal services, the transfer of funds to the Department of Education, and costs associated with processing claims in the Medicaid Management Information System (MMIS). Funding for this line consists of a transfer of spending authority from the "(1) Executive Director's Office; (A) General Administration, Operating Expenses" line item, "(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts" line item, and the "(5) Other Medical Services; Public School Health Services" line item. Also included in this line item is funding for the Department's contract with Public Consulting Group, Inc. (PCG). PCG's scope of work includes planning and administering time studies to support the rate-setting methodology, training school staff, defining allowable cost, and providing assistance in the certification of public expenditures process.

PUBLIC SCHOOL HEALTH SERVICES

The Public School Health Services program began in 1997 with the passage of SB 97-101. The intent of the program is to use Medicaid funds to support local school health services, increase access to primary and preventive care programs to low-income, under or uninsured children, and improve the coordination of care between schools and health care providers.

Unlike most other programs administered by the Department, the State's contribution of funding to the program is derived from certification of public expenditures. This process allows participating school district providers to certify the expenditure of state funds on eligible services that can be matched by the federal government through Title XIX of the Social Security Act. It is important to note that 70% of the matched funds for this program must help expand health services for all children while the remaining 30% can be put towards initiatives that seek to expand the coverage for under or uninsured children.

The administration of the Public School Health Services program is split between the Department of Health Care Policy and Financing (the Department) and the Department of Education through an Interagency Agreement. The Department pays for claims processing, personnel, and contracting costs. The Department of Education provides technical assistance to medical staff at participating school districts, receives and reviews all local services plans, reviews annual reports, and pays for additional personnel. The costs incurred by the two departments for administration are deducted from the federal matching funds. Pursuant to 25.5-5-318 (8)(b), C.R.S., the Department may retain a maximum of 10% of federal funds received for the program for administrative purposes.

(6) DEPARTMENT OF HUMAN SERVICES MEDICAID-FUNDED PROGRAMS

This section of the Department's budget is for Medicaid funding for services provided or administered by the Colorado Department of Human Services (DHS). Programs include services for persons with developmental disabilities, high-risk (substance abuse) pregnant women, individuals with mental health needs, certain youth who are in the juvenile justice system, other child welfare clients, and community services for the elderly. DHS also receives the Department's share of the costs to support the Colorado Benefits Management System (CBMS) and other information technology support, as well as operations costs separately accounted for but related to the other groups of clients mentioned above. Medicaid funds for these programs are transferred from the Department to DHS as reappropriated funds. Although the funds are considered reappropriated from the perspective of DHS, the funding sources for these transfers from the Department are General Fund, federal funds, and cash funds.

Until FY 2001-02, Medicaid funding for DHS was appropriated in one line item. In FY 2001-02, the General Assembly separated the DHS appropriations into 18 separate line items to improve expenditure tracking and reconciliation. These lines have changed over time, and there are currently 21 line items in the Department's budget within the DHS Medicaid-Funded Long Bill group. A description of each of the line items currently within the Department's budget follows.

All funding requests in this Long Bill group originate with DHS, and any inquiries related to the Department's Budget Request should be directed to DHS. The Department of Health Care Policy and Financing is a financing agency for these appropriations, meaning that the Department must validate the DHS funding request is for a Medicaid-allowable purpose as outlined by the federal Centers for Medicare and Medicaid Services (CMS). This Department also performs general oversight of the Medicaid-funded programs to ensure adherence to federal regulations for use of the Medicaid funds.

(A) EXECUTIVE DIRECTOR'S OFFICE

The Executive Director's Office is responsible for the general policy of the Department of Human Services (DHS) and contains staff and associated resources for implementing policy. This appropriation in the Department's budget includes Medicaid funding for two sections in the DHS budget: General Administration and Special Purpose. Because the Executive Director's Office includes a wide range of elements, the authorizations in the Colorado Revised Statutes are also varied. The main authorization is 24-1-120, C.R.S.

General Administration includes the DHS Executive Director and associated administrative staff, including the Department's budget staff, the Public Information Officer, the Legislative Liaison, and the Division of Field Administration that includes the County Commissioner Liaison. These staff members are FTE at DHS, but several of them also perform services related to Medicaid, so part of their salaries and related expenses are reimbursed by the Department.

General Administration is comprised of the following elements:

- Personal Services – salaries and wages for staff associated with the Executive Director's Office, some of whom have Medicaid-related responsibilities;
- Health, Life, and Dental Insurance – often called a POTS line and is a Common Policy, a centralized appropriation for DHS from which Accounting transfers to the other Long Bill Groups for various programs as needed for staff in those programs, partly funded by Medicaid;
- Short Term Disability Insurance – often called a POTS line and is a Common Policy, a centralized appropriation for DHS from which Accounting transfers to the other Long Bill Groups for various programs as needed for staff in those programs, partly funded by Medicaid;
- Amortization Equalization Disbursement – often called a POTS line and is a Common Policy, payments for portion of Public Employees' Retirement Association (PERA) paid by State government – a centralized appropriation for DHS from which Accounting transfers to the other Long Bill Groups for various programs as needed for staff in those programs, partly funded by Medicaid;
- Supplemental Amortization Equalization Disbursement – often called a POTS line and is a Common Policy, additional payments for portion of PERA paid by State government – a centralized appropriation for DHS from which Accounting transfers to the other Long Bill Groups for various programs as needed for staff in those programs, partly funded by Medicaid;
- Salary Survey and Senior Executive Service – a Common Policy, appropriations to cover the costs of salary increases based on a job and wage classification survey conducted by the Department of Personnel and Administration (DPA), partly funded by Medicaid.
- Performance Based Pay – a Common Policy, achievement pay added to Personal Services according to guidelines established by DPA for quality and quantity of each employee's work, partly funded by Medicaid.
- Shift Differential – a Common Policy, additional salary and wages paid to staff who work other than the day time shift in state residential facilities that must be staffed 24 hours, 7 days a week and primarily used by the Mental Health Program and the Developmentally Disabled Program, partly funded by Medicaid;
- Workers Compensation – a Common Policy, estimated share for inclusion in the state workers compensation plan as administered by the Department of Personnel and Administration (DPA) and allocated based on the total number of employees, also designated as an indirect cost, partly funded by Medicaid;
- Operating Expenses – a Common Policy, funding for consumable supplies and materials as well as capital outlay for purchase or replacement of medical equipment, furniture, and other major items if the appropriation balance allows, partly funded by Medicaid;
- Payment to Risk Management and Property Funds – a Common Policy, funding for a share of statewide costs for two programs operated by DPA: (1) liability insurance for liability claims, and (2) property insurance for state buildings and their contents, and this line item is designated as an indirect cost with an allocation based on the number of employees, partly funded by Medicaid; and,
- Injury Prevention Program – 100% Medicaid funded and primarily used by the Mental Health Program and the Developmental Disabilities Program because clients in those programs sometimes have violent tendencies or have serious physical needs that require much physical assistance from health care staff.

Also included in General Administration with no Medicaid funding are line items for Legal Services, Administrative Law Judges, and Staff Training.

Special Purpose funding within the Executive Director's Office includes staff in the Office of Performance Improvement to oversee and to provide support for audits, human resources, and performance management. The Audits Section verifies, through internal and external audits, that State and federal financial assistance has been distributed in accordance with applicable regulations and laws. The Human Resources Section performs all personnel related activities, and the Performance Management Team ensures programmatic accountability for DHS. The above mentioned staff members are FTE in DHS, but their work overlaps Medicaid responsibilities, so the positions are partly funded by Medicaid.

The Health Insurance Portability and Accountability Act of 1996

Security Remediation in the context of The Health Insurance Portability and Accountability Act (HIPAA) of 1996 comprises part of the Special Purpose funding. DHS provides many health-related services to Medicaid eligible clients and non-Medicaid eligible clients. Therefore, it is legally required to comply with HIPAA regulations. Expenditures for the services and programs associated with Medicaid clients are paid with Medicaid funds. Medicaid funding pays for Personal Services and associated Operating Expenses for staff members who perform the following tasks or monitor and audit other staff members who perform the following tasks:

- risk assessment and risk management of health information;
- preparation and enforcement of sanction policies for failures in health information risk management;
- review of health information system activity;
- workforce clearance procedures;
- isolation of health care clearinghouse functions;
- authorization of data access;
- establishment and modifications of data access procedures;
- provision of security reminders and training;
- protection against malicious software;
- monitoring of login reports;
- management of password use;
- establishment of security incident procedures and contingency planning;
- preparation of planning and follow procedures for data back-up;
- preparation of disaster recovery plan and auditing use of the plan if need arises;
- preparation of plans for an emergency mode of operations;
- assurance that business associate contracts are used for vendors and health providers;
- supervising facility access controls;
- monitoring procedures for computer workstation use, including security as well as supplemental devices and media used;
- provision of automatic logoff procedures;

- arranging for encryption and decryption;
- supervising emergency data access procedures; and,
- monitoring transmission authentication of health information and integrity controls.

HIPAA staff members report to the Deputy Executive Director of Operations and Financial Services, but the funding for these functions is included in the Executive Director's Office line item in the budget.

Special Purpose funding also includes administrative review for food stamp quality assurance to perform the federally mandated food stamp quality control, including monthly reviews to ensure accurate eligibility determinations and food stamp allotments to clients, as well as funding for several boards, councils, and commissions under DHS auspices, but these components are not Medicaid funded.

Personal Services actual expenditures from the line item for Regional Centers for the Developmentally Disabled (see later in this section of the line item description) are transferred into the Executive Director's Office line item as a way to track Personal Services for the Regional Centers.

Medicaid funding for all of the above described services are funded into one line item for the Executive Director's Office. A large contributor for changes in appropriated funding from one year to the next is Common Policy adjustments requested by DPA.

(B) OFFICE OF INFORMATION TECHNOLOGY SERVICES – MEDICAID FUNDING

Many of the staff members for the Office of Information Technology have been transferred to the Governor's Office of Information Technology as part of the ongoing reorganization of information-technology services for Colorado State Government. However, some of the budget lines remain at the Department of Human Services (DHS) or the Department in order to access federal funding for the particular projects. The budget line items discussed in this section utilize federal Medicaid funding.

COLORADO BENEFITS MANAGEMENT SYSTEM

The Colorado Benefits Management System (CBMS) tracks client data, determines eligibility, and calculates benefits for medical, food, and financial-assistance programs in the State of Colorado. There is no specific authorization in statute that specifically mentions CBMS; however, authorization can be inferred from 26-1-112, C.R.S.

Prior to February 15, 2007, the development and operational phases of CBMS were overseen by three state agencies: the Governor's Office of Colorado Benefits Management System, DHS, and the Department. CBMS replaced the following six legacy systems: Client Oriented Information Network; Colorado Automated Food Stamps System; Colorado Automated Client Tracking System; Colorado Adult Protection System; the Children's Basic Health Plan eligibility determination system; and, Colorado Employment First. During the development phase of the system and the early years after implementation of the system, the Department's appropriation reflected a fraction – roughly 34.71% – of total costs. Because CBMS handles clients enrolled in programs that receive

varying levels of federal participation rates, the CBMS calculator was developed to allocate costs among the various programs. Expenditures are currently divided between the Department and DHS based on the calculator, which has been revised to reflect the division of work resulting from polling of the county departments of human/social services according to the Random Moment Sampling methodology that has become accepted by the Department and DHS as well as federal regulators. The Department's appropriation since FY 2008-09 reflects 38.31% of the total costs of the system, as indicated by the last major change in percentages reflected in the Random Moment Sampling results; the remaining percentage of expenditures is paid from the appropriation to DHS. When future Random Moment Sampling results reflect another major change in percentages, both departments anticipate a change in funding will be requested through the normal budget-request processes.

A private vendor has been contracted to perform the major operations for CBMS from the beginning of the project. In August 2008, management and operation of the system was reprocured, and Deloitte Consulting LLP (Deloitte Consulting) was awarded the new contract. Deloitte Consulting took over full responsibility for operation of the system on April 1, 2009.

A broad range of components are paid from the appropriation for CBMS. Besides contracted payments to the vendor, the following items are also paid from the appropriation: computer hardware maintenance and repairs; computer software maintenance and upgrades; non-computer equipment rental; building rental; parking-fee reimbursement for staff at a different work location; rental of computer network equipment; rental of personal computers used in the office of the project (avoids purchase of the personal computers); in-state travel for providing training to county departments; other travel expenditures; telecommunication services; printing and reproduction of paper documents; legal services; freight and shipping charges; data-processing supplies; office supplies; postage; copy supplies; non-capitalized equipment purchases; dues and memberships; registration fees; capital lease principal payments; and, capital lease interest payments. The operations vendor contracted payments mentioned above may include both the base contracted amounts and any additional amounts from contract amendments that are necessary to request computer programming changes to implement requirements from special bills passed by the Colorado General Assembly.

The Governor's Office of Information Technology (OIT) currently has oversight of daily operations for the vendor, Deloitte Consulting. However, both DHS and HCPF have CBMS funding appropriated to them because the two departments can claim federal funding from their federal government partners that, in turn, increases the total amount of funding available to OIT as reappropriated funding to cover CBMS expenditures.

COLORADO BENEFITS MANAGEMENT SYSTEM, HCPF-ONLY

Confusion has previously occurred about oversight and payment for Colorado Benefits Management System (CBMS) projects requested and funded only by the Department. To address this issue, the Department submitted S-12, BA-5 "CBMS Technical Adjustment for Fund Splits and HCPF Only Projects" in its January 3, 2012 budget submission, which was approved by passage of the Supplemental Bill HB 12-1184 to create this line item. The initial appropriation to this line contained CBMS funding for HB 09-1293 (Hospital Provider Fee) related projects, but the line item can be used for CBMS projects funded from other sources if the projects are

intended for the benefit of Medicaid and the Department, without benefit to DHS. Authorization for this line item can be inferred from 25.5-4-106, C.R.S. and 25.5-4-204, C.R.S.

CBMS SAS-70 AUDIT

Funding for this line item began in FY 2005-06 for the State Auditor's Office to complete an audit based on the Statement on Auditing Standards 70 (SAS-70), which was recommended by Joint Budget Committee (JBC) staff. There is no specific authorization for the line item in statute; however, authorization can be inferred from 26-1-112, C.R.S. SAS-70 applies to all service organizations, not just to the contractor for CBMS.

Work on the audit funded by this appropriation focused on: 1) management policies, standards and procedures; 2) state and county staff training and subsequent adherence to standards and procedures; 3) general controls over system development, acquisition, maintenance, and change management; 4) operational controls over change management of software, logical and physical security, and contingency planning; and, 5) application controls over source documents, data input, editing and processing, data output, and system access (DHS Supplemental Hearing document, January 13, 2006, page 15). The audit required an assessment regarding which functions of the Colorado Benefits Management System were operating as intended.

SAS-70, named "Reports on the Processing of Transactions by Service Organizations," was developed by the American Institute of Certified Public Accountants as an auditing opinion on the fairness of the presentation of the service organization's description of operating controls and the suitability of the design of these controls to achieve specified objectives. This audit assures both the user organization – in this case, the State of Colorado – and the service organization – in this case, Deloitte Consulting, the contracted vendor – that CBMS has adequate controls in place to handle whatever usual or unusual situations arise in order to operate in normal operating environments and as recovered from disaster environments. This is not a financial audit, but rather an audit of functional controls.

This type of audit is generally completed once a year, so the annual appropriations are renewed each year. These annual appropriations are paid by the Department and DHS to the Colorado Office of State Auditor, which, in turn, contracts with an independent auditor to conduct an audit staffed by control-oriented professionals who have experience in accounting, auditing, and information security. Such an audit allows the service organization to have its control policies and procedures evaluated and tested by an independent party. This audit also allows the user organization to be assured that the service organization is fulfilling its security requirements.

Although the standards for the SAS-70 audit and the requirements from the Health Insurance Portability and Accountability Act (HIPAA) of 1996 were developed independently of each other, the standards of the SAS-70 audit are very similar to the requirements from HIPAA. Generally, one audit of a service organization can satisfy both needs at the same time, per the opinion of accountants associated with the American Institute of Certified Public Accountants.

Because the SAS-70 audit directly relates to CBMS, both departments rely on the Random Moment Sampling methodology to determine how the funding to pay for the audit is shared. The same percentages for funding splits between the departments are used and updated when necessary. The Department paid 34.71% in prior years, but the percentage was changed to 38.31% for FY 2008-09 and FY 2009-10. The Department's share declined to 37.63% in FY 2010-11 and continued to decline to 37.05% for FY 2011-12. For the FY 2012-13 Long Bill, 37.05% was the continued percent allocated to the Department.

COLORADO BENEFITS MANAGEMENT SYSTEM CLIENT SERVICES IMPROVEMENT PROJECT

This line item was created by a 1331 Supplemental Request submitted by both the Department and the Department of Human Services (DHS) to the Joint Budget Committee (JBC), which approved the 1331 request for FY 2008-09 on June 22, 2009. The request used funding from the Department's "Colorado Benefits Management System (CBMS) Medical Assistance Project" line item to combine with program funding from DHS for CBMS projects. The Improvement Project added a Web portal to be used specifically for CBMS. Intelligent Data Entry software also allows clients to enter much of their own information into CBMS, thus reducing the need to travel to local social services offices.

OTHER OFFICE OF INFORMATION TECHNOLOGY SERVICES LINE ITEMS

The "Other Office of Information Technology Services" line item includes Medicaid funding for expenses associated with the DHS Information Systems but specifically excludes CBMS and CBMS SAS-70 funding. The Office of Information Technology is responsible for developing and maintaining the major DHS centralized computer systems, including systems that link to all counties in the State. Not all of these systems support Medicaid functions, and, therefore, not all receive Medicaid funding. The Office supports centralized databases and provides support and training to users, including county staff and private social services providers. The Office of Information Technology Services also helps set policies and strategic directions for de-centralized information technology systems that are operated by individual divisions within DHS. Because the elements covered by this line item vary, there is no one specific source in the Colorado Revised Statutes, but authorization can be inferred from 26-1-120, C.R.S.

The staff members in the Office of Information Technology Services are organized into three functional areas: the Application Systems Team, Technical Operations, and Customer Support Services. The Application Systems Team manages, develops, enhances, and maintains DHS application systems. This team is further organized into three separate units to support: institutional and community functions, disability determinations, and DHS administrative services; children, youth and families and child support services; and, eligibility services. Technical Operations provides support for databases, systems, security, networks, telecommunications, and regional/statewide technical services. The Customer Support Services unit is responsible for four primary areas pertaining to information technology: 1) help desk support, 2) financial management, 3) administrative customer support services, and 4) application training for users. This Office is a service organization because it provides computer support in various ways to the other offices and divisions within DHS. Some DHS staff perform work associated with Medicaid services and part of their salaries come from Medicaid funding.

The Office of Information Technology Services, sometimes called the Division of Information Technology, currently has a dual-reporting structure. The Division reports to both the Deputy Executive Director of Operations and Financial Services in DHS and to the Director of the Governor's Office of Information Technology Services. In FY 2009-10, a new component was added, called Administration for OIT, and was included in the funding for the "Other Office of Information Technology Services" line item.

Some funding in this appropriation is used to support the salaries and operating expenses associated with DHS staff that perform Medicaid related work, as well as for Common Policy items such as Purchases of Services from Computer Center, Microcomputer Lease Payments, and Multi-use Network Payments. In addition, a portion of the computer system expenses associated with the Regional Centers for clients with developmental disabilities are transferred to the "Other Office of Information Technology Services" line item.

(C) OFFICE OF OPERATIONS – MEDICAID FUNDING

The Department of Human Services' (DHS) Office of Operations appropriation contains funding for four divisions: Facilities Management, Accounting, Procurement, and Contract Management, of which some are partially funded with Medicaid funding. This appropriation is for the cost of salaries and operating expenses associated with some of the positions in this Office, as well as for utilities costs and Common Policy items such as Vehicle Lease Payments. POTS funding is centrally appropriated in the Executive Director's Office for these positions and is transferred into the Office of Operations as the fiscal year progresses. Because the elements included in this line item are varied, there is no one specific authorization in the Colorado Revised Statutes; however, authorization can be inferred from 24-1-120, C.R.S.

This line funds various support services for DHS. The funding is appropriated into two groupings: 1) Administration, and 2) Special Purposes. Within Administration are the Division of Accounting, Division of Contract Management, and Division of Procurement. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 Officer also reports to the Deputy Executive Director of Operation and Financial Services, but this officer is funded through the Executive Director's Office. Some components of administration receive partial Medicaid funding. Special Purpose funding includes the Division of Facilities Management and the State Garage Fund, and no Medicaid funding is provided for the special purpose functions.

The Division of Accounting manages all DHS financial operations and resources, including payments to counties and service providers throughout the State for Medicaid, Medicare, and private-party billing for the various DHS community and institutional programs. The Division of Accounting has staff assigned with specific responsibilities to ensure compliance with Generally Accepted Accounting Principles, the Governmental Accounting Standards Board, federal regulations, state fiscal rules, and internal auditing controls.

The Procurement Division has autonomous authority by the Department of Personnel and Administration (DPA) and is responsible for purchasing goods and services for DHS programs with extra concentration on purchasing supplies for mental health and

developmental disabilities centers. The Procurement Division complies with both federal and state laws regarding procurement procedures.

The Contract Management Division is responsible for managing the contracting process including development, approval, and oversight of performance. The Contract Management Division ensures that all requirements for entering into contracts with outside contractors and interagency agreements with other departments in state government are met according to federal and state laws.

A portion of the budget and expenditures relate to needs of the Regional Centers for clients with developmental disabilities. The Office of Operations is responsible for the funding of food purchases and linen services for the Regional Centers. However, these are considered to be room and board and not medical services, thus, they are not Medicaid funded. Office of Operations' Utilities and Vehicle Lease Payments from the Regional Centers are considered Medicaid-related. These expenditures originate in the "Regional Centers" line item and are transferred to the Office of Operations as a financial transaction. The Office of Operations performs similar functions for the Mental Health Institutes by concentrating on economies of scale to achieve financially favorable arrangements.

Vehicle Leased Payments provides funding for payments to DPA for the cost of administration, loan repayment, and lease-purchase payments for new and replacement motor vehicles. The vehicle lease payment provides for the fixed portion of the vehicle leases from fleet management. Although the number of vehicles leased does vary somewhat, the number is generally in the range of 400 to 500 vehicles each year. The variable portion of the motor vehicle costs are charged back to DHS on the "Operating Costs" line. Because some of the vehicles are used by programs with Medicaid funding, the Department reimburses DHS which, in turn, makes payments to DPA.

Utilities expenditures include payments for natural gas, electricity, water, and waste water at DHS residential facilities such as the Division of Youth Corrections, Mental Health Institutes, and Regional Centers for Persons with Developmental Disabilities. Parts of the residential facilities for Mental Health Institutes and Regional Centers are used by Medicaid funded programs, so the Department uses Medicaid funding to reimburse a portion of the utilities costs to DHS.

Administration in the Office of Operations also provides for payments for Leased Space and Capital Complex Leased Space but these components do not relate directly to the Medicaid programs, so no Medicaid funding is currently used for leased spaces.

(D) DIVISION OF CHILD WELFARE-MEDICAID FUNDING

ADMINISTRATION

The Division of Child Welfare is located under the Deputy Executive Director of the Office of Children, Youth, and Families. The Administration of Child Welfare oversees a group of services intended to protect children from harm and to assist families in caring for and protecting their children. These services comprise Colorado's effort to meet the needs of children who must be placed or are at risk of placement outside of their homes for reasons of protection or community safety. The Division of Child Welfare supervises

the child welfare programs that are administered by Colorado's 64 counties. The Department of Human Services (DHS) also conducts periodic, on-site reviews of children who are in residential care. County responsibilities include receiving and responding to reports of potential child abuse or neglect and providing necessary and appropriate child welfare services to the child and family, including residential care of a child when the court determines it is in the best interest of the child to remove them from the home. Many of the child welfare programs receive federal financial participation, and the Division of Child Welfare has a responsibility to show maintenance of effort for continuation of the federal funds.

Administrative functions for this line include: providing supervision to the county departments of human/social services; responding to legislation defining policy and fiscal issues; coordinating with other divisions to eliminate service duplication and assure service integration; policy development and subsequent program development; implementation and monitoring; and, responding to consumer requests for information. Child Welfare is a state-supervised but county-administered system. Authorization for this line item can be found at 26-1-201 (f), (g), (i) and (j), C.R.S.

Although the Division of Child Welfare Administration was created as a separate line item in the budget for DHS in FY 2000-01, the separate line for the Department titled "(D) Division of Child Welfare: Administration" was added to the Department's budget in FY 2005-06. Prior to that fiscal year, both administration and services were in a blended appropriation titled "Division of Child Welfare – Medicaid Funding." The child welfare program receives Medicaid funding under federal Title XIX for the medical needs of children who are in the custody of the county departments of social services, but other types of services are provided under federal Title IV-E funding. The federal Centers for Medicare and Medicaid Services requires that Title XIX and Title IV-E funding be separated.

Staff who oversee the child welfare program for Title IV-E funding are also responsible for oversight of the county work to enroll the children for Medicaid services. The Medicaid funding in this administration line item pays for the portion of the staff salaries related to Medicaid-oversight work. Generally, the automated case-management system used by DHS for child welfare cases (known as Colorado Trails) starts the enrollment process and passes information onto the Colorado Benefits Management System.

CHILD WELFARE SERVICES

The Child Welfare Services line item is the primary source of funding for counties to administer child welfare programs and deliver associated services for children and families. Authorization for this line item includes 26-5-101, C.R.S. The line item provides funding for: (1) county administration for child welfare services; (2) out-of-home placement, including foster care; (3) out-of-home placement in residential-care facilities for children needing behavioral-health treatment; (4) regular adoptions; (5) subsidized adoptions; (6) child welfare-related child care and burials; (7) administration of the Interstate Compact on Placement of Children who are moving in or out of Colorado, including placement of children by Colorado in another state; and, (8) other necessary and appropriate services for children and families. These services comprise Colorado's effort to meet the needs of children who must be placed or are at risk of placement outside their homes for their own protection or for community safety.

Although Medicaid covers both physical and mental health needs of the children in the child welfare system, most of the Medicaid funding in the "Child Welfare Services" line item is reserved for children needing treatment for emotional or mental health reasons. Many of these children qualify for the Medicaid program due to extensive medical needs that include physical health, dental health, and/or mental health issues. Children who enter foster care typically qualify for Medicaid, based upon the circumstances of their case. Each child in foster care is considered to be a family of one person and normally meets Medicaid requirements because the child generally has no income of their own.

The Division of Child Welfare tries to achieve permanency for children by moving a child from foster care to adoption if the child cannot be reunited with that child's birth parents. When adoptive parents need financial assistance to provide medical care for the adopted children, the adopted children continue to qualify for Medicaid for as long as needed, up until the child turns 18, at which point children age out of eligibility for Child Welfare Services. In cases where the adopted child has developmental disabilities, the time period may extend to age 21 to address the child's continuing needs. A young person who has aged out of the foster care program at 18 and enters into independent living due to not having been adopted will continue to qualify for Medicaid until age 21.

In FY 2006-07, DHS and the Department worked together to overhaul the child welfare program. Based on that collaboration, the Department filed a state plan amendment with the federal Centers for Medicare and Medicaid Services. The amendment set forth the methodology for unbundling provider rates. With the passage of HB 06-1395, the child welfare program was redesigned to include three new provider types, each provider offering a different level of care. These three provider types include: psychiatric residential treatment facilities (PRTF); therapeutic residential child care facilities (TRCCF); and, community-based residential child care facilities (CBRCCF).

Psychiatric residential treatment facilities are considered the highest level of care, short of inpatient hospitalization. Children can be referred to this program by physicians in or outside of the Division of Youth Corrections or by the judicial system. These facilities are reserved predominately for those children having one of the 13 high-level mental disorders, having some impairment in reality testing or communication, or major impairment in several areas such as work, school, or family relations. Only a small percentage of youth are estimated to qualify for placement in this program.

Therapeutic residential child care facilities' level of care is similar to that of the prior residential treatment centers' model with the exception that Medicaid funding has been reduced. Specific treatment must now be billed as fee-for-service on behalf of a licensed therapist, with reimbursement rates set by the State Medical Services Board.

Community-based residential child care facilities' level of care is designed to be the least restrictive of the three provider types. The services are less intensive and designed to allow transition to the home or community. Services are billed and reimbursed using a fee-for-service methodology. Only a minor portion of this total program is eligible for Medicaid funding.

The Colorado Children's Habilitation Residential Program (CHRP), is a Home- and Community-Based Services waiver and is designed to promote community placements and prevent institutional placements of children with developmental disabilities. These children are in foster care because their disabilities are so great that their parents are unable to care for them. Children may enter into CHRP at any age from birth through 21 years. Although this waiver relates to developmental-disability services, the services are provided through child welfare services rather than through the separate program for adults with developmental disabilities. After reaching age 21, the children are transitioned into the adult program for developmental disabilities. Authorization for this waiver was provided by SB 96-178. On-going federal approval of this waiver is conditional on having a State FTE administer the waiver, which DHS continues to meet.

The CHRP waiver requires the State to: approve the entry of a child into CHRP; annually review the information on the child to determine continued eligibility for the program; maintain a file to ensure timely re-evaluations of the children served; and, maintain records of evaluations and re-evaluations of children served. Through the waiver, the State has been able to return children to Colorado who were placed out-of-state, develop needed resources for developmentally disabled and multiple-needs children, provide a broad array of services in out-of-home placement to improve the functioning of these children, and maximize federal Medicaid revenue. The CHRP waiver is not an entitlement program. If the federally approved capacity is exceeded, a waiting list is established on a first-come, first-serve basis.

Only 80% of all child welfare services are funded by the State pursuant to Section 26-1-122, C.R.S. The remaining 20% is funded by individual counties. Counties receive capped funding allocations for the administration and provision of child welfare services. At the end of any fiscal year, unexpended funds can be allocated to counties whose expenditures have exceeded their capped amounts. However, counties may only receive additional funds if: 1) the over-expenditures have been authorized; 2) are the result of unanticipated caseload increases; and, 3) are not attributable to administrative or support functions. DHS is directed by statute to annually develop formulas for allocating child welfare funding among the 64 counties through the use of an optimization model. DHS receives input from the Child Welfare Allocations Committee, which consists of eight members – four members appointed by Colorado Counties, Inc. and four members appointed by DHS. Should DHS and the Child Welfare Allocations Committee fail to agree to an allocation methodology, the two entities each present alternative methodologies to the Joint Budget Committee (JBC) for selection.

The Department and DHS have statutory authorization to transfer unlimited amounts of General Fund between the two departments when required by changes from the levels in the amount of Medicaid cash funds (or reappropriated funds in the DHS budget) earned through programs or services provided under the supervision of the departments per 24-75-106, C.R.S. This provision is commonly used for the "Child Welfare Services" line item. If an unexpectedly large number of children receive services that are eligible for Medicaid reimbursement, DHS may transfer extra General Fund to the Department to receive federal financial participation for the services provided. Conversely, if child welfare Medicaid services are lower than the amounts reflected in the appropriation, DHS can request that the Department transfer the General Fund portion of the associated Medicaid appropriation back to DHS so that the General Fund may be used to provide other child welfare services that are not eligible for federal financial participation for Medicaid.

(E) OFFICE OF SELF SUFFICIENCY – MEDICAID FUNDING

SYSTEMATIC ALIEN VERIFICATION FOR ELIGIBILITY

The Systematic Alien Verification for Eligibility (SAVE) was a new line item beginning with the FY 2010-11 Long Bill (HB 10-1376). The system is part of the website for U.S. Citizenship and Immigration Services that is now part of the federal Department of Homeland Security. The database is a nationally accessible database of selected immigration-status information on legal immigrants entering the United States. SAVE enables federal, state, and local government agencies and licensing bureaus to obtain immigration status information that they need to determine a non-citizen applicant's eligibility for many public benefits. The SAVE database also administers employment verification programs to enable employers to verify quickly and easily the work authorization of their newly hired employees. The Colorado Department of Human Services (DHS) has a Memorandum of Understanding with the federal SAVE program to verify eligibility for public benefits. The Department shares with DHS in the use of the database to verify eligibility for the Medicaid program. Accessing SAVE is done in addition to the regular Colorado Benefits Management System determination of eligibility for benefits. Because of the cost sharing arrangement between the departments, the Department receives funding to transfer to DHS. Although this line item appeared for the first time in the FY 2010-11 Long Bill, the line has existed for several years in appropriations for DHS. Previously, the Department's share of the funding for SAVE was included in the Department's Medical Services Premiums line item.

(F) MENTAL HEALTH AND ALCOHOL AND DRUG ABUSE SERVICES-MEDICAID FUNDING

ADMINISTRATION

The "Mental Health and Alcohol and Drug Abuse Services – Medicaid Funding, Administration" line item funds the Medicaid portion of Personal Services and Operating Expenditures for oversight of the mental health services provided by the Department of Human Services (DHS). Colorado provides mental health care to a larger population than just Medicaid clients, but this line item is prorated from the total state expenditures for mental health care to represent only the Medicaid portion. There is no specific statutory reference for Mental Health Administration, but a reference may be inferred from 24-1-120, C.R.S.

The Deputy Executive Director of Behavioral Health and Housing oversees the Division of Behavioral Health, the Division of Community Mental Health (for non-Medicaid clients), the Division of Mental Health Institutes, the Division of Supportive Housing and Homelessness, and the Domestic Violence Program. Administration includes: development of policies, standards, rules and regulations; planning; contracting; allocation of resources; program and contract monitoring; technical assistance; program evaluation and outcome measurement; end-user work for development and maintenance of management information systems (technical systems work done in the Office of Information Technology) related to mental health; and, interfaces with budgeting and accounting functions within DHS.

The administration at DHS, however, does not oversee the Medicaid portion of the mental health program for community services provided by the behavioral health organization to categorically eligible Medicaid clients, except occasionally when a client with severe mental health needs that would usually be served by a Medicaid community behavioral health organization is referred to a facility under the jurisdiction of DHS. Since HB 04-1265 was signed into law, the Medicaid community behavioral health organizations have been under oversight and funded through appropriations in the Department.

Personal Services for the staff in this administrative line item include salaries and associated expenditures. Other Personal Services related appropriations (such as Health life and Dental, Short Term Disability, and other items) are centrally appropriated in the Executive Director's Office of DHS and are transferred into this administrative line throughout the fiscal year as needed.

RESIDENTIAL TREATMENT FOR YOUTH

HB 99-1116 created the Child Mental Health Treatment Act to improve the probability that children with significant mental health needs receive treatment. Children served under this Act are often referred to as 1116 Kids. This act is codified in 27-10.3-101, C.R.S. This legislation was passed to help mitigate parents' difficulty in navigating the various governmental systems including child welfare, mental health, law enforcement, juvenile justice, education, and youth corrections in seeking help for their children. Often these situations resulted from a court action of dependency and neglect that caused parents to give up custody of their children to the local departments of human/social services. The Child Mental Health Treatment Act set up a framework for getting mental health treatment for these children without resorting to the dependency and neglect action. However, during the evaluation process for admission to the residential treatment center, if it is determined that the child is a victim of child abuse, the case is referred to child welfare services.

Mental health agencies are responsible for providing the full range of mental health treatment services, including residential care for these children who do not start out to be categorically eligible for Medicaid but who may be determined to be eligible for Supplemental Security Income (SSI) and, by virtue of qualification for SSI, also become eligible for Medicaid. These children are served under the Medicaid funding for this line item of Residential Treatment for Youth. Children who need this service but do not qualify for either SSI or Medicaid are considered to be private-pay clients at the Residential Treatment Centers, and the child's parents are expected to pay for the treatment if the costs are not covered by private insurance. If none of the aforementioned payment options are available, the Department of Human Services (DHS) pays for treatment from the larger appropriation for Residential Treatment for Youth, which includes reappropriated Medicaid funds to be use only for Medicaid clients.

Although there had been a therapeutic residential child care facility located at the Colorado Mental Health Institute at Fort Logan, the therapeutic residential child care section was closed during FY 2009-10 as a budget-balancing measure (see additional discussion of closures in the of ental Health Institutes line item). Other Residential Treatment Centers – privately operated facilities or local government owned – have been contracted to provide this type of care. These treatment centers are referred to as a therapeutic residential child care facility (TRCCF) because they provide the highest, most intensive level of care for children. Often there may also be children who are in the custody of Child Welfare in DHS or in the custody of the Division of Youth Corrections at DHS who are also treated with mental health care in the same therapeutic residential child care facility. The difference for the 1116 Kids is that

they remain in the custody of their parents even though the children are temporarily in an out-of-home placement situation, but not in the custody of a governmental organization.

Historically, there used to be much larger Medicaid appropriations for this line item because the treatment at these facilities included room and board as well as mental health medical care. The federal Centers for Medicare and Medicaid Services has indicated that Medicaid would not cover room and board, so that only physical and mental health medical care is covered beginning in FY 2006-07.

MENTAL HEALTH INSTITUTES

The State operates two hospitals for the severely mentally ill: the Colorado Mental Health Institute at Fort Logan, established in 1961 in Denver, and the Colorado Mental Health Institute, established in 1879 in Pueblo. These institutes are codified in 27-13-101 and 27-15-101, C.R.S. The institutes provide inpatient psychiatric hospital services to citizens of Colorado having a major illness such that the individual cannot be expected to function and/or be treated in the community. Both locked and unlocked treatment units are provided, with a wide variety of assessment and treatment services offered to patients. Services have included: individual, group, and family therapy; treatment goal-setting; work therapy; community-readiness skills; medication and health education; education programs; pastoral services; substance abuse education and treatment; and, discharge and aftercare planning. The Fort Logan location does not have an inpatient treatment program for substance abuse.

The Mental Health Institutes play an important role in the continuum of care in the mental health system in Colorado. Residential occupancy at both Fort Logan and at Pueblo has declined over a period of time as the institutes have moved away from simply housing mentally ill patients to providing active treatment in a secure setting with the goal of reintegrating mentally ill individuals back into the community. Availability of modern, effective, psychotropic prescription drugs has assisted and enhanced the reintegration process for mentally ill clients. The intention is that the institutes provide short-term secure stabilization services only to the most severely mentally ill citizens. The majority of the clients in the institutes are referred by Community Mental Health Centers or Behavioral Health Centers if a client is too unstable for effective treatment in the community.

The capacity of the Mental Health Institutes has also been affected by State budget balancing needs caused by the economic downturn. During FY 2009-10, the facility for children and youths was closed at the Fort Logan location, causing a shift of inpatient care to private facilities. The facility for elderly mentally ill clients was also closed at the Fort Logan location, causing a shift of these clients to nursing care facilities, other private mental health facilities, or to family care and local Community Mental Health Centers.

Over the years, the number of court-ordered and competency evaluations has increased significantly. To meet this need, the Colorado Mental Health Institute at Pueblo has a separate unit called the High Security Forensics Institute for clients who have been charged with crimes but are believed to be mentally incompetent. These clients have been referred by court order for sanity and competency evaluations, and this unit serves an important function because, otherwise, the clients would have to wait in jail until other arrangements could be made. If a client is found to be mentally incompetent, the purpose of treatment at this high security location is to restore competency if at all possible.

Funding for the institutes comes from a variety of sources such as disability payments, Medicare, Medicaid, third-party insurers or insurance companies, counties, school districts, and other State Departments (such as the Department of Corrections or the Department of Education). These institutes also transfer a portion of their revenues to other offices in DHS that provide support for operations of the institutes. Such supporting operations include facilities management and accounting functions in the Office of Operations and computer functions in the Office of Information Technology. The Department pays for the services provided to Medicaid clients at the institutes as well as the Medicaid portion of the functions in the Office of Operations and Office of Information Technology that relate to Medicaid services at the institutes.

The institutes do not have a separate appropriation for capital outlay. All such purchases are included in the main appropriation. Capital outlay covers purchases of furniture, fixtures, and special equipment when the items cost over $5,000. A portion of those purchase costs are paid by Medicaid if the items are to be used by Medicaid clients. However, capital outlay purchases take a lower priority than the general costs of providing everyday services to all of the clients, including Medicaid clients.

ALCOHOL AND DRUG ABUSE DIVISION, ADMINISTRATION

The DHS appropriation was funded in part by the Department and supports staff activities including: 1) formulating and maintaining alcohol and other drug treatment licensing standards authorized by the State Board of Human Services; 2) investigating complaints and critical incidents involving licensed treatment providers and medical practitioners; 3) partnering with federal, State, county, and local agencies to design, initiate, and maintain additional treatment and prevention resources; and, 4) managing the statewide involuntary commitment process that includes making treatment recommendations, arranging placements, and monitoring progress for persons who are legally committed to the Division by the court because they pose a danger or are incapacitated due to the abuse of alcohol and other drugs. Additionally, this funding also supports: 5) maintaining a central registry of all clients enrolled in opiate replacement treatment programs; 6) developing and expanding specialized substance abuse services for women, pregnant women, and women with dependent children; 7) contracting for a survey of 6th, 8th, 10th, and 12th graders to determine their use of alcohol and other drugs; 8) maintaining a prevention resource system that provides technical assistance and training materials for school districts, community agencies, and the general public; and, 9) collecting, processing, analyzing, and providing reports to the State and federal agencies, State and local planning groups, the media, and general public on data that measures and evaluates the nature and extent of substance abuse, the existing and needed level of prevention and treatment resources, program activity, and the outcome and impact of services.

Other functions the Alcohol and Drug Abuse staff manages are the federal block grants and contracts with the four managed service organizations that subcontract with approximately 42 treatment providers in approximately 200 treatment facilities throughout Colorado. Finally, staff oversees and provides technical assistance to 98 prevention program contracts. No specific reference for Alcohol and Drug Abuse Administration is in the Colorado Revised Statutes, but authority can be inferred from 24-1-120, C.R.S.

Medicaid funding has been provided to the Alcohol and Drug Abuse Division (ADAD) to assure that substance abuse treatment programs meet distinct requirements of ADAD licensure and to ensure that substance abuse clinicians meet certification or licensure requirements to abide by treatment standards. All client services are delivered according to the current versions of the American Society of Addiction Medicine patient placement criteria, which is the accepted national standard for substance abuse treatment services in both public and private sector programs.

The Medicaid funding covers the portion of the Personal Service and Operating Expenses pro-rated for Medicaid purposes. Other Personal Services related appropriations (such as Health life and Dental, Short Term Disability, and other items) are centrally appropriated in the Executive Director's Office and transferred throughout the fiscal year as needed to cover the benefits associated with Personal Services in the "Alcohol and Drug Abuse Division, Administration" line item.

During the figure setting process for the FY 2011-12 Long Bill, Joint Budget Committee (JBC) staff recommended that funding for this line item be added to the line item for regular administration of "Mental Health and Alcohol and Drug Abuse Services – Medicaid Funding," so that all Mental Health Administration could be combined for efficiencies. All of the same functions are covered but under only one line item. The JBC approved this recommendation, thus, this line item is eliminated beginning in FY 2011-12.

ALCOHOL AND DRUG ABUSE DIVISION, HIGH-RISK PREGNANT WOMEN PROGRAM

This line item provides Medicaid funding for prenatal and postpartum substance abuse treatment services for women at risk of a poor birth outcome due to alcohol or substance abuse. The High-Risk Pregnant Women Program, also called "Special Connections," is a state-wide voluntary alcohol and drug treatment program for pregnant women who are at risk of poor birth outcomes due to substance abuse-related disorders. This program was developed with the following goals: 1) delivery of healthy infants; 2) reduce or stop substance abuse in pregnant woman during and after pregnancy; 3) promote and ensure a safe child-rearing environment for the newborn and other children; and, 4) maintain the family unit. Low-income pregnant women, regardless of Medicaid eligibility, may receive these services from 16 designated treatment facilities throughout the State. Services include an in-depth risk assessment, individual and group counseling, case management services, health education, and urinalysis screening and monitoring. Services are provided on an outpatient or residential basis, depending upon client risk and placement criteria. The program includes cessation treatment for abuse of alcohol, hallucinogens, opiates, amphetamines, stimulants, barbiturates, inhalants, tranquilizers, sedatives, and cocaine. Infants who have been exposed to those substances require extensive and expensive medical treatment after birth. The program is an entitlement program fully funded by Medicaid but administered by the Alcohol and Drug Abuse Division in DHS. Authority for the program is provided at 25-1-212 through 25-1-213, C.R.S. The Medicaid Assistance portion of this program is also authorized by 25.5-5-310 through 312, C.R.S.

The outpatient program is available though the Addiction Research and Treatment Services in Denver; Arapahoe House locations in Denver, Aurora, and Thornton; Boulder County Health Department; Centennial Mental Health Center in Sterling; Cortez Addictions Recovery Services located in the four corners area of Colorado; Crossroad's Turning Point locations in Pueblo, Walsenburg, and

Trinidad; Denver Area Youth Services (DAYS) in Denver, El Paso County Health Department in Colorado Springs; Jefferson County Health Department; and, Outpatient Behavioral Health Services at Denver Health and Hospital Authority.

For residential treatment, a total of 74 beds are available. Of this total, 16 beds are in Littleton, 16 beds are in Westminster, 16 beds are in Pueblo, and 26 beds are in Denver. The services offered by the residential program are the same as those offered on an outpatient basis. Residential treatment is provided for pregnant women who cannot maintain abstinence in an outpatient setting. However, Medicaid pays for only the medical treatment. Room and board can be provided to the women in the residential program through a federal Substance Abuse Block Grant managed by DHS.

Fetal Alcohol Spectrum Disorders, resulting from alcohol use during pregnancy, is a preventable birth defect. Alcohol use during pregnancy causes brain damage to the unborn. Stimulants restrict the blood flow from the mother to the newborn via the placenta, which can lead to lower birth weight, and these newborns require longer hospital stays. Future physical and mental health needs of the children of the mothers enrolled in the program can often be prevented as a result of the services provided. Cost savings accrue from this program by preventing higher costs required to pay for the children's physical and mental health problems if substance abuse treatment had not been provided to their mothers.

(G) SERVICES FOR PEOPLE WITH DISABILITIES-MEDICAID FUNDING

COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, ADMINISTRATION

This line item supports approximately 90% of the total costs associated with 36 administrative FTE at the Department of Human Services (DHS). These FTE are responsible for the oversight of state programs for persons with developmental disabilities, including services directly administered by Community Centered Boards (CCBs). This line also funds 70% of the costs for the Community and Contract Management System (CCMS), which is used to authorize services, collect individual data, bill for services, and collect demographic data for people with developmental disabilities. CCMS also tracks disability resources and contracts, as well as wait-list information. This line funds approximately 95% of operating expenses and 100% of the Support Level Administration costs.

COMMUNITY SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, PROGRAM COSTS

The "Adult Program Costs" and the "Services for Children and Families, Program Funding" line items in this section were consolidated into the "Community Services for People with Developmental Disabilities, Program Costs" line in FY 2007-08. This line item currently appropriates funds for Medicaid-eligible services for clients through three waivers (described below) supporting the Adult Comprehensive Services, Adult Supported Living Services, and Children's Extensive Support Services Programs. Twenty Community Centered Boards (CCBs) provide case-management, utilization review/quality assurance (UR/QA), and Pre-Admission Screening and Annual Resident Reviews (PASARR) to clients throughout the state. Waiver services are delivered through community providers, including CCBs and three state-operated regional centers. Case Management services are currently appropriated for approximately 8,000 Medicaid clients under the new consolidated line item. The number of clients served has increased each of the past five years.

The "Comprehensive Home- and Community-Based Services Waiver for People with Developmental Disabilities" line item (under the former "Adult Program Costs" and "Services for Children and Families, Program Funding" line items) was replaced by funding all three waivers individually under the new line item. The three waivers are Supported Living Services (SLS), Comprehensive Developmental Disabilities (DD, or Adult Comp), and Children's Extensive Support (CES).

The SLS waiver provides supported living in the home or community to persons with developmental disabilities. Services include: the provision of specialized medical equipment and supplies; counseling and behavioral therapies; dental; vision; hearing; day habilitation; supported employment; home modification; personal assistance; supported living consultation; and transportation. The Comprehensive DD waiver provides services and support to persons with developmental disabilities, allowing them to continue to live in the community outside of the family home, yet within a 24-hour care model. Services provided under this waiver include: day habilitation; residential habilitation; transportation; specialized medical equipment and supplies; supported employment; skilled nursing; counseling; dental; and vision. The CES waiver provides various services for children who require nearly 24-hour supervision due to the severity of the child's developmental disability. Services include: the provision of specialized medical equipment and supplies; community connection services; home modifications; personal assistance; and professional services.

Service providers assisting SLS and DD waiver clients are paid rates based on an individual's evaluated Support Level. In turn, the Support Level is based primarily on the Supports Intensity Scale (SIS) assessment tool. Over the past few years, there has been an unanticipated increase in the number of people whose needs are being re-evaluated, and these re-evaluations generally result in higher Support Level assignments, which then drive higher payments in the Department of Human Services (DHS) rate structure. In addition to the SIS evaluation, two external factors – "Danger to Self" and "Community Safety Risk" – are considered when determining an individual's Support Level.

Prior to July 1, 2006, the Department of Human Services operated under a "Systems Change Project," which applied a quasi-managed care approach, akin to a block grant, to delivering developmental disability services, which allowed CCBs to negotiate rates with their providers to get a better rate for each service. DHS used a bundled rate methodology to reimburse the CCBs through the CCMS for client services. However, based on results of an audit issued by the Centers for Medicare and Medicaid Services on April 26, 2004, indicating a lack of accountability of and eligibility for federal Medicaid funding, the State was instructed to establish a new, uniform, rate-setting methodology for the Home- and Community-Based Services – Developmental Disabilities waiver, which included the mandatory "unbundling" of rates. In addition, the audit required the State to: 1) provide evidence assuring State administrative authority over the waiver; 2) ensure an effective quality management system to address incidents and other health and welfare issues; and 3) place all financial accountability for waivered programs on the Department.

Based on these audit requirements, the State, in order to address the aforementioned problem areas, organized a steering committee comprised of DHS and Department representatives, Office of State Planning and Budgeting staff, and members from the CCBs. Based on committee efforts, a new, interim, seven-tiered services matrix, based upon a fee-for-service reimbursement methodology,

was developed and put into use beginning July 1, 2006. The interim rate structure would serve until the final rate methodology could be completed. Under this new methodology, clients are assigned to one of seven acuity levels according to their required service needs, and all providers must bill the State directly or through the CCBs. However, the CCBs must now bill through the Medicaid Management Information System (MMIS) to ensure the required audit trail is established.

To implement the new rate setting methodology, the State hired a consultant to modify an existing, behavioral-assessment tool, the Supports Intensity Scale (SIS) Tool, to effectively gauge the level of care needed for every individual enrolled in the Home- and Community-Based Services - Developmental Disabilities waiver. Once the level of care has been established for each client, the State will be able to adjust its estimated expenditures accordingly.

In FY 2006-07, DHS wrote a 1331 Supplemental to remove a considerable amount of funding from the Community Services Adult Program Costs and CCMS Replacement line. The request cited underutilization of the Home- and Community-Based Services, Supported Living Services, and Children's Extensive Support waiver programs as justification for the under-expenditure. The 1331 Supplemental requested that a portion of the under-expenditure be used to pay for the purchase, modification, and user training for the aforementioned Supports Intensity Scale Tool, temporary assistance in processing Prior Authorization Reviews, and modifications to the Community Contract and Management System. These changes, according to the request, were necessary to keep the developmental disabilities programs running smoothly.

During FY 2007-08, a steering committee -- composed of members from the Department, DHS, representatives of the CCBs, and representatives from the community -- met monthly to develop the contents of an updated waiver to be submitted to the federal Centers for Medicare and Medicaid Services (CMS). The updated waiver amendment was submitted April 29, 2008. Also during FY 2007-08, a Rates Development Committee met frequently to develop current rates on a fee-for-service basis to be implemented July 1, 2008. Implementation of the new rates was postponed until January 1, 2009, to allow time for further study of the new rates.

More recently, due to the consistent increases in expenditures, the fee-for-service model is being closely monitored. The Department and DHS are working together and with various stakeholders to explore ways to reduce expenditures within the existing model. The Department is currently statutorily prohibited from using a managed-care model. The departments will continue to explore available and potential options.

Due to the passage of Referendum C and HB 05-1262 "Tobacco Tax Implementation," the State elected to reduce the number of waiting-list clients for the Children's Home- and Community-Based Services and Children's Extensive Support by increasing the number of slots available within the waivers. As these additional waiver slots met the definition of expansion populations as defined in HB 05-1262, state funding for these new clients was appropriated from tobacco tax revenues and matching federal funds.

An executive order was issued by the governor in the summer of 2012 establishing the Office of Community Living within the Department. The general purpose for the Office is to help meet the growing need for long-term services and supports by people with disabilities and aging adults.

REGIONAL CENTERS

The State operates three regional centers that provide direct support for adults with developmental disabilities. These are individuals who have significant needs and for whom adequate services and support are not available in the Community-Centered Board (CCB) system to safely meet their needs. The regional centers are located in Grand Junction, Pueblo, and Wheat Ridge. Regional centers serve adults in community group homes that provide services for between four and eight people. The majority of regional center beds are operated under the same comprehensive Home- and Community-Based waiver program that supports most community-based residential services. The regional center campuses also house Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID).

Many persons served by regional centers have multiple disabling conditions, such as maladaptive behaviors or severe, chronic medical conditions that require specialized and intensive levels of services. Regional centers provide active treatment through a number of services including: 24-hour supervision, residential services, day programming, habilitation, medical, training and behavioral intervention, and short-term emergency/crisis support to the community system. Regional centers work closely with the CCB system, which provides community-operated services for persons with developmental disabilities. Since April 2003, the regional centers have used the following admissions criteria: (1) individuals who have extremely high needs requiring very specialized professional medical support services; (2) individuals who have extremely high needs due to challenging behaviors; and/or (3) individuals who pose significant community safety risks to others and require a secure setting.

The Department provides funding for Personal Services, Operating Expenses, capital outlay for patient needs, leased space, residential incentive allowance, and the purchase of services. Funding has recently been allocated through the budget process to address staffing, wait-lists, and Medicaid waiver changes.

REGIONAL CENTER DEPRECIATION AND ANNUAL ADJUSTMENTS

This line item enables the State to capture depreciation payments from federal authorities associated with regional centers of the Department of Human Services (DHS). The line item was added through the FY 2003-04 Supplemental Bill (HB 04-1320) to reflect historic department practice. DHS is required to conduct annual depreciation calculations as part of its federal cost reporting. Depreciation amounts, allowed by federal authorities, have been included in the daily rates DHS charges to the Department for regional center consumers (all of whom are Medicaid eligible). However, because depreciation is associated with a past expenditure and is not an operating expense that is included in the DHS operating budget, DHS has never had the authority to spend these monies. Instead, the depreciation amounts paid by the Department (which are based on a standard 50% federal financial participation) may be reverted at the end of the year. In addition, provision of this line item assists the State in managing the discrepancy that may exist between the cash based accounting method used by the Department and the accrual based accounting method used by DHS (the

"Annual Adjustments" component). A benefit of the depreciation appropriation is a 100% return on General Fund dollars per year through the addition of federal financial participation.

(H) ADULT ASSISTANCE PROGRAMS; COMMUNITY SERVICES FOR THE ELDERLY – MEDICAID FUNDING

This line item was created to support funding of the State Ombudsman program of the Department of Human Services (DHS), which manages the program through a contract with the Legal Center for Persons with Disabilities and Older Persons. This program provides liaison services between DHS and its clients who are being served by the Division of Aging and Adult Services. The programs provided for the elderly are administered through the county departments of human/social services or through regional Area Agencies on Aging. This program also provides statewide advocacy for residents in long-term care facilities. The advocate can investigate complaints made by or on behalf of residents in the long-term care facilities. The Ombudsman program is codified in 26-11.5-101 through 112, C.R.S.

The types of services provided under this program include a nutrition program, a caregiver program, a senior employment program, the long-term care ombudsman program mentioned above, and other supportive services. Because Medicaid pays for services in long-term care facilities to clients who are categorically eligible for Medicaid, the possibility exists that clients in those facilities may need someone to intervene on their behalf when the need arises. Therefore, Medicaid pays a small contribution to the overall costs of the State Ombudsman Program.

(I) DIVISION OF YOUTH CORRECTIONS – MEDICAID FUNDING

The Division of Youth Corrections is under the direction of the Deputy Executive Director for Children, Youth, and Families at the Department of Human Services (DHS). The Division of Youth Corrections provides management and oversight to state-operated and private-contract residential facilities, as well as community-based alternative programs, that serve youth between 10 and 20 years of age who: have demonstrated delinquent behavior; are detained while awaiting adjudication; or are committed to the Division of Youth Corrections after adjudication. Facilities for youth offenders include intensive secure units, medium care units, staff secure units, and non-secure community residential programs. Only residents in non-secure, community residential programs would qualify for Medicaid. Other youths in secured, locked facilities have their medical care paid entirely through State General Fund.

The Division's responsibility for committed juveniles extends through a six-month mandatory parole period during which the youth is in the community. In addition, juveniles may be sentenced as a condition of parole for up to 45 days to a detention facility. While not all services are eligible for Medicaid funding, services provided by the Division of Youth Corrections includes 24-hour supervision, meals, therapy, and vocational and educational assistance. Youth Corrections in the Colorado Revised Statutes can be found in 19-2-402 through 418, C.R.S.

The Division is currently organized into Administration, Institutional Programs, and Community Programs; Medicaid funding is provided only within the Community Programs section. Within the Community Programs section, the Medicaid funding covers a portion of Personal Services, a portion of Purchase of Contract Placements (mental health services), and a portion for a Managed Care Pilot Project.

Personal Services for Community Programs covers case managers, support staff, and regional administrators who are responsible for overseeing contract placements and the overall operations of Division of Youth Corrections services. The role of case managers has been combined with parole officers so the same individual manager tracks a juvenile through the system from commitment to the end of parole. Other Personal Services related appropriations (such as Health life and Dental, Short Term Disability and other items) associated with the Personal Services are centrally appropriated in the “DHS Executive Director’s Office, General Administration” section. This funding is transferred to the Division of Youth Corrections on an as-needed basis as the fiscal year progresses.

The Division of Youth Corrections has augmented its capacity through the Purchase of Contract Placements subprogram, which is essential to the operations of the total Youth Corrections program. The Purchase of Contract Placements provides mental health services to youth in custody of Youth Corrections. The mental health services involve placement in a Therapeutic Residential Child Care Facility or in a Psychiatric Residential Treatment Facility, depending on level of acuity of mental health needs. This subprogram contracts with private vendors that provide a range of services depending on specific treatment and counseling needs. Although these services provide residential care, Medicaid pays for only the medical care expenditures. Basic room and board at the residential care centers are paid by DHS from General Fund appropriated for that purpose.

The Managed Care Pilot Project is a managed care agreement between the Division of Youth Corrections and Boulder County for handling adolescent delinquent youth. The Integrated Managed Partnership for Adolescent Community Treatment, sometimes called IMPACT, is a community-based effort to integrate care from the Boulder County Social Services, Boulder County Mental Health services, and the state Division of Youth Corrections. The Medicaid contribution is primarily through the Boulder County Mental Health services. The partnership arrangement performs gate keeping, assessment, concurrent-utilization review, and quality-assurance reviews for delinquent youth who are already in placement or at risk of placement. The Division of Youth Corrections would like to expand this project to other counties, but, at the present time, only Boulder County is participating.

In FY 2009-10, the Ridgeview Youth Services Center in the Denver-Aurora area was granted a change of license to be classified as an unlocked, non-secure, community residential facility. The new type of license allowed Ridgeview to be considered a community facility in which residents may qualify for Medicaid. Each resident at Ridgeview is viewed by Medicaid as being a low-income family of one, since the residents generally have no independent income. Thus, the residents at Ridgeview qualify under the same category of eligibility as foster care children. Tracking the Ridgeview clients is done on an individual basis, as they blend into the foster care category in Medicaid caseload. The federal Centers for Medicare and Medicaid Services continues to review this change in applicability for Medicaid eligibility of youths under the jurisdiction of Colorado Division of Youth Corrections.

(J) OTHER CONTRACTUAL SERVICES

FEDERAL MEDICAID INDIRECT COST REIMBURSEMENT FOR DHS PROGRAMS

This line item was created in the FY 2009-10 Long Bill (SB 09-259) at the recommendation of the Joint Budget Committee (JBC). An indirect cost is for a service that is provided for one department but used jointly by several divisions within the Department. As such, it is difficult to assign costs to a particular cost center such as a specific division. Indirect costs are usually constant for a wide range of services and are grouped under fixed costs because the cost is still occurring even if there is a change in work activities. Indirect costs go by other names as well, including common costs, overhead costs, or joint costs. Colorado Revised Statutes do not specifically cover this line item. However, a general authorization for the Department as the single state agency for Medicaid is found in 25.5-4-104, C.R.S.

Federal regulations describe the requirements for federal indirect costs as listed in Appendix E of 2 CFR §225, A.1: "Indirect costs are those that have been incurred for common or joint purposes. These costs benefit more than one cost objective and cannot be readily identified with a particular final cost objective without effort disproportionate to the results achieved. After direct costs have been determined and assigned directly to Federal awards and other activities as appropriate, indirect costs are those remaining to be allocated to those benefitted cost objectives. A cost may not be allocated to a Federal award as an indirect cost if any other cost incurred for the same purpose, in like circumstances, has been assigned to a Federal award as a direct cost."

Similarly, in federal regulations related to the Medicaid program, 42 CFR §433.34 states that "A State plan under Title XIX of the Social Security Act must provide that the single or appropriate Agency will have an approved cost allocation plan one file with the Department in accordance with the requirements contained in subpart E of 45 CFR part 95. Subpart E also sets forth the effect on FFP [federal financial participation] if the requirements contained in that subpart are not met."

Federal indirect costs offset General Fund costs for related Medicaid programs. This line item currently covers a portion of the costs for Payment to Risk Management and Property Funds in the Executive Director's Office at the Department of Human Services (DHS) and Vehicle Lease Payments and Utilities in the Office of Operations at DHS. However, the portion of these mentioned indirect costs that this line item covers is associated with the Regional Centers for People with Developmental Disabilities. Other programs in DHS, some of which are Medicaid programs, also have indirect costs allocated to them, but the other programs claim the federal indirect costs through a non-appropriated line item in the Department's budget.

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medical Services Premiums Request

Priority Number: R-1

Dept. Approval by: John Bartholomew JB 10/29/12 Date

OSPB Approval by: [signature] 10/30/12 Date

- ☑ Decision Item FY 2013-14
- ☐ Base Reduction Item FY 2013-14
- ☐ Supplemental FY 2012-13
- ☐ Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$3,985,613,386	$0	$4,026,532,673	$255,256,258	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,050,603,677	$0	$1,092,869,207	$78,363,224	$0
	GFE	$312,202,624	$0	$312,202,624	$0	$0
	CF	$651,181,857	$0	$626,082,971	($1,837,669)	$0
	RF	$3,215,340	$0	$1,215,340	$0	$0
	FF	$1,968,409,888	$0	$1,994,162,531	$178,730,703	$0
(2) Medical Services Premiums	Total	$3,985,613,386	$0	$4,026,532,673	$255,256,258	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,050,603,677	$0	$1,092,869,207	$78,363,224	$0
	GFE	$312,202,624	$0	$312,202,624	$0	$0
	CF	$651,181,857	$0	$626,082,971	($1,837,669)	$0
	RF	$3,215,340	$0	$1,215,340	$0	$0
	FF	$1,968,409,888	$0	$1,994,162,531	$178,730,703	$0

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

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

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

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

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Department of Health Care Policy and Financing
Medical Services Premiums

FY 2012-13, FY 2013-14, and FY 2014-15 Budget Request

November 1, 2012

TABLE OF CONTENTS

MEDICAL SERVICES PREMIUMS ***2***

I. BACKGROUND ***2***

II. MEDICAID CASELOAD ***4***

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS ***4***

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS ***7***

Exhibit A - Calculation of Total Request and Fund Splits **7**
Summary of Request 7
Calculation of Fund Splits 8
Exhibit B - Medicaid Caseload Projection **13**
Exhibit C - History and Projections of Per-Capita Costs **13**
Exhibit D - Cash Funds Report **14**
Exhibit E - Summary of Premium Request By Service Group **14**
Summary of Total Requested Expenditure by Service Group 14
Comparison of Request to Long Bill Appropriation and Special Bills 14
Exhibit F – Acute Care **14**
Calculation of Acute Care Expenditure 14
Breast and Cervical Cancer Program Per-Capita Detail and Fund Splits 23
Antipsychotic Drugs 25
Family Planning - Calculation of Enhanced Federal Match 25
Indian Health Service 27
Prior-Year Expenditure 27
Exhibit G - Community-Based Long-Term Care **27**
Calculation of Community-Based Long-Term Care Expenditure 28
Colorado Choice Transitions 33
Prior-Year Expenditure 34
Exhibit H - Long Term Care And Insurance Services **37**
Summary of Long Term Care and Insurance Request 37
Class I Nursing Facilities 37
Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category 49

Class II Nursing Facilities 49
Program of All-Inclusive Care for the Elderly (PACE) 49
Supplemental Medicare Insurance Benefit (SMIB) 51
Health Insurance Buy-In (HIBI) 54
Exhibit I – Service Management 55
Summary of Service Management 55
Single Entry Points 55
Disease Management 57
Prepaid Inpatient Health Plan Administration 59
Exhibit J - Hospital Provider Fee Funded Populations 63
Summary of Cash Funded Expansion Populations 63
Hospital Provider Fee Fund 63
Medicaid Buy-in Fund 64
Hospital Provider Fee Supplemental Payments 65
Exhibit K - Upper Payment Limit Financing 65
Exhibit L – Department Recoveries 66
Exhibit M – Cash-Based Actuals 67
Exhibit N – Expenditure History by Service Category 69
Exhibit O – Comparison Of Budget Requests And Appropriations 69
Exhibit P – Global Reasonableness 69
Exhibit Q – Caseload Graphs 70

V. ADDITIONAL CALCULATION CONSIDERATIONS 70

New Legislation and Impacts from FY 2012-13 Budget Cycle Requests 70
Prior-Year Legislation, Impacts from Previous Budget Cycles, and Other Adjustments 74

MEDICAL SERVICES PREMIUMS

I. BACKGROUND

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

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

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

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

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

2. The Department's request includes a number of references to various budget reduction items and early supplemental budget reductions. Effective July 1, 2009, September 1, 2009, December 1, 2009, July 1, 2010, July 1, 2011, and again on July 1, 2012, the Department implemented various reductions to reduce its budget in order to meet the revenue shortages being predicted by the various revenue forecasts and to bring the State into compliance with its balanced-budget requirement. In response, the Department began a process of identifying possible targets for reduction, engaging stakeholders regarding those possibilities, and submitting various budget change requests to reduce funding.

3. The Department's request identifies, and in some cases amends, the fiscal impact of these reductions through a series of bottom-line impacts. Bottom-line impacts can be found by service category (e.g., Acute Care, Community-Based Long-Term Care, Long-Term Care, Insurance, etc.) in the respective sections of this request. Those bottom-line impacts include the identification number of the originally submitted request, so that the bottom-line impact in the current year may be traced to the originally submitted budget change request document. Additionally, the annualization of a particular reduction's fiscal impact will be found in the out-year bottom-line impacts. Revisions to bottom-line impacts between requests are primarily limited to changes in implementation timeline. The Department generally does not adjust fiscal impact assumptions unless a deviation from assumptions in the original budget action is clear and significant.

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

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

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

7. The Department's request includes a forecast for FY 2012-13, FY 2013-14, and FY 2014-15. Because previous requests included only forecasts for the current and request years, additional exhibits and changes in formatting to accommodate the additional year are present throughout.

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

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

10. Effective November 2012, the Department has changed the way it forecasts expenditure for Community-Based Long-Term Care services. Previously, the forecast was done at the eligibility category level for all services. Now, the forecast is specific to each individual service.

The Department's exhibits for Medical Services Premiums remain largely the same as previous budget requests. Minor differences are noted in the description of each exhibit and/or program in sections IV and V.

II. MEDICAID CASELOAD

The Medicaid caseload analysis, including assumptions and calculations, are included in a separate section of this request. Please refer to the section titled "Medicaid Caseload."

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

Once caseload is forecasted, the next step in the process is to forecast per-capita costs. Per-capita costs contain price, utilization, and Special Bill impacts. Inherent in the per-capita cost is the differential "risk" of each eligibility category. The concept of "risk" can be roughly described as follows: due to the differences in health status (age, pre-existing condition, etc.), generally healthy clients are less costly to serve (lower "risk") than clients with severe acute or chronic medical needs requiring medical intervention (higher "risk"). For example, on average, a categorically eligible low-income child is substantially less costly to serve than a disabled person each year. Because Medicaid caseload is growing and receding at differing rates by individual eligibility categories, it is essential to determine the anticipated cost per capita for all types of eligibility categories that will be served. In very broad terms and for most services, the rate of change experienced across actual expenditure reference periods is applied to the future in order to estimate the premiums needed for current and request years. To that base, adjustments are made due to policy items or environmental changes (e.g., Change Requests and new legislation).

A detailed discussion of how the projection was prepared for this budget request follows.

Rationale for Grouping Services for Projection Purposes

The Medical Services Premiums calculations are grouped into like kinds of services and similar calculation considerations. Actual collection of data for expenditures is very detailed, but for purposes of preparing projections, premium calculations are clustered into several groupings. This is done to improve the reasonableness of the projections that result from the calculations. The objective is to cluster services that have like characteristics (e.g., community-based long-term care services) or which demonstrate a high degree of relationship (e.g., the impact of health maintenance organization service utilization on inpatient hospital, outpatient, physician

services, etc.). Adversely, the approach of projecting the budget by individual service category and applying historic rates generates a materially higher forecast.

Following are the service groupings used in computing the projections or summarizing individual service calculations in this Budget Request.

Acute Care:

- Physician Services and the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
- Emergency Transportation
- Non-emergency Medical Transportation
- Dental Services
- Family Planning
- Health Maintenance Organizations
- Inpatient Hospitals
- Outpatient Hospitals
- Lab & X-Ray
- Durable Medical Equipment
- Prescription Drugs
- Drug Rebate
- Rural Health Centers
- Federally Qualified Health Centers
- Co-Insurance (Title XVIII-Medicare)
- Breast and Cervical Cancer Treatment Program
- Prepaid Inpatient Health Plan Services
- Other Medical Services
- Home Health
- Presumptive Eligibility

Community Based Long-Term Care:

- Home- and Community-Based Services: Elderly, Blind and Disabled
- Home- and Community-Based Services: Mental Illness
- Home- and Community-Based Services: Disabled Children

- Home- and Community-Based Services: Persons Living with AIDS
- Home- and Community-Based Services: Brain Injury
- Home- and Community-Based Services: Children with Autism
- Home- and Community-Based Services: Pediatric Hospice
- Private Duty Nursing
- Hospice

Long-Term Care:

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-inclusive Care for the Elderly

Insurance:

- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management:

- Single Entry Points
- Disease Management
- Prepaid Inpatient Health Plan Administration

Financing:

- Hospital Provider Fee Financed Programs and Populations
- Department Recoveries
- Upper Payment Limit Financing
- Outstationing Payments
- Other Supplemental Payments

Note that for services in the Long-Term Care, Insurance, and Service Management categories and Financing, separate forecasts are performed. Only Acute Care and is forecast as a group.

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

EXHIBIT A - CALCULATION OF TOTAL REQUEST AND FUND SPLITS

Summary of Request

For the current year, the Department sums total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from page EA-3. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the current year.

For the request year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the request year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-5. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year.

For the out year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the out year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-6. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the out year.

Totals for the base request on this page correspond with Columns 2, 4, and 5 on the Schedule 13, where appropriate.

Federal Medical Assistance Percentages

The Department's standard federal medical assistance percentage (FMAP) is 50%. The FMAP for Medicaid is recomputed by the Federal Funds Information Service each year and is based on a statewide per-capita earnings formula that is set in federal law.

The FMAP was impacted by the American Recovery and Reinvestment Act of 2009 (ARRA). One provision of ARRA was an enhanced FMAP for specified Medicaid programs. The effective period of this enhanced rate was originally October 1, 2008, through December 31, 2010; however, federal legislation (HR 1586) extended the effective period of ARRA to June 30, 2011. The enhanced FMAP from ARRA beyond December 31, 2010, underwent a staged phase-out. Additional relief was available for states that

experienced increased unemployment; there were three defined tiers of the rate of increased unemployment percentage with respective increases to the enhanced FMAP. ARRA included a "hold harmless period"; if the FMAP for any calendar quarter from January 1, 2009, and ending before July 1, 2010, was less than the FMAP for the preceding quarter, the higher percent continued to be in effect for each subsequent calendar year ending before July 1, 2010. Below is a table detailing the Department's FMAP for FY 2008-09 through FY 2011-12. ARRA continues to be a relevant component of the Department's request as certified public expenditure receives the enhanced FMAP associated with the period of time during which the expenditure was initially included. This specifically impacts upper payment limit financing. See Exhibit K for additional details.

FMAP Rate		Effective Period	Fiscal Year Quarters
50.00%	Pre-ARRA	Through September 2008	Through first quarter of FY 2008-09
58.78%	Enhanced rate per ARRA	October 2008 through March 2009	Second and third quarters of FY 2008-09
61.59%	Enhanced rate per ARRA	April 2009 through December 2010	FY 2009-10, First and second quarters of FY 2010-11
58.77%	First stage of ARRA phase out	January 2011 through March 2011	Third quarter of FY 2010-11
56.88%	Final stage of ARRA phase out	April 2011 through June 2011	Fourth quarter of FY 2010-11
50.00%	Post-ARRA	July 2011 forward	First quarter of FY 2011-12 forward

The resulting FMAP for FY 2010-11 was a weighted average of the multiple FMAPs available during the fiscal year, totaling 59.71%.

Calculation of Fund Splits

These pages take the total estimated expenditure by service group and calculate the required source of funding for each. For each service category, the federal medical assistance percentage (FMAP) is listed on the right-hand side of the table. The FMAP calculations reflect the participation rate information provided from the federal Centers for Medicare and Medicaid Services (CMS), as reported through the Federal Register or as specified in federal law and/or regulation.

In order to calculate appropriate fund splits, the Department selectively breaks out the large service groups (e.g., Acute Care) by programs funded with either a different state source or a different FMAP rate. The majority of programs in Medical Services Premiums are paid with 50% General Fund and 50% federal funds. However, the following programs are paid for using different funding mechanisms:

- Breast and Cervical Cancer Program: This program receives a 65% federal financial participation rate. To determine State funding, the population is separated into two groups: traditional clients and expansion clients. Traditional clients, who gained eligibility through SB 01S2-012, have funding sources specified in statute, at 25.5-5-308(9), C.R.S. (2012). For FY 2012-13 and FY 2013-14, 50% of state funding for traditional clients comes from the Breast and Cervical Prevention and Treatment Fund and 50% comes from the General Fund. For FY 2014-15, 100% of the state share comes from General Fund. This is due to the sunset of legislation authorizing the cash fund June 30, 2014. Expansion clients, who gained eligibility through additional screenings funded in HB 05-1262, receive State funding through the Prevention, Early Detection, and Treatment fund, which is administered by the Department of Public Health and Environment. Please see Exhibit F for calculations.

- Family Planning: The Department receives a 90% FMAP available for all documented family planning expenditures. This includes those services rendered through health maintenance organizations. Please see Exhibit F for calculations. This line also includes reappropriated funds from the Department of Public Health and Environment to fund the State share of a family planning waiver program; see section V for additional details.

- Home Health Telemedicine Services: In HB 10-1005, the Department received authority to use gifts, grants, and donations to fund home health telemedicine services. The Department has been informed by CMS that these funds are not eligible for a federal match. Therefore, the Department assumes the grant funding will be used as State-only funds and that the remainder of the expenditure will be funded with General Fund and federal funds. See section V for additional details.

- Indian Health Services: The federal financial participation rate for this program is 100%. The total is a rough estimate based on the Department's most recent two years of paid expenditure.

- Affordable Care Act Drug Rebate Offset: The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. As a result, this provision of the ACA is intended to be budget neutral to the State. Drug rebates are recorded as an offset to total fund expenditure in Acute Care (exhibit F), and the Department's total fund expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in exhibit A, as the increased drug rebate will offset total federal funds expenditure.

- SB 11-008: "Aligning Medicaid Eligibility for Children": This bill specifies that the income eligibility criteria for Medicaid that applies to children aged five and under shall also apply to children between the ages of six to 19. Beginning January 1, 2013, children under the age of 19 will be eligible for Medicaid if their family income is less than 133% of the federal poverty level (FPL). The Department assumes FMAP for clients these clients will remain at the same level had the clients enrolled in the

Children's Basic Health Plan (CHP+) instead of Medicaid, or 65%. The Department estimates the provisions of this bill will not be implemented until FY 2012-13 due to needed federal approval and system changes.

- SB 11-250: "Eligibility for Pregnant Women in Medicaid": This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133% to 185% of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to move from CHP+ to Medicaid effective January 1, 2013. As with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients.

- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act): Provisions of federal healthcare reform require Medicaid agencies to compensate primary care physician services at a level equal to Medicare reimbursement. The difference in rates between July 1, 2009, and January 1, 2013, will be paid for by the federal government through an enhanced FMAP of 100%. Additional details are provided in sections IV and V.

- Nursing Facility Supplemental Payments: HB 08-1114 and SB 09-263 directed the Department to implement a new methodology for calculating nursing facility reimbursement rates, introduced a cap on General Fund growth for core components of the reimbursement rate, and authorized the Department to collect a provider fee from nursing facilities statewide. Any growth in the portion of the per-diem reimbursement rate for core components beyond the General Fund cap is paid from the Nursing Facility Provider Fee cash fund, as are all supplemental payments. Please refer to Exhibit H for calculations and additional details.

- Tobacco Tax Funded Disease Management: The Department annually receives funding from the Department of Public Health and Environment for the operation of disease management programs that address cancer, heart disease, lung disease, and the risk factors associated therewith. The funding for these programs is a constant $2,000,000 allocation of tobacco tax cash funds from the Prevention, Early Detection, and Treatment Fund overseen by the Department of Public Health and Environment. For FY 2012-13, the Department received authority to use a portion of the funding for chronic disease management programs administered by the Unit on Aging in the Department of Public Health and Environment; see Exhibit I for further details. In accordance with SB 08-118, Money Transfer for Medicaid Programs, FY 2012-13 is the last year in which this transfer will occur.

- Children with Autism Waiver Services: This program provides case management and behavioral therapy services to 75 children living with autism. The available funding is a fixed allocation of Tobacco Master Settlement Funds equal to $1,000,000 per year; the Department receives funding through the Colorado Autism Treatment Fund. Clients are limited to a cap of $25,000 in waiver services. The Department estimates the funding needed from the Colorado Autism Treatment Fund based on the program estimate in Exhibit G, which includes $163,500 in administration paid to the Community Centered Boards to serve as the single entry point agency for services and as the care planning agency for eligible children.

- Disabled Buy-In: Funds for this population come from three sources: Hospital Provider Fee, premiums paid by clients, and federal funds. While the program will receive federal match on the Hospital Provider Fee contribution, the premiums paid by clients are not eligible. Premium estimates and additional calculation of fund splits can be found in Exhibit J.

- Adults without Dependent Children: This population began participation in Medicaid in FY 2011-12. The population is funded with a combination of federal funds and Hospital Provider Fee. Calculations and information regarding this population can be found in Exhibit J.

- Physician Supplemental Payments: The Department draws a federal financial match on uncompensated expenditures by Denver Health Medical Center on physician and other non-physician practitioner professional services. The State share of funding is through certification of public expenditure.

- Expansion Adults to 100% Adjustment: HB 09-1293, the Colorado Health Care Affordability Act of 2009, authorizes the Department to collect hospital provider fees for the purpose of obtaining federal financial participation for the State's medical assistance programs and using the combined funds to: 1) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program; 2) increase the number of persons covered by public medical assistance; and 3) pay the administrative costs to the Department in implementing and administering the program. These adjustments allocate Hospital Provider Fee to each applicable service categories. See Exhibit J for additional information and detailed calculations.

- Supplemental Medicare Insurance Benefit: Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive a 100% federal financial participation rate. In aggregate, the Department estimates that approximately 84.5% of the total will receive federal financial participation in FY 2012-13, 82.5% in FY 2013-14, and 80.5% in FY 2014-15. The Department anticipates the decline in the portion of premiums matched with federal funds as a result increased Disabled Buy-In enrollment over time.

- Coordinated Care for People with Disabilities Program: The coordinated care for people with disabilities pilot program, as authorized by SB 06-128, allows the Department to pay per-member per-month administration fees to a nonprofit organization which operates a system that is a client-centered, comprehensive, integrated approach to primary, acute, and long-term care designed to reduce the incidences of emergency room visits, hospitalizations, secondary disabilities, and institutionalizations. The State funding for this program comes from the Coordinated Care for People with Disabilities Fund, which was created by SB 06-128 and is generated by interest earned in the Breast and Cervical Cancer Prevention and Treatment Fund.

- Upper Payment Limit Financing: The Upper Payment Limit financing offset to General Fund is a bottom-line adjustment to total expenditures. This is further described in Exhibit K.

- Denver Health Outstationing: Federal funds are drawn to reimburse Denver Health federally qualified health centers for the federal share of their actual expenditures in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund. The FY 2012-13, FY 2013-14, and FY 2014-15 totals are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.

- Department Recoveries Adjustment: Department Recoveries used to offset General Fund are incorporated as a bottom-line adjustment to total expenditure. Further detail is available in exhibit L.

- Cash Funds Financing: This item includes the impact of legislation which reduces General Fund expenditure through cash fund transfers. Please refer to Section V for more detailed information on the legislation which authorized the transfers. The table below shows the impact, by cash fund for FY 2012-13, FY 2013-14, and FY 2014-15.

Cash Funds	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**
Tobacco Tax Cash Fund (SB 11-210)	$2,230,500	$2,230,500	$2,230,500
Hospital Provider Fee Cash Fund (SB 11-212, HB 12-1335)	$40,700,000	$15,700,000	$15,700,000
Total	**$42,930,500**	**$17,930,500**	**$17,930,500**

In addition, the Department's appropriation includes a $1,750,000 transfer of reappropriated funds for FY 2012-13 from the Prevention, Early Detection, and Treatment fund, which is funded through the Department of Public Health and Environment's Prevention Programs line. This amount is eliminated in FY 2013-14 when the statutory authority for this transfer expires.

- Provider Settlements: The Department's forecast includes a one-time General Fund only impact due a expected provider settlement in FY 2012-13. The estimated impact is $3,900,000.

- Health Care Expansion Fund Transfer Adjustment: In previous years, the Department received an appropriation from the Health Care Expansion Fund to cover the costs of programs funded with tobacco tax revenues. However, beginning in FY 2011-12, the Health Care Expansion Fund was insolvent and no longer covered the cost of the programs. The balance in the Health Care Expansion Fund is appropriated to the Department to offset the costs of these programs. In the Department's calculations in this

exhibit, this transfer appears as a General Fund offset because the costs of the programs are included as General Fund in the calculations at the top of the exhibit.

The Department's request no longer includes an adjustment for "Prenatal Costs for Optional Legal Immigrants." In FY 2008-09, prenatal services were provided as a state-only option and therefore required to be funded through 100% General Fund with the exception that delivery costs qualify for the standard 50% federal financial participation rate. However, effective July 1, 2010, the Department granted full eligibility to clients enrolled in its prenatal state-only program who meet all eligibility criteria except citizenship status; this allows the Department to receive federal financial participation for these clients without enrolling any new populations. This change was made possible due to new provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Because the Department is now receiving a 50% federal match on these services, the Department no longer needs to separate out prenatal expenditure.

<u>EXHIBIT B - MEDICAID CASELOAD PROJECTION</u>

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1995-96 through FY 2014-15. Adjustments for HB 09-1293 funded populations such as Disabled Buy-In and Adults without Dependent Children, and children and women who gain eligibility through SB 11-08 and SB 11-250, are shown on page EB-2. Totals unadjusted for special populations are shown on EB-3

Pages EB-4 and EB-5 provide historical monthly caseload without retroactivity for each of the eligibility types for FY 2006-07 through FY 2011-12.

A description of the forecasting methodology for Medicaid caseload is located in the section titled "Medicaid Caseload" of this request.

<u>EXHIBIT C - HISTORY AND PROJECTIONS OF PER-CAPITA COSTS</u>

Medical Services Premiums per-capita costs history (through the most recently completed fiscal year) and projections are included for historical reference and comparison. The Department provides two separate tables. On page EC-1, the Department provides the per-capita cost history based on the cash-based actuals (i.e., the actual expenditure paid in the fiscal year). On page EC-2, the Department providers the per-capita cost history adjusted for the FY 2009-10 payment delay; that is, the claims delayed at the end of FY 2009-10 (and paid in FY 2010-11) are included in the FY 2009-10 totals.

For FY 2002-03 through FY 2008-09, expenditures for the Prenatal State-Only program are included in the Non-Citizens aid category. These expenditures are included in the Baby Care Program – Adults aid category for FY 2009-10 and forward.

EXHIBIT D - CASH FUNDS REPORT

This exhibit displays spending authority, total request, and incremental request for each source of cash funds in the Medical Services Premiums line item. This information is a summary of the information presented on Exhibit A. In addition, for the current year, total spending authority is broken out between the Long Bill and other special bills; this information is used to calculate the revised letternote amount on the Schedule 13. The Department also provides the specific requested changes to special bill appropriation clauses, when appropriate.

EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

Summary of Total Requested Expenditure by Service Group

This exhibit is a summary of the requests by service group and by eligibility category for the current year, request year, and out year. It aggregates information from the calculations contained in exhibits F, G, H, and I, along with presenting totals for populations without specific exhibits (Disabled Buy-In and Adults without Dependent Children), financing and supplemental payments, and caseload information.

Comparison of Request to Long Bill Appropriation and Special Bills

This exhibit contains a detailed summary of the Department's Budget Request by service category. In addition, this exhibit directly compares the Department's Budget Request to the Department's Long Bill plus Special Bills appropriation, as well as compares the current request to the Department's most recent prior requests for Medical Services Premiums. The Department has isolated individual components of the appropriation based on information provided by the Joint Budget Committee during Figure Setting and subsequent actions, including additional information provided by Joint Budget Committee staff. This exhibit includes all bottom-line impacts and financing but does not break the request down by eligibility type or funding source. Totals on this portion of the exhibit match the totals on Exhibit A, and the Schedule 13.

EXHIBIT F – ACUTE CARE

Calculation of Acute Care Expenditure

Acute Care services expenditure is calculated in a series of steps. At the top of page EF-1, historical expenditures and the annual percent changes are provided. Historical per-capita costs and the annual percent changes are also provided. The first step of the calculation is to select a historical per-capita percent change rate, if possible, to trend the last actual per capita to the next year. Finally, bottom-line adjustments are made for legislation and other impacts not included in historical trends. Total expenditure after

bottom-line adjustments is divided by the projected caseload to obtain a final per-capita cost for the current year. To calculate the request year expenditure, the same methodology is applied to the projected request year per capita, including a per-capita trend factor and bottom-line impacts. The total estimated expenditure for Acute Care is added to total estimated expenditure in other service groups and bottom-line impacts to generate the total request for Medical Services Premiums.

Calculation of Per-Capita Percent Change

The per-capita percent change for several different years is computed for each eligibility category on a per-capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2002-03 through FY 2011-12. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the top of page EF-2, the Department has provided a list of historic trends. Included are two-year, three-year, four-year, and five-year trends, ending in the three most recent historical years. Typically, the same percentage selected to modify current-year per-capita costs were used to modify the request-year per-capita costs, although the Department makes adjustments to the selected trend where necessary. In light of changes resulting from the Medicare Modernization Act of 2003, trends that incorporate historical data from FY 2005-06 or earlier have been omitted for the following eligibility types: Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59. For these categories, pharmaceutical expenditure was drastically reduced in FY 2006-07, resulting in artificially deflated trends.

Percentages selected to modify per-capita costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, per-capita trend factors must not take into account changes in caseload or changes accounted for as bottom-line adjustments. Because the eligibility categories differ in eligibility requirements, demographics, and utilization, different trends are used for each eligibility category.

The table below describes the trend selections for FY 2012-13, FY 2013-14, and FY 2014-15. In some cases, though not all, the Department has held the trend constant between the three years. On Exhibit F, the selected trend factors have been bolded for clarification. As described in the Department’s caseload narrative, populations sensitive to economic conditions are growing at substantial rates. Historically, rapid caseload growth leads to per-capita declines, due to several factors. First, clients may not receive services immediately upon receiving eligibility; there is typically a lag between when eligibility is determined to when clients receive services and when those services are billed. For this reason, under cash accounting where services are accounted for in the period where the claim is paid, expenditure growth will typically lag caseload growth, causing a per-capita decline. Additionally, new caseload for economically sensitive populations may previously have had health insurance and may generally be healthier than populations who have not had access to care. These clients may require fewer services, further lowering the overall per-capita cost.

The selected trend factors for FY 2012-13, FY 2013-14, and FY 2014-15, with the rationale for selection, are as follows:

Aid Category	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	Justification
Adults 65 and Older (OAP-A)	0.70% One half the per-capita growth from FY 2009-10 to FY 2010-11	0.70% One half the per-capita growth from FY 2009-10 to FY 2010-11	0.70% One half the per-capita growth from FY 2009-10 to FY 2010-11	Following several years of rate and budget reductions, per-capita expenditure is expected to revert to an underlying pattern of growth in the population. The Department has selected a trend that captures the underlying stability in the per-capita growth pattern for this population for FY 2012-13 through FY 2014-15.
Disabled Adults 60 to 64 (OAP-B)	2.06% The average per-capita growth from FY 2007-08 through FY 2009-10	2.06% The average per-capita growth from FY 2007-08 through FY 2009-10	2.06% The average per-capita growth from FY 2007-08 through FY 2009-10	This eligibility type displayed growth despite rate reductions and other bottom line impacts which put downward pressure on per-capita growth. The Department anticipates continued per-capita growth over the next three years, similar to what was experienced between FY 2009-10 and FY 2010-11.
Disabled Individuals to 59 (AND/AB)	2.38% The per-capita growth from FY 2009-10 to FY 2010-11	2.38% The per-capita growth from FY 2009-10 to FY 2010-11	2.38% The per-capita growth from FY 2009-10 to FY 2010-11	This eligibility category experienced modest growth in FY 2011-12. Primary cost drivers for this eligibility type (Physician, Inpatient Hospital, Outpatient Hospital, Pharmacy, and Home Health) increased by approximately 4% in per-capita expenditure in the last fiscal year. With a strong history of growth, the Department expects this trend to continue and has selected a trend that reflects the most recent year's expenditure patterns.
Disabled Buy-in	22.60%	2.38%	2.38%	The Department has limited expenditure data for this newly eligible population. Consequently, the Department assumes per-capita expenditure will be equal to the weighted average per-capita expenditure of the traditional Medicaid disabled populations (OAP-B and AND/AB) in FY 2012-13 and will assume the same growth rate as Disabled adults to 59 in FY 2013-14 and FY 2014-15.

Aid Category	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	Justification
Categorically Eligible Low-Income Adults (AFDC-A)	0.91% The per-capita growth rate from FY 2005-06	0.91% The per-capita growth rate from FY 2005-06	0.91% The per-capita growth rate from FY 2005-06	With high growth in caseload, per-capita figures have declined in the last three years. Caseload is anticipated to continue to grow but at a less aggressive rate over the next three years. Consequently, the Department has selected a trend that accounts for the expected reversion to per-capita growth for this population.
Expansion Adults to 60%	2.18%	2.18%	2.18%	Per-capita growth for this population has stabilized, indicating the population has matured. The trend selected for this population allows for a modest amount of continued growth over the next three years.
Expansion Adults to 100%	8.21%	2.03%	2.13%	In recent months, per-capita expenditure for Expansion Adults to 100% has appeared to converge to 95% of the per capita of Expansion Adults to 60%. This occurrence is consistent with previous Department assumptions, which are based on the expectation that marginally higher income is correlated with marginally better health status. Base per-capita expenditure for this population is held at 95% of the base per capita of Expansion Adults to 60% for all three forecast years.
Adults without Dependent Children	324.81%	2.57%	3.22%	The Department has limited data for this newly implemented population. Consequently, per-capita expenditure is assumed to be equal to 90% of the Disabled to 59 population, plus 10% of the Categorically Eligible Low-Income Adults' per-capita expenditure for all three forecast years.

Aid Category	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	Justification
Breast & Cervical Cancer Program (Page EF-7)	-3.24%	-1.62%	-0.81%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program Per-Capita Detail and Fund Splits" for a description of this trend factor.
Eligible Children (AFDC-C/ BCKC-C)	-3.39% One half the FY 2011-12 growth rate	-3.39% One half the FY 2011-12 growth rate	0%	Growth in per-capita costs has been decreasing over the last three fiscal years. However, the magnitude of the most recent years decrease includes factors such as rate cuts, efficiency measures, and increases in caseload. Continued strong caseload growth indicates continuation of decline in per capita. In FY 2014-15, as growth in caseload is expected to decline and with it the downward pressure on per-capita expenditure, the Department assumes no growth in per-capita expenditure for children.
Foster Care	1.97% One half the average per-capita growth from FY 2007-08 through FY 2010-11	1.97% One half the average per-capita growth from FY 2007-08 through FY 2010-11	1.97% One half the average per-capita growth from FY 2007-08 through FY 2010-11	Historically, this eligibility category has had significant variation in per-capita growth from year to year; on average, growth is moderate to strongly positive. FY 2010-11 growth reflected this trend of moderate positive growth. The Department expects FY 2012-13 through FY 2014-15 growth to follow this trend.
Baby Care Program - Adults (BCKC-A)	-1.64% One half the per-capita growth rate of FY 2011-12	-1.64% One half the per-capita growth rate of FY 2011-12	-1.64% One half the per-capita growth rate of FY 2011-12	The most recent two years have demonstrated per-capita declines. To account for a long-term history of stability, the Department assumes a growth rate that is one half the FY 2011-12 growth rate.

Aid Category	FY 2012-13 Trend Selection	FY 2013-14 Trend Selection	FY 2014-15 Trend Selection	Justification
Non-Citizens	7.45% The average per-capita growth from FY 2010-1 through FY 2011-12	7.45% The average per-capita growth from FY 2010-1 through FY 2011-12	7.45% The average per-capita growth from FY 2010-1 through FY 2011-12	The Department has selected a per-capita trend for these clients that reflects the most recent years aggressive per-capita growth while maintaining consideration for the volatile history of the population.
Partial Dual Eligibles	7.39% The average per-capita growth from FY 2008-09 through FY 2011-12	7.39% The average per-capita growth from FY 2008-09 through FY 2011-12	7.39% The average per-capita growth from FY 2008-09 through FY 2011-12	Continued aggressive growth is expected for this population, as both utilization increases and the portion of expenditure not covered by Medicare increase over time.

Legislative Impacts and Bottom-line Adjustments

To account for programmatic changes which are not incorporated in the prior per-capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. These impacts are described briefly below and in detail in section V, Additional Calculation Considerations:

- R-5 (FY 2012-13), FQHC/RHC Gainsharing, allows the Department to share budgetary savings with FQHC/RHC providers that assist in the generation of savings.
- R-5 (FY 2012-13), BHO Gainsharing, allows the Department to share savings with behavioral health organization that help generate savings through the better management of psychotropic drugs for significantly and persistently mentally ill clients.
- R-6 (FY 2012-13), Synagis Prior Authorization Review, changed prior authorization criteria and review processes to ensure that utilization of this expensive drug is restricted to cases where utilization is clinically appropriate.
- R-6 (FY 2012-13), Expansion of Physician Administered Drug Rebate Program, is a Department initiative to ensure rebates collection on physician administered drugs is maximized.
- R-6 (FY 2012-13), Reimbursement Rate Alignment for Developmental Screenings, changed rates for select screening procedures to better align with industry standards.

- R-6 (FY 2012-13), Public Transportation Utilization, seeks to generate cost savings by increasing utilization of public transportation by clients utilizing the non-emergent medical transportation benefit.
- R-6 (FY 2012-13), Seroquel Restrictions, altered prior authorization criteria to eliminate off-label utilization of the antipsychotic drug.
- R-6 (FY 2012-13), Dental Efficiency, reflects a refinement of Department policy regarding provision of orthodontics. Payment structure and clinical qualifying criteria for authorization are being evaluated.
- R-6 (FY 2012-13), Augmentative Communication Devices, accounts for the availability of new, cheaper, communication assistance technology for clients with disabilities impairing their ability to communicate.
- R-6 (FY 2012-13), DME Preferred Provider, generates additional rebate revenue as the Department leverages purchasing power to ensure diabetes testing supplies are purchased at the lowest net cost possible.
- R-6 (FY 2012-13), Pharmacy Rate Methodology Transition, is a significant fiscal impact driven by a change in reimbursement methodology for pharmaceuticals.
- SB 12-060, Improving Medicaid Fraud Detection, accounts for savings expected due to increased client fraud recovery activities by counties.
- SB 11-008, Aligning Medicaid Eligibility for Children, is an adjustment made to account for lower average per-capita expenditure expectations for clients migrating from CHP+ to Medicaid under the implementation of the bill.
- BRI-1 (FY 2011-12), Client Overutilization, expanded the Department's Client Over-Utilization Program (COUP). The program reduced expenditure by identifying clients that over utilize ER, pharmaceutical, or physician services and assisting them in managing their care in a more cost-effective manner.
- BRI-5 (FY 2011-12), State Maximum Allowable Cost Expansion, expands the list of drugs reimbursed under the State Maximum Allowable Cost (SMAC) pricing methodology. Savings results as drugs reimbursed under this methodology typically have lower levels of reimbursement than other pricing methodologies.
- BRI-5 (FY 2011-12), Reduce Rates for Diabetes Supplies, reduced reimbursement for diabetic test strips. Prices were reduced to reflect the current median market price for the product, $18.00 per box of 50.
- BRI-5 (FY 2011-12), Reduce Payment for Uncomplicated C-Sections, set reimbursement for uncomplicated c-sections equal to the rate paid for complicated vaginal deliveries.
- BRI-5 (FY 2011-12), Reduce Payments for Renal Dialysis, reduced the amount paid for inpatient renal dialysis from 185% of cost to 100% of cost. The Department agreed to reduce payment to 129.42% rather than 100% after negotiations with affected providers.
- BRI-5 (FY 2011-12), Deny Payment of Hospital Readmissions within 48 hours, stopped payment to hospitals for clients readmitted to the same hospital within 48 hours of the original discharge for a condition related to the original admission.

- BRI-5 (FY 2011-12), Prior Authorize Certain Radiology, requires prior authorization for MRI, CT, PET, and SPECT scans in the outpatient setting except in the case of emergency.
- BRI-5 (FY 2011-12), Limit Acute Home Health Services, requires enforcement of the Department's policy to require prior authorization for acute home health services beyond 60 days.
- BRI-5 (FY 2011-12), HMO Impact to Rates, accounts for the impact to HMO rates that results when fee-for-service rates are reduced.
- BA-9 (FY 2011-12), 0.75% Provider Rate Reduction, reduced reimbursement for most acute care services by 0.75%. The Department's original request was for a 0.50% rate reduction.
- BA-9 (FY 2011-12), Limit Fluoride Application Benefit, restricts the fluoride application benefit to three applications per year.
- BA-9 (FY 2011-12), Limit Dental Prophylaxis Benefit, limits the routine dental cleaning benefit to two per year.
- BA-9 (FY 2011-12), Eliminate Reimbursement for Oral Hygiene Instruction, terminated the oral hygiene instruction benefit.
- BA-9 (FY 2011-12), Limit Number of Physical and Occupational Therapy Units for Adults, limited the number of units of therapy an adult can receive to 48 per year, regardless of prior authorization.
- BA-9 (FY 2011-12), Home Health Billing Changes, requires providers to utilize a brief visit billing code for services that should require only a brief home health visit.
- Estimated Impact of Increasing PACE Enrollment – accounts for the Department's initiative to increase enrollment of new PACE providers. The Department anticipates that this increased enrollment will cause a shift in expenditure from the Acute Care and Community-Based Long-Term Care service groups to the PACE service category.
- SB 11-177, Sunset of Pregnancy Prevention Program, provides for the continuation and expansion of the Department's teen pregnancy and dropout prevention program. Through the program, teens receive vocational, health, and educational counseling.
- Managed Care Organization Reconciliations account for recoupment payments the Department received from managed care organizations in FY 2011-12. The Department does not know when future reconciliations will occur and therefore annualized the full amount of the payments out in FY 2012-13. The Department will include reconciliations in future requests as the payment timelines are known.
- BRI-1 (FY 2010-11), Prevention and Benefits for Enhanced Value (P-BEV) and BA-12 (FY 2010-11) Evidence-Guided Utilization Review (EGUR), increased utilization review funding in order to provide an evidence-guided utilization review program. Savings is expected as a result of increased utilization reviews. In addition, the Department is able to expand a set of dental procedures to be performed by dental hygienists and improve non-emergency medical transportation policies.
- BRI-2 (FY 2010-11), Coordinated Payment and Payment Reform, implements proposed steps toward payment coordination and payment reform. Payment coordination is characterized by streamlined payment processes, enhanced recovery efforts, and proactive integration of care. The payment reform component supports performance-based payment structures which incentivize desired outcomes.

- Accountable Care Collaborative (ACC) Savings accounts for reductions in Acute Care expenditure resulting from ACC program activities. Saving estimates were previously reported under S-6 (FY 2010-11) and BA-9 (FY 2011-12); savings estimates have been consolidated. Additional detail can be found both in section V and in the Service Management section of the narrative.
- SB 10-167, Colorado False Claims Act, has four components. The first component increases enrollment in the Health Insurance Buy-In (HIBI) program. Beginning in April, 2011, 1,500 new enrollees will be added incrementally to the HIBI program. The second component of SB 10-167 is an automated prepayment review of claims. This system will produce savings by identifying coding errors prior to reimbursement of claims. The third component is a systems change that allows for coordination of the Department's pharmacy benefit with other payers. The final component of SB 10-167 is the addition of an internal auditor. The auditor will identify clients currently enrolled in Colorado Medicaid who are eligible to enroll in the Medicaid programs of other states.
- ACA 4107 Smoking Cessation Counseling for Pregnant Women – Section 4107 of the Affordable Care acts requires states to implement a program offering pharmacotherapy and smoking cessation counseling to pregnant women. The requirement does not receive additional funding to support it. Currently, the Department offers coverage for tobacco cessation pharmacotherapy to all Medicaid clients but does not have coverage for counseling. In implementing a counseling benefit, the Department has restricted services by allowing a maximum of five counseling sessions up to 10 minutes and three counseling sessions of more than 10 minutes. The Department opened billing codes to implement the program in January 2012.
- Implementation of SB 10-117, Over the Counter Medications, accounts for savings incurred through the implementation of SB 10-117. This bill allows pharmacists to directly prescribe certain over-the-counter medication to Medicaid clients without prior authorization or a prescription from the client's primary care physician. The Department anticipates initial implementation by January 1, 2013.
- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act) accounts for the increase in primary care physician rates as mandated by federal health care reform legislation. This is effective January 1, 2013.
- Colorado Choice Transitions. This adjustment accounts for increased home health service expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. Additional detail can be found in exhibit G.

Initiatives that impact FY 2013-14 or FY 2014-15 only:

- Fifty-Three Pay Periods in FY 2013-14 – the Department's claims processing cycle includes a 53rd payment period every seven years; this next occurs in FY 2013-14. This adjustment accounts for the addition payment period in FY 2013-14. The annualization of this one-time impact returning to expenditure to a 52-week base is found in FY 2014-15.

Breast and Cervical Cancer Program Per-Capita Detail and Fund Splits

In 2001, the General Assembly passed SB 01S2-012, which established a breast and cervical cancer treatment program within the Department. In 2005, the General Assembly passed HB 05-1262, which provided additional funding to the Department of Public Health and Environment to increase the number of cancer screenings. HB 05-1262 also provided additional funding to the Department to pay for increased caseload as a result of increased screenings. The Department cannot identify which clients in the Breast and Cervical Cancer Treatment Program come into the program solely because of the increased screenings. In the Department's February 15, 2006 Budget Request, the Department stated that the Department of Public Health and Environment is funding approximately 30% of all screening with Amendment 35 funds. The Department suggested the same allocation could be used for the treatment program. During Figure Setting, the Joint Budget Committee approved the Department's allocation plan (Figure Setting, March 13, 2006, page 104). Therefore, 30% of the total Breast and Cervical Cancer Treatment patients are allocated as Prevention, Early Detection, and Treatment Fund patients and the other 70% of the total Breast and Cervical Cancer Treatment patients are considered "traditional" clients.

Per-Capita Cost

In the Department's November 1, 2006 Budget Request, the Department observed the expenditure and per-capita costs in FY 2005-06 grew at an unexpected rate. The Department investigated the issues involved and determined the total expenditure in FY 2005-06 contained a large amount of retroactive transactions, which caused the expenditure for FY 2005-06 to appear overstated. The residual effects of this experience continue, as the affected caseload is very small and changes to total expenditure, therefore, have a large impact on per-capita calculations. Per-capita expenditure has grown from year-to-year by as much as 26.55% and has been reduced by as much as -32.73%.

For this reason, the Department has been using only the most recent months of expenditure history to forecast per capita for this program. In the past few years, however, program caseload has grown at a steep rate, resulting in substantial decreases in per-capita expenditures. The Department assumes the decline in the per-capita expenditures is a temporary product of the increasing caseload and, as the new clients incur costs, the per-capita rate will begin to slow down in its decline. In the past 12 months, the per-capita expenditure has decreased more slowly than in previous periods, indicating the negative growth is beginning to moderate. For the current and request years, the Department analyzed per-capita data since April 2008, when there were enough clients in the program for a robust time-series analysis. The Department regressed rolling average per-capita expenditure on caseload, monthly dummy variables, and a time trend, producing a model that explained much of the variation in the per-capita expenditures with an R-squared of 0.9965. The Department calculated the average of the percent changes of the predicted values produced by the regression model for the current year and annualized the average for a full-year effect. The resulting trend factor is -3.24%. The Department reduces this trend by half for the request year and again in half for the out year – the regression model produces much larger negative trends

for those years but, as discussed above, the Department believes per-capita expenditure will not continue to decline as quickly as it has in the past. The trend factor for each year is applied to the base per capita on page EF-4.

Fund Splits

The second half of this exhibit calculates the portion of Breast and Cervical Cancer Program expenditure that will be allocated to the Prevention, Early Detection, and Treatment Fund and the amount allocated to the Breast and Cervical Cancer Prevention and Treatment Program Fund.

Per 25.5-5-308(9)(d) and (e), C.R.S. (2012), enacted in HB 08-1373, State funding for ”traditional” Medicaid Breast and Cervical Program clients comes, in part, from the Breast and Cervical Cancer Prevention and Treatment Fund. According to the original legislation, beginning in FY 2009-10 and into the future, State funding would be split: 50% from General Fund and 50% from the Breast and Cervical Cancer Prevention and Treatment Fund.

SB 09-262 revised the statute, requiring 100% of state funding in FY 2009-10 through FY 2011-12 for these clients comes from the Breast and Cervical Cancer Prevention and Treatment Fund. Beginning FY 2012-13, State funding will be split, with 50% coming from the General Fund and 50% from the Breast and Cervical Cancer Prevention and Treatment Fund. Per 24-22-117(2)(d)(II), C.R.S. (2012), State funding for clients who have gained eligibility due to the Health Care Expansion Breast and Cervical Cancer Program comes from the Prevention, Early Detection, and Treatment Fund. Using the allocation methodology described above, 70% of clients are funded through the Breast and Cervical Cancer Prevention and Treatment Fund, while the remaining 30% of clients are funded through the Prevention, Early Detection, and Treatment Fund. All Breast and Cervical Cancer Program expenditures have a 65% federal match rate.

The Department is requesting a change to the allocation of traditional and expansion clients in FY 2012-13 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment’s appropriation for the Breast and Cervical Cancer Treatment program is $1,215,340. On a go-forward basis, the Department will continue to limit the amount paid from this fund source for this program to this amount. Any expenditure beyond this amount will be allocated to the Breast and Cervical Cancer Prevention and Treatment Fund and the General Fund, in accordance with statute.

At the end of FY 2013-14, the legislation authorizing the Breast and Cervical Cancer Prevention and Treatment fund sunsets. The Department assumes the State portion of funding for traditional BCCP clients will be 100% General Fund in FY 2014-15 as a result.

Antipsychotic Drugs

Antipsychotic drugs were moved from the Department's premiums line to the Department of Human Services for FY 2001-02. For FY 2003-04, the General Assembly removed antipsychotic drugs from the Department of Human Services' portion of the budget and located those costs within the Medical Services Premiums line item of the Department. These expenditures are now included in the Acute Care service group within the Pharmaceutical Drug service category. Exhibit F, page EF-8 through EF-9, shows annual costs by aid category and per-capita cost in two versions: with and without the estimated impact of drug rebate. The Department has eliminated the projection of expenditure in this area due to the elimination of the informational-only line item in Long Bill group (3), effective with HB 08-1375.

Federal Funds Only Pharmacy Rebates

The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. Drug rebates are recorded as an offset to total funds expenditure in Acute Care (Exhibit F), and the Department's total funds expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure. In this exhibit, the Department estimates the incremental amount of rebates that are federal funds only. Estimates are based on data through quarter four of FY 2011-12. Historical actuals have been restated as the Department has transitioned from accrual-based accounting to cash-based accounting.

Family Planning - Calculation of Enhanced Federal Match

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must be able to uniquely identify these services. The services are provided through fee-for-service, and, beginning in late FY 2001-02, the Department was able to identify those family planning services provided by health maintenance organizations. Therefore, the State receives the enhanced match on all family planning services provided to Medicaid clients. Totals listed on page EF-10 are taken directly from the Department's reporting to the Centers for Medicare and Medicaid Services for enhanced federal funds.

As of FY 2005-06, the Department no longer has contingency-fee based contracts to calculate the managed care portion of the enhanced family planning match rate. This calculation is now done by the Department. Historically, calculations for fee-for-service and health maintenance organizations were done independently. However, due to changes in the Department's managed care program, the totals were combined beginning in FY 2008-09, and a single combined estimate is now produced. In FY 2009-10 the

Department submitted a managed care claiming methodology proposal to the Center for Medicare and Medicaid Services (CMS). The Department did not claim managed care family planning until the methodology was approved in FY 2010-11. As a result, managed care claims for the stagnant period were realized in FY 2010-11 through a large, but temporary, increase in managed care expenditure.

The Department believes the 40.31% increase in reported total expenditure between FY 2007-08 and FY 2008-09 represents a level shift in expenditure that is the result of a concerted effort to educate providers as to which services are billable as family planning services. This effort was motivated by research indicating that, at the time of the study, only a fraction of allowable services were being appropriately billed.

In light of the Department's view of the increase between FY 2007-08 and FY 2008-09 as a one-time level shift, the FY 2012-13 estimate for total reported expenditure is the average of annual total reported expenditures for FY 2008-09 through FY 2011-12. This methodology is motivated by the Department's expectation of an upward expenditure trend, despite the sporadic behavior of total annual expenditures observed over the previous four fiscal years. As the Department anticipates family planning expenditures to resolve into a more stable growth pattern, estimates for FY 2013-14 and FY 2014-15 total expenditure are the result of the application of the average of annual growth rates for FY 2005-06 and FY 2006-07 to the previous year's estimated expenditure. The Department selected this time period as a model for future expenditure growth because it represents the most recent occasion for which moderate growth was observed in consecutive fiscal years.

In FY 2010-11, the Department submitted BA-16 "Implementation of Family Planning Waiver." which would add $1,903,500 in FY 2012-13 to implement a Medicaid family planning waiver to serve individuals up to 200% of the federal poverty level. The State share of the funding was to be transferred from the Department of Public Health and Environment (DPHE) to the Department as reappropriated funds. However, after further discussion between the two agencies, the Department has removed its application for federal waiver approval. Populations that would have been served under the waiver would be eligible by July 2014 for services either through Medicaid or through a subsidized plan under the Colorado Health Benefit Exchange. In addition, system changes necessary to implement the program would be delayed due to federally mandated changes that could not be done concurrently with the changes necessary to implement the family planning waiver. The Department has removed all impacts of the family planning waiver from this request.

SB 11-177 "Sunset Teen Pregnancy and Dropout Program" is expected to contribute $13,327 in local funds for FY 2012-13, $13,780 in local funds for FY 2013-14, and $14,248 in local funds for FY 2014-15. These contributions represent a substantial decrease relative to previous estimates. This is largely attributable to the Montrose County Department of Health of Human Services discontinuing their implementation of the program due to funding limitations. The Department will continue to explore opportunities to expand this program.

Indian Health Service

In 1976, the Indian Health Care Improvement Act (PL 94-437) was passed with the goal of improving the health status of American Indians and Alaskan Natives and encouraging tribes to participate as much as possible in the management of their health services. The law specified that the payments for inpatient and outpatient services and emergency transportation for Medicaid clients who are Indians with a legal tribe affiliation receive 100% federal financial participation. The Indian Health Service is the federal agency within the Department of Health and Human Services that provides services to American Indians and Alaskan Natives directly through its hospitals, health centers, and health stations, as well as indirectly by coordinating with tribe-administered health care facilities.

The Department uses historical expenditure to estimate total expenditure for services to these clients. In FY 2008-09, Indian Health Service expenditure grew by 44.48%; in FY 2011-12, expenditure decreased by 14.21%. In an effort to forecast future expenditure growth in a fashion representative of more-regular patterns observed in other fiscal years, the average annual growth for FY 2009-10 and FY 2010-11 was applied to previous-year expenditure to derive estimated expenditures for FY 2012-13, FY 2013-14, and FY 2014-15.

Prior-Year Expenditure

As an additional reasonableness check, this section presents last fiscal year's actual and per-capita expenditure by six month intervals. Year-to-date average caseload for this exhibit has been taken from Exhibit B of this request. The change in per capita by six-month period can be quickly compared, and the prior year's per-capita costs may be referenced with page EF-1 and 2 of this request.

EXHIBIT G - COMMUNITY-BASED LONG-TERM CARE

Community-Based Long-Term Care (CBLTC) services are designed to provide clients who meet the nursing facility level of care with services in the community. The increased emphasis on utilizing community-based services has served to keep the census in Class I nursing facilities relatively flat. In FY 1981-82, with the implementation of the first wave of Home- and Community-Based Service (HCBS) waivers, Class I nursing facility census was over 12,500 clients. Almost immediately, the census dropped to just over 10,000 clients. The HCBS census generally remained in this range though FY 2002-03. However, since that time, HCBS utilization has risen sharply; in FY 2011-12, the Department paid HCBS claims for an average of 23,651 clients per month.

Clients receiving CBLTC services have access to 12 HCBS waivers each targeted to specific populations. Of the 12 waivers, nine are administered by the Department, and the other three are managed by the Department of Human Services. The waivers administered by the Department of Health Care Policy and Financing include;

- Elderly, Blind and Disabled Adult Waiver
- Community Mental Health Supports Adult Waiver
- Disabled Children's Waiver
- Persons Living with AIDS Adult Waiver
- Consumer Direct Attendant Support State Plan Waiver
- Brain Injury Adult Waiver
- Children with Autism Waiver
- Children with Life Limiting Illness Waiver
- Spinal Cord Injury Adult Waiver

Calculation of Community-Based Long-Term Care Expenditure

In FY 2012-13, the Department adjusted the CBLTC forecasting methodology from an eligibility-type forecast to one that forecasts each of the Department's HCBS waivers individually. The Department believes this to be a more accurate way of forecasting CBLTC because each waiver targets certain populations and provides services targeted at those clients. In CBLTC, each eligibility type has clients receiving services in a number of waivers. Because each waiver's services vary depending on the target population, any change to a program could impact multiple eligibility types thus making it difficult to forecast and identify the root of significant changes in historical trend.

The new methodology includes a forecast for each waiver's enrollment and cost per enrollee. Percentages selected to modify enrollment or per-enrollee costs are calculated to assess the percentages in light of any policy changes or one-time costs that may skew just one trend year. At the same time, trend factors must not take into account changes accounted for as bottom-line adjustments. Because each HCBS waiver differs in eligibility requirements, demographics, and utilization, different trends are used for each waiver.

The selected enrollment trend factors for FY 2012-13, FY 2013-14, and FY 2014-15, with the rationale for selection, are below. In most cases, the Department kept the trend for the out year the same as the request year. In situations where the out years do not carry the same trend, the variation is noted.

Home and Community Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Elderly, Blind and Disabled Waiver	5.41%, FY 2010-11 through FY 2011-12 trend	2.16%, FY 2009-10 growth rate	Enrollment history is very steady, growing a little over 5% per year. This trend was selected to be consistent with the history. Many service cost per-enrollee costs have recently dropped (Personal Care, ACFs); however, CDASS per enrollee continues to grow, as the does the percentage of the population enrolled in high-utilizer cost programs such as CDASS and IHSS. Because cost per enrollee for these programs appears to be tapering off slightly, the Department selected the FY 2009-10 trend to represent positive but tapering growth.
Community Mental Health Supports Waiver	Linear Forecast	1.92%, Half the FY 2008-09 trend	Enrollment history is very steady but appears to be tapering off. The linear trend is consistent with this slowing. While per-enrollee costs for ACFs (the highest per enrollee expenditure category) decreased last year, some of this decline could be attributed to rate cuts. In addition, enrollment in personal care and CDASS continue to grow. Because the per-utilizer cost for CDASS is much higher than the average CMHS client, the Department chose a positive trend for FY 2012-13 and carried it over through FY 2014-15.

Home and Community Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Disabled Children's Waiver	FY 2012-13: -0.67%, Half the FY 2009-10 growth rate FY 2013-14 and FY 2014-15: -0.34%, half the FY 2012-13 trend.	FY 2012-13: 41.5%, Average FY 2010-11 through FY 2011-12 growth rate FY 2013-14 and FY 2014-15: 20.75%, half the FY 2012-13 trend.	Enrollment growth has been significantly negative, as the waiver eligibility criteria changed. The Department anticipates this shifting of clients has slowed and so selected the FY 2009-10 trend. Only two services are offered on the waiver: IHSS and case management. Extremely large growth in per-utilizer costs driven by IHSS enrollment and expenditures. Nearly doubled the number of clients and a 37% increase in cost per client on IHSS in FY 2011-12. With only 60 out of 1,000 clients on the waiver enrolled in IHSS, the Department does not foresee per-utilizer cost growth slowing any time soon as more families enroll in IHSS.
Persons Living with AIDS Waiver	5.26%, FY 2011-12 growth rate	FY 2008-09 growth rate, -0.45%	Enrollment has been increasing steadily. This trend was selected to be consistent with the history, as there are no indications this should change. Per-utilizer costs have been dropping over the last few years. There have been major advances in drug therapy for these clients, so it is likely they do not need as intensive services provided in the waiver, as their health is more easily stabilized with medication.
Consumer Directed Attendant Support-State Plan	-4.88%, FY 2010-11 growth rate	7.58%, Average FY 2010-11 through FY 2011-12 growth rate	Additional enrollment in this program is currently prohibited; the selected negative growth rates reflect clients leaving the program. The Department chose a trend to be

Home and Community Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
			consistent with a small number of clients leaving the program each year. The Department moved to a needs-based allocation plan in FY 2011-12 to align with the CDASS waiver benefit. As clients continue to age, the Department assumes their needs will continue to increase. The trend was selected in anticipation that costs per enrollee would continue to grow.
Brain Injury Waiver	1.84%, FY 2011-12 growth rate	1.80%, Average of FY 2010-11 to FY 2011-12 trend	Historically there has been a slow and steady growth trend for BI enrollment. The Department chose the FY 2011-12 growth rate to be consistent with the trend. There has been steady, small, positive, per-enrollee cost growth over the last several years. The Department chose the average of FY 2010-11 to FY 2011-12 to reflect this growth.
Children with Autism Waiver	0.00%	0.00%	This waiver is capped at 75 clients. This cap has already been met, and the waiver currently has a waiting list. Average monthly enrollment is consistently below 75 clients because of client churn; however, there are no available spots on the waiver. It is likely the reason costs per enrollee have been dropping is that clients are not on the waiver very long before they age out. As a result, the clients do not receive many services while on the waiver. The Department anticipates this will slow and chose a trend of 0% to reflect it.

Home and Community Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Children with Life Limiting Illness Waiver	FY 2012-13: 19.76%, FY 2011-12 growth rate FY 2013-14 and FY 2014-15: 0%	5.77%, half the FY 2011-12 trend	The Department anticipates children will continue to enter the waiver, especially as programmatic changes improve the program. The Department selected the FY 2011-12 growth rate for FY 2012-13 enrollment and then a trend of 0.00%, as the waiver is capped at 200 clients. The program has only been operational since FY 2008-09, resulting in limited data that has been highly variable. To be conservative, the Department took half the FY 2011-12 trend to trend FY 2012-13.
Alternative Therapies Waiver	0.00%	2.16%, trend selected for the Elderly, Blind, and Disabled waiver.	The Department anticipates 67 clients will enroll immediately. There will be little turnover as clients are likely to remain on the waiver for an extended period of time as they receive services. For per-enrollee growth, the Department chose the same trend as the EBD waiver, as the services are EBD, other than chiropractic care, acupuncture, and massage.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-enrollee or trend factors, the Department adds total-dollar bottom-line impacts to the projected enrollment or expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the Request for Community-Based Long-Term Care:

Enrollment Impacts:

- HB 09-1047 "Alternative Therapies" - This legislation created a new HCBS waiver to allow chiropractic care, massage, and acupuncture services for clients with spinal cord injuries. The Department assumed clients would be moving from the EBD waiver to the Spinal Cord Injury (SCI) waiver and adjusted estimated enrollment by shifting 67 clients from the EBD waiver to the SCI waiver.

Expenditure

- BA-9 "Medicaid Reductions," 0.50% Rate Reduction - Reduce long-term care providers by 0.5%, effective July 1, 2011.
- Annualization of BRI-5 Medicaid Reductions, Cap CDASS Wage Rates - The Department proposed to put a limit on the wages that CDASS attendants could be paid. This change was implemented in March 2012.
- HB 10-1146 "State Funded Public Assistance Programs" - This bill clarifies that persons currently receiving both Home Care Allowance program and Medicaid Home- and Community-Based Services benefits will now be limited to receiving Medicaid HCBS benefits only. In addition, the Department of Human Services is given authority to contract with single entry point (SEP) agencies for the Home Care Allowances (HCA) and Adult Foster Care (AFC) programs as of July 1, 2010. While the Department anticipated an increase in HCBS enrollment as a result of this bill, implementation of the project has been delayed. DHS has assumed responsibility for payment to SEPs for enrollment of clients into the HCA program, but system changes necessary to move clients into solely HCBS waivers delayed implementation to FY 2011-12.
- HB 09-1047 "Alternative Therapies for Clients with Spinal Cord Injuries" - HB 09-1047 enabled the Department to create a pilot program centered on alternative therapies for clients with spinal cord injuries. Services include massage, acupuncture, and chiropractic care. The Department received approval for the waiver in July 2012.
- Colorado Choice Transitions - The Department was awarded Money Follows the Person federal grant monies to implement a program designed to transition clients from nursing facilities into community-based services. The program will begin enrolling clients in January 2013.

Colorado Choice Transitions

The Department was awarded the Money Follows the Person federal grant designed to help clients currently residing in nursing facilities to transition into Community-Based Long-Term Care. The grant allows the Department to provide transitional services to ease the movement from nursing facility to the community and provides an enhanced federal match to those services, existing HCBS waiver services, and home health services. The grant is designed to offer clients enhanced services for one year after transitioning from a nursing home to allow them to adapt to the community setting. Savings from the enhanced match are required to be used to improve the long-term care service system as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services. The Colorado Choice Transitions exhibit illustrates the total cost of the program by delineating the two types

of services the Department will offer through the program, demonstration (new services offered through the program), and qualified services (existing waiver services and home health). These costs are reflected in exhibits F and G, Community-Based Long-Term Care as a bottom line impact. The exhibit then reports the savings anticipated from transitioning clients from nursing facilities which is reflected in exhibit H, Class I Nursing Facilities as a bottom-line impact. Following the net impact of the program, the Department reports on the rebalancing funds the Department anticipates earning. Rebalancing funds are calculated as 25% of total expenditure and are 100% federal funds.

The Department has had to delay implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The Department currently anticipates approximately 100 clients will transition per calendar year beginning in January 2013. The Department estimates the total impact to Medical Services Premiums to be a reduction of $8,188 total funds in FY 2012-13 and a reduction of $603,033 in FY 2013-14. These figures do not include any expenditure from the rebalancing fund.

Prior-Year Expenditure

As an additional reasonableness check, the Department has split FY 2010-11 actual expenditure into two half-year increments to analyze the changing rates of expenditure over time.

Hospice

Hospice expenditure for FY 2012-13, FY 2013-14, and FY 2014-15 is forecasted as the sum of two primary categories of services. The first – Nursing Facility Room and Board expenditure – are expenses incurred on a per-diem basis for clients receiving hospice services in a full-time capacity at a nursing facility. These expenditures represented approximately 78% of total hospice expenditure in FY 2011-12. The remaining portion of hospice expenditure is represented under the Hospice Services category and includes Hospice General Inpatient Care, Hospice Routine Home Care, Hospice Inpatient Respite, Hospice Continuous Home Care, and vision, dental, hearing, and other Post-Eligibility Treatment of Income (PETI) benefits.

Payments made to nursing facilities for services provided to hospice clients differ from payments made for Class I Nursing Facility clients, most significantly in two predominant ways: there is no patient payment component of the per diem, and the per diem for hospice clients is prescribed to 95% of the per diem for Class I Nursing Facility clients. Otherwise, the methodology for forecasting nursing facility room and board expenditures for hospice clients mirrors the Class I Nursing Facility forecast.

To create the patient days forecast, the Department used claims information adjusted by an incurred-but-not-reported (IBNR) analysis to determine historical patient day counts; then, the Department used an autoregressive model with seasonality and linear time trend to

estimate patient days for the years covered in this request. As hospice client nursing facility per diems are linked to the per diem for Class I Nursing Facility clients, they are assumed to grow at the same 3% per-year rate. Rate reductions are accounted for in the same fashion as they are for nursing facilities: their impact is included in calculations as a bottom-line impact. Hospice nursing facility room-and-board total expenditure estimates for a particular fiscal year are the product of forecasted patient days and forecasted patient per diem, with additional bottom-line impact adjustments made for rate cuts applied to claims paid that were incurred in the previous fiscal year.

Please refer to the portion of the narrative devoted to Class I Nursing Facilities for a more detailed description of IBNR analysis, the 3% general fund growth cap for nursing facility rates, and nursing facility rate reductions. Additional information is available in footnotes (1) through (6) in the footnotes section of the hospice forecast.

The second category of hospice expenditure, referred to throughout the hospice forecast as Hospice Services, contains all hospice expenses other than those accrued as payments to nursing facilities for room and board for hospice clients.

The largest component of this expenditure category is Hospice Routine Home Care; this is considered the standard level of hospice care provided to hospice clients in their homes typically two to three times per week, generally by nurses. In FY 2011-12, Hospice Routine Home Care expenditure was approximately $7.5 million and thus represented 81% of hospice services expenditure and 22% of total hospice expenditure, respectively. Hospice Routine Home Care expenditures are computed as a product of patient days and the daily rate. The Department arrives at an estimate for FY 2012-13 days by adding the average change in annual days between FY 2008-09 and FY 2011-12 to observed FY 2011-12 days. Estimates for FY 2013-14 and FY 2014-15 are the result of adding the same number to the previous fiscal year's estimate. The Hospice Routine Home Care per diem is forecasted by applying a linear time trend to observed daily rates between FY 2007-08 and FY 2011-12.

The next-largest component of hospice services expenditures is hospice general inpatient care. These expenditures are incurred for services provided to hospice patients at inpatient facilities under severe circumstances. In FY 2011-12, the Department paid approximately $1.7 million for Hospice General Inpatient Care. As a linear time trend applied to historical claims data explains 98.6% of expenditure variation, the Department selected that methodology to develop expenditure forecasts for FY 2012-13, FY 2013-14, and FY 2014-15.

The remaining components of hospice services expenditures in total represent less than $80,000 of expenditure for FY 2011-12; in every prior year, they accounted for less than $50,000 of combined expenditure. As such, the Department chose to aggregate the remaining expenditure and apply the average growth rate for FY 2008-09, FY 2009-10, and FY 2010-11 to the FY 2011-12 observation for the same aggregation to develop an estimate for FY 2012-13 expenditure. FY 2013-14 and FY 2014-15 expenditure estimates are results of the application of the same growth rate to the previous fiscal year's estimate.

Private Duty Nursing

Private Duty Nursing (PDN) services are face-to-face skilled nursing services provided in a more individualized fashion than comparable services available under the home health benefit or in hospitals or nursing facilities and are generally provided in a client's home. PDN services are billed hourly; maximum daily eligibility is 16 hours for adults and 24 hours for pediatric clients. There are five categories of PDN expenditure: individual services provided by a registered nurse (RN), group services provided by a registered nurse (RN-group), individual services provided by a licensed practical nurse (LPN), group services provided by a licensed practical nurse (LPN-group), and blended services. RN services are associated with the highest hourly rate and LPN-group services with the lowest. The remaining three services – RN-group, LPN, and blended – charge the same intermediate rate. PDN rates are based on the Department's fee-schedule, and there is no mechanism forcing them to change.

As PDN expenditure is the product of the hourly rate and the number of hours, and the Department expects rates to remain constant, expenditure forecasts for FY 2012-13, FY 2013-14, and FY 2014-15 are primarily based on days forecasts for those fiscal years. The days forecast is separated into three pieces that are consistent with the three rate groups: RN hours; RN-group, LPN, and blended hours; and LPN-group hours.

In FY 2011-12, the Department paid claims for 1,036,429 total hours for PDN services; 596,723 were billed as RN hours. Linearly regressing RN hours between FY 2008-09 and FY 2011-12 explains 98.8% of the variation in hours. As such, the Department chose to apply a linear time trend to historical claims data over this time frame to produce estimates for FY 2012-13, FY 2013-14, and FY 2014-15. This model predicts growth between 10% and 12% annually over the course of the next three fiscal years.

RN hours were stable prior to FY 2008-09 but began increasing significantly in FY 2009-10. The Department examined RN hours per distinct client per month between FY 2005-06 and FY 2011-12 in an effort to investigate potential causes for the increase in hours. While there was a slight upward trend in RN hours per distinct client per month over the course of this period, this alone is far from sufficient to explain the growth in aggregate hours. This analysis was extended to the other two groups of PDN service. No discernible trend exists in changes of hours per distinct client per month. For all three categories of PDN service, changes in usage appear to be driven entirely or almost entirely by the addition of new clients.

As is consistent with RN services, paid hours for the intermediate-rate group of PDN services – RN-group, LPN, and blended – were largely stable between FY 2005-06 and FY 2008-09 before reporting rapid growth in FY 2009-10 and FY 2010-11. Unlike RN services, however, growth for these services was very small between FY 2010-11 and FY 2011-12. To this end, the Department elected to estimate hours for FY 2012-13 for these services by applying the average annual growth rate between FY 2008-09 and FY 2011-12 to the FY 2011-12 observation. This methodology produces a more moderate increase in hours relative to the previous year

than a linear forecast. The same growth rate is applied to the previous year's estimate to derive forecasts for FY 2013-14 and FY 2014-15.

LPN-group services have both the smallest rate and represent by far the smallest portion of PDN claims. In FY 2011-12, these services accounted for only 29,004 hours of claims, or 2.8% of total hours. Due to erratic growth rates in recent years, the Department chose to forecast future LPN-group hours by applying the annual growth rate from FY 2011-12 (3.4%) to the FY 2011-12 hours observation. This same growth rate is again applied to the previous year's estimate to produce estimates for FY 2013-14 and FY 2014-15.

Final expenditure estimates for FY 2012-13, FY 2013-14, and FY 2014-15 are produced by multiplying projected hours by the projected rate for each of the three service category and then summing these figures. The Department is forecasting between 9% and 10% growth in annual total expenditure for PDN services in each of the three upcoming fiscal years.

EXHIBIT H - LONG TERM CARE AND INSURANCE SERVICES

This section is for a series of services that, for a variety of reasons, are individually computed and then allocated to the eligibility categories based on experience. Those services are:

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-Inclusive Care for the Elderly (PACE)
- Supplemental Medicare Insurance Benefits
- Health Insurance Buy-In

Summary of Long Term Care and Insurance Request

This exhibit summarizes the total requests from the worksheets within Exhibit H.

Class I Nursing Facilities

Class I nursing facility costs are a function of the application and interpretation of rate reimbursement methodology specified in detail in State statute, the utilization of the services by Medicaid clients, and the impact of the effect of cost offsets such as estate and income trust recoveries. The traditional strategy for estimating the cost of these services is to predict: 1) the costs driven by the estimated Medicaid reimbursement methodology (the weighted average per diem allowable Medicaid rate and the estimated average patient

payment), 2) the estimated utilization by clients (patient days without hospital backup and out of state placement), and 3) the estimated cost offsets from refunds and recoveries and the expected adjustments due to legislative impacts.

Overall, patient days have declined since FY 1999-00, although caseload in the Department's Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories has increased by approximately 20.8% (through the FY 2009-10 total) since FY 1999-00. This is due to efforts by the Department to place clients in Home- and Community-Based Services (HCBS) and in the Department's Program for All-Inclusive Care for the Elderly (PACE). Recent history indicates this trend is changing and the Department no longer anticipates a continued decline in patient days.

Patient payment is primarily a function of client income. As clients receive cost-of-living adjustments in their supplemental security income, their patient payment has increased accordingly.

HB 08-1114 directed the Department to change the existing method of reimbursing Class I Nursing Facilities. In addition, the legislation authorized a new quality assurance fee to be collected by the Department from certain Class I Nursing Facilities, including facilities that do not serve Medicaid clients. The fee can be used for administrative costs related to assessing the fee and to limit growth of General Fund expenditures to 3% annually. The Department received federal approval of both the nursing facility fee and the new rate reimbursement method from the federal Centers for Medicare and Medicaid Services (CMS) on March 26, 2009, effective retroactive to July 1, 2008.

The new reimbursement methodology was further amended by SB 09-263, which specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period, adjusted the cap on General Fund growth, specified conditions for supplemental payments, created an upper limit on the nursing facility provider fee, replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate, included a hold harmless provision for administration and general services under certain circumstances, and made changes to the method of implementing pay-for-performance payments. The Department received federal approval of the changes to the reimbursement methodology in December 2009, effective retroactive to July 1, 2009.

HB 10-1324 imposed a 1.5% reduction to FY 2009-10 rates, effective March 1, 2010. HB 10-1379 imposed a 2.5% reduction to FY 2010-11 rates, effective July 1, 2010. The effect of the rate reductions is not cumulative; that is, the total reduction in FY 2010-11 is 2.5%. The rate is restored to the full level effective July 1, 2011. HB 10-1379 also reduced the maximum General Fund growth of the core per-diem rate to 1.9% for FY 2010-11, increasing to 3% in FY 2011-12 and subsequent years.

SB 11-125 reprioritized the components of nursing facility supplemental payments made from the Nursing Facility Provider Fee as well as increased the maximum allowable fee per non-Medicare day. These changes, however, had no impact on the General Fund

portion of nursing facility rates. SB 11-215 continued the 1.5% rate reduction of HB 10-1324 into FY 2011-12 effective July 1, 2011. The additional 1.0% rate decrease from HB 10-1379 expired at the end of FY 2010-11.

HB 12-1340 extended the 1.5% rate reduction of SB 11-125 into FY 2012-13. As all other rate reductions expired before the start of FY 2012-13, this reduction represents the total value of the rate reduction for FY 2012-13. The reduction expires June 30, 2013. For complete information regarding specific calculations, the footnotes in pages EH-6 through EH-9 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[1]:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2012-13.
- Using historic claims data from the MMIS, the Department calculates the estimated patient payment for claims that will be incurred in FY 2012-13. The difference between the estimated per-diem rate for core components and the estimated patient payment is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2012-13 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2012-13.
- The product of the estimated Medicaid reimbursement per day for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2012-13.
- Of the estimated total reimbursement for claims incurred in FY 2012-13, only a portion of those claims will be paid in FY 2012-13. The remainder is assumed to be paid in FY 2013-14. The Department estimates that 92.43% of claims incurred in FY 2012-13 will also be paid during FY 2012-13. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2012-13.
- During FY 2012-13, the Department will also pay for some claims incurred during FY 2011-12 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2011-12 to calculate an estimate of outstanding claims to be paid in FY 2012-13.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2012-13 prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in footnotes 6 and 7.
- Legislative impacts are added as bottom-line adjustments. For FY 2012-13, this includes run out from SB 11-215, which introduced a 1.5% rate reduction effective July 1, 2011. HB 12-1340, which continued the SB 11-215 rate reduction into FY 2012-13, is also included.

---

[1] For clarity, FY 2012-13 is used as an example. The estimates for FY 2013-14 and FY 2014-15 are based on the estimate for FY 2012-13, and follow the same methodology.

- Once the "non-rate" factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2012-13 expenditure.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes that are not incorporated in the prior per-capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2012-13, FY 2013-14, and FY 2014-15 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom-line adjustments for FY 2012-13 through FY 2014-15. Please refer to Footnote 6 on page EH-8 for more detail. The estimates for FY 2012-13, FY 2013-14, and FY 2014-15 are predicated on an assumption of stable enrollment: the HBU program is being evaluated by the Department and additional clients are to be enrolled on a case-by-case basis.
- Prior to FY 2010-11, the Department reduced expenditure by the amount received in estate and income trust recoveries. The Department will no longer be including these recoveries as an offset to expenditure. See the narrative section for Exhibit L for further detail.
- The Department recovers funds from in-house audits of nursing facilities; the estimated amount of recoveries is included as a bottom line impact for FY 2012-13, FY 2013-14, and FY 2014-15. FY 2010-11 BRI-2, "Coordinated Payment and Payment Reform," increased the number of Department auditors resulting in additional audits of nursing facilities. As such, there was a large increase in recoveries observed in FY 2012-13 related to the prior fiscal year. This bottom line impact has been incorporated into the forecast of overpayment recoveries. Footnote 7 on page EH-9 contains additional detail about these recoveries.
- SB 11-215 implemented a 1.5% rate reduction for Class I nursing facilities per diems effective July 1, 2011, through June 30, 2012. As a result of claims run-out, the fiscal impact of this bill extends into FY 2012-13. Footnote 9 on page EH-9 contains additional detail regarding the fiscal impact of this bill.
- SB 11-125 reprioritized the components of nursing facility supplemental payments. Growth beyond the General Fund cap now has the lowest priority. Quality incentives and acuity adjustments now take higher priority. Additionally, the maximum allowable fee per non-Medicare day increased to $12.00 per day plus inflation with this legislation. As a result, the Nursing Facility Provider Fee will be able to fully fund quality/performance incentives and acuity based adjustments but will be unable to fully fund growth beyond the General Fund cap. The Department estimates approximately 68% of growth beyond the General Fund cap will be supported by the provider fee.
- HB 12-1340 extended the 1.5% nursing facility per diem rate cut of SB 11-215 into FY 2012-13, effective July 1, 2012.

- The Colorado Choice Transitions adjustment accounts for the reduction in class I nursing facility expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. Additional detail can be found in exhibit G.

Incurred-But-Not-Reported Adjustments

As part of the estimates for the allowable per-diem rate, patient payment, and patient days, the Department utilizes the most recent four years of incurred claims to calculate estimates for the current year and the request year. However, because not all claims which have been incurred have been reported, the Department must adjust the incurred data for the expected incidence of claims which will be paid in the future for prior dates of service. Without such an adjustment, the claims data would appear to drop off at the end of the year, erroneously introducing a negative trend into the estimate.

The Department uses an extensive model which examines past claims by month of service and month of payment to estimate the amount of claims that will be paid in the future. This is known as an "Incurred But Not Reported" (IBNR) adjustment. The IBNR adjustments analyze the prior pattern of expenditure (specifically, the lag between the time past claims were incurred and when they were paid) and applies that pattern to the data. This enables the Department to use its most recent data, where there is a significant volume of claims which have yet to be paid.

Separate IBNR adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department's estimate of claims paid in the current year for current year dates of service, particularly footnotes 4 and 5 of Exhibit H, page EH-4. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2011-12 that will be paid in FY 2012-13 and the percentage of claims incurred in FY 2012-13 that will be paid in FY 2012-13 and subsequent years. The Department applies the same factor to the FY 2013-14 and FY 2014-15 estimates.

The Department uses the IBNR adjustment calculation for the November 2012 Budget Request using paid claims data through April 2012. For reference, the following table lists IBNR factors calculated for previous Change Requests and compares them with the current IBNR factor. There is a slight increase in the factors over time, suggesting the time between the date of service and the payment date of a typical claim may be decreasing.

Date of Change Request:	IBNR Factor:
November 2006	91.54%
February 2007	91.82%
November 2007	91.78%
February 2008	91.94%
November 2008	92.75%
February 2009, November 2009, February 2010	92.27%
November 2010	92.89%
February 2011	92.46%
November 2011	92.30%
February 2012	92.47%
November 2012	92.43%

Patient Days Forecast Model

To forecast patient days, the Department selected a seasonal, auto-regressive model with a linear time trend. This model was selected because the data exhibits monthly seasonality and follows a trend over time. In addition, the value in a given month is partially a function of the value in the previous month; this is represented by an auto-regressive term in the forecasting model.

The Department presents two sets of statistical results supporting the selection of this forecasting model. First, the F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. Second, the stationarity of the model needs to be tested to determine the validity of the forecasts. A non-stationary time series cannot be forecast without additional manipulation to the data. The Department tested for stationarity by performing a Dickey-Fuller unit root test. In this test, the first difference of the values predicted by the forecast model is a function of an auto-regressive term and a linear trend term. The resulting regression coefficient of the lagged term is the calculated d-statistic. This is compared again the Durbin-Watson d-statistic upper and lower bounds. If the absolute value of the calculated statistic is lower than the lower bound value, there is evidence of serial autocorrelation, and the model cannot be assumed stationary. If the absolute value of the calculated statistic is higher than the upper bound value, then there is no evidence of serial autocorrelation, and the model can be assumed stationary. If the value of the calculated statistic lies between the upper and lower bounds, then the evidence is inconclusive.

Testing the Overall Predictive Ability of the Model

The F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. This test indicates how well the components of the model together generate valid forecasts. With a p-value of 0.0000, the patient days model is statistically significant at the 99% confidence level.

Testing the Stationarity of the Model

The second set of statistics test the stationarity of the models. This is important because if a model is not stationary it cannot be used to predict values for time periods outside of the period represented by the actual data. The Department tested stationarity by performing a Dickey-Fuller unit root test. Theoretically, this test checks to see if the predictive components defined in the forecasting model are actually generating random predictions even though the overall model is statistically significant. With any model, a portion of the predicted value will be random. So, while having a random element in the model is not in itself a problem; stationarity issues result from a model in which the components assumed to be generating defined results are actually generating random results.

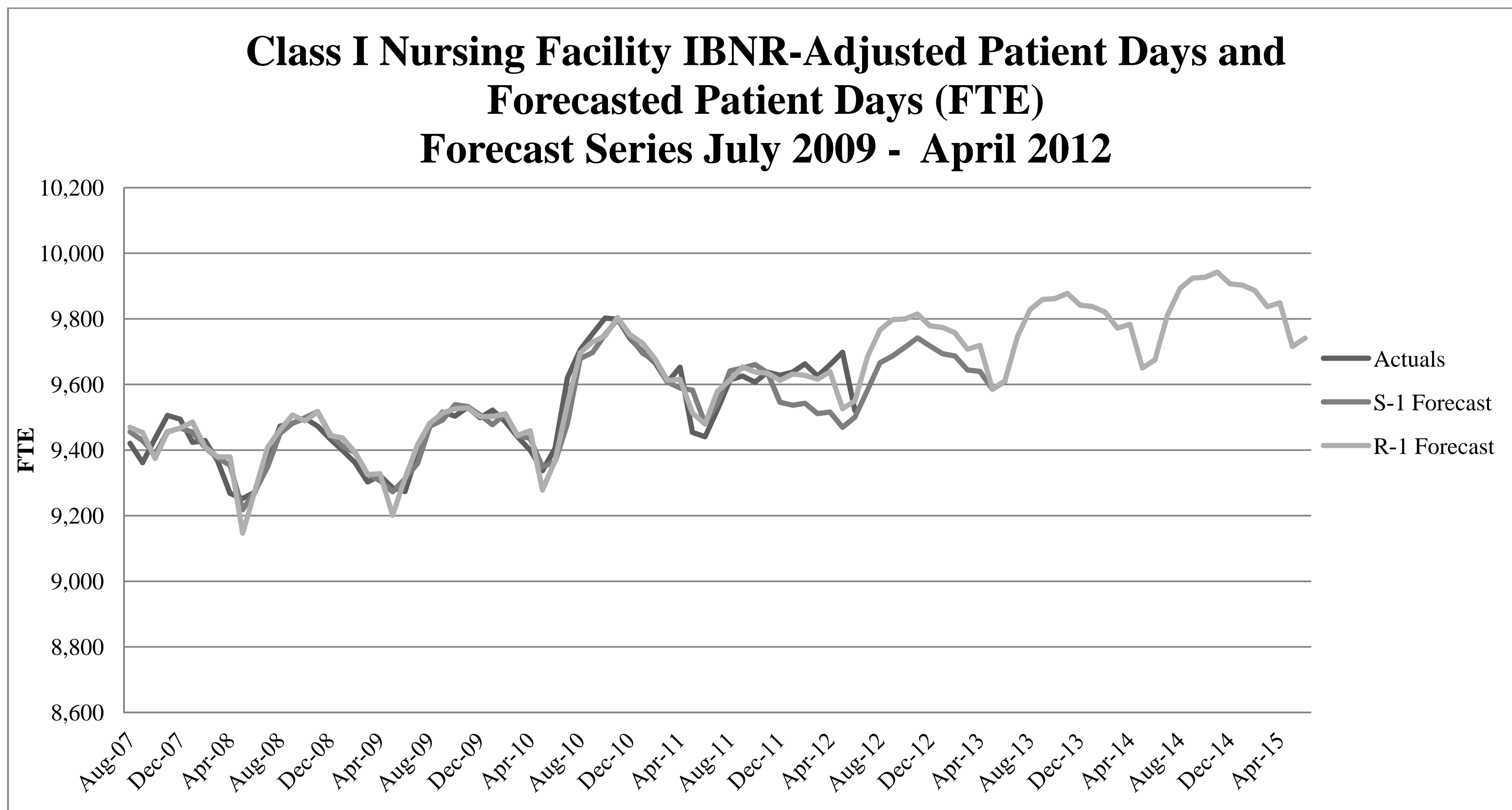
Technically, the test is performed by creating a model where the first difference (the current month minus the previous month's value) of each value predicted by the forecast model is a function of an auto-regressive term and a linear trend term. The corresponding coefficient from this regression is used to test for a unit root. The Department utilized statistical analysis software to test for a unit root in the FTE series. The result is summarized in the following table:

Augmented Dickey-Fuller Unit Root Test of Stationarity		
	T-Statistic	**P-Value**
Augmented Dickey-Fuller Test Statistic	**-3.622**	**0.0368**
Conclusion: Reject that null hypothesis that there is a unit root at the 96% confidence level. An auto-regressive model can be used with this series.		

Forecasting Patient Days

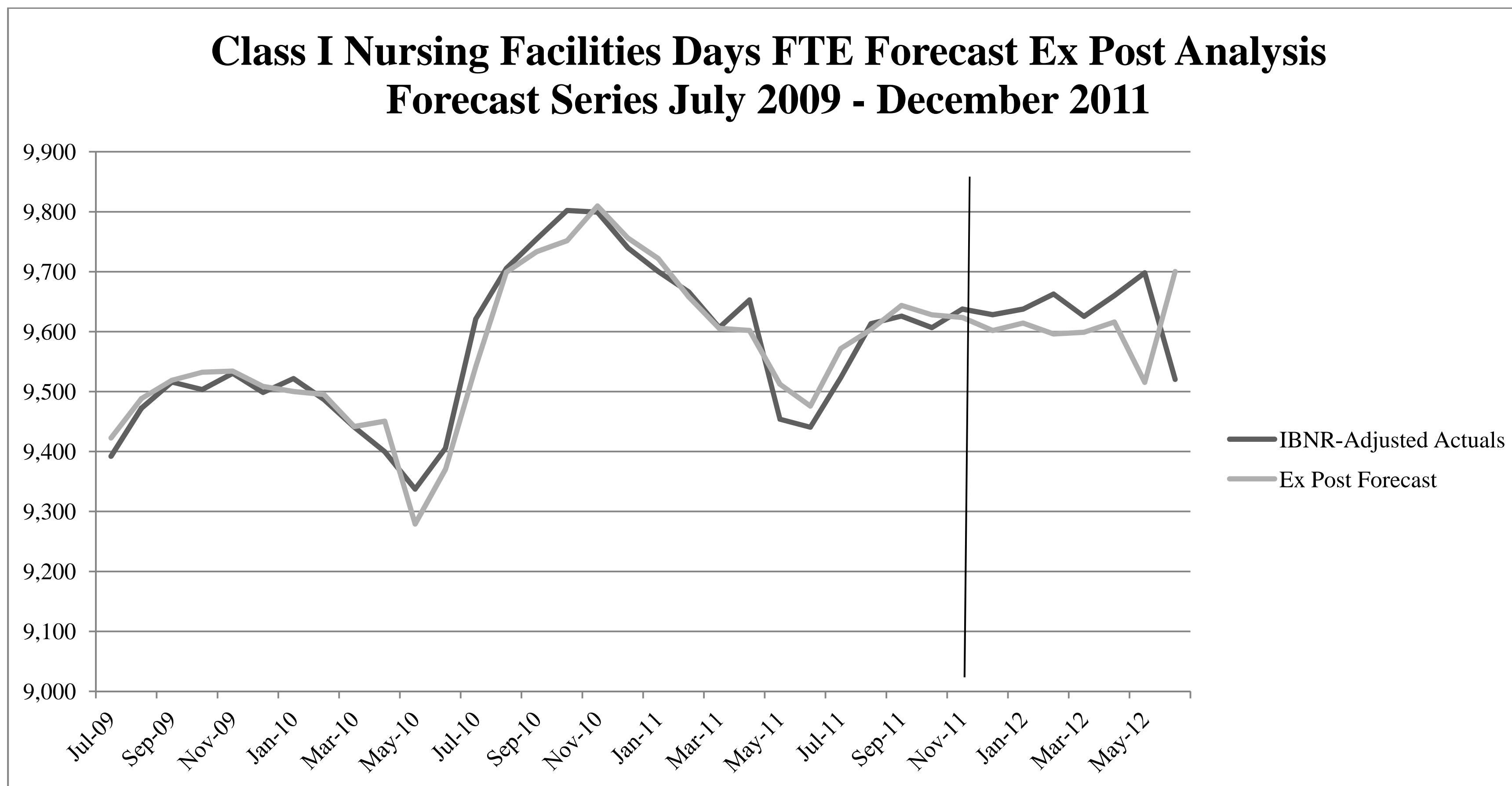
Since the number of monthly patient days is influenced by the number of days in each month, the data needs to be normalized before trending calculations are executed. The total number of days in each month is divided by the number of days in the month to create the number of FTE (full0time equivalent) days. Trending is done using the FTE days, and then the total patient days are calculated by multiplying the FTE figures by the number of days in each month.

Historically, the Department's efforts toward increasing utilization of Home- and Community-Based Services have resulted in downward pressure on the Class I Nursing Facility days trend. However, in the face of an aging population and ever-increasing demand for long-term care services, the most recent years have displayed a return to marginal annual growth in patient days.



Ex Post/In-sample Forecasts

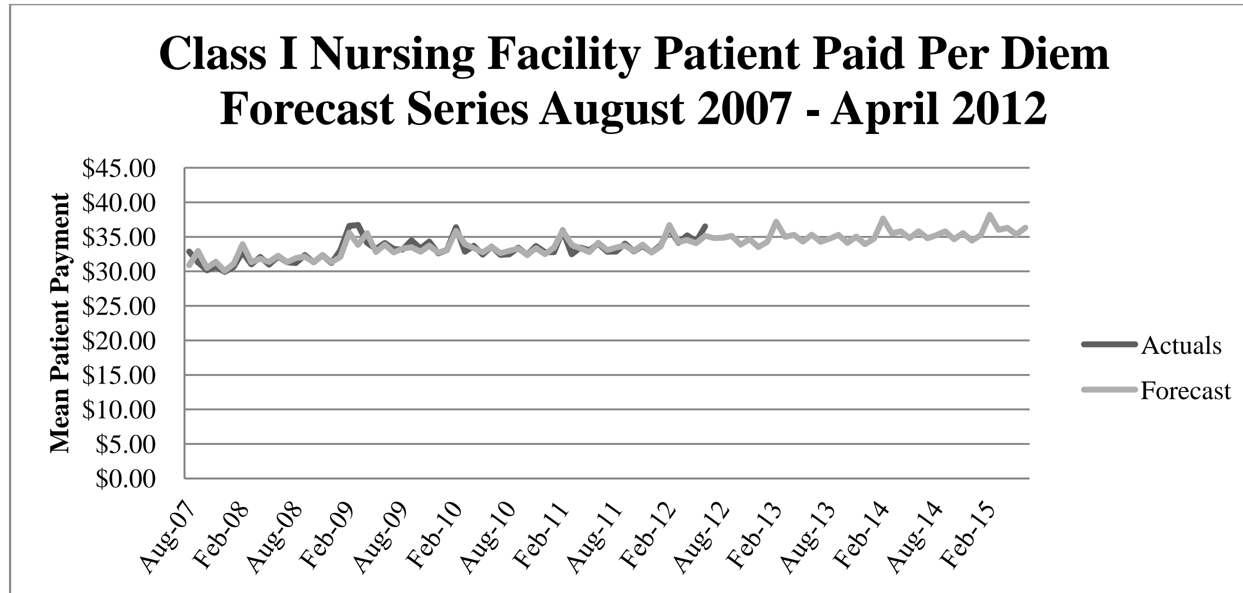
As an additional test of the reasonableness and robustness of the forecasts, the Department calculated in-sample forecasts (using the data from May 2008 through May 2011) and compared the results to actual data reported for June 2011 through November 2011.



It is worth noting the Ex Post Forecast model underestimates FTE in the forecast period from January 2012 to June 2012. Observed patient days in FY 2011-12 make a departure from previously observed seasonality. More information is necessary to determine whether this is anomalous.

Patient Payment Forecast Model

As with the days forecast, the Department utilizes a seasonally adjusted autoregressive model to forecast patient payment.



Testing the Stationarity of the Model

To test the stationarity of the patient paid series, the Augmented Dickey-Fuller Unit Root Test of Stationarity is again used. The series is stationary.

Augmented Dickey-Fuller Unit Root Test of Stationarity		
	T-Statistic	**P-Value**
Augmented Dickey-Fuller Test Statistic	**-3.398**	**0.00134**
Conclusion: Reject that null hypothesis that there is a unit root at the 99% confidence level. An auto-regressive model can be used with this series.		

Testing the Overall Predictive Ability of the Model

Again utilizing the F-statistic, an analysis of the model's overall statistical significance can be done. Like the patient-days model, the patient-payment model also has a p-value of 0.0000 and is statistically significant at the 99% confidence level. R-squared for the model is 0.976, suggesting 97.6% of the variation in this series can be explained by the linear trend.

Nursing Facility Rate Methodology Changes

The following is a timeline of changes to Class I Nursing Facility policy:

- FY 1997-98 8% Health Care Cap and 6% Administrative Cap Implemented
- FY 1998-99 No change
- FY 1999-00 8% Health Care Cap temporarily removed and Case Mix Cap Implemented
- FY 2000-01 No change
- FY 2001-02 8% Health Care Cap permanently removed and Quality of Care Incentive Program/Resident Centered Quality Improvement Program discontinued
- FY 2002-03 Administrative Incentive Allowance removed for three months then reinstated
- FY 2004-05 8% Health Care Cap reinstated
- FY 2005-06 No change
- FY 2006-07 8% Health Care Cap removed for facilities with an average annual Medicaid resident census that exceeds 64% of the number of actual residents in that facility for that same period. Established a rate floor of 85% of the statewide average rate, or 110% of the facility's current year rate, whichever is lower (SB 06-131). Provisions from SB 06-131 are applicable for FY 2006-07 only.
- FY 2007-08 Established the Nursing Facility Grant Rate Program (HB 07-1183). Providers affected by the end of provisions implemented in SB 06-131 are given additional funding to mitigate the impact of the end of the rate floor.
- FY 2008-09 New methodology introduced for calculating nursing facility reimbursement rates (HB 08-1114): the 8% Health Care and 6% Administrative and General caps are removed, and an Administrative and General price is set based on 105% of the median cost for all facilities. Add-on rates are implemented for performance and for facilities with residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury. The Department is authorized to collect a provider fee from nursing facilities statewide.
- FY 2009-10 The new methodology established in HB 08-1114 was further amended by SB 09-263 which: specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period; adjusted the cap on General Fund growth; specified conditions for supplemental payments; created a maximum for the nursing facility provider fee; replaced the 8% cap on the

	direct and indirect health care services component of the reimbursement rate; included a hold harmless provision for administration and general services under certain circumstances; and made changes to the method of implementing pay-for-performance payments. HB 10-1324 implemented a 1.5% rate reduction to the core rate components effective March 1, 2010 through June 30, 2010.
FY 2010-11	HB 10-1379 implemented a 2.5% rate reduction to the core rate components effective July 1, 2010, through June 30, 2011. This bill also reduced the maximum general funds portion of the core per-diem rate to 1.9% growth for FY 2010-11.
FY 2011-12	SB 11-125 increased the level of the provider fee to $12.00 per non-Medicare day plus annual inflation. Additionally the bill reprioritized the hierarchy for the components of nursing facility supplemental payments. Growth beyond the General Fund cap is prioritized last under the new hierarchy.
FY 2011-12	SB 11-215 extended the 1.5% rate reduction from the prior year. The rate reduction expires July 1, 2012.
FY 2012-13	HB 12-1340 extended the 1.5% rate reduction from the prior year. The rate reduction expires July 1, 2013.

Department Forecast Methodology Change

With the Department's November 1, 2011 Budget Request, the forecast methodology has been altered to increase the predictive capability of the model while aligning the components of the forecast with the rate-setting methodology in statute. To generate the nursing facility forecast using the previous methodology, claims that were 100% patient paid were excluded from the data set. This was done to prevent patient days with no associated Medicaid payment from inflating forecasted expenditure when multiplied by the effective per diem. As current legislation allows the aggregate statewide average per diem net of patient payment to grow by a fixed amount annually, claims that have 100% patient payment impact the next year's rate. To more accurately forecast the per-diem rates, the revised forecast methodology, claims with 100% patient payment are included in the data set. This has several noticeable effects; both patient payment and days increase when these claims are included in the data set. Restated historical values can be found in the footnotes section of Exhibit H.

This methodology allows for a more accurate forecast of the statewide aggregate per-diem net of patient payments. Additionally, with this methodology, patient payment and patient days more accurately reflect what were actually paid or incurred.

The Department updated its methodology for calculating the nursing facility per diem for the November 2012 request. Rather than forecasting current-year per diems, the Department developed weighted-average per diem for FY 2012-13 by crosswalking prescribed by-provider per diems with a provider-days distribution for FY 2011-12. Previously, the Department forecasted per diems in aggregate; this methodology would only be accurate if the provider-days distribution were uniform. As this is not the case, the Department's new methodology addresses variance between the forecasted per diem and the observed per diem in two ways: first, the

current year per diem is based on actual rates rather than a projection of rates, and, second, the Department uses provider days from FY 2011-12 as a proxy for provider days for FY 2012-13 rather than assume the distribution to be uniform.

Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category

For comparison purposes to other service categories, this exhibit lists prior-year expenditure along with the projected expenditure from page EH-3. Estimated totals by aid category are split proportionally to the most recent year of actual expenditure. Additionally, the Department calculates per-capita costs for each year. Supplemental payments made to Class I nursing facilities through the Nursing Facility Provider Fee program are not included in total expenditure.

Totals for each aid category are used to calculated total expenditure by aid category in Exhibit E, and total per capita by aid category in Exhibit C.

Class II Nursing Facilities

This service category is for specialized private nursing facility care for developmentally disabled clients, which was the focus of the Department of Human Services' initiative to deinstitutionalize these clients by placing them in appropriate care settings. The deinstitutionalization strategy was completed in April of FY 1997-98. Beginning in FY 1998-99, the service category was limited to one facility. There are no plans to eliminate this facility, as it functions more like a group home than an institutional facility. At the end of FY 2005-06, the provider increased its enrollment from 16 clients to 20 clients. During FY 2006-07, the census at this facility has remained constant. Additionally, this facility received an annual cost-based rate adjustment, similar to Class I nursing facilities. As a result, this service category has experienced expenditure growth that differs sharply from any recent year. FY 2009-10 to FY 2011-12 enrollment rates were slightly lower than in the previous years. However, for FY 2010-11 and FY 2011-12, the Department anticipates enrollment will return to the 20 client enrollment level. The estimated growth rate for FY 2012-13 reflects changes in per-diem rates based on audited cost reports from CY 2011. The estimated growth rate for FY 2013-14 is based on anticipated changed in per-diem reimbursement using information from unaudited cost reports for CY 2012. Because all clients are paid the same rate regardless of aid category, is the Department anticipates change in expenditure per aid category will only change if enrollment varies by aid category. However, total expenditure would still remain the same; therefore, differences between aid categories are less relevant.

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

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 55 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as

independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older (OAP-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB). PACE rates are adjusted once per year, generally on January 1 of each year.

Effective with the November 1, 2007 Budget Request, the Department has substantially revised the methodology used to calculate the projections for PACE expenditure. In prior years, the Department performed a per-capita-based estimate, similar to the Acute Care and Community-Based Long-Term Care projections. However, enrollment trends in PACE are different from the overall Medicaid population. Therefore, the standard per-capita measure is unreliable, in that it does not reflect the true cost of serving a client enrolled in PACE.

HB 08-1374 removed the requirement that the Department reimburse PACE providers at 95% of the equivalent fee-for-service cost, effective July 1, 2008. The Department now pays providers the lesser of the 100% rate or the federal upper payment limit.

To better forecast expenditure, the Department began providing two new metrics in FY 2008-09: average monthly enrollment and average cost per enrollee. The average monthly enrollment is based on the number of distinct clients for whom capitations were paid to PACE providers in each fiscal year, as determined by claims information from the Medicaid Management Information System. The average cost per enrollee is the total expenditure divided by the average monthly enrollment for each fiscal year.

In recent years, the Department has added a number of new PACE providers. Senior Community Care of Colorado (Volunteers of America), a new provider, began serving clients on August 1, 2008, in Montrose and Delta counties. The organization originally planned to open a third facility in Grand Junction in the spring of 2010, however this plan is on hold. Rocky Mountain Health Care began serving clients on December 1, 2008, in El Paso County. Total Longterm Care, the Department's oldest PACE organization, opened a facility in late 2009 to serve clients in Pueblo.

Expenditure estimates for PACE for FY 2012-13, FY 2013-14, and FY 2014-15 are the product of two pieces: projected enrollment and projected cost per enrollee. As is consistent with convincing historical enrollment data suggesting linear trends for PACE enrollment, linear regression models are used to estimate future enrollment on a by-provider by-eligibility-type basis. Enrollment caps are not anticipated to limit growth for the forecast period as a result of the manner in which PACE services are provided: that is, clients are not full-time residents of PACE facilities.

The Department anticipates a new Total Longterm Care facility in northern Colorado to begin serving clients between January and March of 2013. The Department views the Total Longterm Care facility in Pueblo as a best-guess model of enrollment patterns for this facility and, for forecasting purposes, assumes that it will open in February 2013.

Per-enrollee costs for FY 2012-13 are determined by cross-walking the actual FY 2012-13 rates for PACE services with an eligibility-type distribution estimate derived from FY 2012-13 enrollment projections. As such, they only represent an estimate to the extent that eligibility-type and provider distributions for FY 2012-13 are unknown. The rates were determined at the beginning of the fiscal year and are known for this forecast.

PACE rates have been declining since FY 2008-09. The Department believes rate cuts for other services that are components of the PACE rate calculations have contributed significantly to this trend. Additionally, there has been a shift in the methodology for the calculation of institutional-to-non-institutional client splits for PACE, which has resulted in a dramatically-different view of the client population. Previously, the calculation – prepared externally – reflected a proportion of high-cost institutional clients as high as 85%. A revision to this process resulted in estimates of high-cost clients of only 50% to 55%. As the Department views this revision as representative of a level-shift in reported client distribution, this source of downward rate pressure is not expected to drive changes in PACE rates in the future. Further, the Department anticipates other components of the PACE rate calculation will demonstrate upwardly-trending behavior. To this end, the Department is projecting moderate growth in cost-per-enrollee figures for FY 2013-14 and FY 2014-15. The rate trend is the average of FY 2008-09 and FY 2009-10 cost-per-enrollee growth (3.67%) and is applied to each eligibility type separately rather than in an aggregate fashion.

Supplemental Medicare Insurance Benefit (SMIB)

The Supplemental Medicare Insurance Benefit (SMIB) consists of two parts: Medicare Part A, the insurance premium for hospital care, and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients who have both Medicaid and Medicare coverage) or Partial Dual Eligibles receive payment for Medicare Part B and, in some cases, Medicare Part A. The Partial Dual Eligibles aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility group only.[2] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

The federal law that requires Medicaid to pay the Medicare Part B premium for qualifying individuals whose income is between 120% and 135% of the federal poverty level was scheduled to expire September 30, 2003. However, eligibility was extended. This population was referred to as “Medicare Qualified Individual (1).” Legislation for the second group, referred to as “Medicare

[2] Most Medicare beneficiaries do not make a Part A payment, because they have contributed to Medicare for 40 or more quarters during their working life. The Department only subsidizes Part A payments for Qualified Medicare Beneficiaries who do not meet the 40 quarter requirement.

Qualified Individual (2)," comprised of individuals whose income was between 135% and 175% of the federal poverty level and expired April 30, 2003. Formerly, Medicaid paid the portion of the increase in the Part B premium due to the shift of home health services from Medicare Part A to Part B insurance. Qualified Individuals are 100% federally funded, subject to an annual cap.

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:[3]

History of Medicare Premiums

Calendar Year	Part A	% Change	Part B	% Change
2003	$316.00	-	$58.70	-
2004	$343.00	8.54%	$66.60	13.46%
2005	$375.00	9.33%	$78.20	17.42%
2006	$393.00	4.80%	$88.50	13.17%
2007	$410.00	4.33%	$93.50	5.65%
2008	$423.00	3.17%	$96.40	3.10%
2009	$443.00	4.73%	$96.40	0.00%
2010	$461.00	4.06%	$110.50	14.63%
2011	$450.00	-2.39%	$115.40	4.43%
2012	$451.00	0.22%	$99.90	-13.43%

These premiums reflect the standard Medicare premiums paid by most Medicare recipients or by the Department on their behalf. Clients with between 30 and 39 work quarters of Medicare Covered Employment require a higher Part A premium. Additionally, some clients pay higher Part B premiums based on higher adjusted gross income, however, the Department is only required to pay the base premium cost.

During FY 2007-08, the Department made its July 2007 payment for Medicare premiums several days late. As a result, Medicare automatically deducted the balance from the Department's Medicaid grant. As a result, from the perspective of Medicare, the Department effectively double-paid July, and the difference became a credit against the September total. As a result, the total expenditure for this line does not reflect payment for one month, because the federal funds Medicare received directly from the

[3] Premium information taken from the Centers for Medicare and Medicaid Services, http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment|PremiumCostInfo#TabTop

Medicaid grant did not pass through the State's accounting system. Therefore, in order to accurately project expenditure, the Department used the actual Medicare invoice totals for FY 2007-08 instead of the actual expenditure for FY 2007-08. This ensures the projection base is not understated, which would lead to a material under-projection in the forecast.

To forecast FY 2012-13, the Department inflates the actual expenditure from the second half of FY 2011-12 by the increase caseload from FY 2011-12 to FY 2012-13. This generates the anticipated expenditure for the first half of FY 2012-13, as there will be no increases to Medicare premiums during this period. Expenditure for the second half of FY 2011-12 is calculated by inflating the estimated first half of the year's expenditure by the anticipated increase in Medicare premiums effective January 1, 2013, or 6.49%. This change in premiums is based on the average change in premiums from CY 2004 to CY 2012. Rates for CY 2013 have not yet been announced by CMS. The Department will update this component of the forecast in the February supplemental request. The total estimated expenditure for FY 2012-13 is the sum of the first half actual expenditures and the second half estimated expenditures.

To forecast FY 2013-14, the Department first inflates the estimated expenditure from the second half of FY 2012-13 by the estimated caseload trend for FY 2013-14 as reported in exhibit B. This figure represents the approximate expenditure for the first half of FY 2013-14. Then, the Department inflates the estimated first half expenditure by the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2013-14 is the sum of the first half and second half estimates. The forecast of FY 2014-15 expenditure utilizes the same methodology as the forecast of FY 2013-14.

Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2012-13, FY 2013-14, and FY 2014-15 calculations for the Supplemental Medicare Insurance Buy-In Program:

- Contractor to Enroll Clients in Medicare – the Department is working with a contractor on a full contingency basis to enroll Medicare eligible Medicaid clients in Medicare. This initiative is an extension of work previously done under the Department's FY 2010-11 BRI-2 "Coordination of Payments and Payment Reform" initiative. Savings generated through additional Medicare enrollments are found in Acute Care while premium payments and contractor funding are incorporated in the SMIB forecast.

Health Insurance Buy-In (HIBI)

The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost-effective. This is known as the Health Insurance Buy-In (HIBI) program, permitted under 25.5-4-210, C.R.S. (2012). In recent years, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. In particular, during FY 2005-06, due to the implementation of the Medicare Modernization Act, many of the health plans that were previously cost-effective became ineffective, since the costs of those health plans included a drug benefit. This caused a significant decrease in HIBI expenditure and enrollment in FY 2005-06. Additionally, the Department found that, with rare exceptions, it was no longer cost effective to purchase commercial insurance for clients in the Adults 65 and Older (OAP-A) aid category. Instead, the majority of expenditure was shifted to Disabled Individuals to 59 (AND/AB) for clients who do not qualify for the Medicare Part D benefit.

In FY 2006-07, the Department experienced significant growth in the program, although the cause appears to be related to administrative changes rather than other factors. For example, a single outside agency had referred approximately 50 new clients to the Department for enrollment in the program. Additionally, during FY 2006-07, the Department examined and upgraded the existing process to determine client eligibility for the program. This change enabled the Department to process clients more efficiently, resulting in an increase in caseload.

Contrary to previous budget submissions where the Department examined per-capita growth trends to forecast the HIBI budget, for FY 2011-12 through FY 2013-14, the Department examined total expenditure trends to estimate expenditure. The Department believes this methodology to be more accurate as per-capita growth has fluctuated significantly historically because HIBI enrollment does not bear a direct relationship to Medicaid caseload. The Department selected 9.39%, the FY 2011-12 expenditure growth rate for AND/AB clients to trend expenditure in FY 2012-13 for the Disabled Adults 60 to 64 (OAP-B), Disabled Individuals to 59 (AND/AB), Eligible Children, Categorically Eligible Low-Income Adults (AFDC-A), and Baby Care Program Adults aid categories. All FY 2012-13 trend selections were held constant for FY 2013-14 and FY 2014-15.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2012-13, FY 2013-14 and FY 2014-15 calculations for the Health Insurance Buy-In Program:

- SB 10-167 “Medicaid Efficiency and Colorado False Claims Act” impacts the HIBI program in FY 2012-13 by requesting the purchase of private health insurance coverage through the Health Insurance Buy-In Program for an additional 1,500 eligible clients

to create cost savings for the state. Savings as a result of SB 10-167 are captured in the Acute Care exhibit. The Department has adjusted costs associated with this bill by changing the payment methodology for the contractor from a contingency fee to a per-member per-month payment. In addition, adjustments were made to reflect additional premium payments that would be made as the number of clients utilizing the program increases. The estimate was also adjusted for delays in the implementation timeline and enrollment capabilities of the contractor. Please see section V for a complete description of the bill and changes.

EXHIBIT I – SERVICE MANAGEMENT

This service group includes administrative-like contract services within the Medical Services Premiums budget. The group is comprised of Single Entry Point agencies, disease management, and administrative fees for prepaid inpatient health plans.

Summary of Service Management

This exhibit summarizes the total requests from the worksheets within Exhibit I.

Single Entry Points

Single Entry Point (SEP) agencies were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. The single entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients in order to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients, pursuant to 25.5-6-105, C.R.S. (2012). A single entry point agency is an agency in a local community through which persons 18 years or older, who are in need of long-term care services, can access needed long-term care services.

The single entry point agency is required to serve clients of publicly funded long-term care programs including nursing facility care, Home- and Community-Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons living with acquired immune deficiency syndrome, HCBS for persons with brain injury, HCBS for persons with mental illness, long-term home health care, home care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965.

The major functions of single entry point agencies include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and

maintaining fiscal accountability. Single entry point agencies also serve as the utilization review coordinator for all community based long term care services.

Single entry point agencies are paid a case-management fee for each client admitted into a community-based service program. Single entry point agencies also receive payment for services provided in connection with the development and management of long-term home health prior authorization requests for work associated with client appeals and for utilization review services related to home- and community-based services and nursing facilities.

On November 1, 2002, the Department submitted a report for Footnote 52 of HB 02-1420, describing the payment methodology for single entry point agencies. However, recently it has come to light the process described in the footnote report is not being used. Instead, individual single entry point agency contract amounts are determined using data from each single entry point agency's previous year's history of client and activity counts. At the end of the contract year, the actual client and activity counts are reconciled against the projected client and activity counts. This process results in either funds owed to single entry point agencies for services delivered in excess of funds received or funds owed to the Department for payments made in excess of services delivered. The Department then issues a reconciliation statement to collect for overpayment or adjusts for underpayment up to the amount allocated. This payment methodology, combined with close Department oversight, encourages single entry point agencies to enroll only those clients who are appropriate for community-based services.

Annual financial audits are conducted by the Department to verify expenditures were made according to the contract scope of work and to assure single entry point agency compliance with general accounting principles and federal Office of Management and Budget (OMB) circulars. If the audit identifies misused funds, the amount misused is collected through a recovery order.

SB 04-206 directed the Department to implement a pediatric hospice program; the impact of this legislation is fully annualized in the budget request. Entry into the program must be approved by single entry point agencies. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to add a pediatric hospice effective January 1, 2008.

Also fully annualized in the budget request is the impact of HB 05-1243, which allowed the Department to add consumer directed care to home- and community-based waiver services. These services must be approved by single entry point agencies. The Department received approval from CMS to add consumer-directed care to the Elderly, Blind, and Disabled waiver and the Mental Illness waiver in 2007. The Department began to provide these services effective January 1, 2008.

Effective with the November 1, 2007 Budget Request, the Department has revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, single entry points are generally paid a fixed fee for each year, although this amount may be adjusted based on actual experience. In recent years, the number of clients processed by single entry

points has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, single entry points would be required to serve an increasing population with the same funding.

Therefore, the Department's request includes an increase to single entry point contracts. The requested increase is based on the expected increase in Home- and Community-Based Services (HCBS) utilization, as determined by average monthly paid enrollment in the Department's HCBS programs. These figures do not reflect the actual enrollment in HCBS programs, nor do they reflect actual single entry point caseload; rather, they are based on the number of clients for whom the Department has paid a related claim during each fiscal year. This figure is therefore consistent with the cash accounting basis of Medical Services Premiums. The Department believes that growth in paid enrollment is a good proxy for growth in single entry point caseload.

In FY 2010-11 the Department began reporting cost per HCBS waiver utilizer to provide additional information about SEP expenditure and to use in trending expenditure forward.

For FY 2011-12, the Department's projection uses the total base contracts amount, which is the current amount allocated to single entry points in the FY 2010-11 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds legislative impacts (see below). For FY 2012-13, the Department estimates the increase in HCBS utilization based on the average percent change in average monthly paid enrollment from FY 2007-08 through FY 2010-11 for the Adults 65 and Older. For Disabled Adults 60 to 64, the Department used the year-to-date growth rate in paid HCBS utilization. For the Disabled Individuals to 59 aid category, the Department trended HCBS-paid enrollment using the average percent change in average monthly paid enrollment from FY 2006-07 through FY 2010-11. The overall HCBS utilization growth rate from FY 2006-07 to FY 2010-11 was selected to trend expenditure for the remaining aid categories: Categorically Eligible Low-Income Adults, Eligible Children, Foster Care, Non-Citizen, and Partial Dual Eligibles. The estimated FY 2011-12 total expenditure is inflated by this percentage, and legislative impacts are added to estimate the total FY 2012-13 and FY 2013-14 expenditure.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per-capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department does not anticipate any new changes that impact expenditure for SEPs from FY 2011-12 through FY 2013-14.

Disease Management

Beginning in July 2002, the Department implemented several targeted disease management pilot programs, as permitted by HB 02-1003. Specifically, the Department was authorized "to address over- or under-utilization or the inappropriate use of services or

prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease or combination of diseases" (25.5-5-316, C.R.S. (2012)). Initially, pilot programs were funded solely by pharmaceutical companies; the programs began and ended at different times between July 2002 and December 2004.

During the pilot program, the Department initiated seven disease-management programs to identify the most appropriate strategies to contain rising health care costs, improve access to services, and improve the quality of care for the fee-for-service Medicaid clients. The targeted disease conditions included high-risk infants, clients with asthma, clients with diabetes, clients with schizophrenia, female clients with breast and cervical cancer, and clients with chronic obstructive pulmonary disease. Additionally, the Care Management Organization pilot was established to coordinate all of the disease management programs and to establish a means for additional fee-for-service clients to obtain intensive case management or health counseling.

The pilot programs revolved around three, key, managed care principles: appropriate and timely access to health care services, evaluation and support for adherence to appropriate medical regimens/treatments, and provision of nationally recommended practice guidelines for each chronic disease. The pilot programs enabled the Department to obtain actual Colorado Medicaid disease management data and experience to be utilized for future program development.

As a result of the pilot programs, the Department entered into permanent contracts with two disease-management companies for two health conditions: clients with asthma and clients with diabetes. In order to provide appropriate management to achieve cost-savings, reducing hospitalizations, and reducing emergency room visits, the Department contracted with Alere Medical Incorporated for clients with asthma and with McKesson Health Solutions for clients with diabetes. Over time, the Department has added and changed contracts as appropriate to ensure that Medicaid clients continue to receive quality care.

At the start of FY 2008-09, the Department had five disease management contracts covering specific conditions. Those conditions were: asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), high risk obstetrics, and weight management. The Department also employed a contractor to do more general disease management via telemedicine. The Department's funding for these contracts was a combination of General Fund, Prevention Early Detection and Treatment Fund, and federal funds. Certain restrictions, specified in section 24-22-117(2)(d)(IV.5), C.R.S. (2012), limit the use of Prevention Early Detection and Treatment Fund. Therefore, the Department separated the amount of base funding (contracts financed with General Fund) and the amount of expansion funding (contracts financed with Prevention Early Detection and Treatment Fund) in order to ensure that its request reflects the correct amount from each funding source. For FY 2008-09 only, this separation was reflected as a bottom-line impact.

The Department's disease-management contractors operated on a fixed budget (specified in the contract), and client enrollment could not exceed a fixed number of clients that the Department has determined shall be managed on that budget. Contractors accepted new clients only up to the enrollee limit as specified in the contract.

Effective June 30, 2009, the Department discontinued the five specific Disease Management programs. The remaining funds were used toward services related to the treatment of the health conditions specified in 24-22-117(2)(d)(V), C.R.S. (2012) (further described in exhibit A). The Department's telemedicine program has two months of expenditures encumbered for FY 2009-10; the encumbered amount of $63,488 is included in the FY 2009-10 request. The Department did not renew the telemedicine contract when it expired on September 30, 2009.

In the estimate of expenditure for FY 2011-12, the Department's appropriation includes $500,000 total funds to continue its Adult Medical Home pilot program. Although currently funded through the Department's Health Resources and Services Administration (HRSA) grant, the State share for this program would be paid for from the Prevention, Early Detection, and Treatment funds described above.

FY 2012-13 remains at the same level as FY 2011-12. However, in FY 2013-14, the statutory authorization for this funding expires. Expenditure in the out year and any year following is expected to be $0.

In collaboration with DPHE, the Department allocated $500,000 in FY 2011-12 to fund an education initiative for clients with the purpose of providing instruction related to the management of chronic diseases. The Department will do so again in FY 2012-13 but does not anticipate pursuing this initiative in subsequent years due to the statutory expiration of the funding.

In FY 2011-12, The Department requested a transfer of spending authority from DPHE for the purpose of attaining federal funds to establish the Smoking Cessation Quitline for Medicaid Clients. The Department anticipates a total funds impact of $577,316 for FY 2011-12, $1,373,470 in FY 2012-13, and $1,281,040 in FY 2013-14.

Prepaid Inpatient Health Plan Administration

Prepaid inpatient health plans (formerly known as Administrative Service Organizations) are an alternative to traditional health maintenance organizations. They offer the case management and care coordination services of a health maintenance organization for a fixed fee. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. The Department began using this type of organization to deliver health care to Medicaid clients during FY 2003-04. In FY 2005-06, the Department ended its contract with Management Team Solutions. Since then, the Department contracted with only one prepaid inpatient health plan Rocky Mountain Health Plans until FY 2009-10. The Department contracted with three additional prepaid

inpatient health plans in FY 2009-10. These include Colorado Access and Kaiser Foundation Health Plan, which are jointly part of the Colorado Regional Integrated Care Collaborative (CRICC), and Colorado Alliance & Health Independence (CAHI). In FY 2010-11, the Department implemented the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Care Collaborative Organizations (RCCOs), the Primary Care Providers (PCPs), and the Statewide Data Analytic Contractor (SDAC) are administrative fees that are incorporated in the prepaid inpatient health plan exhibit.

Prepaid inpatient health plans receive a fixed amount administrative fee per client. Exhibit EI-6 depicts the administrative fee expenditures for the Department's current contractors, including estimated cost-avoidance payments for Rocky Mountain Health Plans. The service costs for these organizations are included in Acute Care and Community-Based Long-Term Care. In the current request, the Department forecasts enrollment and costs for each program separately.

Rocky Mountain Health Plans

Because the administrative fees remain the same in FY 2012-13 and FY 2013-14, the Department uses actual enrollment to forecast expenditure for Rocky Mountain Health Plan for FY 2013-14. In prior budget requests, enrollment for Rocky Mountain Health Plan was forecasted by eligibility group. For this request, enrollment is forecasted in aggregate for each provider, as it is based more on the provider's ability to expand to new clients than on the growth in caseload by eligibility group. The administrative fees paid to the providers are the same regardless of the eligibility category of the clients served.

To forecast enrollment in Rocky Mountain Health Plan for the current and request years, the Department assumes the provider will be concentrating the majority of its resources to enroll new clients into the ACC and its network as a RCCO instead of into its health plan. Therefore, the Department estimates that the only growth into the health plan in FY 2012-13 will be the base trend from the June 2012 level. In FY 2012-13 and FY 2013-14, the Department assumes there will be no additional enrollment beyond the baseline trend in the health plan.

In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost-avoidance payments to Rocky Mountain Health Plan. During FY 2007-08, the Department and Rocky Mountain Health Plan were unable to come to an agreement on the correct amount of cost avoidance for the contract year FY 2005-06, and no payment was made. At that time, the Department anticipated it may make a combined payment for FY 2005-06 and FY 2006-07 in FY 2008-09 with existing funding. In addition, the Department anticipated making a single contracted payment in FY 2009-10 for services rendered in FY 2007-08. However, since that time, federal Centers for Medicare and Medicaid Services (CMS) directed the Department to cease making any cost avoidance payments until all historical encounter data for prepaid inpatient health plan claims is integrated into the Medicaid Management Information System (MMIS). The Department has completed all CMS requirements pertaining to Rocky Mountain Health Plan and made a cost-avoidance payment to Rocky Mountain Health Plan for services rendered

in FY 2009-10 in the latter half of FY 2011-12. Rocky Mountain Health Plan and the Department agreed with the methodology used to calculate the payment and will use it as the standard methodology for all future payments. They also agreed no cost avoidance payments will be made for fiscal years prior to FY 2009-10, as they were not able to compromise on the correct amount to be paid. In addition to the FY 2009-10 payment, the Department also made a cost avoidance payment in FY 2011-12 for services rendered in FY 2010-11. For all subsequent fiscal years, the Department will make one cost avoidance payment for the year prior to it.

For FY 2012-13, FY 2013-14, and FY 2014-15, the Department assumed the cost avoidance payments would be similar in magnitude to the calculated payment for FY 2009-10 and carried that amount forward for all forecast years. The final payments will differ from the budgeted amount, as the Department will calculate the actual amount of cost avoidance, which may be higher or lower than the estimated levels.

Colorado Regional Integrated Care Collaborative Programs (Colorado Access and Kaiser Foundation Health Plan)

The Colorado Regional Integrated Care Collaborative (CRICC) is part of a larger national collaborative sponsored by the Center for Health Care Strategies (CHCS). This program aims to better serve Medicaid clients with the highest needs and costs by coordinating physical, mental health, and substance abuse services. The Colorado Access contract for CRICC was altered from a risk-based, capitated program to an Administrative Services Organization (ASO) after the provider informed the Department that the risk-based model would no longer be sustainable. The Department and the provider negotiated an alternative that would allow for continuity of services while altering the reimbursement structure to a more sustainable model. This transition occurred on April 1, 2010. Expenditure for administrative fees to Access as an ASO is accounted for in the prepaid inpatient health plan exhibit. The contract for Colorado Access in the CRICC program expired on June 30, 2011, at which time all of the clients in the program were disenrolled. A study on the effectiveness of the program is being completed by MDRC, a nonprofit, nonpartisan policy research organization. The study will analyze the program in terms of quality of care, utilization, and expenditure. MDRC's evaluation of Colorado Access will be completed and available to the Department in 2012.

Kaiser Foundation Health Plan began enrolling clients for CRICC in August of 2009. The claims for Kaiser are not paid for through the MMIS; therefore, there is no information in the system on the number of enrolled clients by month as there is for Colorado Access. This program was discontinued effective June 30, 2012. However, due to the lag in payments, it is expected there will be one additional payment to be made in FY 2012-13. MDRC is currently studying the effectiveness of the program at Kaiser and will complete the evaluation for the Department at the beginning of 2013.

Colorado Alliance & Health Independence (CAHI)

Colorado Alliance & Health Independence (CAHI) was authorized in SB 06-128 as a new, integrated approach to care for people with disabilities up to age 64 designed to provide a network of services that are high-quality and cost-effective. It is funded through the Coordinated Care for People with Disabilities Program. The pilot program was launched on January 1, 2010. The claims for CAHI are now paid for through the MMIS, allowing the Department to forecast enrollment based on actual clients served by month. The Department is working with CAHI to determine the cost effectiveness of the program. Until the program has demonstrated cost effectiveness, the Department will not be enrolling additional clients. The FY 2012-13, FY 2013-14, and FY 2014-15 forecast assume enrollment levels that are equal to the enrollment level at the end of FY 2011-12 (225 clients).

Accountable Care Collaborative (ACC)

The Accountable Care Collaborative (ACC) is a Department initiative requested originally in FY 2009-10 DI-6 "Medicaid Value Based Care Coordination Initiative" and revised in FY 2010-11 S-6/BA-5 "Accountable Care Collaborative." The Department enrolled the first clients into the program in May 2011 and enrollment increased to 60,000 by December 2011. Enrollment expanded to 123,000 clients in May 2012, which was requested in FY 2011-12 BA-9 "Medicaid Budget Balancing Reductions." The Department has since expanded enrollment in the program and is projected to reach an enrollment total of 200,000 early in CY 2013. The cost savings estimated for this program are included in acute care; please see Exhibit F and Section V for more information on its impact to acute care. The monthly management fees are estimated in the prepaid inpatient health plan exhibit. The fees in FY 2012-13 include $3,000,000 paid to the SDAC, an average PMPM of $10.17 PMPM paid to the RCCOs, $3.00 PMPM paid to the primary care providers for each client who has been enrolled with them for at least a month, and a $2.00 monthly incentive payment divided between the providers and the RCCOs. The fees in FY 2013-14 are the same, with the exception of the average PMPM paid to RCCOs, which will be $9.64 (incentive payments can still be earned). In the current and request years, the Department assumes the full $2.00 incentive will be paid out to the RCCOs and PCMPs for each of their members even though the incentive payment will only be paid out if the providers meet certain predetermined benchmarks; the total PMPM for the program may be less if providers are not meeting their benchmarks. The Department will analyze this in FY 2012-13 and may estimate a lower PMPM depending on the average percentage of the incentive payments paid to providers. The FY 2014-15 estimate incorporates the same PMPM amounts and enrollment levels as FY 2013-14.

Legislative Impacts and Bottom- Line Adjustments

To account for programmatic changes not incorporated in the prior per-capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans, as detailed above.

EXHIBIT J - HOSPITAL PROVIDER FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

These exhibits summarize the source of funding for Health Care Affordability Act of 2009 cash-funded expansion populations. These estimates are incorporated into the Calculation of Fund Splits in Exhibit A. Information regarding Tobacco Tax funds has been removed from this exhibit with the Department's November 1, 2011 request as Tobacco Tax funding is now appropriated to the Department at a fixed value that is independent of the actual caseload or per-capita costs associated with clients that would have otherwise been funded by Tobacco Tax.

Hospital Provider Fee Fund

HB 09-1293 established this fund, which provides for the costs of the following expansion populations that impact the Medical Services Premiums budget:

Expansion Adults to 100%

While the Health Care Expansion Fund originally provided funding for parents of children enrolled in Medicaid from approximately 24% to at least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund extends eligibility to parents from 61% to 100% of the federal poverty level (FPL). This expansion population receives the standard Medicaid benefits. Eligibility for this population under Medicaid was effective May 1, 2010.

The Department assumes the medical and mental health per-capita costs for this expansion group will be approximately 95% of those for the Medicaid Expansion Adults to 60% FPL. Per-capita cost estimates for this population have been updated to reflect the most recent projection of per-capita costs for the Expansion Adults population.

For caseload estimates and methodology, please see the Section II of this narrative.

Adults without Dependent Children

This expansion allows Adults without Dependent Children to be eligible for Medicaid benefits. Eligibility for this population began in May 2012. The Department was granted a Section 1115 Demonstration Waiver in order to implement the population. The Department submitted the Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) in December 2011, and rules were approved by the State Medical Services Board (MSB) in January 2012.

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the economic statistics of disabled and uninsured Colorado residents. The data showed there

were 143,191 uninsured Adults without Dependent Children in Colorado in 2009, 49,511 of which were in the 0-10% FPL bracket. This data, along with a cost analysis, led the Department to conclude that it must initially cap enrollment for this expansion at 10,000.

The Department assumes the per-capita costs for this population will be a blend of the historical per capitas trended forward for the Low-Income Adults from approximately 24% to 60% of the FPL and the Disabled Individuals to 59 (AND/AB). The experiences from other states and a literature review on this population confirm this assumption. As the Department is only implementing up to 10% FPL, the Department assumes these clients will be the most high-need clients, with a lot of pent-up demand. With these assumptions, the Department assumed a blended per capita with 10% resembling the Low-Income Adults from approximately 24% to 60% of the FPL, with the other 90% resembling the Disabled Individuals to 59 (AND/AB) population., which is consistent with assumptions made in the Department's federal waiver for this population. These proportions were applied to the per capitas for the Low-Income Adults and the Disabled Individuals to 59 calculated by the Department's contractor using the historical data of both populations. To allow for potentially higher-than-anticipated costs with the rollout of a new population, the Department is requesting additional funding beyond the amount indicated in the per-capita estimates. If expenditure falls short of the requested amount, all funds will remain in the hospital provider fee cash fund.

Medicaid Buy-in Fund

This fund is administered by the Department to collect buy-in premiums and support expenditures for the Buy-in for Individuals with Disabilities expansion population, as authorized by HB 09-1293.

Buy-in for Individuals with Disabilities
This expansion allows for disabled individuals with income up to 450% of the federal poverty level to purchase Medicaid benefits. Eligibility for the working adults with disabilities with income up to 450% of the FPL began in March 2012, with eligibility to children with disabilities with income up to 300% of the FPL following in June 2012. The Department does not have an implementation timeframe for non-working adults with disabilities at this time.

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the economic statistics of disabled and uninsured Colorado residents. The Department first excluded individuals who, due to income, would either already be eligible for Medicaid or who would be required to pay the full cost of their services under federal regulations. As there is always some portion of a given population that is eligible but not enrolled for a given program, the Department assumed penetration rates depending on FPL bracket and adult/child category. The Department assumed children would have a higher penetration rate than adults and assumed the penetration rate would vary by FPL group due to interactions with other programs. Furthermore, while the Department acknowledges that, as individuals' incomes increase, they may

be more likely to obtain their own insurance. The Department learned many may buy into the program to receive "wraparound" benefits, where they would receive benefits not available through their own plan.

The Department assumes the Medical Services Premiums expenditure for the Disabled Buy-In program will be comparable to those for the current Medicaid Disabled Individuals to 59 (AND/AB). The Department also assumes most clients in the Buy-In program will have lower utilization of many Home- and Community-Based Services (HCBS) waivers and other Long-Term Care services. The Department assumes proportionally fewer individuals with the ability to work would meet the level of care for either a waiver or nursing facility than in the current Disabled Adults to 59 population. In addition, clients who are working are more likely to have access to employer-sponsored insurance, which would be utilized to the maximum of the offered benefits before Medicaid services are utilized. In addition, the Department also assumes 75% of the adult population would be dual-eligible for Medicare, which will decrease the costs to the Medicaid program as Medicare will pay for most of the utilized services. Buy-in participants will also be eligible for Consumer Directed Attendant Support Services (CDASS) through either the Department's HCBS waivers or the existing state plan option, and the Department assumes 10% of the population will use these services. Overall, the Medicaid Disabled Individuals to 59 Acute Care per capita has been adjusted based on all of the above factors, some of which act to increase and some of which act to decrease the per capita. These adjustments were applied to the total per capita rather than at the service category level.

Hospital Provider Fee Supplemental Payments

Hospital payments are increased for Medicaid hospital services through a total of 13 supplemental payments, 11 of which are paid out of Medical Services Premiums directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, Colorado Indigent Care Program (CICP) and Disproportionate Share Hospital (DSH) payments, and targeted payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to ensure access to hospital services for Medicaid and CICP clients.

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

The Upper Payment Limit (UPL) financing methodology accomplishes the following:

- Increases the Medicaid payment up to the federally allowable percentage for all public government owned or operated home health agencies, outpatient hospitals, and nursing facilities without an increase in General Fund.
- Maximizes the use of federal funds available to the State under the Medicare upper payment limit through the use of certification of public expenditures.
- Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditures.

The basic calculation for UPL financing incorporates the difference between Medicare and Medicaid reimbursement amounts, with slight adjustments made to account for different types of services and facilities. Because actual Medicare and Medicaid reimbursement amounts are not yet known for the current fiscal year, prior year's data for discharges, claims, and charges are incorporated into the current year calculation.

Funds received through the UPL for home health services and nursing facilities are used to offset General Fund expenditures. These offsets started in FY 2001-02. While nursing facilities account for the larger portion of Upper Payment Limit funding, home health has expenditures that are relatively small by comparison and will experience little impact related to changes in reimbursement rates.

In FY 2005-06, the Department certified expenditure for only a half year due to a federal audit requiring the Department to certify expenditure on a calendar-year basis. During Figure Setting in March 2006, the Department's FY 2006-07 Base Reduction Item 2 (November 15, 2005) was approved. Starting in FY 2006-07, the Department will record exactly the certified amount as Cash Funds Exempt.

During FY 2007-08, the Department was informed by the Centers for Medicare and Medicaid Services (CMS) it would no longer be permitted to certify public expenditure for nursing facilities. However, in FY 2008-09, CMS and the Department came to an agreement which allowed for a certification process as long as it included a reconciliation process to provider cost. Therefore, the Department has included expenditure for certification of public nursing facility expenditure. Where applicable, the Department's estimates will be adjusted for any reconciliation performed.

In prior fiscal years, the Department was able to utilize UPL financing for outpatient hospital services as well. However, FY 2010-11 was the last year the Department was able to certify public expenditure for Outpatient Hospital services. This was due to HB 09-1293, which allowed the Department to use other State funds to draw federal funds to the upper payment limit.

EXHIBIT L – DEPARTMENT RECOVERIES

This exhibit displays the Department's forecast for estate recoveries, trust recoveries, and tort/casualty recoveries. Prior to FY 2010-11, these recoveries were utilized as an offset to expenditure in Medical Services Premiums. In compliance with State Fiscal Rule 6-6, the Department now reports the recovery types listed above as revenue.

In addition to anticipated recovery revenue, Exhibit L also shows the anticipated contingency fee to be paid to contractors for recovery efforts. The Department's revised forecast for the activity reflects changes to contingency fee paid to the contractor as the contract was reprocured in FY 2011-12. Total revenue used to offset General Fund and federal funds, as shown in Exhibit A, is the sum of all recoveries less contingency fee paid to contractors.

Recoveries made for dates of service under periods where the State received an enhanced federal match are given the same federal match as was applicable when the services were rendered. The Department previously assumed a larger percentage of recoveries would fall under periods of enhanced federal match. However, the most recent expenditure data indicates a smaller percentage of recoveries are from periods with enhanced federal match. Consequently, the Department has revised assumptions regarding federal match on recoveries accordingly.

EXHIBIT M – CASH-BASED ACTUALS

Actual final expenditure data by service category for the past 11 years are included for historical purpose and comparison. This history is built around cash-based accounting, with a 12-month period for each fiscal year, based on paid date. This exhibit displays the estimated distribution of final service category expenditures by aid category from the estimated final expenditures by service categories. This is a necessary step because expenditures in the Colorado Financial Reporting System (COFRS) are not allocated to eligibility categories. The basis for this allocation is data obtained from the Department's Medicaid Management Information System (MMIS). This data provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community-Based Long-Term Care, Long-Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management.

This exhibit also includes six-month cash-based actuals for July 2011 through December 2011.

Effective with the November 1, 2007 Budget Request, the Department has made several labeling changes to this exhibit:

Service Group	Old Title	New Title
Acute Care	Administrative Service Organizations - Services	Prepaid Inpatient Health Plan Services
Community-Based Long-Term Care	Home- and Community-Based Services - Case Management	HCBS - Elderly, Blind, and Disabled
Community-Based Long-Term Care	Home- and Community-Based Services - Mentally Ill	HCBS - Mental Illness
Community-Based Long-Term Care	Home- and Community-Based Services- Children	HCBS - Disabled Children

Service Group	**Old Title**	**New Title**
Community-Based Long-Term Care	Home-and Community-Based Services - People Living with AIDS	HCBS - Persons Living with AIDS
Community-Based Long-Term Care	Consumer Directed Attendant Support	HCBS - Consumer Directed Attendant Support
Community-Based Long-Term Care	Brain Injury	HCBS - Brain Injury
Service Management	Administrative Service Organizations Administrative Fee	Prepaid Inpatient Health Plan Administration

Effective with the February 15, 2008 Budget Request, the Department restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 2006-07. The Department has adjusted the allocation to exclude categories that did not utilize this service category. The total amount in aggregate remains the same.

Effective with the November 3, 2008 Budget Request, the Department restated actuals for Single Entry Points from, by using HCBS utilization rates as opposed to total expenditure in Community-Based Long-Term Care and Long-Term Care service categories.

Effective with the November 1, 2010 Budget Request, the Department provided three pages for FY 2009-10 expenditure: cash-based actuals, the total amount delayed in FY 2009-10 as a result of a mandated payment delay, and the estimated FY 2009-10 expenditure adjusted for the payment delay.

Effective with the November 1, 2011 Budget Request, the Department made numerous changes to this exhibit:

- The Department restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 2002-03 forward. The Department altered the methodology for distributing expenditure between eligibility types to more accurately reflect expenditure actually incurred in the service category.
- The Department separated Expansion Adults into Expansion Adults to 60% and Expansion Adults to 100%.
- The Department included totals for financing categories in Medical Services Premiums. As a result, this exhibit now matches the totals shown in other places in the budget, notably the Schedule 3.
- The Department removed historical totals prior to FY 2002-03. These pages remain available on the Department's website and upon request.

Effective with the November 1, 2012 Budget Request, the Department is reporting expenditure for Adults without Dependent Children and Disabled Buy-in eligibility types.

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2002-03 through FY 2011-12 final actual expenditures are included in this Budget Request for historical purpose and comparison.

Effective with the November 1, 2010 Budget Request, the Department included a second version of this exhibit that adjusts for the payment delays imposed in FY 2009-10.

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

This exhibit displays the FY 2011-12 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2011-12 appropriation, and the per-capita cost per client. The per-capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

Additionally, this exhibit compares the Department's Budget Requests by broad service category to the Department's Long Bill and special bills appropriations for FY 2008-09, FY 2009-10, FY 2010-11, and FY 2011-12 in the chronological order of the requests/appropriations. Shaded areas indicate the request or appropriation has not yet taken place.

EXHIBIT P – GLOBAL REASONABLENESS

This exhibit displays several global reasonableness tests as a comparison to the projection in this Budget Request. In addition, on page EP-3, this exhibit displays the FY 2012-13 year-to-date expenditures through September 2011 and the cash flow pattern of actual expenditures for the first quarter of FY 2012-13 to determine a rough estimate of FY 2012-13 expenditures, with certain exceptions. This exhibit is a rough projection utilizing past expenditure patterns as a guide to future expenditures. The Cash Flow Pattern is one forecasting tool used to estimate final expenditures on a monthly basis. It is not meant to replace the extensive forecasting used in the official Budget Request and is not always a predictor of future expenditures.

In places where the Department does not expect the prior year cash flow pattern to be relevant to the current year, the Department has made adjustments based on knowledge of current program trends. Exceptions to the cash flow pattern are noted in footnotes on page EP-3.

V. ADDITIONAL CALCULATION CONSIDERATIONS

Several bills passed during prior legislative sessions affect the Department's Request for Medical Services Premiums. Additionally, the Department has added several bottom-line impacts for factors which are not reflected in historical trends. This section details the adjustments the Department has made to the Request for Medical Services Premiums.

New Legislation and Impacts from FY 2012-13 Budget Cycle Requests

This section describes the impact from legislation passed during the 2012 Legislative Session and includes impacts from the Department's FY 2012-13 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

HB 12-1235 – FY 2012-13 Long Bill

The FY 2012-13 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2012 Legislative Session that impact the Medical Services Premiums budget request. Except where noted, the Department uses the appropriated value as the bottom-line impact. All figures listed are total funds.

- Medicaid Fee-for-service Reform (R-5): Three initiatives were included in the budget action: Behavioral Health Organization gainsharing, Federally Qualified Health Center and Rural Health Center gainsharing, and Accountable Care Collaborative gainsharing. Each of these initiatives provides financial incentives for different provider types to engage clients and care management differently to improve outcomes and generate savings. Because these changes require an investment on the part of the provider, gainsharing becomes a mechanism for compensating providers for the investment without an upfront outlay of funding by the State. Through stakeholder engagement with CMS and the provider community, the Department has revised the gainsharing proposal to facilitate an alignment of financial incentives to support the Accountable Care Collaborative care management system. All three gainsharing activities have been streamlined into a single gainsharing program wherein care management entities, behavioral health organizations, and primary care providers must work together collaboratively to produce savings through integration of behavioral health and physical health to improve total health outcomes.

- Medicaid Budget Reductions (R-6): This budget action encompassed 16 different policy initiatives targeted at addressing the statewide budget shortfall. The majority of the proposals are efficiency measures that align Medicaid practices with industry standards to maximize clinical efficacy while maintaining fiscal responsibility. A brief summary of the original proposals and fiscal impacts follow.

- *Preterm Labor Prevention*: The Department is offering coverage of alpha hydroxyprogesterone caproate injections, which reduce the occurrence of preterm labor.
- *Synagis PAR Review*: The Department will be increasing review of prior authorizations for Synagis to ensure only appropriate dosages are utilized of this drug.
- *Expansion of the Physician Administered Drug Rebate Program*: The Department has expanded the list of physician-administered drugs for which it collects rebates, as well as performed outreach to providers to ensure sufficient information is provided for the Department to claim rebates.
- *Reimbursement Rate Alignment for Developmental Screenings*: Effective August 1, 2011, the Department reduced the rates paid and implemented appropriate age limits for developmental and adolescent depression screenings to better align the rates with both Medicare and private insurers. Previously, the rate paid for developmental and depression screenings was well above the rates paid by Medicare and commercial insurance plans for these screenings.
- *Physician Administered Drug Pricing and Unit Limits*: The Department has realigned the pricing and unit limits on three physician-administered drugs to achieve both consistency for billing and cost savings.
- *Public Transportation Utilization*: The Department has built incentives and expectations into the non-emergent medical transportation program to increase the utilization of public transportation in the Denver-metro area.
- *Home Health Therapies Cap*: The Department is limiting the number of home health visits for therapy to 48 visits per calendar year. This budget action was not approved by the General Assembly, and the Department has not included any savings for this initiative.
- *Home Health Care Cap*: The Department has limited the number of hours of skilled care a patient can receive in the home health setting to eight per day. This budget action was not approved by the General Assembly, and the Department has not included any savings for this initiative.
- *Seroquel Restrictions*: The Department has implemented policies to prevent the utilization of Seroquel for off-label use.
- *Dental Efficiencies*: The Department will clarify rules regarding eligibility for orthodontics. These clarifications are expected to reduce utilization of orthodontics for all cases except those where the client has a severely handicapping malocclusion.
- *Augmentative Communication Devices*: The Department has implemented an initiative to provide access to less-costly durable medical equipment for disabled clients that require the aid of augmentative communication devices.
- *Durable Medical Equipment Preferred Provider:* The Department initiated a competitive procurement process to acquire a sole-source diabetic testing supply provider whereby the Department can leverage purchasing power to obtain significant rebates.
- *Continuation of Nursing Facility Reduction:* The Department proposes a continuation of the 1.5% rate reduction to nursing facility reimbursement current scheduled to end July 1, 2012.

- *Ambulatory Surgical Centers:* The Department has initiated a pilot project to shift outpatient surgery utilization from the outpatient hospital setting to the less costly ambulatory surgical setting.
- *Utilization Management Vendor Funding*: The Department is requesting additional funding to expand the scope of work of the Department's contracted utilization management vendor to perform prior authorizations for the savings initiatives in this request.
- *Pharmacy Rate Methodology Transition*: To accommodate a change in available drug pricing information, the Department is changing the reimbursement methodology for pharmaceuticals. As part of the change in reimbursement methodology, reimbursement for ingredient costs will be decreased, the dispensing fee will be increased, and net savings of $4,000,000 total funds will be achieved. This budget action was approved with zero savings.
- *Hospital Provider Fee Financing*: The Department is utilizing hospital provider fee to offset lost federal funds associated with certification of public expenditure for outpatient hospital services. An annual amount of $15,700,000 cash funds will be used to offset General Fund in the Medical Services Premiums line.

The following table summarizes each initiative's fiscal impact:

FY 2012-13 R-6: Summary of Funding by Initiative

FY 2012-13	Original Requested Amount	FY 2012-13 Appropriated Amount	FY 2013-14 R-1 Requested Amount	Difference from Appropriation	Note
Policy Initiative	**($30,199,322)**	**($21,699,706)**	**($25,979,104)**	**($4,279,398)**	
Preterm Labor Prevention	($902,736)	($902,736)	($902,736)	$0	
Synagis Prior Authorization Review	($419,772)	($419,772)	($419,772)	$0	
Expansion of Physician Administered Drug Rebate Program	($2,418,276)	($2,418,276)	($2,418,276)	$0	
Reimbursement Rate Alignment for Developmental Screenings	($2,092,701)	($2,092,701)	($2,092,701)	$0	
Physician Administered Drug Pricing and Unit Limits	($416,472)	($416,472)	($416,472)	$0	

FY 2012-13 R-6: Summary of Funding by Initiative

FY 2012-13	Original Requested Amount	FY 2012-13 Appropriated Amount	FY 2013-14 R-1 Requested Amount	Difference from Appropriation	Note
Public Transportation Utilization	($209,574)	($209,574)	($209,574)	$0	
Home Health Therapies Cap	($382,453)	$0	$0	$0	
Home Health Care Cap	($4,117,163)	$0	$0	$0	
Seroquel Restrictions	($1,931,172)	($1,931,172)	($1,931,172)	$0	
Dental Efficiency	($1,641,594)	($1,641,594)		$1,641,594	Fiscal impact revised due to implementation delays necessary for additional stakeholder outreach.
Augmentative Communication Devices	($492,000)	($492,000)	($451,000)	$41,000	Fiscal impact revised due to implementation delays.
DME Preferred Provider	($1,150,732)	($1,150,732)	($740,333)	$410,399	Fiscal impact revised due to implementation delays.
Continuation of Nursing Facility Reduction(1)	($9,024,677)	($9,024,677)	($9,397,068)	($372,391)	Fiscal impact revised - See Exhibit H, Class I Nursing Facility Footnotes for detailed calculations
Ambulatory Surgical Centers	($1,000,000)	($1,000,000)	$0	$1,000,000	The Department is not expanding the pilot program as originally anticipated.
Pharmacy Rate Methodology Transition(2)	($4,000,000)	$0	($7,000,000)	($7,000,000)	Fiscal impact revised based on more complete information.
Hospital Provider Fee Financing	$0	$0	$0	$0	

(1) As this initiative requires legislation to implement, the fiscal impact listed here is duplicative of HB 12-1340 "Nursing Facility Reduction Per-Diem Rate"
(2) The JBC did not include savings for this initiative in the Long Bill. Because the survey of Colorado pharmacies was not yet complete, the Department's fiscal estimate was based on the experience of other states. The revised estimate of a $7,000,000 impact in FY 2012-13 is based on complete survey data.

- SB 12-060 "Improve Medicaid Fraud Prosecution": By providing additional financial incentives for counties to identify Medicaid client fraud, this bill is expected to reduce expenditure in Medical Service Premiums by increasing the amount of client fraud recoveries. A reduction of $54,156 is expected in FY 2012-13.
- SB 12-159 "Evaluation Children with Autism Medicaid Waiver": This bill clarified the frequency and content of evaluations for children with autism seeking enrollment in the Medicaid autism waiver. Additional expenses for this activity are included in the Department's forecast of Community-Based Long-Term Care services.
- HB 12-1340 "Nursing Facility Reduction Per Diem Rate": This bill extended the 1.5% rate reduction to Class I Nursing Facility rates from FY 2011-12 that would have expired absent legislation. The estimated fiscal impact is shown in the table above, as the Department's request for this action was included in the FY 2012-13 R-6 "Medicaid Budget Reductions Request." Detailed calculations can be found in Exhibit H, Class I Nursing Facility Footnotes.

Prior-Year Legislation, Impacts from Previous Budget Cycles, and Other Adjustments

- *Client Overutilization Program Expansion (BRI-1):* Increase enrollment by 200 clients in the Client Overutilization Program (COUP) by paying providers an incentive payment to participate and changing some of the criteria in the MMIS to allow a broader range of providers to participate as lock-in providers. This program generates savings by decreasing excessive use of medical services and thereby reducing the expenditure for medically unnecessary claims. The program criteria primarily target the abuse of prescription medication but also include inappropriate use of emergency room and/or physician services. The expansion has been delayed due to a delay in the required system changes. The Department projects it will expand to 200 clients by January 2013 through more outreach efforts by its utilization management vendor and by completing the system change that will broaden the pool of providers who can participate. It is uncertain at this time when the Department will be able to make incentive payments through the MMIS, as that change has not yet been prioritized. The Department will continue to evaluate whether this payment is necessary to maintain at least 200 clients in the program.

- *Medicaid Reductions (BRI-5):* This budget reduction item included a series of initiatives that were proposed to reduce Medicaid expenditure and meeting budget balancing goals. The initiatives imposed a combination of rate adjustments to realign incentives, service restrictions, and financial efficiencies, as listed below.

  - Pharmacy State Maximum Allowable Cost Expansion: Add more drugs to be placed on the SMAC list, reducing expenditure by $1,833,334 in FY 2011-12 and annualized in FY 2012-13 to an additional reduction of $166,666.
  - Reduce Rates for Specific Diabetes Supplies: Reduce payment for blood glucose/reagent strips from $31.80 per box of 50 strips to the current median market price of $18.00. This rate cut reduces expenditure by $842,728 in FY 2011-12 and an additional $150,066 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.

- Reduce Payments for Uncomplicated Cesarean Section Deliveries: Reduce the amount paid for uncomplicated cesarean section deliveries to the amount paid for complicated vaginal deliveries, which reduces expenditure by $6,276,004 in FY 2011-12 and an additional $811,545 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Reduce Payments for Inpatient Renal Dialysis: Reduce the amount paid for inpatient renal dialysis from 185% of cost to 100% of cost. The Department agreed to reduce payment to 129.42% rather than 100% after negotiations with affected providers. This results in a reduction of $1,418,733 in FY 2011-12 and an additional $183,455 in FY 2012-13. The request amount also includes an adjustment to account for cash accounting.
- Deny Hospital Readmissions within 48 Hours: Cease making a separate payment to hospitals for clients who are readmitted within 48 hours to the same hospital for a related condition, reducing expenditure by $2,475,418 in FY 2011-12 and an additional $320,094 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Prior Authorize Specific Radiology Services at Outpatient Hospitals: Require prior authorization in outpatient hospitals for MRIs, CT scans, PET scans, and SPECT scans, except for in emergency situations. This policy reduces expenditure by $672,136 in FY 2011-12 and an additional $3,720,409 in FY 2012-13. It is on track to be implemented in April 2012.
- Normalize Consumer Directed Attendant Support Services Wage Rates: Impose a cap on the wage rate a client enrolled in the CDASS program is allowed to pay attendants based on current rates for similar services in the HCBS EBD waiver. This results in a reduction of $473,564 in FY 2011-12 and an additional reduction of $1,204,144 in FY 2012-13 to community-based long-term care. The request amount was adjusted for a delay in the implementation date from July 2011 to March 2011, and it includes an adjustment to account for cash accounting.
- Enforce Existing Limitations on Acute Home Health Services: Enforce requirement that prior authorization is needed for acute home health services beyond 60 days, reducing expenditure by $1,131,555 in FY 2011-12 and an additional $286,551 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Reduction to Managed Care Organization: Incorporate the reductions to Medicaid fee-for-service in the rates paid to the Department's managed care organization, resulting in a reduction of $1,906,233 in FY 2011-12 and an additional reduction of $81,968 in FY 2012-13. The Department has adjusted its request to account for initiatives that were not appropriated and will therefore not affect the rates paid to the managed care organization.

- *Medicaid Budget Balancing Reductions (BA-9):* In this budget amendment, the Department proposed to reduce Medicaid expenditure through a series of initiatives, including: an expansion of the Accountable Care Collaborative, deinstitutionalization efforts through the Department's "Money Follows the Person" federal grant, and a combination of service limitations and rate reductions.

- Expand the Accountable Care Collaborative: Enroll 63,000 additional clients in the ACC by November 2011, for a total program enrollment of 123,000. Please see the section below on the Accountable Care Collaborative for a more detailed explanation of the program and the costs and savings estimated it.
- Money Follows the Person Deinstitutionalization Efforts: Use grant funds to provide additional transitional services to move clients from nursing facilities to Community-Based Long-Term Care. The Department was unable to transition these clients due to receiving significantly less grant funds than anticipated. The clients specified in this initiative would be moved earlier than the actual Money Follow the Person program began using administrative funding provided by the grant. Since the Department did not receive enough administrative funding to move clients early, this initiative could not be implemented.
- Limit Fluoride Application Benefit: Limit fluoride application benefit to a maximum of three applications per year, reducing expenditure by $30,982 in FY 2011-12 and an additional $6,101 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Limit Dental Prophylaxis Benefit: Restrict dental prophylaxis (routine dental cleaning) to two procedures per fiscal year, reducing expenditure by $161,936 in FY 2011-12 and an additional $31,892 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Eliminate Reimbursement for Oral Hygiene Instruction: Eliminate reimbursement for oral hygiene instruction. This results in a reduction of $4,241,026 in FY 2011-12 and an additional $835,251 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Limit Number of Physical and Occupational Therapy Units for Adults: Limit number of physical and occupational therapy units that adults can receive to 48 total units of service per year, regardless of prior authorization. Implementation of this has been delayed from July 2011 until March 2012, as the Department is awaiting feedback from a new utilization management contractor to appropriately implement the proposal. The Department adjusted its request accordingly. For FY 2011-12, expenditure is reduced by $154,227, and for FY 2012-13, it is reduced by an additional $400,840. The request amount also includes an adjustment to account for cash accounting.
- Require Specific Billing for Certain Home Health Visits: Require home health providers to specifically bill codes for brief visits in circumstances in which only a short visit is required, reducing expenditure by $2,511,443 in FY 2011-12 and an additional $636,809 in FY 2012-13. The request amount includes an adjustment to account for cash accounting.
- Provider Rate Reduction: Reduce acute care physical health provider rates by 0.75% and community-based long-term care providers by 0.5%, effective July 1, 2011. This results in a $12,092,847 reduction in FY 2011-12 with an additional $2,904,019 in FY 2012-13 to Acute Care, and a $1,561,829 reduction in FY 2011-12 with an additional $361,468 in FY 2012-13 to Community-Based Long-Term Care.

The following table shows the original request amount, FY 2012-13 appropriation amount, and FY 2012-13 R-1 request amount for each of the FY 2012-13 impacts requested in BRI-5 and BA-9, as detailed above:

Initiative	Department Priority	Original Request Amount	FY 2011-12 Appropriation	FY 2012-13 R-1 Request Amount (Annualization)
State Allowable Cost Expansion	BRI-5	($1,833,333)	($1,833,334)	($166,666)
Reduce Rates for Diabetes Supplies	BRI-5	($842,727)	($919,340)	($150,066)
Reduce Payment for Uncomplicated C-Section	BRI-5	($6,276,004)	($6,846,550)	($811,545)
Reduce Payments for Renal Dialysis	BRI-5	($2,169,701)	($2,366,947)	($183,455)
Deny Payment of Hospital Readmissions 48 hrs	BRI-5	($2,475,418)	($2,700,456)	($320,094)
Prior Authorize Certain Radiology	BRI-5	($672,136)	($672,136)	($3,720,409)
Cap CDASS Wage Rates	BRI-5	($1,420,692)	($1,549,846)	($1,204,144)
Limit Acute Home Health Services	BRI-5	($1,131,555)	($1,234,424)	($286,551)
HMO Impact to Rates	BRI-5	($2,945,547)	($2,707,680)	($81,968)
Estimated ACC Net Savings(1)	BA-9	($9,537,806)	($4,768,903)	-
Clients Moved from Nursing Home	BA-9	($624,975)	($625,704)	$0
Limit Fluoride Application Benefit	BA-9	($29,898)	($33,798)	($6,101)
Limit Dental Prophylaxis Benefit	BA-9	($156,274)	($176,658)	($31,892)
Limit Oral Hygiene Instruction	BA-9	($4,092,739)	($4,626,574)	($835,251)
Limit Physical and Occupational Therapy	BA-9	($446,504)	($504,744)	($416,301)
Home Health Billing Changes	BA-9	($2,423,629)	($2,739,756)	($636,809)
0.75% Acute Care Provider Rate Reduction	BA-9	($8,261,265)	($11,711,574)	($2,904,019)
0.5% CBLTC Provider Rate Reduction	BA-9	($1,507,220)	($2,260,830)	($361,468)
Total		**($46,847,423)**	**($48,279,254)**	**($12,116,739)**

(1) Savings from each of the ACC budget actions have been aggregated and are presented in the ACC section of the narrative.

In cases where savings estimates have been reduced due to implementation delays, the Department accounts for the full impact in FY 2012-13.

SB 11-008 – Concerning Medicaid Eligibility for Children

This bill specifies the income eligibility criteria for Medicaid that applies to children aged five and under shall also apply to children between the ages of six and 19. As of January 1, 2013, children under the age of 19 will be eligible for Medicaid if their family income is less than 133% of the federal poverty level (FPL). The Department assumes the federal match for clients these clients will remain at the same level it would have had the clients enrolled in CHP+ instead of Medicaid, or 65%.

Fiscal Year	Caseload	Total Fund Expenditure
FY 2012-13	2,499	$2,833,686
FY 2013-14	16,320	$18,317,437
FY 2014-15	18,887	$20,745,330

SB 11-125 – Concerning Nursing Home Fees and Order of Payments

This bill alters the hierarchy of the supplemental payment components funded by the Nursing Facility Provider Fee and increases the maximum allowable fee assessed to nursing facilities.

Nursing facility rates are cost-based. However, the General Fund portion of a nursing facility's rate is limited by statute, regardless of the amount of growth seen. Facilities are compensated for cost growth beyond the General Fund cap though supplemental payments from the Nursing Facility Cash Fund. On the aggregate level, nursing facilities typically see approximately 4.25% growth in costs each fiscal year.

As quality and performance incentives were previously funded after growth beyond the General Fund Cap and the provider fee was unable to fully fund all components of the supplemental payments, these quality and performance components were not always funded. Under this statute, quality and performance incentives take priority over growth beyond the General Fund cap. As a result, the provider fee is able to fully fund quality and performance incentives but can no longer fully fund growth beyond the General Fund cap.

SB 11-177 – Concerning Pregnancy and Dropout Prevention

SB 11-177 extended the sunset deadline and expanded the Teen Pregnancy and Dropout Prevention program for Medicaid clients. In FY 2010-11, the Department offered teen pregnancy prevention services to at-risk teenagers through two providers: Hilltop Community Resources, Incorporated (Hilltop) and the Montrose County Department of Health and Human Services (Montrose). This program provides services such as: group and individual counseling; vocational, health and educational guidance; science-based instruction concerning human sexuality; and home visits. In FY 2008-09, Hilltop served approximately 150 teens at a cost of $98,776 total funds. Montrose served approximately 140 teens at a cost of $125,453 total funds in FY 2008-09. The program receives a 90% federal financial participation match rate, which is drawn through local funds paid to the Department.

Through this bill, the Department is able to hire one FTE to administer this program, which was historically absorbed by other Departmental resources. The Department believes the increased administration will allow the program to expand to additional providers at a rate of two to three new providers per year. The Department assumes the cost of the FTE will be offset in Acute Care through avoided births.

The Department anticipates receiving $40,335 in FY 2012-13 and $13,327 in FY 2013-14 to operate. While the Department had previously anticipated an expansion of the program, there have been no new providers added to the program. The Department currently assumes the program will continue to operate at current levels.

SB 11-210 – Concerning the Phase Out of Supplemental Old Age Pension Health Fund

As part of the Joint Budget Committee's budget balancing package, this bill allows for an annual transfer of $2,230,500 from the Health Care Expansion Fund to be used as a General Fund offset for services in the Medical Service Premiums line beginning FY 2011-12. This statute eliminates the additional step of transferring funds from tobacco tax to the OAP fund and then appropriating funds from the OAP fund to the MSP line. The fiscal impact of this bill is accounted for in Exhibit A.

SB 11-211 – Concerning Tobacco Revenues Offsetting Medical Services

Also part of the JBC budget balancing package, this bill allows for the use of $33,000,000 in tobacco tax funds for services in the Medical Services Premiums line. Of this amount, $17,758,594 is from the Tobacco Education Program Fund, $11,955,055 is from the Prevention, Early Detection, and Treatment fund, and $3,286,351 is reappropriated funds from the Department of Public Health and Environment. The fiscal impact of this bill is accounted for in Exhibit A. This was one-time funding, and an annualization removing these funds from the FY 2012-13 base budget is seen in Exhibit A.

SB 11-212 – Concerning the Use of Provider Fee to Offset Medicaid Expenditure

This bill authorized the Department to utilize $50,000,000 in Hospital Provider Fee funds as a direct offset to General Fund expenditure for services in the Medical Services Premiums line in FY 2011-12 and $25,000,000 in FY 2012-13.

SB 11-215 – Concerning the 2011 Nursing Facility Rate Reduction

Effective July 1, 2011, SB 11-215 continued the 1.5% reduction to Class I Nursing Facility reimbursement from HB 10-1324 which expired on June 30, 2011. The total fiscal impact of this bill will depend on the number of patient days incurred in FY 2011-12. Exhibit H of the Department's request contains detailed calculations for the fiscal impact of this bill.

SB 11-219 – Concerning 2011 Transfers for Health Care Services

This bill authorized the Department to use $15,775,670 in funds from the Primary Care fund as offset to General Fund expenditure in the Medical Services Premiums line. The fiscal impact of this bill is accounted for in Exhibit A. This was one-time funding and has been removed from the Department's spending authority in FY 2012-13.

SB 11-250 – Concerning Eligibility for Pregnant Women

This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133% to 185% of the federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to transition from the Children's Basic Health Plan (CBHP) to Medicaid. As with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients and assumes the first fiscal impact within the Medical Services Premiums line will occur in FY 2012-13 due to necessary systems changes.

Fiscal Year	Caseload	Total Fund Expenditure
FY 2012-13	372	$2,997,688
FY 2013-14	744	$6,052,494
FY 2014-15	750	$5,843,790

Federal Legislation

Section 1202 of the Health Care and Education Reconciliation Act – Primary Care Physician Rates to 100% of Medicare

Section 1202 of the Health Care and Education Reconciliation Act (part of the Affordable Care Act) states that for calendar years 2013 and 2014, states must provide for payment for primary care services at a rate not less than 100% of the Medicare rate. The difference in rates between July 1, 2009, and January 1, 2013, will be paid for by the federal government through an enhanced federal medical assistance percentage (FMAP). The increased FMAP rate will apply to certain primary care services -- including evaluation and management and immunizations -- performed by physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine.

The Department estimates the difference in rates between July 1, 2009, and January 1, 2013, will generate an estimated $4,950,838 total funds in FY 2012-13 and $12,872,971 total funds in FY 2013-14, all of which will be 100% federally funded. In addition, the Department will need to increase physician rates from the level at which they are currently set to the rates that were effective on July 1, 2009. This gap represents rate cuts that were taken since July 1, 2009, due to budget reduction measures. The Department estimates increasing rates to the July 1, 2009, level will increase expenditure by $1,347,828 in FY 2012-13 and $3,234,787 in FY 2013-14. These amounts will be matched by the federal government at the standard FMAP rates. The enhanced federal funding is not available in FY 2014-15. An annualization reducing expenditure to original levels can be found in Exhibit F, Acute Care.

Section 4107 of the Affordable Care Act – Providing Smoking Cessation Counseling for Pregnant Women

Section 4107 of the Affordable Care acts requires states to implement a program offering pharmacotherapy and smoking cessation counseling to pregnant women. The requirement does not receive additional funding to support it. Currently, the Department offers coverage for tobacco cessation pharmacotherapy to all Medicaid clients but does not have coverage for counseling. In implementing a counseling benefit, the Department has restricted services by allowing a maximum of five counseling sessions up to 10 minutes and three counseling sessions of more than 10 minutes. The Department opened billing codes to implement the program in January 2012.

The Department estimates this initiative will have a net savings of $46,357 in FY 2012-13, annualizing to $142,333 savings in FY 2013-14. By reducing the smoking rate of pregnant women, the Department anticipates savings through a reduction to low birth rate births (attributed to smoking mothers) which tend to be more costly than a normal birth.

Colorado Choice Transitions (Money Follows the Person Grant)

The Department was awarded the Money Follows the Person federal grant designed to help clients currently residing in nursing facilities to transition into Community-Based Long-Term Care. The grant allows the Department to provide transitional services to ease the movement from nursing facility to the community and provides an enhanced federal match to those services, existing HCBS waiver services, and home health services. Savings from the enhanced match are required to be used to improve the long-term care service system, as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services. The grant is designed to offer clients enhanced services for one year after transitioning from a nursing home to allow them to adapt to the community setting.

The Department had to delay implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The Department anticipates approximately 100 clients will transition per calendar year beginning in January 2013. The Department estimates the total impact to Medical Services Premiums to be a reduction of $8,188 total funds in FY 2012-13 and a reduction of $603,033 in FY 2013-14. These figures do not include any expenditure from the rebalancing fund.

Prior-Year Legislation

This section describes the impact from legislation passed during the 2009 and 2010 legislative sessions and includes impacts from the Department's budget cycle requests prior to FY 2011-12. Information from budget requests has been updated to be consistent with any approval granted by the legislature. Please note the descriptions in this section only discuss those portions of approved initiatives that have an impact in this budget request. The budget requests, or portions of budget requests, from prior cycles that have been implemented and do not require further adjustment in this request (such as a bottom line impact) are not discussed in this narrative. For information on the Department's complete requests, please consult the narrative for prior years or the original requests.

- *Evidence Guided Utilization Review (EGUR) (FY 2010-11 BA-12) and Prevention and Benefits for Enhanced Value (P-BEV) (BRI-1):* This Budget Reduction Item increases FY 2010-11 expenditure by an estimated $282,653, with an additional $481,092 in FY 2011-12, in order to provide increased utilization review funding in order to create an evidence guided utilization review program. Savings is expected as a result of increased utilization reviews. In addition, the Department is able to expand a set of dental procedures, including fluoride treatment, and improve non-emergency medical transportation policies. Delayed implementation has shifted a portion of anticipated Medical Services Premiums savings to FY 2012-13. The Department estimates FY 2012-13 savings to be $382,297 total funds. The revised implementation date for this initiative was November 1, 2011, when the Department began paying a new utilization management contractor.

- *Coordinated Payment and Payment Reform (BRI-2):* This budget reduction item reduces expenditure in FY 2011-12 and FY 2012-13 for both Acute Care Services and Community-Based Long-Term Care Services. The table below demonstrates these reductions by service category.

  This budget reduction item implements proposed steps toward payment coordination and payment reform. This request included four proposed initiatives which work in tandem to serve the goal of lowering the cost of providing medical services to Medicaid clients while improving health outcomes and access to care. The initiatives aim to consolidate payment and billing processes, expand audits conducted by the Nursing Facilities Section, initiate a pilot audit of a Community Mental Health Center, and increase enrollment of Medicare-eligible clients into Medicare. In addition, the Department is targeting three, payment rate reform initiatives. The first, directed at Home- and Community-Based Services waivers, will initiate research into the potential of applying an outcomes-based approach to the payment of claims for waiver services. A similar approach will be taken to investigate the potential to apply outcomes-based approach to the payment of physician payment rates. The third initiative targeted at changing the methodology of Federally Qualified Health Centers (FQHCs) payments aims to investigate the feasibility of creating an outcomes-based performance payment for FQHCs. Savings in FY 2012-13 are associated with the enrollment of Medicare eligible clients in Medicare. The Department has enlisted the services of a contractor to perform outreach to clients and to assist clients with the Medicare application project. The Department has revised savings estimates based on lower per-capita savings assumptions and lower than anticipated initiative participation rates as well as a adjustments for partial delays in implementation. The estimated fiscal impact in FY 2012-13 is $275,000.

- *Accountable Care Collaborative (S-6, BA-5):* The Department was appropriated an overall reduction in expenditure of $514,730 in FY 2010-11, annualizing to $10,268,779 in FY 2011-12 in order to provide Medicaid clients, regardless of age or health status, a coordinated delivery system beginning in FY 2010-11. For this request, the Department limited enrollment to 60,000 clients with the anticipation of enrolling more clients as the program becomes established. Please see the section below on the Accountable Care Collaborative for a more detailed explanation of the program and the costs and savings estimated it.

HB 10-1005 - Concerning Home Health Care through Telemedicine Pursuant to the "Colorado Medical Assistance Act"

HB 10-1005 alters the provision of home health telemedicine services established in SB 07-196. This bill asserts: telemedicine services are now eligible for Medicaid reimbursement; reimbursement rates are no longer required to be budget-neutral; reductions in travel costs by home health care and home- and community-based service providers are no longer required to be considered when setting reimbursement rates; and incorrect references to the way reimbursement payments are made are removed.

Additionally, payments of telemedicine reimbursements are contingent upon the receipt of gifts, grants, and donations in the newly created Home Health Telemedicine Cash Fund for FY 2011-12 and FY 2012-13. The bill increases Department expenditure by $182,336 in FY 2012-13.

As of December 2010, the Department has received donations to implement the telemedicine program. However, after review by the Centers for Medicare and Medicaid Services, the donated funds will not receive a federal match. Within this bill, the Department is given authority to request General Fund to continue operating the program after donated funds are completely utilized. The Department believes this authority grants the Department an exemption from requirements in HB 10-1178 which prohibits agencies from requesting General Fund to continue grant and donated fund programs.

Client enrollment began late in FY 2011-12

SB 10-167 - Concerning Increased Efficiency in the Administration of the "Colorado Medical Assistance Act," and, in Connection Therewith, Creating the "Colorado Medicaid False Claims Act"

This bill creates efficiencies in the Department by creating the Colorado Medicaid False Claims Act, as described below. The bill originally reduced Department expenditure $2,390,570 in FY 2010-11, and annualizing to $3,699,827 in FY 2011-12, by requiring the Department to implement a number of initiatives. While the Department has been able to partially implement the components of SB 10-167, full implementation was not anticipated until spring of 2012. Consequently, a portion of the savings originally anticipated in FY 2010-11 has been shifted to FY 2011-12 and FY 2012-13. The initiatives are as follows:

National Correct Coding Initiative

With this initiative, the MMIS is enhanced to perform prepayment review of claims. The system checks for medically unlikely billing code pairs and medically unlikely unit quantities. Due the magnitude of changes required to the MMIS as well as issues in rate structures that need to occur for the coding edits to be effective, there have been delays in the implementation of this component of SB 10-167. In FY 2010-11 the Department manually implemented approximately 200 of the highest utilized coding pairs (out of over 3 million in total) to achieve savings despite delays in implementation. The FY 2011-12 NCCI impact of $12,500 reflects both delays in implementation and savings achieved through the manual implementing codes in FY 2010-11.

Rx Coordination of Benefits

The Rx Coordination of benefits program implements system changes that allow the Department to perform prepayment review of pharmacy claims to determine whether another party should be primary payer for the claim. A delay in system

change implementation has resulted in a shift of savings from FY 2011-12 to FY 2012-13. Estimated savings for FY 2012-13 total $321,990 and $351,262 in FY 2013-14. The program was implemented August 1, 2012.

<u>Colorado Medicaid False Claims Act:</u>
Anyone who knowingly submits a false claim or intends to defraud the state or a political subdivision is liable for up to three times the amount of damages, the costs of civil action, and a civil penalty of between $5,000 and $10,000. Persons ineligible to receive State funds and who report to the Attorney General within 30 days of receiving such funds may be liable for two times the amount of damages and no civil penalty provided certain conditions are met. The bill specifies certain investigative, notification, and court procedures for false claims and requires the Attorney General to prepare an annual report for certain legislative committees.

<u>Enhanced Internal Audits</u>
Appoint an internal auditor and to ensure duplicate benefits are not being paid by other states to clients enrolled in Department programs through creating access to the Public Assistance Reporting Information System (PARIS) which will allow the Department to identify and eliminate clients receiving medical services premiums in other states.

<u>Health Insurance Buy-In Program Expansion</u>
Purchase private health insurance coverage through the Health Insurance Buy-In Program for an additional 1,500 eligible clients to create cost savings for the State by enrolling clients into individual insurance plans where enrollment is deemed cost-effective. This initiative has been delayed to implement in April 2012 to allow for contract execution. The Department has identified a vendor and began in July 2012. The vendor anticipates 90 clients will be enrolled per month until the maximum of 2,000 clients is reached.

In addition to adjusting savings estimates for implementation delays in the HIBI expansion, the Department has revised both cost and savings estimates to better reflect the impact the Department anticipates with the increased enrollment in this program. First, the Department changed the payment methodology from a contingency based payment plan to PMPM payment. The Department believes this methodology better allows the Department to reimburse for managing payments to clients' primary insurance agencies. In addition, the Department adjusted the monthly savings based on FY 2011-12 per-capita costs. Finally the Department added costs associated with premium reimbursement to the estimated cost of the bill. This captures the additional costs to the Department for increased enrollment in the HIBI program. The following table illustrated the full impact of SB 10-167 on the HIBI program for FY 2012-13 through FY 2013-14.

FY 2012-13 and FY 2013-14 Total HIBI Impact from SB 10-167		
Item	**FY 2012-13**	**FY 2013-14**
Provider Payment	$317,955	$315,068
Premiums Payment	$1,365,554	$2,443,792
Savings (Realized in Acute Care)	($3,340,516)	($5,984,276)
Total Impact	**($1,657,007)**	**($3,225,416)**

SB 10-117 – Concerning Over-the-Counter Medication for Medicaid Clients

SB 10-117 allows pharmacists to directly prescribe certain medications, as approved by the Department, to Medicaid clients. By including only drugs that, when access is increased, reduce the likelihood of more expensive exacerbation of conditions, savings can be achieved. Avoided ER visits, physician office visits to obtain prescriptions for over-the-counter drugs (as is current policy for over-the-counter drug coverage under Medicaid), and avoided births are the primary vectors of savings. Through an extensive stakeholder outreach process, the Department has developed a list of medications that is anticipated to generate savings.

Emergency contraceptives generate the most significant amount of savings as the costs associated with birth are nontrivial. The Department's analysis excludes first-year-of-life costs and thus represents a conservative estimate of savings.

Because of the significant health consequences associated with smoking, expenditure on nicotine replacement therapies have been shown to reduce health care expenditure as quickly as one year post investment. Returns continue to increase over time. While there is an initial increase in expenditure associated with covering nicotine replacement therapy under the provisions of SB 10-117, the Department anticipates short-term returns on investment. Further, the increase in expenditure is completely offset by savings achieved by other drugs in the program.

Over-the-counter medications such as fever reducers are likely to reduce the utilization of emergency/urgent care services when easily accessible. While the Department has not estimated the savings associated with avoided emergency/urgent care service utilization, the Department believes that, as the estimated costs are sufficiently low, costs are offset by savings from other drugs on the list, and there are likely cost savings, that inclusion of these drugs on the list are appropriate.

The Department anticipates full implementation by January 1, 2013. The Department will continue to evaluate the list of medications to determine any needed changes or additional opportunities for savings.

Estimated Impact of Increasing PACE Enrollment

As described in the narrative for Exhibits F and H, the Department is currently in the process of adding several new Program of All-Inclusive Care for the Elderly (PACE) providers to the Medicaid program. Like other risk-based managed care organizations (including the Department's health maintenance organizations and behavioral health organizations), the monthly payment to the provider covers all services provided by the provider –in the instance of a PACE provider, the payment covers acute care and long-term care. While the Department does not adjust its request for each additional client enrolled in PACE – enrollments in existing providers are considered part of the base trend – the addition of new providers will cause an expenditure shift from fee-for-service categories to the PACE service category.

The impact to Acute Care and Community-Based Long-Term Care (CBLTC) is not "dollar-for-dollar." The PACE program is designed to keep clients who have high community-based long-term care needs out of nursing facilities. The clients who move into the PACE program, typically, are those clients whose needs are no longer met by an HCBS program. Thus, clients are moving from a lower-cost option (HCBS) to a higher-cost option (PACE). However, the Department still anticipates the move is at least budget neutral in the long-term; clients who do not move to a PACE program will typically require nursing facility coverage, which is more expensive than PACE coverage.

The impact to acute care and CBLTC is calculated as the percentage of the PACE cost per enrollee attributable to those services (based on the actuarially certified capitation rates), adjusted for the cash-flow issues related to transitioning a client from fee-for-service to managed care under cash accounting. The cash-flow impact is calculated as one-twelfth the total enrollment impact and distributed proportionally to the acute care and HCBS reductions.

	Estimated Savings due to Pace Enrollments			
FY 2012-13	**OAP-A**	**OAP-B**	**AND/AB**	**Total**
Acute	($850,218)	($256,601)	($22,297)	($1,129,116)
CBLTC	($1,609,316)	($267,772)	($105,323)	($1,982,411)
Total	**($2,459,535)**	**($524,373)**	**($127,620)**	**($3,111,528)**
FY 2013-14	**OAP-A**	**OAP-B**	**AND/AB**	**Total**
Acute	($974,321)	($656,662)	($342,627)	($1,973,610)
CBLTC	($1,564,905)	($257,232)	($97,613)	($1,919,750)
Total	**($2,539,226)**	**($913,894)**	**($440,240)**	**($3,893,360)**
FY 2014-15	**OAP-A**	**OAP-B**	**AND/AB**	**Total**
Acute	($938,485)	($556,734)	($269,048)	($1,764,267)
CBLTC	($1,507,347)	($218,088)	($76,650)	($1,802,085)
Total	**($2,445,831)**	**($774,822)**	**($345,698)**	**($3,566,352)**

Managed Care Organization Reconciliations

This impact accounts for an annualization of recoupment payments the Department received from Denver Health Medicaid Choice and Colorado Access in FY 2011-12. The recoupment payments included overpayments for clients who were later determined to have third-party liability at the time of payment, as well as the amount paid for fee-for-service claims for HMO-covered services on behalf of clients who were later determined to be enrolled in the HMO at the time of service. The Department does not know when future reconciliations will occur and, therefore, annualized the full amount of the payments out in FY 2012-13. The Department will include reconciliations in future requests as the payment timelines are known.

HB 09-1047 – Concerning a Program for Providing Additional Therapies to Certain Persons with Disabilities Who are Eligible to Receive Medicaid

This legislation created a new HCBS waiver to allow chiropractic care, massage, and acupuncture services for clients with spinal cord injuries. The Department assumed clients would be moving from the EBD waiver to the Spinal Cord Injury (SCI) waiver and adjusted estimated enrollment by shifting 67 clients from the EBD waiver to the SCI waiver. Additional detail regarding this program can be found in the Community-Based Long-Term Care Section of the narrative.

FY 2009-10 BA-33: Prior Authorization of Anti-Convulsants

Anticonvulsants can be used to treat a variety of conditions. By ensuring this drug class is used only for the treatment of organically originating conditions, expenditure is reduced. This initiative, originally scheduled for implementation in FY 2009-10, required the auto prior-authorization system to be in place prior to implementation. Previous savings estimates were adjusted to account for implementation delays. While the system is now in place, savings estimates have been further adjusted to account for the likely reduced savings potential stemming from the fact many of the drugs are now available in a generic form. The Department estimates annualized savings of $60,000 in FY 2012-13. See FY 2009-10 BRI-1 below for additional information regarding the auto PA.

FY 2009-10 BRI-1 Pharmacy Technical and Pricing Efficiencies

This budget reduction item reduced FY 2009-10 expenditure by an estimated $1,022,887, with an expected additional $1,848,763 reduction in FY 2010-11, as the result of an automated prior-authorization system for pharmacy claims, as well as through changing the reimbursement rates for drugs using a state maximum allowable cost structure. The Department has adjusted savings estimates to reflect a delay in the implementation of the automated prior-authorization system. The system came online in October 2011. While the auto PA system is now operational, programming needs to be completed to fully implement the initiative. The Department estimates an annualization of $1,217,310 in FY 2012-13.

Accountable Care Collaborative

The Accountable Care Collaborative (ACC) was originally requested in FY 2010-11 S-6, BA-5 as a pilot program of 60,000 clients and expanded in FY 2011-12 BA-9 to 123,000 clients. The program is designed to improve clients' health and reduce costs. Clients in the ACC receive the regular Medicaid benefits package, and the Department makes additional payments to doctors and care coordination organizations to help manage clients’ care. The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds providers accountable for health outcomes. The program began in the spring of 2011, and enrollment reached 123,000 Medicaid clients statewide in FY 2011-12. The program continues to expand and is currently on track to achieve an enrollment level of 200,000 early in CY 2013. The central goals of the program are to improve health outcomes through a coordinated, client-centered system and to control costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources.

The key components of the ACC are the Regional Care Collaborative Organizations, the Primary Care Medical Providers, and the Statewide Data and Analytics Contractor, which are outlined below.

The Regional Care Collaborative Organizations (RCCOs) are regional entities that provide for the coordination and integration of care within the ACC framework and are contracted with the Department through competitive procurement. There are seven RCCOs, which provide the following services:

- medical management, particularly for medically and behaviorally complex clients, to ensure they get the right care, at the right time and in the right setting;
- care-coordination among providers and with other services such as behavioral health, long-term care, single entry point (SEP) programs, and other government social services such as food, transportation, and nutrition; and
- provider support, such as assistance with care-coordination, referrals, clinical performance and practice improvement, and redesign.

Primary Care Medical Providers (PCMPs) are contracted with RCCOs and act as "health homes" for ACC members. As a health home, the PCMP provides comprehensive primary care and coordinates and manages a client's health needs across specialties and along the continuum of care.

The Statewide Data and Analytics Contractor (SDAC) builds and implements the ACC data repository, creates reports using advanced health care analytics, hosts and maintains a web portal, provides a continuous feedback loop of critical information, fosters accountability and ongoing improvement among RCCOs and providers, and identifies data-driven opportunities to improve care and outcomes. The SDAC is paid through a fixed-price contract.

Medicaid clients who are enrolled in the ACC are assigned to a RCCO based on the client's county of residence and are linked with a PCMP via existing claims data that shows a relationship between the client and the provider, if that data is available. The RCCO and the PCMP are both paid a per-member per-month (PMPM) amount and are responsible for providing enhanced care coordination services, improving health outcomes, and reducing unnecessary costs.

The Department estimates the PMPM costs for the RCCOs and PCMPs, as well as the fixed-price contract for the SDAC, in Exhibit I. The Department estimates the savings that will accrue as a result of the program in Exhibit F. Due to attrition and replacement enrollments, it is no longer possible to isolate an original 60,000 member cohort or expansion cohort. Consequently, expenditure and savings adjustments are shown in aggregate for the program. It is of note the Department is estimating only a small increase to net savings, though adding 77,000 more clients. Because children make up a large portion of caseload in Medicaid, the greatest opportunity for ACC expansion lies within this population. As children also have relatively lower per-capita expenditure, the savings opportunity from enrollment in the ACC for this population is smaller than other populations. As a result the Department conservatively assumes net savings will increase by only a small amount relative to prior estimates. Further, RCCO rates have been adjusted to reflect the new case mix under an expanded program. As more data becomes available regarding program efficacy with children, the Department will revise this assumption in future requests.

The chart below shows program expenditure and estimated savings for FY 2012-13, FY 2013-14, and FY 2014-15.

Accountable Care Collaborative Expenditure and Assumed Savings

Service Category		FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
Program Administration (Exhibit I, PIHP)	**SDAC**	$650,000	$2,700,000	$3,000,000	$3,000,000
	RCCO	$182,819	$12,303,473	$25,845,818	$26,938,800
	PCMP	$54,592	$2,904,360	$9,068,708	$10,080,000
	Total Administration	**$887,411**	**$17,907,833**	**$37,914,526**	**$40,018,800**
Program Savings (Exhibit F, Acute)	**Total**		**($20,616,544)**	**($43,844,251)**	**($46,478,732)**
	Incremental[1]			**($23,227,707)**	**($2,634,481)**
Net ACC Program Fiscal Impact				**($5,929,725)**	**($6,459,932)**

(1) The incremental value shown is equal to the annualization values in Exhibit F, Acute Care.

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medicaid Mental Health Community Programs

Priority Number: R-2

Dept. Approval by: John Bartholomew — Date: [handwritten: 10/26/12]

OSPB Approval by: — Date: [handwritten: 10/30/12]

- [x] Decision Item FY 2013-14
- [ ] Base Reduction Item FY 2013-14
- [ ] Supplemental FY 2012-13
- [ ] Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$316,728,340	$0	$320,163,135	$32,384,988	$65,945,956
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$144,786,787	$0	$145,988,965	$10,284,849	$22,824,620
	GFE	$0	$0	$0	$0	$0
	CF	$13,648,932	$0	$13,648,932	($1,313,268)	($5,109,605)
	RF	$0	$0	$0	$0	$0
	FF	$158,292,621	$0	$160,525,238	$23,413,407	$48,230,941
(3) Medicaid Mental Health Community Programs; Mental Health Capitation Payments	Total	$312,580,712	$0	$316,015,507	$31,839,522	$65,256,944
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$142,712,972	$0	$143,915,150	$10,012,117	$22,480,115
	GFE	$0	$0	$0	$0	$0
	CF	$13,648,932	$0	$13,648,932	($1,313,268)	($5,109,605)
	RF	$0	$0	$0	$0	$0
	FF	$156,218,808	$0	$158,451,425	$23,140,673	$47,886,434
(3) Medicaid Mental Health Community Programs; Medicaid Mental Health Fee for Services Payments	Total	$4,147,628	$0	$4,147,628	$545,466	$689,012
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,073,815	$0	$2,073,815	$272,732	$344,505
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,073,813	$0	$2,073,813	$272,734	$344,507

Letternote Text Revision Required? Yes: ✓ No:

If yes, describe the Letternote Text Revision:
See page R-2.BB-2 for summary table of letternote revision breakdown.

Cash or Federal Fund Name and COFRS Fund Number:

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

Approval by OIT? Yes: No: Not Required: ✓

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Department of Health Care Policy and Financing
Medicaid Mental Health Community Programs

FY 2012-13, FY 2013-14, and FY 2014-15 Budget Request

November 1, 2012

TABLE OF CONTENTS

MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS ... ***2***
History and Background Information ... 2
Program Administration ... 8
Medicaid Anti-Psychotic Pharmaceuticals ... 8
MENTAL HEALTH CAPITATION PAYMENTS AND MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS ... ***9***
Exhibit AA - Calculation of Current Total Long Bill Group Impact ... **11**
Exhibit BB - Calculation of Fund Splits ... **12**
Exhibit CC - Medicaid Mental Health Community Programs Summary ... **14**
Exhibit DD - Mental Health Caseload, Per Capita, and Expenditure History ... **14**
Exhibit EE - Estimate and Request by Eligibility Category ... **15**
Incurred but not Reported Estimates ... 16
Exhibit FF - Medicaid Mental Health Retroactivity Adjustment and Partial Month Adjustment Multiplier ... **18**
Retroactivity Adjustment Multiplier ... 18
Partial Month Adjustment Multiplier ... 19
Exhibit GG - Medicaid Mental Health Capitation Rate Trends and Forecasts ... **19**
Exhibit HH - Forecast Model Comparisons ... **21**
Final Forecasts ... 21
Capitation Trend Models ... 22
Exhibit II - Recoupments and Reconciliations ... **25**
Exhibit JJ - Expansion Populations ... **26**
Exhibit KK - Medicaid Mental Health Fee-for-Service Payments ... **28**
Exhibit LL - Global Reasonableness Test for Mental Health Capitation Payments ... **30**

MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS

The following is a description of the budget projection for the Medicaid Mental Health Community Programs.

History and Background Information

In 1993, under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act, the Centers for Medicare and Medicaid Services (CMS) granted the State waivers that allowed the State to implement a pilot managed care mental health program. The pilot program operated until 1995. In 1995, SB 95-078 directed the Department and the Department of Human Services to implement a statewide capitated mental health managed care program. In 1997, SB 97-005 authorized the Department to provide mental health services through a managed care program.

The structure of managed care has changed over time. In 1995, implementation of the Medicaid Mental Health Capitation Program in 51 counties of the State was complete, with the remaining 12 counties added in 1998. A 64th county was added when Broomfield became a county in November 2001. Through a competitive bid process, eight mental health assessment and service agencies were awarded contracts to be service providers in the program. Again through competitive procurement, the Department reduced the number of regions from eight to five and awarded managed care contracts to five behavioral health organizations effective January 1, 2005. The five behavioral health organizations were reprocured through a competitive bid process effective July 1, 2009. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

Each behavioral health organization is responsible for providing or arranging medically necessary mental health services to Medicaid-eligible adults 65 and older, disabled individuals through 64, low-income adults, adults without dependent children, eligible children, foster care children, and Breast and Cervical Cancer Program adults enrolled with a behavioral health organization. Services provided by those organizations include, but are not limited to: inpatient hospitalization, psychiatric care, rehabilitation, and outpatient care; clinic services, case management, medication management, and physician care; and non-hospital residential care as it pertains to mental health. The capitation program also includes alternatives to institutionalization. The Department is required to make monthly capitation payments to contracted behavioral health organizations for services for each eligible Medicaid recipient. Payments vary across each behavioral health organization, as well as each eligibility category.

Since the inception of the Medicaid Mental Health Community Programs, the Department has been responsible for oversight and contracting with the managed care organizations. The budget projections, day-to-day operations, and administration of the program were the responsibility of the Department of Human Services. In 2004, the administration and programmatic duties were transferred from the Department of Human Services to the Department. These duties include budget projections and accounting for the program, site reviews of the institutions, and contract negotiations. The transfer resulted in a new Long Bill group for the Department in the FY

2004-05 Long Bill (HB 04-1422). Subsequently, SB 05-112 transferred: (1) the Mental Health Administration appropriation for Personal Services, Operating Expenses, and External Quality Review Organization Mental Health from Medicaid Mental Health Community Programs – Program Administration to the Executive Director's Office Long Bill group; (2) Single Entry Point case management services from Medicaid Mental Health Fee-for-Service Payments to Medical Services Premiums; and (3) services for the developmentally disabled from the Colorado Department of Human Services for People with Disabilities – Community Services and Regional Centers to Non-Emergency Medical Transportation, Medical Services Premiums, and Mental Health Fee-for-Service appropriations within the Department. As a result, only the Medicaid Mental Health Community Programs expenditures are addressed in this section.

The recent history of the Medicaid Mental Health Community Programs is summarized as follows:

- HB 02-1420 also provided funding for three alternative programs in the Medicaid Mental Health Community Programs: Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program. Each of these programs was the result of reductions in institutional care. Contracting through mental health assessment and service agencies, community mental health centers offered to provide services through managed care at a much lower cost. Initially part of the Mental Health Capitation Payments line, separate appropriations were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-On (SB 05-209). Funding for Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program was incorporated into the capitation base during the request for proposal process for contracts effective January 1, 2005. Due to this new contractual provision with behavioral health organizations, separate appropriations were no longer needed as of FY 2005-06.

- In FY 2002-03, budget reductions were implemented and capitation payments were reduced significantly for FY 2002-03 through FY 2003-04. This led to a reduction of services provided by the behavioral health organizations. Increasing caseload for Medicaid Mental Health Community Programs and incorporating funding for alternative programs to inpatient hospitalization tempered the effect reductions had on the capitation budget.

- Due to a temporary federal change, the Medicaid federal financial participation match was enhanced for the last quarter of FY 2002-03 and the entire FY 2003-04 to 52.95% (up from 50%), while the State's share was reduced to 47.05%. The federal financial participation match rate returned to 50% for FY 2004-05.

- SB 03-196 mandated the Department to move from accrual-based accounting to cash-based accounting for the Medical Services Premiums and the Medicaid-funded services in the Department of Human Services' budget. This resulted in a one-time savings of

approximately $70 million in Medical Services Premiums and $7 million in the Department of Human Services' Medicaid-funded services during FY 2002-03. With cash-based accounting, all expenditures became based on the date of payment, regardless of when the date of service occurred, thus eliminating the six-month accounts payable period maintained under accrual-based accounting. Ideally, all prior expenditure history for mental health services would have been rebuilt on a cash basis for historical comparison purposes, using both the Colorado Financial Reporting System and the Medicaid Management Information System data. However, the Department's prospective per-capita budget methodology did not require the use of historical data prior to FY 2002-03.

- SB 03-282 gave the Department and the Department of Human Services' Medicaid-funded programs a one-time appropriation of $1,000,000 in FY 2003-04, wherein $500,000 was from the Tobacco Litigation Settlement Cash Fund, and the remaining $500,000 was from federal funds for mental health capitation and performance incentive awards.

- Within the appropriation for Medicaid Mental Health Community Programs, the FY 2004-05 Long Bill (HB 04-1422) provided funding for the Mental Health Institute Rate Refinance Adjustment. This funding was necessary because in 2001 it was discovered the capitation-based payment for Medicaid clients did not cover bed costs at mental health institutes. Separate appropriations for the Mental Health Institutional Rate Refinance Adjustment were made in the FY 2004-05 Long Bill (HB 04-1422) and the FY 2004-05 Long Bill Add-on (SB 05-209). New contracts with behavioral health organizations effective January 1, 2005, began fully covering the negotiated bed cost at the mental health institutes in new capitation rates via payments withheld from behavioral health organizations and made directly to the Mental Health Institute. Therefore, a separate appropriation for the Mental Health Institute Rate Refinance Adjustment was no longer needed as of FY 2005-06.

- HB 04-1422 reorganized the Medicaid Mental Health Community Programs Long Bill group into the following sections:

  1. Mental Health Capitation Payments, which included Capitation Base Payments, Mental Health Services for Breast and Cervical Cancer Patients, Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, and the Mental Health Institute at Fort Logan and Alternatives to the Fort Logan Aftercare Program. SB 05-209 consolidated these line items into one Mental Health Capitation Payments line item in FY 2005-06.

  2. Other Medicaid Mental Health Payments, which included Medicaid Mental Health Fee-for-Service Payments, Child Placement Agency, and Anti-Psychotic Pharmaceuticals. Child Placement Agency and Anti-Psychotic Pharmaceuticals were listed under Other Medicaid Mental Health Payments for informational purposes only. Detailed explanations of the Child Placement Agency and Anti-Psychotic Pharmaceuticals programs and appropriations can be found in the Department of Human Services Child Welfare section and the Department's Medical Services Premiums section, respectively. SB 05-209 did not change these line items. However, in November 2004, the Department received an order from CMS to cease making Child Placement

Agency payments since they were considered supplemental payments outside the scope of the existing waiver. Payments were discontinued in December, and the line item has been removed from the Department budget.

- HB 05-1262, known as the Tobacco Tax bill, established two funds that provide capitated mental health benefits to an increasing population of Medicaid clients. Increased caseload funded by the Health Care Expansion Fund, administered by the Department, and the Prevention, Early Detection, and Treatment Fund, administered by the Department of Public Health and Environment, are included in both the current year and the out-year requests and are elaborated below.

- The Joint Budget Committee approved the Department's September 20, 2006 1331 Supplemental Request to transfer funding from the Department of Human Services to the Department. This transfer allowed for the inclusion of the Goebel enhanced services in the Medicaid Mental Health Capitation rates and eliminated the need to classify and track them separately.

  The Goebel Lawsuit Settlement line item was created in FY 2003-04 to fund specialized and enhanced mental health services for approximately 1,600 Medicaid and non-Medicaid clients with mental illness in northwest Denver. The Goebel lawsuit claimed that residents of northwest Denver with chronic mental illness were being denied services. The FY 2003-04 Supplemental Bill (HB 04-1320) established the Goebel Lawsuit Settlement as a separate line item in the Department's Department of Human Services Medicaid-Funded Programs Long Bill group and paid it separately from Medicaid Mental Health Community Programs payments.

  On March 31, 2006, the Goebel lawsuit was dismissed. After consultation with the Department's contracted actuary and review of the Goebel-specific encounter and eligibility data, it was determined an actuarially certified payment would become part of the Mental Health Capitation Payments line item. An adjustment was made for the inclusion and it began being included in the FY 2006-07 capitations.

- SB 07-002 and SB 08-099 expanded Medicaid eligibility for foster care children up to age 21.

- HB 08-1320 designated Cash Funds Exempt as cash funds and Reappropriated Funds, in effect moving the Health Care Expansion Fund from Cash Funds Exempt to cash funds and clearly distinguishing transfers from the Department of Human Services to the Department as Reappropriated Funds.

- HB 08-1373 continued and extended the Breast and Cervical Cancer Treatment Program to July 1, 2014. The bill designates funding sources for the program: a) for FY 2008-09, 100% of the State costs for the Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund; and b) for FY 2009-10 through FY 2013-14, 50% of State costs for the

Program shall be appropriated from the Breast and Cervical Cancer Prevention and Treatment Fund and 50% shall be from the General Fund.

- SB 09-262 shifted state funding for the Breast and Cervical Cancer Program from 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund to 100% Breast and Cervical Cancer Prevention and Treatment Fund, effective until FY 2011-12. Beginning FY 2012-13, State funding for the Breast and Cervical Cancer Program will be shifted to 50% General Fund and 50% Breast and Cervical Cancer Prevention and Treatment Fund.

- Effective January 1, 2009, the Department issued, and the Behavioral Health Organizations (BHOs) actuarially certified, a new set of rates above the actuarial midpoint of the rate setting range. Rates are set using a combination of historical rate experience and recent encounter data. Under direction from CMS, the Department has gradually put more weight on the encounter data per-member per-month (PMPM). FY 2005-06 was the first year of rate setting that used a combination of historical rate experience and recent encounter data. These capitation rates were calculated using 5% encounter data and 95% of the historical rate experience. During the rate setting process resulting in the January 2009 rates, the Department altered the weight to 35% encounter and 65% historical. However, the Department found estimated service expenditures to be generally valued at an amount less than expected, relative to the BHO's audited financial statements. The Department believes there are two primary reasons for this discrepancy. First, the non-traditional, federally waivered (b)(3) service data was newly included in the FY 2006-07 encounter data used for rate setting and appeared to not be completely reported. Additionally, inconsistencies in coding and accounting practices cause some difficulties in the encounter pricing methodology. To offset the discrepancy, the Department paid its mental health rates at 3% above the actuarial midpoint. See description of Exhibit GG for additional information.

- HB 09-1293, the "Colorado Health Care Affordability Act," provided health care coverage for more than 100,000 uninsured Coloradans. The bill was implemented in April 2010 when the Department began collecting the hospital provider fee. Mental health services were subsequently expanded to parents up to 100% of the federal poverty level using the Hospital Provider Fee cash fund to cover the additional expenses. Mental health services were expanded further in FY 2011-12 to adults without dependent children with income up to 10% of the federal poverty level and disabled individuals with income up to 450% of the federal poverty level. For more detail, please see Exhibit J in the Medical Services Premiums Request.

- The June 22, 2009 General Revenue forecast indicated additional General Fund cuts would be necessary in FY 2009-10. On August 24, 2009, the Department released a series of early supplemental requests (ES), which affected the Department's mental health programs in the following ways:

1. As a part of FY 2010-11 ES-2 "Medicaid Program Reductions," the Department reduced the reimbursement rate for the mental health capitation program by 2.5%, effective September 1, 2009, and accounted for the recoupment of net overpayments on prior years' mental health capitation payments.

2. As a part of NP-ES-5 "Close Beds at the Mental Health Institutes," the Department of Human Services proposed that specific beds at the mental health institutes be closed as of January 1, 2010. These bed closures impacted the Department by immediately making those displaced from the mental health institutes clients available for the capitated mental health program. While treated at the institutes, Department of Human Services funding preempted Medicaid payment, with Medicaid being the "payer of last resort." Displacing these clients allowed them to be eligible to receive Medicaid funded benefits and increased expenditure for mental health services.

- Effective January 1, 2010, the Department calculated a new set of mental health rates and set them below the actuarial midpoint. Three of the Behavioral Health Organizations (BHOs) were paid 2.5% below the actuarially set midpoint of the new set of rates. Two of the contracted Behavioral Health Organizations (BHOs) were unable to actuarially certify that they could operate at the new payment schedule. In January 2010, the Joint Budget Committee voted to appropriate funds to continue paying these two BHOs at the previously set rates (the rates from the last rate setting process, with the 2.5% cut from September 2009). These rates remained in effect through CY 2010. See the description of Exhibit GG for additional information.

- Effective January 1, 2011, the Department calculated a new set of mental health rates for calendar year 2011. The new rates implicitly included the 2.5% reductions taken by the BHOs, as the rate cuts were part of the historical and encounter data used in the rate-setting methodology. In addition, the rates were set at 1.71% below the point estimate rates in order to achieve an appropriated savings of $2,170,355. The Department worked with the BHOs in order to ensure they were able to certify the rates and continue to provide quality services to their clients, even while their rates were being reduced. The result of that negotiation process was to begin a series of rate reforms, the first of which was to include a new component in the rate called a "case rate" adjustment that was applied to the CY 2011 rates. The case rate is the BHO statewide average cost by diagnosis category. The case rate allows the Department to comply with CMS's direction by increasing the weight of the encounter data in the rate-setting process. The BHOs can accept the increased weight of encounter data because the case rate allows for any savings achieved to be spread across the entire system, rather than directly reducing the rate of the BHO responsible for generating savings. Incorporating the case rate serves to better align the rate-setting process with the Department's goals by incentivizing the BHOs to be more efficient without sacrificing the quality of the care provided to their clients.

- The Department requested to continue to apply the 1.71% reduction to the BHO rates in the current and request years in FY 2011-12 BRI-5 "Medicaid Reductions." The reduction was appropriated in the FY 2011-12 Long Bill.

- The FY 2011-12 Long Bill transferred $616,044 from the Division of Youth Corrections appropriation, which is administered by the Department of Human Services, to the appropriation for Medicaid Mental Health Community Programs to fund mental health services provided to children living at the Ridge View Youth Services Center. In FY 2009-10, the Ridge View Youth Services Center in the Denver-Aurora area was granted a change of license to be classified as an unlocked, non-secure, community residential facility. The new type of license allowed Ridge View to be considered a community facility in which residents may qualify for Medicaid. Each resident at Ridgeview is viewed by Medicaid as being a low-income family of one, since the residents generally have no independent income. Thus, the residents at Ridgeview qualify under the same category of eligibility as foster care children. Prior to FY 2011-12, the expenditure for mental health services provided to Ridge View clients was transferred from the appropriation for Medicaid Mental Health Community Programs and into the appropriation for the Division of Youth Corrections. Its appropriation was transferred to the mental health long bill line to streamline the process and avoid manually transferring expenditure. Since the Ridge View clients have been incorporated in the caseload data since FY 2009-10, the Department assumes that the impact of these clients on mental health expenditures will be captured in the caseload forecasts and does not need to be added as a bottom line impact to Exhibit BB.

- SB 11-008, "Aligning Medicaid Eligibility for Children," will expand Medicaid eligibility from 100% to up to 133% of the federal poverty level for children ages six through 18. The bill shifts impacted children from the Children's Basic Health Plan (CHP+) to Medicaid beginning January 1, 2013. The Department assumes the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for CHP+. SB 11-250, "Eligibility for Pregnant Women in Medicaid," will expand Medicaid eligibility from 133% to 185% of the federal poverty level for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from CHP+ to Medicaid on January 1, 2013. The Department assumes the expenditure for these women will continue to receive a 65% federal match rate.

Program Administration

In FY 2005-06, SB 05-112 transferred all of Medicaid Mental Health Community Programs - Program Administration expenditures into the Executive Director's Office Long Bill group and is reflected in the lines for Personal Services, Operating Expenses, and Mental Health External Quality Review Organization. The current year and out-year requests for Program Administration are included in the Executive Director's Office Long Bill group.

Medicaid Anti-Psychotic Pharmaceuticals

Prior to FY 2008-09, as part of the Long Bill, estimated expenditures for anti-psychotic pharmaceuticals were appropriated to this Long Bill group as Cash Funds Exempt. This was an informational-only line item; the costs for these drugs were and are paid in the

Department's Medical Services Premiums Long Bill group, and no actual transfer took place. Because there was no corresponding decrease to the Medical Services Premiums Long Bill group, this double counted the funding for these drugs.

In its November 1, 2007 Budget Request, the Department officially requested the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item and subsequently received approval. The Department continues to report expenditure for anti-psychotics in its Budget Request (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan).

MENTAL HEALTH CAPITATION PAYMENTS AND MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS

The Mental Health Capitation Payments line item reflects the appropriation that funds Medicaid mental health services throughout Colorado through managed care providers contracted by the Department. As a result of competitive procurement, five behavioral health organizations were awarded contracts with updated capitation rates and services effective January 1, 2005. Payments for Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program were separate payments prior to FY 2005-06 and incorporated into the Mental Health Capitation Payments line item in FY 2005-06. Effective July 1, 2009, the five behavioral health organizations were reprocured through a competitive bid process. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged.

The behavioral health organizations are responsible for providing or arranging all medically necessary mental health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category. Amounts are prorated for partial months of service and retroactive eligibility is covered. Payments vary across behavioral health organizations, as well as eligibility categories.

The Medicaid populations that are eligible for mental health services covered by capitation rates are combined into seven categories, as indicated below. Partial dual-eligible clients and non-citizens are ineligible for Medicaid mental health services.

The eligible Medicaid mental health populations are:

- Adults 65 and Older (OAP-A)
- Disabled Individuals Through 64 (AND/AB, OAP-B)
- Low Income Adults

- Adults without Dependent Children
- Eligible Children (AFDC-C/BC)
- Foster Care
- Breast and Cervical Cancer Prevention and Treatment Program

Analysis of Historical Expenditure Allocations across Eligibility Categories

At the beginning of a contract cycle, behavioral health organization capitation rates were entered in the Medicaid Management Information System (MMIS). Monthly payments were paid based on eligibility categories. The MMIS provided detailed expenditures by behavioral health organization and eligibility category but did not include offline transactions and accounting adjustments. The only source that included all actual expenditure activity is the Colorado Financial Reporting System (COFRS). The drawback was the COFRS provided total expenditures, but not by eligibility category. The exception was the Breast and Cervical Cancer Treatment Program eligibility category, which was reported separately in the COFRS. Since an allocation had to be calculated to determine the amount of actual expenditures across the other eligibility categories, a ratio was calculated for each eligibility category by dividing the MMIS eligibility category expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) by the total MMIS expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category). The ratio for each category was multiplied by the total expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) from the COFRS. This calculation estimated actual COFRS expenditures across each eligibility category. Variance between the two systems was less than 0.67%

Description of Transition to New Methodology

Member month methodology was used prior to 2005 when the administration of Medicaid Mental Health Community Programs was transferred from the Department of Human Services to the Department. Historical expenditures were divided by the capitation rates for the region served by each mental health assessment and service agency (now known as behavioral health organizations) to estimate the number of member months for which capitation payments were made. Mental health caseload growth rates were applied to these member months to calculate projected member months. Member months were multiplied by the capitation rates for the upcoming year to determine the projected capitation base payments. The problem with this system was that member months, which reflected the impact of retroactive payments, were not equivalent to the Medicaid caseloads used in Medical Services Premiums, which did not include retroactivity. This methodology was used until February 15, 2005.

From February 2005 until the present Request, the Department had been transitioning towards a per-capita methodology. Previous year actual amounts were trended forward by eligibility category, generating an estimated per capita. Prior to this Request, the Joint

Budget Committee had asked the Department to explore the possibility of projecting budgets by behavioral health organization as well as by eligibility category. The Department has determined that such a projection is not yet possible due to the following: a) the recent (FY 2005-06) consolidation of eight mental health assessment and service agencies into five behavioral health organizations, b) the disproportionate impact of Goebel driven expenditures into one behavioral health organization's capitation rate, and c) the volatile nature of specific capitation rates as compared to the overall trend of capitation rate increases within respective eligibility categories. However, the Department will continue to explore this methodology as new data becomes available.

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per-capita rates, the Department moved to a capitation trend forecast model for the FY 2008-09 Estimate and FY 2009-10 Request. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends directly, rather than through a per-capita methodology, future expenditures are forecasted directly through the primary cost drivers: the actuarially agreed-upon capitation rate and caseload. By tying forecasts directly to capitation rates, the methodology may provide more accurate estimates of expenditures by eligibility category, rather than simply in aggregate, as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to behavioral health organizations.

Additionally, the Department has incorporated an incurred but not reported methodology similar to other portions of this Request submitted by the Department (e.g., Nursing Facilities; see Section E, Exhibit H). The Department is adjusting its request to capture the reality that some mental health claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

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

EXHIBIT AA - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

Effective with the November 2, 2009 Budget Request, in this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from Exhibit BB. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

Exhibit AA now presents a concise summary of spending authority affecting the Medicaid Mental Health Programs. In previous budget requests, the Department presented historical expenditure and caseload figures in graphical form. This information can be found in table form in Exhibit DD (see below).

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

EXHIBIT BB - CALCULATION OF FUND SPLITS

Exhibit BB details fund splits for all Mental Health Community Programs budget lines for the current fiscal year Supplemental and the out-year Budget Request. For all of the capitation payments except the Breast and Cervical Cancer Program, the funding is 50% State funds and 50% federal funds. Payments for clients in the Breast and Cervical Cancer Program receive a 65% federal match rate and are described separately below. Capitation expenditures are split between traditional clients and expansion clients funded from Hospital Provider Fee funds. Finally, the recoupments from prior years for mental health capitation overpayments, retractions for capitations paid for clients later determined to be deceased, and estimated reconciliations for the adults without dependent children population are also presented (see Exhibit II for recoupment calculations).

In the capitation base for both years, most clients are paid for with 50% General Fund and 50% federal funds. Expansion clients funded through HB 09-1293 receive State share funding from the Hospital Provider Fee Cash Fund. These clients also receive a 50% federal match.

Medicaid Mental Health Fee-for-Service Payments also receive 50% General Fund and 50% federal funds. The sum of the capitations and the fee-for-service payments comprise the Department's request.

Mental Health Services for Breast and Cervical Cancer Program Adults

SB 01S2-012 created the Breast and Cervical Cancer Prevention and Treatment Program. SB 05-209 and HB 08-1373 incorporated funding for the Breast and Cervical Cancer patients into the appropriation for Medicaid Mental Health Community Programs Capitation Payments, effective with the FY 2005-06 budget. Mental health care for clients in the Breast and Cervical Cancer Program is managed through the capitation contracts with the behavioral health organizations. Therefore, the budget is based on the mental health caseload that includes the Breast and Cervical Cancer Program eligibility category. For this reason, they are shown as a separate eligibility category where appropriate.

Annual designations of General Fund contributions to program costs are specified in sections 25.5-5-308(8), (9), and (10) C.R.S. (2012). Exhibit BB details funds splits for the Mental Health Community Programs Capitations line. The funding for the clients already enrolled in the program, called "traditional clients," is 17.5% General Fund, 17.5% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund, and 65% federal funds in FY 2012-13 and FY 2013-14. In FY 2014-15, the funding for traditional clients is 35% General Fund and 65% federal funds. In addition, the Department received funding from the Tobacco Tax Bill (HB 05-1262) to enroll more clients in the Breast and Cervical Cancer Program. These clients, called the "expansion clients," are funded by the Prevention, Early Detection, and Treatment Fund administered by the Department of Public Health and Environment and the Tobacco Tax Bill (see the explanation below and Exhibit JJ, which shows all Tobacco Tax impacts, for a full explanation). The funding for the expansion clients was 35% reappropriated funds and 65% federal funds.

The Department is requesting a change to the allocation of traditional and expansion clients in FY 2012-13 in order to avoid overspending the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program is $1,215,340. The Department is requesting $1,215,340 in reappropriated funds for Breast and Cervical Cancer Program expansion clients in request S-1, "Request for Medical Services Premiums." As this is the total balance of available reappropriated funds, the Department is requesting to fund all Breast and Cervical Cancer Program clients in the Medicaid Mental Health Community Programs Long Bill group with the Breast and Cervical Cancer Prevention and Treatment Fund and General Fund.

Mental Health Services for Hospital Provider Fee Expansion Clients

HB 09-1293 established a funding mechanism for a series of expansion clients. The first set of expansion clients that are funded through the bill was parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these clients are funded through the Hospital Provider Fee Cash Fund. These clients are assumed to be similar to other adult clients, and expenditure for these clients are therefore calculated using the same per capita rate as other adult clients (see exhibit JJ). Starting in FY 2011-12, additional expansion populations will also receive funding through the Hospital Provider Fee Cash Fund. These include disabled individuals with income limits up to 450% of the federal poverty level and adults without dependent children, both of which will receive services through the BHOs as part of their benefit package. The disabled individuals with income limits up to 450% are assumed to be similar to other disabled clients, and expenditure for these clients are therefore calculated using the same per-capita rate as other disabled clients (see exhibit JJ). For the adults without dependent children, the BHOs will be reimbursed at a separate capitation rate than other eligibility categories. The Department estimated expenditure for this population using preliminary assumptions about the rate that will be set for adults without dependent children and the reconciliation method that will be used to ensure that the Department adequately pays the BHOs to serve this new population. See exhibits EE, GG, II, and JJ for more detailed explanations of these assumptions.

Mental Health Services for Expansion Populations in SB 11-008 and SB 11-250

SB 11-008, "Aligning Medicaid Eligibility for Children," extends Medicaid eligibility to up to 133% of the federal poverty level (FPL) for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifts impacted children from the CHP+ to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for CHP+.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extends Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifts impacted women from CHP+ to Medicaid on January 1, 2013. The Department assumes that the expenditure for these women will continue to receive a 65% federal match rate.

EXHIBIT CC - MEDICAID MENTAL HEALTH COMMUNITY PROGRAMS SUMMARY

Exhibit CC presents a summary of mental health caseload and capitation expenditures itemized by eligibility category as well as a summary of the rest of the Mental Health Community Programs. The net capitation payments include the impacts of actions with perpetual effect, such as the decrease in payment rates by 1.7%, as well as caseload driven impacts such as the various recoupments and retractions for clients determined to be ineligible. Exhibit EE illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT DD - MENTAL HEALTH CASELOAD, PER CAPITA, AND EXPENDITURE HISTORY

Exhibit DD contains the caseload, per-capita, and expenditure history for each of the 11 eligibility categories. Each of the tables that comprise Exhibit DD is described below.

Medicaid Mental Health Community Programs Caseload

Medicaid Mental Health Community Programs caseload is displayed in two tables. The first table shows total caseload for the combined disabled categories as well as the combined adult categories. The second table displays caseload by all mental health eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The mental health caseload excludes the caseload for partial dual eligible clients and non-citizens and ties to the caseload presented in the Request for Medical Services Premiums, Section E, exhibit B. Please see the Medicaid Caseload section of the Medical Services Premiums narrative for further discussion of Medicaid caseload projections. The caseload numbers are used in numerous exhibits throughout the Medicaid Mental Health Community Programs Exhibits and narrative.

Medicaid Mental Health Community Programs Per Capita Historical Summary

As with caseload, Medicaid Mental Health Community Programs per capita is displayed in two tables. The first table sets forth total per capita for the combined disabled categories as well as the combined adult categories. The second table displays per capita by all mental health eligibility categories. However, since the actual per capita from the first table is the same for both disabled categories, and the four adult categories have a single per capita, the true per capita is shown in those categories and will not mathematically be the same as dividing each individual category expenditure by the caseload. Figures for fiscal years up to the present fiscal year are actual per capitas, while the current fiscal year and the request year per capitas are estimates.

Medicaid Mental Health Community Programs Expenditures Historical Summary

The history of expenditures includes combined category and expanded category tables as well as total expenditures for both capitation and fee-for-service expenditures. For fee-for-service expenditure, service categories are listed separately.

Actual expenditures are only available from the Colorado Financial Reporting System (COFRS). Expenditures by eligibility category, other than the Breast and Cervical Cancer Treatment Program, are not available from COFRS. The Medicaid Management Information System (MMIS) does provide expenditures by eligibility category but does not include offline transactions and accounting adjustments. The two systems typically have minor discrepancies in reported expenditure, often due to accounting adjustments made to COFRS as fiscal periods close. Because the variance is minor, data from the MMIS can be used to distribute total expenditures from the COFRS across eligibility categories.

A ratio is calculated for each eligibility category by dividing the MMIS eligibility category expenditures by the total MMIS expenditures. The ratio is multiplied by the total expenditures from the COFRS. This calculation estimates actual COFRS expenditures across each eligibility category. The Breast and Cervical Cancer Treatment Program expenditures are carved out of both totals before the calculations are done, since this is the only category that does not need to be estimated. Once the overall expenditures by eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category.

EXHIBIT EE - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

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

The Department has adopted a methodology based on forecasting a capitation rate, multiplying that rate by monthly caseload, multiplying again by the number of months that the forecasted rate will be in effect, and then adjusting for incurred claims that will be

paid in subsequent years as well as for claims from former years that will be paid in the year of the request. The methodology is a zero-based budget tool that allows the Department to examine projected expenditures each year without building in inappropriate assumptions, estimates, or calculations from preceding years.

The forecasted capitation rate is derived from exhibits FF through HH and will be presented in more detail below. The caseload is the same as presented in Medicaid Medical Services Premiums, Section E, Exhibit B (excepting partial dual eligible clients and non-citizens, as discussed above).

The Department has broken down the current fiscal year and the request year into two components: a first and second quarter estimate (Q1 and Q2) and a third and fourth quarter estimate (Q3 and Q4). This accounts for the fact that the Department makes rate adjustments on a calendar year basis. As such, the Q1 and Q2 capitation rate is known and is the point estimate rate from the previous two quarters (the first two quarters of the calendar year). For the Department's November requests, the current year's Q1 and Q2 rates are known and the remaining rates are estimated. In the February supplemental, the rates for the current year and the first half of the request year are known and only the final two quarters of the request year are estimated. By the time February numbers are presented, the Department has completed its most recent rate setting process, adding to the known set of data. As presented in Exhibit EE, the estimated capitation rate is multiplied by the monthly caseload and then multiplied by the number of months the rate will be in effect.

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown starting on page EE-3.

After calculating total expenditure, the anticipated date-of-death retractions for each fiscal year are estimated and added to total expenditure. The Department began an aggressive retraction of payments for deceased clients in FY 2009-10; this activity resulted in retraction of payments originally made between FY 2004-05 and FY 2008-09 and reduced prior period dates of service expenditure. The Department is continuing to identify these claims and retracts payments twice a year. For the current year, the retractions are estimated as a 10% reduction in the total amount retracted in the previous year. For the request year, the retractions are estimated as a 10% reduction in the estimated amount that will be retracted in the current year. The retractions are expected to decline, as there is a smaller pool of historical clients from which to retract and current processes of identification become more effective.

Incurred-but-not-Reported Estimates

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred-but-not-reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims

incurred in July of the current fiscal year have 11 more months of the fiscal year in which the claims can be paid; however, claims incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years and determined the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Pages F.EE-4 through F.EE-5 presents the percentage of claims paid in a six-month period that come from that same period and those which come from previous periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

Historically, for each eligibility category except disabled individuals through 64, over 99% of incurred claims are paid by the end of the fiscal year in which the claims were incurred. For the disabled individuals, it takes a full 18 months for 99% of claims to be paid. This is likely due to the relative difficulty in determining and documenting disability as opposed to criteria such as age or income. Hence, a larger percentage of claims from previous periods exist for this category of clients.

It is of note that beginning November 1, 2009, the Department instituted a policy of denying retroactive capitation claims that are from a period beyond 18 months prior to the payment month. For those clients with retroactive claims beyond 18 months who are found to have received services, the Department will reimburse the BHOs through a fee-for-service payment. Since capitations are calculated to pay for actual services delivered by spreading that cost to caseload regardless of whether services are received, the net effect of eliminating cap payments and reimbursing for services may be cost neutral. The Department will monitor this policy change, and, should there be any expenditure fluctuations, the Department will seek to adjust through future budget requests.

The IBNR factor for the Adults without Dependent Children eligibility category cannot be calculated with the methodology which is used in all other eligibility categories because of insufficient periods of observation. Instead the Department chooses 98% for FY 2012-13 Q1 and Q2 and onward because the population is capped below its natural level due to financial constraints, and the turnaround between disenrollment and enrollment is rapid, which suggests the IBNR factor should be high. In future requests, the Department will use actual cost data available for this new population to determine the true, population-specific IBNR factor and rate adjustments that should be applied.
On pages F.EE-6 through F.EE-8, the Department calculates the estimated outstanding expenditure from claims remaining from previous period by aid category. The sums are then carried forward to the calculations on pages F.EE-1, F.EE-2, and F.EE-3.

Actuarially Certified Capitation Rates

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

historically certified capitation rates to derive the capitation rate presented in Exhibit EE. The methodology for determining the forecasted capitation rate is the subject of Exhibits FF through HH.

EXHIBIT FF - MEDICAID MENTAL HEALTH RETROACTIVITY ADJUSTMENT AND PARTIAL MONTH ADJUSTMENT MULTIPLIER

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

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the behavioral health organizations to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can (and indeed do) trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the Mental Health Capitation program. This difference is captured through a partial-month adjustment multiplier.

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last five years of claims and caseload data. Page F.FF-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The relatively steady percentage values across each respective eligibility category suggest the ratio is indeed systemic (as created by retroactivity) rather than a unique circumstance. The Department analyzed the data, however, and determined the amount of retroactivity in the claims incurred each period is steadily changing over time and has trended downward for all eligibility categories except for disabled individuals. For this reason, the Department assumes the most recent period with adequate time for run-out of claims is the best representation of how much retroactivity will affect the claims-to-caseload ratio in the current and request years.

Partial Month Adjustment Multiplier

To derive the partial month adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last five years of data were examined. Prior to FY 2006-07, capitation rates were radically adjusted to capture systemic changes including, but not limited to, shifting to the Department the bulk of Medicaid program responsibility from the Department of Human Services, the consolidation to five behavioral health organizations from eight, and program and financing adjustments resulting from the Goebel lawsuit. Due to these adjustments, the volatility of capitation rates prior to FY 2006-07 would not be a quality indicator of any future comparisons to claims paid.

As presented on page F.FF-2, for each eligibility category, the weighted average claims-based rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was compared to the weighted capitation rate (similarly weighted). Then, the claims-based rate as a percentage of the capitation rate was calculated, providing a simple comparison of any trend in claims-based rates as compared to capitation rates. The percentages are similar across years, indicating claims-based trends are matching capitation trends. The Department analyzed the data, however, and determined the amount of partial months paid each period is steadily changing over time within each eligibility category. For this reason, the Department assumes the most recent period with adequate time for runout of claims is the best representation of how much partial-month payments will affect the claims-based rate in the current and request years.

EXHIBIT GG - MEDICAID MENTAL HEALTH CAPITATION RATE TRENDS AND FORECASTS

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e., the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was examined. Exhibit GG presents historical data as well as the forecasted weighted rates.

Beginning in January of 2009, the Department switched its rate-setting cycle from a state fiscal-year cycle to a calendar-year cycle. Capitation rates are now effective from January 1 through December 31. Therefore, the Department now presents its forecasted rates in six-month blocks to account for the rate change occurring in the middle of a state fiscal year.

The weighted rate is presented along with the percentage change from the previous six months as well as from the average rate of the entire previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit HH.

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

It is important to note the overall weighted point estimate presented in the exhibit is weighted across two factors. First, the rate is weighted within an eligibility category (that is, weighted by the behavioral health organizations' proportion of claims processed within that eligibility category). Second, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the Weighted Mental Health Total rate may not be a clear indicator of the rate trends across all eligibility categories.

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

From January 1, 2009, to June 30, 2009, the Department paid rates 3% above the actuarial midpoint due to a new rate-setting methodology. Beginning September 1, 2009, in accordance with FY 2010-11 ES-2, the Department paid rates that were 2.5% below the actuarial midpoint. New rates were established for the 2010 calendar year and set 2.5% below their certified midpoint rates. However, the Department's rate-setting process and federal regulation require that both the Department and the BHOs actuarially certify they will be able to operate at the proposed paid rates. With the January 1, 2010 rates, two BHOs were unable to certify. The Joint Budget Committee voted to appropriate funding to continue those two BHOs at a continuation of their most recent previously certified rates, the September 1, 2009 rates. These two BHOs continued to be paid their September 1, 2009 rates through CY 2010. The 2.5% reductions to the BHOs' rates will continue to be in effect through future fiscal years, as they are now part of the encounter and historical data used in the rate-setting process. In addition, the rates were reduced by 1.71% in CY 2011. This was originally requested in FY 2010-11 BRI-6 as a 2.0% cut to be effective July 2010. The Joint Budget Committee decided to delay this cut until January 2011 and appropriated it as a savings of $2,170,355 to be achieved in FY 2010-11. The Department determined it would be able to realize savings in FY 2010-11 in this amount by cutting the CY 2011 rates by 1.71%. This rate reduction will continue to be built into the rates in the current and request years, as requested in FY 2011-12 BRI-5.

The Department added a new rate cell in FY 2011-12 for the adults without dependent children expansion population, which will be funded through the Hospital Provider Fee Cash Fund. The rate for CY 2012 for the adults without dependent children is actuarially

certified at $100.81. The rate is based on data from Disabled Adults and Low-Income Adults rates. In prior budget requests, the Department assumes a large reconciliation component to be paid retroactively; this was, in part, due to the fact there were a great number of unknowns related to the rate setting process. Based on the current expenditure projections, however, the Department has removed the reconciliation component from its expenditure calculations.

EXHIBIT HH - FORECAST MODEL COMPARISONS

Exhibit HH produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in Exhibit EE. Pages F.HH-1 and F.HH-2 present the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in Exhibit FF.

On page F.HH-3, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into pages F.HH-1 and F.HH-2. Based on the point estimates, the adjustments presented in Exhibit FF are then applied and the final, adjusted point estimate is then used in the expenditure calculations of Exhibit EE.

Final Forecasts

Page F.HH-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page F.HH-3 (see below). For Funding Requests, the rate applied to the first six months of the current year is known due to the calendar year rate setting cycle (see the description of Exhibit GG, above). The rate applied to the next six months of the current year is then estimated from a series of trend models and historical changes (see below). That same rate is then carried forward into the first six months of the request year due to the calendar year rate setting cycle. The rate for the last six months of the request year is estimated by taking the percent change in rates from the last known rate to the first forecasted rate and carrying that percentage change forward.

For Supplemental Requests, the rate for the entirety of the current year and the first six months of the request year are known due to the calendar year rate setting cycle. The rate for the final six months of the request year is estimated using the various trend models and historical information described below.

The projected rate is then adjusted by any policy impacts. In accordance with the FY 2010-11 ES-2 budget action, beginning September 1, 2009, the Department has paid rates that are 2.5% below the actuarial midpoint. This rate cut is now incorporated in the data used during the rate-setting process and is no longer included as an adjustment factor in exhibit HH. For Q3 and Q4 of FY 2010-11, the Department reduced rates by an additional 1.71%. The Department requested this reduction in FY 2010-11 BRI-6, "Medicaid

Reductions," for the full year but will be implemented for only two quarters of FY 2010-11, per instructions from the Office of State Planning and Budgeting. The 1.71% reduction will continue to be in effect in the current and request years.

The forecasted rate is also adjusted by the partial month adjustment multiplier, calculated on page F.FF-2. The multiplier is applied to adjust for the fact that the full capitation rate is not paid for every member month. The rate for paid claims is impacted by payments made for partial months of eligibility; this type of payment will not be for a "whole" capitation payment at the current fiscal period's capitation rate. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Finally the claims-based rate is adjusted a third time, this time by the retroactivity adjustment. From Exhibit FF, page F.FF-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit FF, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep mental health caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to drive the expenditure calculation presented in Exhibit EE. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page F.HH-3 and historical midpoint rates are presented in Exhibit GG.

For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

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

Capitation rates are required to be actuarially sound and are built from a blend of historical rates and recent year encounter data (provider expenditure on services). The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. Beginning with FY 2008-09 the Department has experienced unusual trends for the mental health capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models' reliance on historical performance for predicting future performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. As such, the Department believes the most recent years' experience is the most predictive of the likely current year and future year experiences. The following table shows the trends selected for the current and request years by eligibility category.

Aid Category	CY 2013 Trend Selection	CY 2014 Trend Selection	CY 2015 Trend Selection	Justification
Adults 65 and Older (OAP-A)	2.99% Rate change from FY 2009-10 to FY 2010-11	2.99% Rate change from FY 2009-10 to FY 2010-11	2.99% Rate change from FY 2009-10 to FY 2010-11	Historical capitation rates for adults 65 and older have increased slowly over time. The percentage change for the most recent calendar year was negative. The Department anticipates the rate will not continue to decline in future years, but grow at a moderate rate. The Department chose the percentage change in weighted fiscal year rates from FY 2009-10 to FY 2010-11 to trend the rates forward.
Disabled Individuals Through 64 (AND/AB, OAP-B)	5.68% Rate change from FY 2009-10 to FY 2010-11	5.68% Rate change from FY 2009-10 to FY 2010-11	5.68% Rate change from FY 2009-10 to FY 2010-11	The rate for the disabled populations has increased along a linear trend since the incorporation of the Goebel settlement into the rate methodology, except for the last calendar year -- the percentage change was negative. The Department expects the rate will not continue to decline but will grow slowly in future years due to rate reform initiatives that reward BHOs for cost-savings efforts. Therefore, the percentage change in weighted fiscal year rates from FY 2009-10 to FY 2010-11 was selected to trend the rates forward.

Aid Category	CY 2013 Trend Selection	CY 2014 Trend Selection	CY 2015 Trend Selection	Justification
Low-Income Adults	3.58% Rate change from FY 2010-11 to FY 2011-12	3.58% Rate change from FY 2010-11 to FY 2011-12	3.58% Rate change from FY 2010-11 to FY 2011-12	The low-income adults category has also seen steady increases in its rate, and that growth has followed closely to a linear trend since FY 2002-03. The percentage change for the most recent calendar year was negative. As with the Adults 65 and Older and Disabled Individuals Through 64 rates, the Department anticipates the rate for this category will increase rather than decrease but at a moderate rate. The most recent percentage change in weighted fiscal year rates was selected to trend the rates forward.
Adults without Dependent Children	4.63% Average of trends selected for Disabled Individuals Through 64 and Low Income Adults	4.63% Average of trends selected for Disabled Individuals Through 64 and Low Income Adults	4.63% Average of trends selected for Disabled Individuals Through 64 and Low Income Adults	The adults without dependent children rate was set assuming expenditure would reflect the disabled individuals through 64 and low-income adults mental health expenditure. Therefore, the Department assumes the trend for this rate will be an average of the trends of the two categories.
Eligible Children (AFDC-C/BC)	5.14% Average growth model	5.14% Average growth model	5.14% Average growth model	The rate for the children category has been steadily increasing over recent years. The Department expects it to increase again to a similar degree in CY 2013, CY 2014, and CY 2015. The Department chose the average growth over the last six periods to trend the CY 2012 rate forward.

Aid Category	CY 2013 Trend Selection	CY 2014 Trend Selection	CY 2015 Trend Selection	Justification
Foster Care	-2.02% One-fourth change from CY 2011 to CY 2012	-1.01% One-eighth of rate change from CY 2011 to CY 2012	-.051% One-sixteenth of the rate change from CY 2011 to CY 2012	The rate for this eligibility category has decreased over the last several years but has begun to level off; the Department expects this will continue. The Department selected one-fourth of the CY 2012 percentage growth to trend the CY 2013 rate and one-eighth of the CY 2012 percentage growth to trend the CY 2014 rate.

The selected point estimates of the capitation rates are adjusted on pages F.HH-1 and F.HH-2, as described above, for use in the expenditure calculations presented in Exhibit EE.

EXHIBIT II - RECOUPMENTS AND RECONCILIATIONS

Recoupments

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System (MMIS). When clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the MMIS. When clients are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is completed separately. Exhibit II summarizes the expected fiscal impacts.

The Department has worked to reduce the payments to the behavioral health organizations for clients later deemed ineligible for Medicaid. Historically, monthly capitation payments were made on a prospective basis. In February 2004, the Department converted to concurrent capitation payments. FY 2004-05 was the first full year for monthly capitation payments on a concurrent basis.

No recoupments were made during FY 2005-06 due to a computer programming change, and this has delayed the recoupment process. In FY 2006-07, recoupments from FY 2003-04 were processed. In FY 2007-08, no recoupments were processed as the Department sought to verify eligibility information provided by the behavioral health organizations. This process has proven to be complicated by the various reporting practices of the community mental health centers that provide services to clients. The Department collaborated with the Centers for Medicare and Medicaid Services (CMS) to develop a retrospective eligibility validation process which the Department implemented in FY 2009-10. Recoupments from FY 2005-06 through FY 2007-08 were processed in the latter half of FY 2009-10. In FY 2010-11, recoupments were collected for FY 2004-05. The Department recouped expenditure for FY 2008-09 ineligibles at the beginning of FY 2011-12. The recoupments from incurred expenses in FY 2008-09 were altered in their federal fund

split due to the impact of the American Recovery and Reinvestment Act. Since those expenditures were made with enhanced federal funds, any recoupments will also see a disproportionate share of federal funds retrieved. Recoupments from FY 2009-10 were set for collection in FY 2012-13, but due to timely filling, requirements from CMS were collected in FY 2011-12. Recoupments for FY 2009-10 are altered by the enhanced federal match from the year the claims were processed. Recoupments from FY 2010-11 will be collected in FY 2012-13, and those from FY 2011-12 will be collected in FY 2013-14.

The most recent recoupment made by the Department was for FY 2009-10 ineligibles. The methodology used to calculate the recoupment for that year differs slightly from previous years. The data for that fiscal year is also more reliable than past fiscal years due to data standardization and verification efforts undertaken by the BHOs and the Department. For those reasons, the Department estimated future recoupments using the FY 2009-10 actual amount as a base and inflating it by the growth rate in caseload for that fiscal year.

EXHIBIT JJ - EXPANSION POPULATIONS

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Colorado Health Care Affordability Act (HB 09-1293) and other bills to the Medicaid Mental Health Community Programs. This exhibit presents projected caseload and costs itemized by eligibility category for the current year and the request year. Note the caseloads shown are the average monthly number over each year and will fluctuate throughout the year.

Tobacco Tax Bill:

HB 05-1262 established a number of funds, two of which provide funding to the Medicaid Mental Health Community Programs line: the Health Care Expansion Fund administered by the Department; and the Prevention, Early Detection, and Treatment Fund administered by the Department of Public Health and Environment. The Health Care Expansion Fund provided capitated mental health funding for expansion adults, individuals eligible as a result of the removal of the Medicaid asset test, the expansions of the Children's Extensive Support and Children's Home and Community Based Services waiver programs, optional legal immigrants eligible for services as a result of HB 05-1086, and foster care clients eligible for services up to the age of 21 as a result of beginning SB 07-002. The Health Care Expansion Fund became insolvent in FY 2010-11. Any additional revenue that comes into the fund will be used to offset General Fund expenditure in Medical Services Premiums; effective in FY 2011-12, there are no longer any mental health services funded by the Health Care Expansion Fund.

The Prevention, Early Detection, and Treatment Fund provides funding for cancer treatment through its Breast and Cervical Cancer Treatment program, and historically 30% of the Breast and Cervical Cancer Program caseload is paid for out of this fund. The Department is requesting a change to the allocation of traditional and expansion clients in FY 2012-13 in order to avoid overspending

the amount appropriated to the Department of Public Health and Environment for transfer to the Department for Breast and Cervical Cancer Treatment. The Department of Public Health and Environment's appropriation for the Breast and Cervical Cancer Treatment program is $1,215,340. The Department requested $1,215,340 in reappropriated funds for Breast and Cervical Cancer Program expansion clients in request S-1, "Request for Medical Services Premiums." As this is the total balance of available reappropriated funds, the Department is requesting to fund all Breast and Cervical Cancer Program clients in the Medicaid Mental Health Community Programs Long Bill Group from the Breast and Cervical Cancer Prevention and Treatment Fund and General Fund.

Colorado Health Care Affordability Act

HB 09-1293, the "Colorado Health Care Affordability Act" provided funding to provide health care coverage for uninsured Coloradans in FY 2009-10 and beyond. The Department began collecting fees from hospitals in April 2010 for the Hospital Provider Fee cash fund and started extending benefits to expansion clients in May 2010.

The first expansion population to be affected by HB 09-1293 is the expansion adult population with income limits up to 100% of the federal poverty level (FPL). The Department assumes that the costs for this population will be the same as for the traditional population, as the vast majority of mental health services payments are made via capitation and do not change based on client utilization. An additional population has been added in FY 2011-12 consisting of working disabled adults with income up to 450% of the federal poverty level and disabled children with income up to 300% of the federal poverty level. As with adults, the Department assumes that the costs for this population will be the same as for the traditional population.

The Department is also expanding eligibility to cover adults without dependent children in FY 2011-12. The program is initially limited to 10,000 clients. This population receives the full range of mental health services provided by the BHOs, and the BHOs are paid at a different capitation rate for these members than any of its other eligibility categories. The Department's caseload projections for all HB 09-1293 expansion populations are provided in this Budget Request (see exhibit B in Medical Services Premiums).

Aligning Medicaid Eligibility for Children and Eligibility for Pregnant Women in Medicaid

SB 11-008, "Aligning Medicaid Eligibility for Children," extends Medicaid eligibility to up to 133% of the FPL for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifts impacted children from the CHP+ to Medicaid beginning January 1, 2013. The Department assumes the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for CHP+. As with most of the Hospital Provider Fee populations, the Department assumes the per-capita costs for this expansion population will be the same as for the traditional population since the majority of mental health expenditure is paid through the capitation program.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extends Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifts impacted women from CHP+ Medicaid on January 1, 2013. The Department assumes the expenditure for these women will continue to receive a 65% federal match rate and that the per-capita costs will be the same as for the traditional population.

EXHIBIT KK - MEDICAID MENTAL HEALTH FEE-FOR-SERVICE PAYMENTS

Medicaid Mental Health Fee-for-Service Payments is a separate budget line item in Medicaid Mental Health Community Programs. Expenditures for this line are shown in Exhibit KK. The data from Exhibit KK also appears in Exhibits AA, BB, and CC as well as the Schedule 13.

The Medicaid Mental Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a behavioral health organization to receive mental health services or enrolled Medicaid clients to receive mental health services not covered by the behavioral health organizations. The services are not covered either because the client is not enrolled in a behavioral health organization or the services are outside the scope of the behavioral health organization contract. Medicare crossover claims are included in the fee-for-service category; these are behavioral health organization covered services for clients enrolled in a behavioral health organization who are eligible for both Medicare and Medicaid.

Fee-for-service providers include, but are not limited to hospitals, psychiatrists, psychologists, primary care physicians, and mental health centers. The State also reimburses providers through fee-for-service if either the diagnosis or the procedure is not included in the behavioral health organization contract or the patient is not enrolled in a behavioral health organization.

History and Background Information

The nature of Medicaid Mental Health Fee-for-Service Payments has changed in recent years. Prior to FY 2002-03, Fee-for-Service Payments were included in the Medicaid Mental Health Capitation base appropriation. During FY 2002-03, case management services provided by community mental health centers were included in the Mental Health Fee-for-Service Payments appropriation. During FY 2003-04, case management services were provided by Single Entry Point agencies and were still part of the Mental Health Fee-for-Service Payments appropriation, but they were moved to the Medical Services Premiums appropriation in FY 2004-05. Also during FY 2004-05, fee-for-service mental health care for developmentally disabled clients living in Regional Centers was transferred from the Department of Human Services to the Department's Mental Health Fee-for-Service Payments appropriation. The changes to case management services and mental health care for developmentally disabled clients are discussed below.

Historically, community mental health centers provided case management services to the Children's Home- and Community-Based Services for the Mentally Ill waiver clients on a fee-for-service basis. Effective July 1, 2003, the Department began utilizing contracted Single Entry Point agencies for these services instead of the community mental health centers. Funding for these case management services remained in the fee-for-service payments appropriation for FY 2003-04. However, since Single Entry Point contracts are customarily paid from the Medical Services Premiums, the Department requested these services be transferred to the Medical Services Premiums Long Bill group. The supplemental appropriation to the Department (SB 05-112) moved Single Entry Point case management from the Mental Health Fee-for-Service Payments line item to the Medical Services Premiums line item in FY 2004-05 and was effective July 1, 2004.

The supplemental appropriation to the Department (SB 05-112) also authorized the transfer of the fee-for-service mental health care for developmentally disabled clients living in Regional Centers from the Department of Human Services to the Department. This followed a September 3, 2004 1331 Supplemental which was approved by the Joint Budget Committee on September 21, 2004, for the transfer of funds from the Department of Human Services for Developmental Disability State Plan services. This action funded State Plan services provided to clients in the Developmentally Disabled waiver for Children's Home and Community Based Services as required by the Centers for Medicare and Medicaid Services, effective October 1, 2004.

The expenditures in Exhibit KK are broken out into the three major categories which make up Medicaid Mental Health Fee-for-Service: inpatient services, outpatient services, and physician services.

Current Calculations

The current fiscal year's total estimated expenditure is based on the actual expenditures made year to date, trended forward based upon the expected change in caseload from the first half of the year to the second half of the year. The request year estimate is the result of a forward trend of the current-year estimate by the factor of the anticipated change in caseload, and this is then trended forward by the anticipated change in caseload for the out-year estimate.

No rate or utilization increases are forecasted, although the Department is currently investigating the feasibility and necessity of incorporating such adjustments. Mental health fee-for-service expenditure has increased drastically over previous years. The Department has been performing data analysis using fee-for-service claims in an attempt to determine what caused the increase and whether or not it will continue to grow in the future. In the process, the Department discovered there was an error in the MMIS in which certain services billed as fee-for-service claims for BHO-enrolled clients are paying when they should be denied by the MMIS and billed to the appropriate BHO. This error was corrected through a system change effective November 2011. Initial data analysis since November shows there was a decline in the expenditure paid as mental health fee-for-service due to the system change. The

Department will continue to monitor its impact as more data becomes available over time and may request for a decrease in its appropriation if the expenditure decreases as expected through the standard budget process.

EXHIBIT LL - GLOBAL REASONABLENESS TEST FOR MENTAL HEALTH CAPITATION PAYMENTS

The Global Reasonableness Test presented in Exhibit LL compares the percent change between mental health capitation expenditures as reported in Exhibit DD and forecasted in Exhibit EE. The FY 2012-13 appropriation is 14.92% higher than FY 2011-12 actual expenditures, primarily due to caseload growth. The FY 2012-13 estimate incorporates increased caseload projections along with various rate adjustments for budget cutting initiatives and results in a 14.76% increase from FY 2011-12 actual expenditures and a -014% decrease from the current appropriation. The FY 2013-14 estimate is built on the FY 2012-13 estimate and presents a 11.65% expenditure increase. This increase is primarily due to: 1) increased caseload projections for traditional clients; 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations; and 3) adding adults without dependent children mental health expenditure to the Mental Health Community Programs request. The FY 2013-14 request represents a 11.49% increase over the current FY 2012-13 appropriation. The FY 2014-15 Budget Request is built on the FY 2013-14 estimate and represents a 9.61% expenditure increase over the FY 2013-14 request and a 22.20% increase over the FY 2012-13 appropriation.

Schedule 13

Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Children's Basic Health Plan Medical and Dental Costs

Priority Number: R-3

Dept. Approval by: John Bartholomew 10/26/12 Date

OSPB Approval by: 10/30/12 Date

- [x] Decision Item FY 2013-14
- [ ] Base Reduction Item FY 2013-14
- [ ] Supplemental FY 2012-13
- [ ] Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$182,543,053	$0	$133,286,320	$60,591,910	$60,591,910
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,787,355	$0	$20,781,279	$1,923,755	$1,923,755
	GFE	$441,600	$0	$441,600	$0	$0
	CF	$42,220,291	$0	$26,007,927	$19,735,056	$19,735,056
	RF	$0	$0	$0	$0	$0
	FF	$118,093,807	$0	$86,055,514	$38,933,099	$38,933,099
(4) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	Total	$182,543,053	$0	$133,286,320	$60,591,910	$60,591,910
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$21,787,355	$0	$20,781,279	$1,923,755	$1,923,755
	GFE	$441,600	$0	$441,600	$0	$0
	CF	$42,220,291	$0	$26,007,927	$19,735,056	$19,735,056
	RF	$0	$0	$0	$0	$0
	FF	$118,093,807	$0	$86,055,514	$38,933,099	$38,933,099

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

FY 2013-14: Of this amount, $27,490,196 shall be from the Children's Basic Health Plan Trust crated in Section 25.5-8-105 (1), C.R.S., $18,031,151 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402.3 (4), C.R.S., $213,493 shall be from the Colorado Immunization Fund crated in Section 25-4-2301, C.R.S., and $1 shall be from the Health Care Expansion Fund created in Section 24-22-117 (2)(a)(I), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Children's Basic Health Plan Trust Fund 11G, Health Care Expansion Fund 18K, Hospital Provider Fee Cash Fund 24A and Colorado Immunization Fund; FF: Title XXI

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: N/A

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2013-14 Funding Request
November 1, 2012

____
Signature Date

Department Priority: R-3
Children's Basic Health Plan Medical Premium and Dental Benefit Costs

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
Children's Basic Health Plan Medical and Dental Costs	$60,591,910	$1,923,755	0.0

Request Summary:
The Department is requesting to adjust the Children's Basic Health Plan Medical and Dental Costs line item to account for updated caseload and per capita estimates. The FY 2013-14 request is an increase of $60,591,910 from the FY 2013-14 base request, and includes $1,923,755 General Fund, $19,735,056 cash funds and $38,933,099 federal funds. The updated FY 2012-13 estimate is higher than the current appropriation by $15,361,657 total funds, of which $4,708,298 is General Fund, $912,354 is cash funds and $9,741,005 is federal funds. FY 2012-13 estimates are provided for informational purposes only.

The Department is not requesting any change to appropriations for the Children's Basic Health Plan Administration line item, though updated appropriations for internal administration (Personal Services, Operating Costs, Medicaid Management Information System, etc.) are incorporated in the Department's analysis of the Children's Basic Health Plan Trust Fund.

The Department's increased estimate for funding for the Children's Basic Health Plan, marketed as the Child Health Plan *Plus* (CHP+), for FY 2012-13 is due to the caseload increase during FY 2011-12, which left caseload at a higher starting point for FY 2012-13. To account for this level shift, the Department's latest caseload estimate is higher than its previous forecast. This impact is somewhat moderated by low and negative growth trends in the Department's updated FY 2012-13 children's and prenatal per capitas.

The Department's FY 2012-13 caseload estimate includes bottom line adjustments from SB 11-008 and SB 11-250. SB 11-008 increases eligibility for children aged 6 through 18 in Medicaid to 133% of the Federal Poverty Level (FPL). SB 11-250 implements a federal mandate to increase eligibility for pregnant women in Medicaid to 185% FPL. These changes will take effect in January 2013, impacting CHP+ caseload negatively as these clients become eligible for and enroll in Medicaid.

These two bottom line adjustments have been updated from the Department's previous estimates to account for the revised caseload forecast and guidance from the Centers for Medicare and Medicaid Services (CMS). Both adjustments maintain the same methodology used by the Department to estimate the fiscal impact for the bills, but reflect an updated timeline for moving these populations into Medicaid. The

Department's updated estimate of SB 11-008 reflects CMS guidance that existing CHP+ children who become eligible for Medicaid may be phased into Medicaid at their annual redetermination date. In contrast, the updated SB 11-250 estimate accounts for CMS guidance that all pregnant women in this income range will enroll in Medicaid immediately upon implementation, even if they are enrolled in CHP+ at that time. As a result, the updated SB 11-008 adjustment is a smaller negative relative to the Department's November 2011 forecast, while the SB 11-250 adjustment is a larger negative.

The Department is requesting an increase in FY 2013-14 from the base request. The FY 2013-14 caseload forecast for CHP+ is also higher than its previous forecast as the upward level shift from FY 2011-12 is carried forward into out-years. The Department's final caseload also includes two bottom line adjustments from SB 11-008 and SB 11-250.

In FY 2013-14, there is an additional bottom line adjustment to the Department's caseload estimate to account for the implementation of the Modified Adjusted Gross Income (MAGI) required by the Affordable Care Act of 2010 (ACA). The Department anticipates this will negatively impact CHP+ caseload. Please see Attachment A for details.

The Department is also adjusting its FY 2012-13 and FY 2013-14 per capita estimates to account for actual FY 2011-12 per capita costs and the actuarially set FY 2012-13 capitation rates. The updated children's medical and prenatal per capita estimates are lower than the Department's previous estimates, while the dental per capita estimate remains relatively flat.

Problem or Opportunity:

The FY 2013-14 base request is insufficient to fully fund the CHP+ program. Under the ACA, there are Maintenance of Effort (MOE) provisions on eligibility for pregnant women in CHP+ until December 31, 2013 and for children in CHP+ until September 30, 2019. As such, CHP+ resembles an entitlement program like Medicaid. The Department cannot limit enrollment or eliminate the program until after these MOE provisions expire.

Brief Background:

CHP+ provides affordable health insurance to children under the age of 19 and pregnant women in low-income families (up to 250% of the federal poverty level) who do not qualify for Medicaid and do not have private insurance. CHP+ offers a defined benefit package that uses privatized administration.

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

The number of CHP+ enrollees and their per capita costs fluctuate due to changes in economic conditions, federal and state policies, and a number of other factors, resulting in changes in CHP+ program expenditures. Changes in funding from sources such as the Tobacco Master Settlement Agreement and Tobacco Taxes also increase the volatility in funding needs. Thus, the Department periodically updates its caseload and expenditure forecast based on recent experience and submits funding requests to the General Assembly. This ensures that the Department has sufficient spending authority to cover expenditures for CHP+ clients and the program's administration. The Department will submit a separate supplemental request to true up its most recent estimates for FY 2012-13 in January 2013.

For the last two years, the Department has not submitted a request to re-estimate caseload and per capita costs for CHP+ in its February 15 Budget Request as it does for the Medicaid program at the request of the Joint Budget Committee staff. Due to the recent volatility in both caseload and expenditures experienced over the last two years, the Department will be submitting revised estimates in its February 15 Budget Request in order to ensure that the Joint Budget Committee staff has the most recent data available before Figure Setting.

Proposed Solution:
The Department is requesting an increase of $60,591,910 total funds in FY 2013-14 from the base request for the Children's Basic Health Plan Medical and Dental Costs to true up its latest expenditures forecast.

Anticipated Outcomes:
Approval of this request would fully fund the Children's Basic Health Plan Medical and Dental Costs line item in accordance with the Department's latest expenditure forecast.

Assumptions for Calculations:
Please see Attachment A and Exhibits C.1 through C.8 for detailed descriptions of the assumptions and calculations for this request.

Consequences if not Funded:
Not applicable. Under the ACA, there are MOE provisions on CHP+ eligibility until September 30, 2019. As such, CHP+ resembles an entitlement program like Medicaid. The Department cannot limit enrollment or eliminate the program until after these MOE provisions expire.

Cash Fund Projections:
This request includes Cash Funds from the Children's Basic Health Plan Trust and the Hospital Provider Fee Cash Fund. For information on associated revenues, expenditures, and cash fund balances, please see the Schedule 9 "Cash Funds Report" in Section O of this Budget Request.

Relation to Performance Measures:
Federal mandate.

Current Statutory Authority or Needed Statutory Change:
Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj).

The Children's Basic Health Plan Trust fund is created by 25.5-8-105 C.R.S. (2012).

An "eligible person" for the program is defined in 25.5-8-103 (4) C.R.S. (2012).

25.5-8-107 (1) (a) (II), C.R.S. (2012) allows the Department to provide dental benefits though the Children's Basic Health Plan.

Attachment A
Children's Basic Health Plan Medical and Dental Costs

Purpose of Request

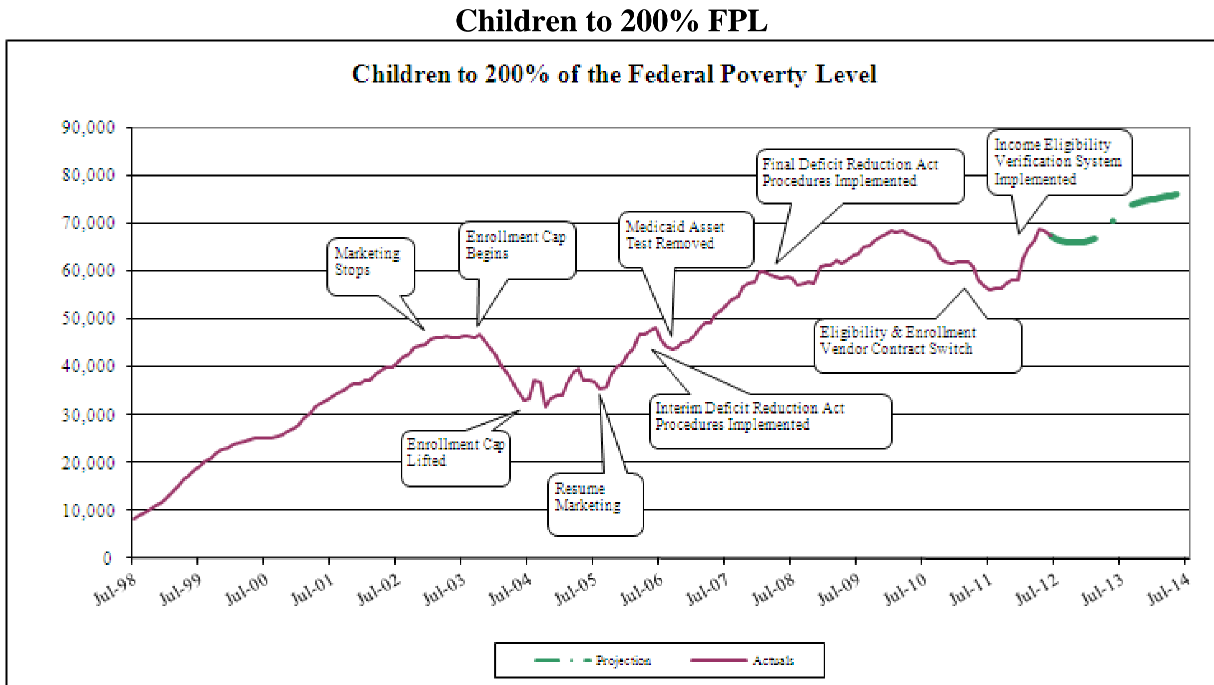
- To adjust the projected enrollment for children and pregnant women in the Plan; and,
- To adjust the per capita costs for medical and dental services in accordance with actuarial projections.

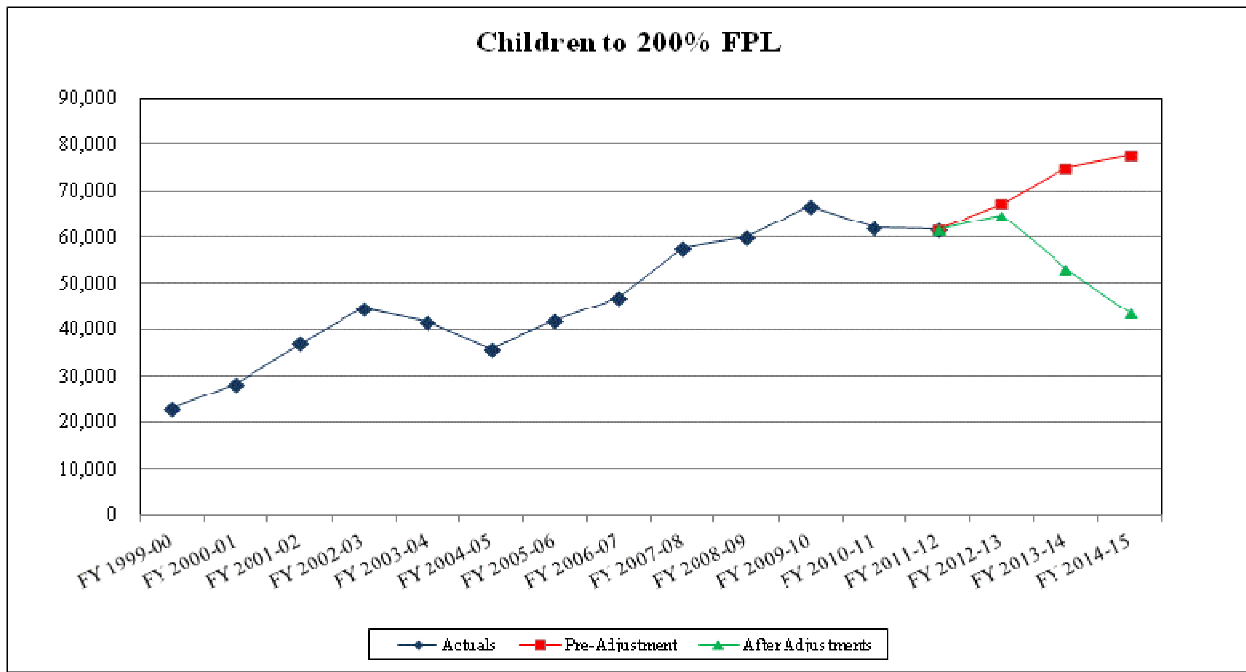
Please note that the Department is only requesting to adjust the FY 2013-14 and all FY 2012-13 estimates are provided for informational purposes only..

I. Description of Request Related to Children's Premiums

Children's Caseload Projections (Exhibit C.6)

Children to 200% FPL





- Growth in children to 200% FPL in FY 2011-12 was significantly higher than the Department's November 2011 forecast, in which annual caseload was projected to be 58,376 and average monthly growth was projected to be 230. The actual caseload for FY 2011-12 increased by an average of 883 children per month. Monthly caseload changes during FY 2011-12 were greater than the long-term average. The Department believes this may be related to the implementation of the federally required Income Eligibility Verification System (IEVS) in August 2011. Per Section 1137 of the Social Security Act, States must use IEVS to request information from other Federal and State agencies to verify applicants' income and resources. IEVS extracts wage information reported by employers to the Colorado Department of Labor and Employment each month to update family incomes for the previous quarter. Since individual and family incomes may vary frequently, even from month to month, the implementation of IEVS has resulted in an increased number of children in low-income FPL categories moving between Medicaid and CHP+ each month. The increase in CHP+ caseload in this category during the first part of calendar year 2012 suggests that the incomes of low-income families may have increased during that time period.
- The selected trend for FY 2012-13 for Children to 200% FPL is higher than the Department's November 2011 forecast and would result in average growth of 373 per month. This higher forecast is reflective of the higher average monthly growth over FY 2011-12. The Department believes that caseload will continue to grow, but at a lower rate as economic conditions are projected to continue to show slow improvement over the next few years. Growth is forecasted to average 0.54% per month in FY 2012-13.
- The Department's existing Section 1115 waiver, which covers the Premium Assistance Program and pregnant women in CHP+, will expire on December 31, 2012. Any eligible CHP+ at Work clients will transition to direct coverage in the CHP+ program beginning in January 2013.
- The FY 2013-14 forecast for the Children to 200% FPL assumes that the slow improvement in economic conditions will continue, resulting in lower caseload growth compared to FY 2012-13. The projected average growth is 374 (0.51%) per month in FY 2013-14.

- There is a bottom-line adjustment to the Children to 200% FPL caseload from SB 11-008, which increases Medicaid eligibility for children from six through 18 years of age to 133% FPL beginning in January 2013. This is expected to have a negative impact on caseload as children that are currently in CHP+ become eligible for and enroll in Medicaid. This adjustment has been updated from the SB 11-008 estimate to account for the revised caseload forecasts with the same methodology used to estimate the fiscal impact of SB 11-008. The adjustment also reflects guidance from CMS that allows the Department to phase in existing CHP+ clients into Medicaid upon their redetermination to allow for greater continuity of coverage.
- Another bottom-line adjustment to the Children to 200% caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of a new income definition, the Modified Adjusted Gross Income (MAGI), required by the Affordable Care Act of 2010 (ACA) beginning in January 2014. States will be required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in health care Exchanges, as well as Medicaid and federal CHIP programs. Due to differences in household size and income calculations that currently exist between Colorado's Medicaid and CHP+ programs, a number of clients with reported household incomes within the official Medicaid eligibility range are actually eligible for CHP+. In FY 2011-12, 22.8% of children in the Children to 200% FPL category reported family incomes under 100% FPL and 51.8% reported family incomes under 133% FPL. Due to the number of children under existing Medicaid income limits, the Department believes the potential impact of MAGI is significant. The Department assumes that with the implementation of MAGI no clients with Medicaid-eligible incomes will remain in CHP+, thus negatively impacting the caseload for children whose incomes are currently documented at or below 133% FPL in CHP+. Although the exact effect of the implementation of MAGI is unknown at this time, the Department has included a negative adjustment to its caseload forecast for FY 2013-14 forward.

Children to 200% FPL

	Actuals	Monthly Change	% Change
Jun-10	66,940	-	-
Jul-10	66,321	(619)	-0.92%
Aug-10	66,126	(195)	-0.29%
Sep-10	64,632	(1,494)	-2.26%
Oct-10	62,786	(1,846)	-2.86%
Nov-10	61,919	(867)	-1.38%
Dec-10	61,662	(257)	-0.42%
Jan-11	61,925	263	0.43%
Feb-11	61,822	(103)	-0.17%
Mar-11	62,097	275	0.44%
Apr-11	60,829	(1,268)	-2.04%
May-11	58,089	(2,740)	-4.50%
Jun-11	56,754	(1,335)	-2.30%
Jul-11	56,237	(517)	-0.91%
Aug-11	56,495	258	0.46%
Sep-11	56,349	(146)	-0.26%
Oct-11	57,549	1,200	2.13%
Nov-11	58,238	689	1.20%
Dec-11	58,258	20	0.03%
Jan-12	62,736	4,478	7.69%
Feb-12	64,579	1,843	2.94%
Mar-12	66,466	1,887	2.92%
Apr-12	69,001	2,535	3.81%
May-12	68,520	(481)	-0.70%
Jun-12	67,346	(1,174)	-1.71%

	Caseload	% Change	Level Change
FY 1999-00	22,935	-	-
FY 2000-01	28,321	23.48%	5,386
FY 2001-02	37,042	30.79%	8,721
FY 2002-03	44,600	20.40%	7,558
FY 2003-04	41,786	-6.31%	(2,814)
FY 2004-05	35,800	-14.33%	(5,986)
FY 2005-06	41,946	17.17%	6,146
FY 2006-07	47,047	12.16%	5,101
FY 2007-08	57,465	22.14%	10,418
FY 2008-09	60,137	4.65%	2,672
FY 2009-10	66,939	11.31%	6,802
FY 2010-11	62,080	-7.26%	(4,859)
FY 2011-12	61,815	-0.43%	(265)
FY 2012-13	67,311	8.89%	5,496
FY 2013-14	74,907	11.28%	7,596
FY 2014-15	77,812	3.88%	2,905

Monthly Average Growth Comparisons		
FY 2011-12 1st Half	251	0.44%
FY 2011-12 2nd Half	1,515	2.49%
November 2011 Forecast	230	0.40%
FY 2012-13 Forecast	373	0.54%
November 2011 Forecast	144	0.24%
FY 2013-14 Forecast	374	0.51%
November 2011 Forecast	198	0.32%

Actuals	Monthly Change	% Change
6-month average	1,515	2.49%
12-month average	883	1.47%
18-month average	316	0.53%
24-month average	17	0.06%

SB 11-008 Adjustment	
FY 2012-13	(2,449)
FY 2013-14	(16,320)
FY 2014-15	(18,887)

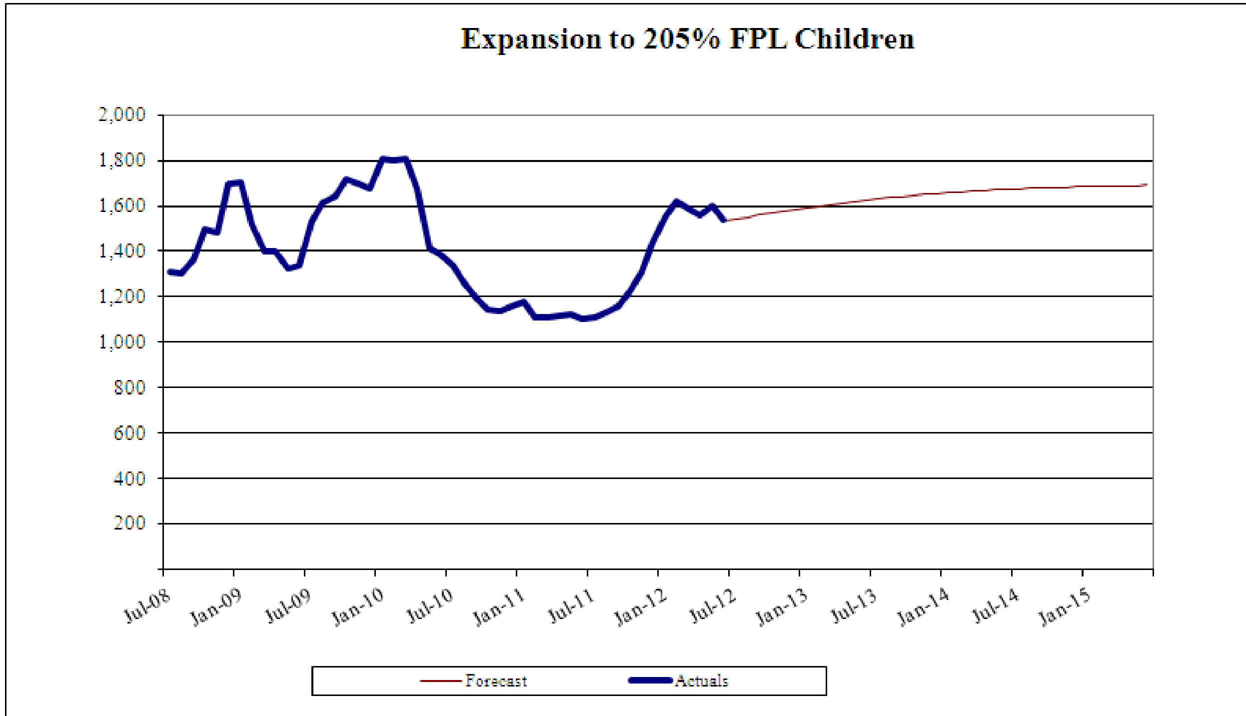
MAGI Adjustment	
FY 2012-13	0
FY 2013-14	(5,434)
FY 2014-15	(15,189)

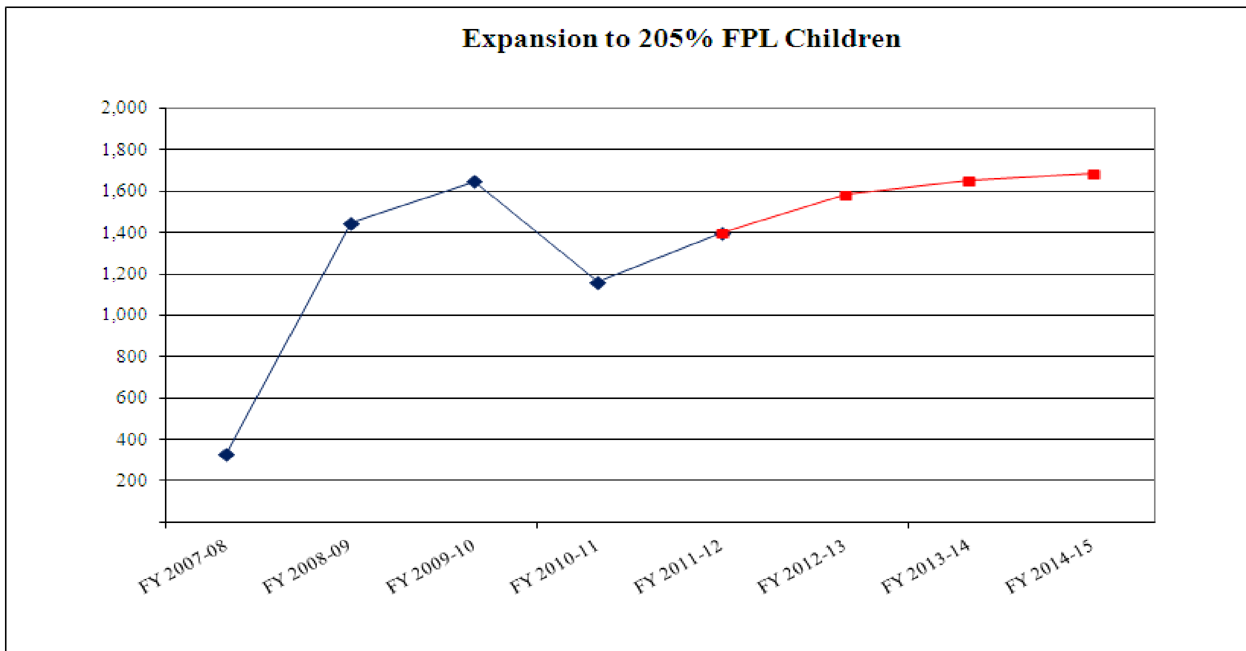
Base trend from June 2012 level			
FY 2012-13	67,346	-0.05%	(35)

November 2011 Trend Selections			
FY 2011-12	58,376	-5.97%	(3,704)
FY 2012-13	60,443	3.54%	2,067
FY 2013-14	62,513	3.42%	2,070

Projections After Adjustments			
FY 2012-13	64,862	4.93%	3,047
FY 2013-14	53,153	-18.05%	(11,709)
FY 2014-15	43,736	-17.72%	(9,417)

Expansion to 205% FPL Children





- This population was created through SB 07-097, and was implemented beginning March 1, 2008. Children in this population have family incomes between 201 and 205% FPL.
- Growth in Expansion to 205% FPL children in FY 2011-12 was higher than the Department's November 2011 forecast, in which annual caseload was projected to be 1,165 and average monthly growth was projected to be 10. Similar to the caseload for Children to 200% FPL, the FY 2011-12 caseload for this population also increased, albeit at a higher rate of an average of 2.87% per month.

This population also exhibited fewer months of caseload declines compared to the Children to 200% FPL caseload.

- The selected trend for FY 2012-13 for Expansion to 205% FPL children is slightly lower than the Department's November 2011 forecast, and would result in average growth of 8 per month. The Department does not believe the caseload will continue to increase as it did in FY 2011-12 as some of the monthly growth was reversed towards the end of the year. Thus, the trend experienced during FY 2011-12 was adjusted downwards to account for the relatively high caseload and negative monthly growth trend experienced at the end of FY 2011-12. Growth is forecasted to average 0.48% per month in FY 2012-13.
- The FY 2013-14 forecast for the Expansion to 205% FPL assumes that the slow improvement in economic conditions will continue, resulting in lower caseload growth compared to FY 2012-13 The resulting average growth is 4 (0.24%) per month in FY 2013-14.

Expansion to 205% FPL Children

	Actuals	Monthly Change	% Change
Jun-10	1,385	(32)	-2.26%
Jul-10	1,338	(47)	-3.39%
Aug-10	1,263	(75)	-5.61%
Sep-10	1,192	(71)	-5.62%
Oct-10	1,144	(48)	-4.03%
Nov-10	1,134	(10)	-0.87%
Dec-10	1,156	22	1.94%
Jan-11	1,178	22	1.90%
Feb-11	1,110	(68)	-5.77%
Mar-11	1,108	(2)	-0.18%
Apr-11	1,118	10	0.90%
May-11	1,121	3	0.27%
Jun-11	1,104	(17)	-1.52%
Jul-11	1,112	8	0.72%
Aug-11	1,130	18	1.62%
Sep-11	1,157	27	2.39%
Oct-11	1,217	60	5.19%
Nov-11	1,313	96	7.89%
Dec-11	1,441	128	9.75%
Jan-12	1,553	112	7.77%
Feb-12	1,620	67	4.31%
Mar-12	1,585	(35)	-2.16%
Apr-12	1,559	(26)	-1.64%
May-12	1,601	42	2.69%
Jun-12	1,535	(66)	-4.12%

	Caseload	% Change	Level Change
FY 2007-08	330	-	-
FY 2008-09	1,445	337.88%	1,115
FY 2009-10	1,649	14.12%	204
FY 2010-11	1,164	-29.41%	(485)
FY 2011-12	1,402	20.45%	238
FY 2012-13	1,585	13.05%	183
FY 2013-14	1,654	4.35%	69
FY 2014-15	1,684	1.81%	30

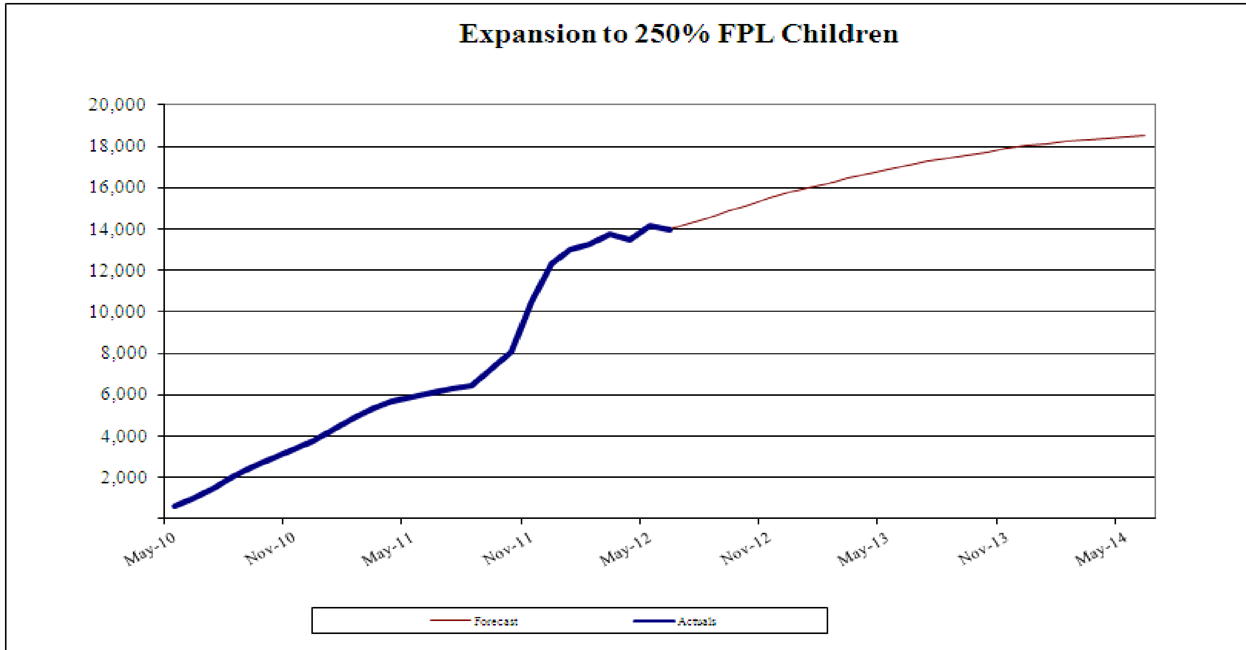
Monthly Average Growth Comparisons		
FY 2011-12 1st Half	56	4.59%
FY 2011-12 2nd Half	16	1.14%
November 2011 Forecast	10	0.83%
FY 2012-13 Forecast	8	0.48%
November 2011 Forecast	10	0.54%
FY 2013-14 Forecast	4	0.24%
November 2011 Forecast	5	0.36%

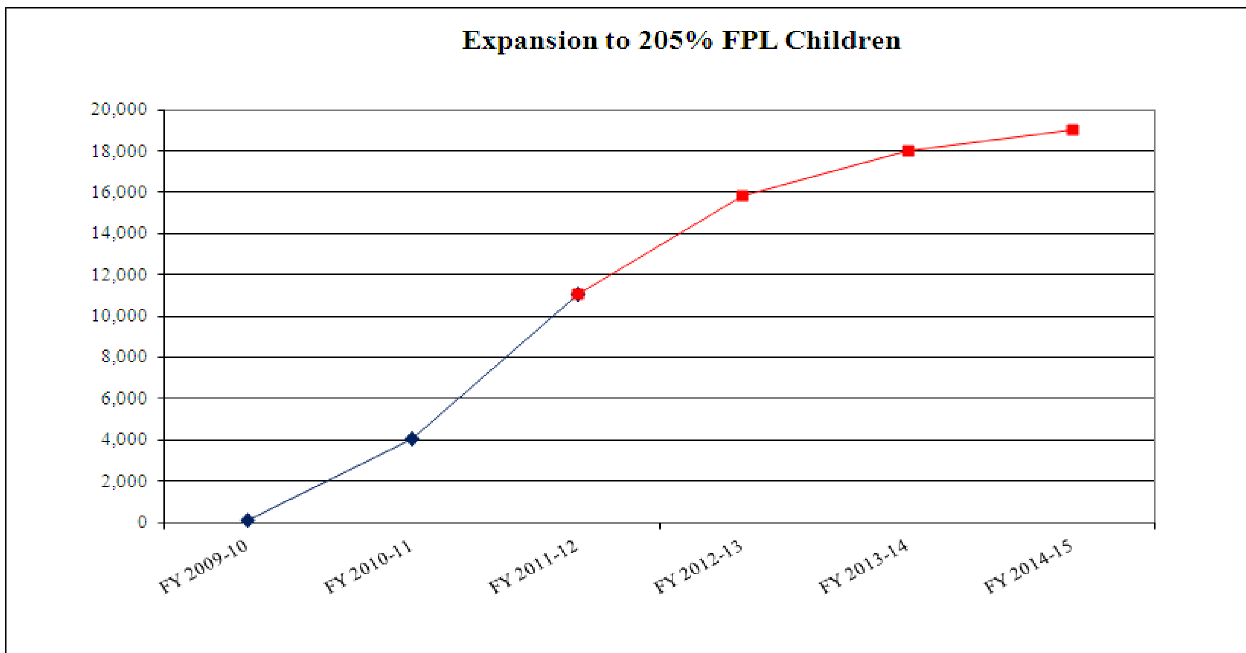
Actuals	Monthly Change	% Change
6-month average	16	1.14%
12-month average	36	2.87%
18-month average	21	1.67%
24-month average	6	0.52%

November 2011 Trend Selections			
FY 2011-12	1,165	0.09%	1
FY 2012-13	1,265	8.58%	100
FY 2013-14	1,336	5.61%	71

Base trend from June 2012 level			
FY 2012-13	1,535	3.26%	50

Expansion to 250% FPL Children





- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Children in this population have family incomes between 206 and 250% of the federal poverty level.
- Growth in FY 2011-12 was higher than the Department's November 2011 estimates in which annual caseload was projected to be 7,891 and average monthly growth was projected to be 253. Actual FY 2011-12 caseload was 11,049 and average monthly growth was 656. The Department has incorporated this substantial level shift upwards and increased its caseload growth forecast to account for the high growth experienced in FY 2011-12. The selected trend for FY 2012-13 for Expansion to 250% FPL children is 1.71%, and would result in average growth of 262 per month. This is based on the average monthly growth from between January 2012 and June 2012.

- The FY 2013-14 forecast for the Expansion to 250% FPL incorporates the substantial level shift upwards and high monthly growth that occurred in FY 2011-12, which was also included in FY 2012-13. The Department assumes that the slow improvement in economic conditions will continue, resulting in lower caseload growth compared to FY 2012-13. This results in average monthly growth of 119 (0.67%) in FY 2013-14.

Expansion to 250% Children

	Actuals	Monthly Change	% Change
Jun-10	1,029	-	-
Jul-10	1,511	482	46.84%
Aug-10	2,018	507	33.55%
Sep-10	2,505	487	24.13%
Oct-10	2,935	430	17.17%
Nov-10	3,342	407	13.87%
Dec-10	3,759	417	12.48%
Jan-11	4,316	557	14.82%
Feb-11	4,888	572	13.25%
Mar-11	5,358	470	9.62%
Apr-11	5,674	316	5.90%
May-11	5,872	198	3.49%
Jun-11	6,098	226	3.85%
Jul-11	6,320	222	3.64%
Aug-11	6,444	124	1.96%
Sep-11	7,275	831	12.90%
Oct-11	8,075	800	11.00%
Nov-11	10,493	2,418	29.94%
Dec-11	12,338	1,845	17.58%
Jan-12	12,985	647	5.24%
Feb-12	13,250	265	2.04%
Mar-12	13,774	524	3.95%
Apr-12	13,492	(282)	-2.05%
May-12	14,169	677	5.02%
Jun-12	13,975	(194)	-1.37%

	Caseload	% Change	Level Change
FY 2009-10	136	-	-
FY 2010-11	4,023	2858.09%	3,887
FY 2011-12	11,049	174.65%	7,026
FY 2012-13	15,795	42.95%	4,746
FY 2013-14	18,002	13.97%	2,207
FY 2014-15	19,045	5.79%	1,043

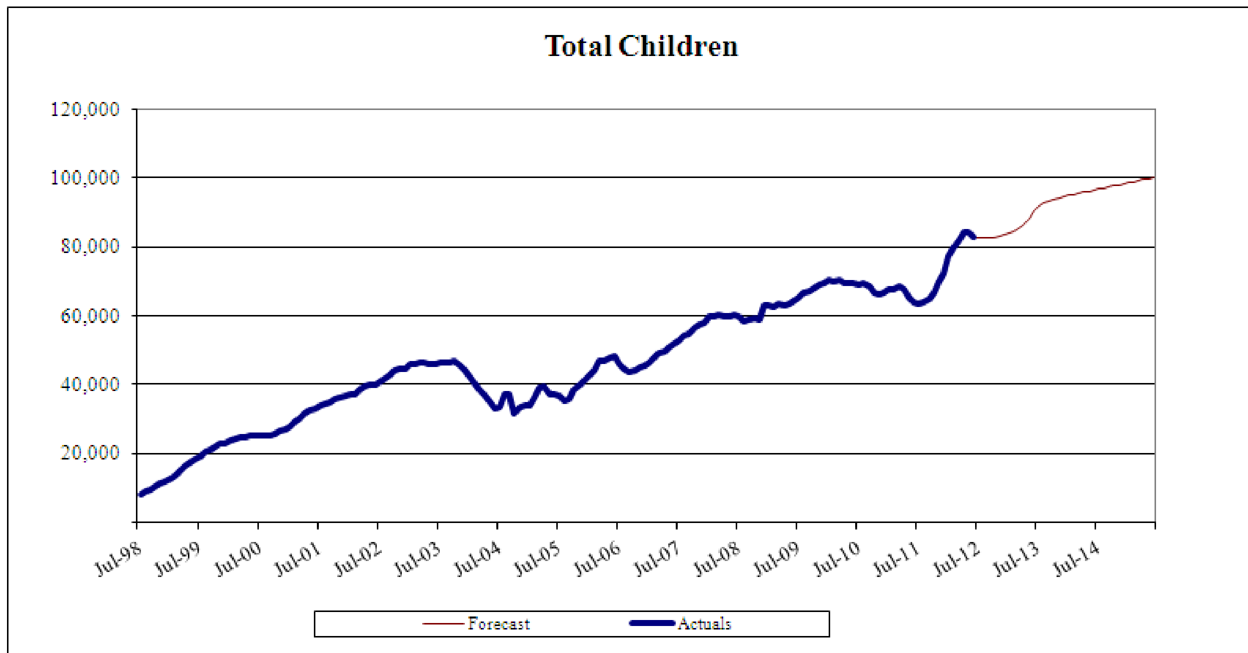
Monthly Average Growth Comparisons		
FY 2011-12 1st Half	1,040	12.84%
FY 2011-12 2nd Half	273	2.14%
November 2011 Forecast	253	3.42%
FY 2012-13 Forecast	262	1.71%
November 2011 Forecast	101	1.04%
FY 2013-14 Forecast	119	0.67%
November 2011 Forecast	61	0.57%

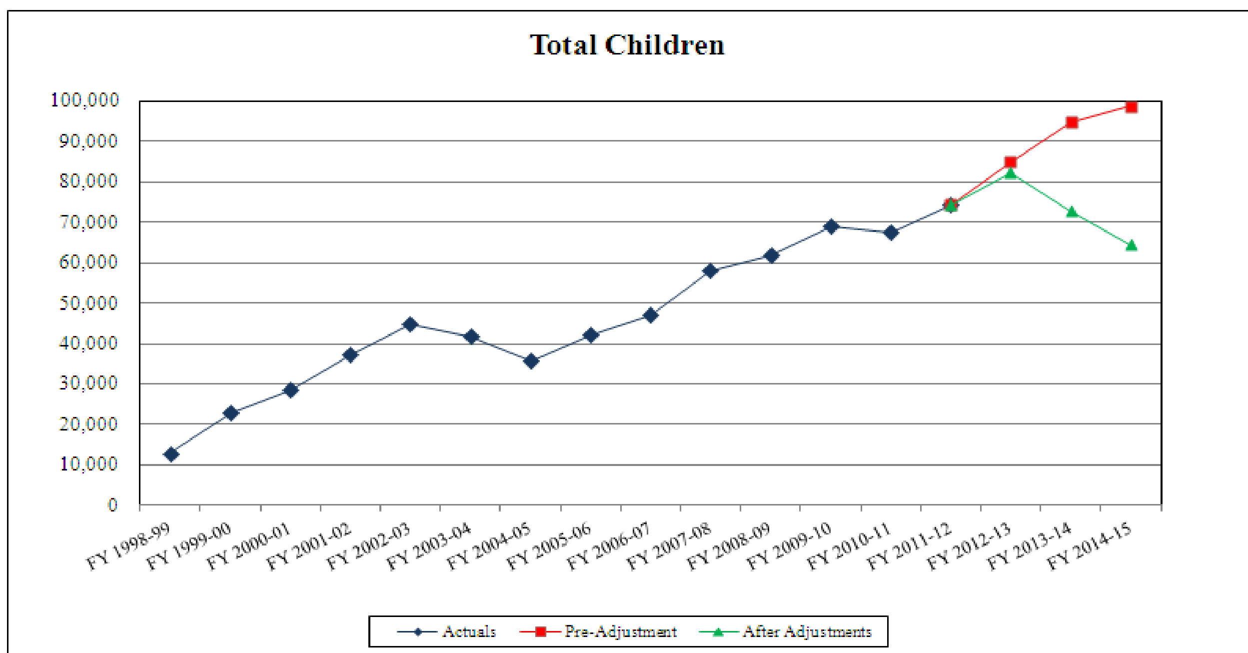
Actuals	Monthly Change	% Change
6-month average	273	2.14%
12-month average	656	7.49%
18-month average	568	7.82%
24-month average	539	12.03%

November 2011 Trend Selections			
FY 2011-12	7,891	96.15%	3,868
FY 2012-13	9,785	24.00%	1,894
FY 2013-14	10,737	9.73%	952

Base trend from June 2012 level			
FY 2012-13	13,975	13.02%	1,820

Total Children





- The FY 2012-13 children's caseload forecast is 84,691, a 14.04% increase over the FY 2011-12 caseload of 74,266. This forecast results in average increases of 643 (0.75%) per month in FY 2012-13.
- The Department estimates that the slow improvement in economic conditions will continue, resulting in lower growth in the CHP+ children caseload compared to FY 2012-13. The annual FY 2013-14 caseload is projected to increase by 11.66% to 94,563, and the FY 2014-15 caseload is forecasted to grow 4.21% to 98,541. Total children's caseload is projected to increase by 0.53% (498 clients) per month in FY 2013-14 and 0.31% (308 clients) per month in FY 2014-15.

- In January 2013, the Department will allow the children of State employees eligible for CHP+ to enroll in the program. Although this policy change is anticipated to have a positive impact on children's caseload, the effects are difficult to anticipate. Per state statute at 25.5-8-109 (1) C.R.S. (2012), the newly eligible children must still comply with a waiting period that requires that they are not insured by a comparable health plan during the three months prior to enrolling in CHP+. The Department believes that the growth rates it has incorporated into the forecast will account for any increases due to this policy change.
- As described in the CHP+ Children to 200% FPL section, there is a bottom-line adjustment to the CHP+ children's caseload from SB 11-008, which increases Medicaid eligibility for children from six through 18 years of age up to 133% FPL beginning in January 2013. This is expected to have a negative impact on CHP+ caseload as some children that would otherwise be eligible for CHP+ become eligible for and enroll in Medicaid. This adjustment has been updated from the SB 11-008 estimate to account for the revised caseload forecasts using the same methodology used by the Department to estimate the fiscal impact of SB 11-008. The adjustment also reflects guidance from CMS that allows the Department to phase in existing CHP+ clients into Medicaid upon their redetermination to allow for greater continuity of coverage.
- Another bottom-line adjustment to the CHP+ children's caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of MAGI in January 2014 as required by the ACA. As described in the CHP+ Children to 200% FPL section, the Department assumes that with the implementation of MAGI no clients with Medicaid-eligible incomes will remain in CHP+. The Department believes this will have a negative impact on the caseload for children whose incomes are currently documented at or below 133% FPL in CHP+. Although the exact effect of MAGI is unknown at this time, the Department has included a negative adjustment to its caseload forecast for FY 2013-14 forward.
- The adjustment for SB 11-008 decreases the FY 2012-13 caseload projection to 82,242 which is a 10.74% increase over FY 2011-12 caseload. The SB 11-008 and MAGI adjustments decrease the FY 2013-14 caseload projection to 72,809, which is an 11.47% decrease from the adjusted FY 2012-13 projection. Both adjustments also decrease the FY 2014-15 caseload projection to 64,465, which is an 11.46% decrease from the adjusted FY 2013-14 projection.

Total Children							
	Actuals	Monthly Change	% Change		Caseload	% Change	Level Change
Jun-10	69,354	-	-	FY 1998-99	12,825	-	-
Jul-10	69,170	(184)	-0.27%	FY 1999-00	22,935	78.83%	10,110
Aug-10	69,407	237	0.34%	FY 2000-01	28,321	23.48%	5,386
Sep-10	68,329	(1,078)	-1.55%	FY 2001-02	37,042	30.79%	8,721
Oct-10	66,865	(1,464)	-2.14%	FY 2002-03	44,600	20.40%	7,558
Nov-10	66,395	(470)	-0.70%	FY 2003-04	41,786	-6.31%	(2,814)
Dec-10	66,577	182	0.27%	FY 2004-05	35,800	-14.33%	(5,986)
Jan-11	67,419	842	1.26%	FY 2005-06	41,945	17.16%	6,145
Feb-11	67,820	401	0.59%	FY 2006-07	47,047	12.16%	5,102
Mar-11	68,563	743	1.10%	FY 2007-08	57,795	22.85%	10,748
Apr-11	67,621	(942)	-1.37%	FY 2008-09	61,582	6.55%	3,787
May-11	65,082	(2,539)	-3.75%	FY 2009-10	68,725	11.60%	7,143
Jun-11	63,956	(1,126)	-1.73%	FY 2010-11	67,267	-2.12%	(1,458)
Jul-11	63,669	(287)	-0.45%	FY 2011-12	74,266	10.40%	6,999
Aug-11	64,069	400	0.63%	FY 2012-13	84,691	14.04%	10,425
Sep-11	64,781	712	1.11%	FY 2013-14	94,563	11.66%	9,872
Oct-11	66,841	2,060	3.18%	FY 2014-15	98,541	4.21%	3,978
Nov-11	70,044	3,203	4.79%				
Dec-11	72,037	1,993	2.85%				
Jan-12	77,274	5,237	7.27%				
Feb-12	79,449	2,175	2.81%				
Mar-12	81,825	2,376	2.99%				
Apr-12	84,052	2,227	2.72%				
May-12	84,290	238	0.28%				
Jun-12	82,856	(1,434)	-1.70%				

Monthly Average Growth Comparisons		
FY 2011-12 1st Half	1,347	2.02%
FY 2011-12 2nd Half	1,803	2.40%
November 2011 Forecast	492	0.74%
FY 2012-13 Forecast	643	0.75%
November 2011 Forecast	252	0.35%
FY 2013-14 Forecast	498	0.53%
November 2011 Forecast	264	0.35%

Actuals		
	Monthly Change	% Change
6-month average	1,803	2.40%
12-month average	1,575	2.21%
18-month average	904	1.25%
24-month average	563	0.77%

SB 11-208 Adjustments	
FY 2012-13	(2,449)
FY 2013-14	(16,320)
FY 2014-15	(18,887)

MAGI Adjustments	
FY 2012-13	0
FY 2013-14	(5,434)
FY 2014-15	(15,189)

Base trend from June 2012 level			
FY 2012-13	82,856	2.21%	1,835

November 2011 Trend Selections			
FY 2011-12	67,432	0.25%	165
FY 2012-13	71,493	6.02%	4,061
FY 2013-14	74,586	4.32%	3,091

Projections After Adjustments			
FY 2012-13	82,242	10.74%	7,976
FY 2013-14	72,809	-11.47%	(9,433)
FY 2014-15	64,465	-11.46%	(8,344)

Children's Medical Per Capita (Exhibit C.5)

CHP+ children are served by either a health maintenance organization (HMO) at a fixed monthly cost, or by the State's managed care network (SMCN), which is administered by a no-risk provider. Actual and estimated caseload ratios between HMOs and the self-funded network are used to develop blended capitation rates and per capita costs. The CHP+ Third Party Administrator (TPA) contract was re-bid for FY 2008-09, and Colorado Access was selected as the new vendor.

For projecting FY 2012-13 SMCN rates, the contracted actuary used actual claims data for FY 2009-10 and FY 2010-11. As the actuary was developing rates for CHP+ during FY 2011-12, data from FY 2011-12 was not available for use in rate-setting. The large annual negative cost trend the contracted actuary found for FY 2009-10 continued into FY 2010-11, becoming more negative at 30.8%. This trend is driven primarily by the change in the hospital reimbursement schedule that was effective on July 1, 2010. While the hospitals were paid 44% of billed charges in FY 2009-10, beginning in FY 2010-11 they are now reimbursed at 135% of the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and 135% of the Colorado Medicaid Outpatient Cost-to-Charge ratio for outpatient services. This means that the program has essentially adopted the Medicaid reimbursement methodologies. Although the FY 2011-12 rates were adjusted to include the projected impact of this change, actual changes in hospital charges could not be included in the base data until the FY 2012-13 rate-setting, which was able to incorporate data from FY 2010-11 when the reimbursement change was in effect. These new reimbursement methodologies resulted in significant savings in the SMCN, which is reflected in the negative annual cost trend for FY 2010-11. The contracted actuary also reviewed published studies to determine industry norms for current and projected health care cost trends, which ranged from 6.0% to 11.6%. To account for the larger than anticipated cost savings generated by the change in hospital reimbursement in the SMCN, the actuary set the unit cost base trend across services at 0.0%. Along with an annual utilization trend of 3.0%, the actuarially set combined utilization and unit cost base trend across services is 3.0% for FY 2012-13.

The FY 2012-13 SMCN children's per member per month rate is $135.21, which includes administrative costs of $24.22 for claims administration and case management and $0.57 for medical home incentive payments. This is a 19.51% decrease from the final FY 2011-12 SMCN rate. The rate decrease is the result of fully accounting for the change in hospital reimbursement methodologies. When SB 11-008, which transitions children aged six to 18 from 100% FPL to 133% FPL from CHP+ to Medicaid, is implemented on January 1, 2013, the enrollment distribution of CHP+ children will change. Although rates set for the individual age and income groups will not change, the blended rate is expected to change as the number of children with incomes between 101% and 133% FPL in CHP+ decreases. The contracted actuary has estimated that the new combined per member per month rate beginning in January 2013 will change only slightly to $136.66, based on anticipated changes in the enrollment distribution of CHP+ children. As a result, the average children's per member per month SMCN rate for FY 2012-13 is $135.95.

The Department is continuing the 3% HMO rate cut that was part of its November 1, 2011 FY 2011-12 Budget Request BRI-4 "CHP+ Program Reductions" and incorporating it into the FY 2012-13 rates. To ensure that this reduced rate is reasonable, the Department asked the contracted actuary to set an actuarial sound rate range for HMO capitation rates for FY 2012-13 rather than a point estimate. For projecting the FY 2012-13 HMO capitation rate, the contracted actuary used actual HMO experience in FY 2009-10 and FY 2010-11 combined with published studies of health care cost trends. Data from FY 2011-12 was not available for use in rate-setting as the actuary was developing rates for CHP+ during FY 2011-12. The range for the annual per member per month trend is 5.5% to 13.4%, with higher cost trends in outpatient hospital services and higher cost and utilization trends in prescription drugs due to high long-term

utilization patterns in these services. For the FY 2012-13 rate setting, the mid range trend was used, which includes average combined utilization and unit cost trend of 9.4%.

With agreement from participating HMOs, the administrative load of 8.5% of total costs is maintained from the previous year. The FY 2012-13 HMO children's per member per month rate is $157.86. This includes the 3% reduction taken from the base rate at the middle of the calculated rate range which results in projected claims costs of $144.54, administrative costs of $12.91 and $0.41 for medical home incentive payments. This is a 3.98% increase from the final FY 2011-12 HMO rate. Similar to the SMCN rates, the Department's actuary has estimated a new combined rate that will result from implementation of SB 11-008 in January 2013. As children previously eligible for CHP+ in the 101% to 133% FPL range move to Medicaid, the overall CHP+ caseload distribution will change. The contracted actuary has estimated that the new combined per member per month rate beginning in January 2013 will change only slightly, to $158.02, based on anticipated changes in the enrollment distribution of CHP+ children. As a result, the average children's per member per month HMO rate for FY 2012-13 is $157.94.

Based on historical experience, the Department estimates that approximately 19% of children will be served in the self-funded network and the remaining 81% will be enrolled in an HMO during FY 2012-13. The Department continues to work with HMOs to expand into geographical areas that were previously served only by the SMCN. The Department is currently working with Colorado Access to expand its CHP+ HMO line of business into El Paso and Teller counties. As Colorado Access and other CHP+ HMOs continue to expand, the estimated percentage of children in HMOs will increase. Since the effects are unknown at this time, the Department is maintaining its conservative estimate of 81% HMO enrollment and will update this figure as more information becomes available. Applying these weights to the actuarial rates yields a blended rate of $153.74 for all children in FY 2012-13. This is a decrease of 1.87% over the final FY 2011-12 blended rate of $156.67 (calculated based on actual caseload shares between HMOs and the self-funded network). See Exhibit C.5, page C.5-2 for calculations.

On July 1, 2012, the Department implemented the increased copayments for CHP+ children with incomes above 100% FPL that were described in the Department's November 1, 2011 FY 2012-13 Budget Request R-7 "Cost Sharing for Medicaid and CHP+." The contracted actuary has included these increases in the 2012-13 SMCN and HMO rates.

Per Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which amended section 2107(e)(1) of the Social Security Act, federal CHIP programs are required to reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) prospectively on a per-visit basis, beginning October 1, 2009. The per-visit rate is specified in the Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Through this prospective payment system (PPS), states are required to reimburse FQHCs and RHCs at 100% of their average cost of providing services during certain "base years," which are adjusted annually by a health care costs index. States are allowed to use the Medicaid PPS or design another prospective payment methodology, including one that is incentive-based, as long as these reimburse at least at the BIPA minimum. After on-going discussions since the fall of 2009, the Department was unable to reach an agreement with FQHCs and RHCs on an incentive-based alternative payment system. In order to be in compliance with federal regulations, however, the Department requested an additional $1,650,176 total funds in FY 2011-12 in its January 3, 2012 FY 2011-12 Budget Request S-11 "Federally Mandated CHP+ PPS Payments" to bring payments for services provided by FQHCs and RHCs from October 2009 to June 30, 2012 to the Medicaid BIPA minimum rate. The Department also anticipated implementing a PPS methodology in a budget-neutral fashion beginning in FY 2012-13.

Some challenges, however, presented themselves as the Department approached the end of FY 2011-12 which delayed the implementation of the PPS going forward. Inconsistencies in the way FQHCs and RHCs were identified by individual CHP+ HMOs were discovered. As a result, the contracted actuary's initial calculation of retroactive payments did not include all FQHC and RHC claims. The Department has begun working with its new contracted actuary to update the calculation of the retroactive payment amount and implement a PPS methodology going forward. As the Department continues to collaborate with FQHCs and RHCs on a PPS methodology, the original implementation date has been postponed. The Department plans to implement a new PPS methodology and make any additional payments during FY 2012-13 to remain compliant with federal regulations. The Department will request any additional funds necessary to make these payments through the supplemental budget process.

The children's medical per capita for FY 2011-12 exhibited a decline from FY 2010-11 and was lower than the Department's November 2011 forecast. This is the result of systems issues that began in the summer of 2011 and affected the number of capitations paid through the Medicaid Management Information System (MMIS). Due to differences between the eligibility determination system, the Colorado Benefits Management System (CBMS), and the MMIS, processing issues occur when loading data from CBMS into the MMIS. Although eligibility information, which shows the period for which a client is eligible for CHP+ benefits is loaded correctly into the MMIS, enrollment information, which shows which managed care plan the client is enrolled in and triggers the generation of a capitation payment, may not complete the loading process. As a result, the number of capitations generated by the MMIS is lower than actual CHP+ enrollment. The problem of enrollment spans in the MMIS, however, has not impacted eligibility determinations for the program.

The Department has established a number of processes to alleviate the cash flow issues for the CHP+ health plans. These ensure that they have accurate records of their enrollees and are receiving appropriate reimbursement for the children that they serve. Moreover, the Department is currently in the process of implementing a systems change that will resolve this issue on an on-going basis. A manual reconciliation process was established when the Department began using CBMS and has been operational for years to address the discrepancy in capitation payments to the participating health plans. This manual reconciliation process is part of the contract with all CHP+ HMOs and requires a 6-month runout period to allow for retroactive enrollments and disenrollments to accurately measure enrollment in the plan for any given month. For a number of years, the level of discrepancy was relatively constant. However, during the summer of 2011, the proportion of capitations being generated out of the MMIS relative to total CHP+ caseload decreased by approximately 20% to 30% and has remained relatively steady since then. While the number of medical capitations being paid for children and pregnant women has decreased, children's dental capitations have remained unaffected.

In order to further alleviate the cash flow issues created for the CHP+ HMOs since the summer of 2011, the Department began making interim reconciliation payments during the last quarter of FY 2011-12 based on enrollment estimates prior to the 6-month runout period. Although this mitigated a portion of the decrease in overall expenditures for the program, the children's medical per capita was still lower than it would have been if the number of capitations generated by the system had not decreased so significantly. The large increase in children's caseload over that year also contributed to the lower per capita in FY 2011-12.

The Department's FY 2012-13 forecasted per capita is based on the actuarially developed capitation rate and the Department's caseload projections. This forecast assumes that the FY 2012-13 capitation rate for the self-funded network is indeed in line with the costs incurred for these children, and that other factors that may affect per capita costs remain constant from FY 2011-12. Examples of other factors that may affect per capita costs include the length of stay in the program and the enrollment mix between the SMCN

and HMOs. The low growth forecasted for the FY 2012-13 per capita is the result of three factors. First, the negative growth in the blended capitation rate results in a lower per capita. Second, by making interim reconciliation payments to CHP+ MCOs, expenditures in FY 2011-12 more accurately reflect the services rendered during that year as some of the payments that would have been made during FY 2012-13 due to the six month runout period for the final enrollment reconciliations were made in FY 2011-12. This results in a lower FY 2012-13 per capita that does not include these payments for services rendered in FY 2011-12. The downward pressure on the per capita is mitigated by the third factor, the permanent fix to the capitations issue discussed above. The Department has been working with the Office of Information Technology to implement a permanent solution which it believes will be in place in January 2013. At this time, the Department anticipates that the number of MMIS capitations being generated will increase substantially. The more accurate enrollment records will result not only in an increase in the number of concurrent capitations, it should also result in the generation of retroactive capitations that were not paid in the previous five months for eligible children. This permanent solution will also greatly reduce the volume of reconciliation payments made to HMOs as the correct number of capitations will be generated automatically, which will eliminate the need to wait until the end of the 6-month runout period for HMOs to receive the correct payments. This results in more predictable cash flow for both the Department and the HMOs. The Department anticipates that most of the relatively large reconciliation payments will be finalized and paid in FY 2012-13.

Due to the interaction between these factors, the Department estimates that the children's medical per capita will experience slight growth of 0.25% over the FY 2011-12 per capita of $1,957.63 for a projected FY 2012-13 per capita of $1,962.55.

The Department assumes that the FY 2012-13 capitation rates have captured all relevant reimbursement and policy changes, so that the volatility experienced during recent years will even out and resume normal trends in FY 2013-14. Based on research and historical experience, the Department believes the children's medical capitation rate will grow by 4.0% in FY 2013-14. As explained above, the changes in cash flow that have occurred due to systems issues and the Department's efforts to mitigate and resolve them have led to low expenditure and per capita growth estimates for FY 2012-13. After a transition period following the implementation of the systems fix for the capitation issue, the Department believes that expenditures will begin to follow caseload plus the growth in the capitation rate more closely, and that expenditures will even out in FY 2013-14 forward. Due to this change in expenditures, along with the estimated children's medical capitation rate, the per capita for FY 2013-14 is projected to be $2,201.30, an increase of 12.17% from the previous year. This per capita accounts for the correction in expenditures that is projected to occur in FY 2013-14 and only appears large when compared to the minimal growth in prior years, particularly FY 2012-13. In addition, the high growth rate is largely driven by the relatively low per capita in FY 2012-13 discussed above.

Children's Dental Per Capita (Exhibit C.5)

For the development of the FY 2012-13 dental per member per month capitation rate, the contracted actuary used actual claims data from FY 2008-09 and FY 2009-10 to estimate an annual unit cost trend of 2% and an annual utilization trend of 3.5%. As the actuary was developing rates for CHP+ during FY 2011-12, data from FY 2011-12 was not available for use in rate-setting. The annual utilization trend was increased from the base data estimate to reflect Department initiatives aimed specifically at increasing dental service utilization in Colorado. The actuarial set rate of $16.08 is a 4.9% increase over the FY 2011-12 rate. The FY 2012-13 monthly capitation rate includes $1.14 in administrative costs and a 1% fully insured risk margin. Similar to the children's medical rates, the Department's actuary has estimated a new combined dental rate that will result from implementation of SB 11-008 in January 2013. As children

previously eligible for CHP+ in the 101% to 133% FPL range move to Medicaid, the overall CHP+ caseload distribution will change. The contracted actuary has estimated that the new combined per member per month rate beginning in January 2013 will change only slightly, to $15.96, based on anticipated changes in the enrollment distribution of CHP+ children. As a result, the average per member per month dental rate for FY 2012-13 is $16.02.

The Department's FY 2012-13 forecasted dental per capita growth rate mirrors that of the actuarially developed rate. This forecast assumes that other factors that may affect per capita costs, such as the length of stay in CHP+ and the average length of time taken for a child to receive dental benefits, remain constant from the FY 2010-11 base period. Additionally, dental capitations have not been affected by the same systems issue that has decreased the number of medical capitations generated over the past year. The base growth of 4.91% from the capitation rate is applied to the calculated FY 2011-12 per capita of $167.16, resulting in a projected FY 2012-13 per capita of $175.37.

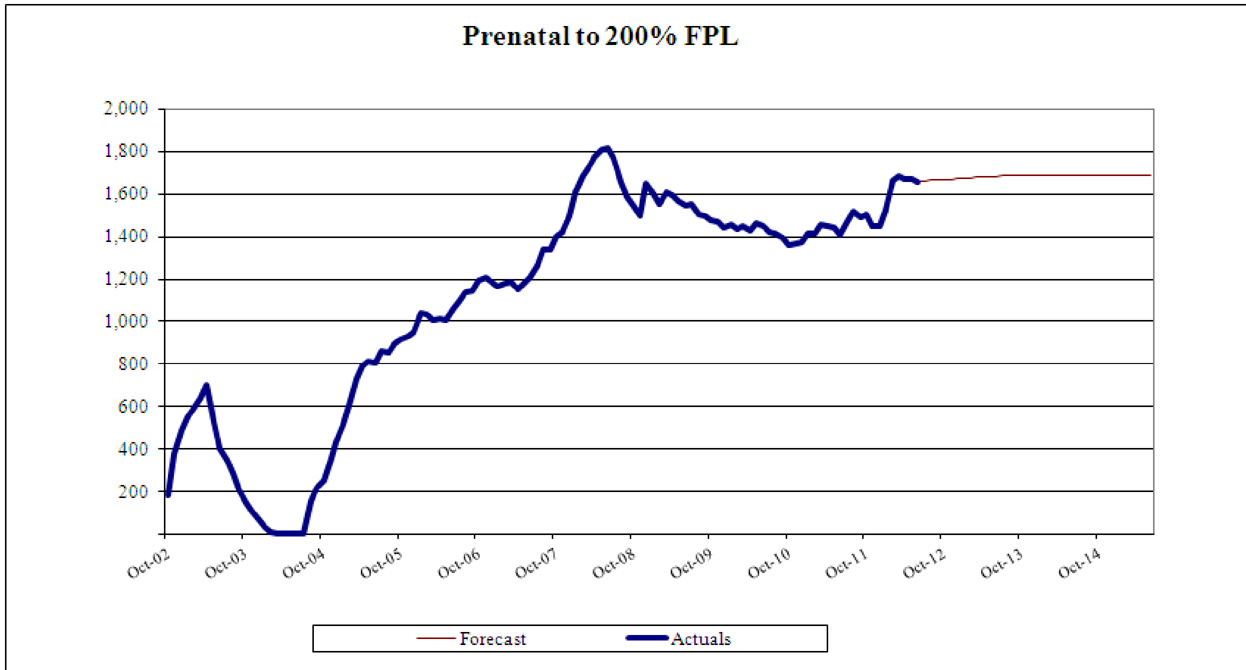
After discussions with Delta Dental, the Department included a provision in their contract that assures a risk margin for Delta Dental but allows the Department to recuperate reimbursements made above this margin. Per the contract between the Department and Delta Dental, if the amount paid in CHP+ dental claims for FY 2011-12 is less than 91.7% of the total per member per month capitation paid to Delta Dental in FY 2011-12, Delta Dental will return the difference to the Department. If that amount is greater than 91.7% there is no action. The Department believes this measure protects the State from unnecessary expenditures while ensuring that Delta Dental receives an acceptable and agreed upon risk margin for the CHP+ line of business. The Department will begin making this calculation in January 2013, to allow for six months of dental claims runout.

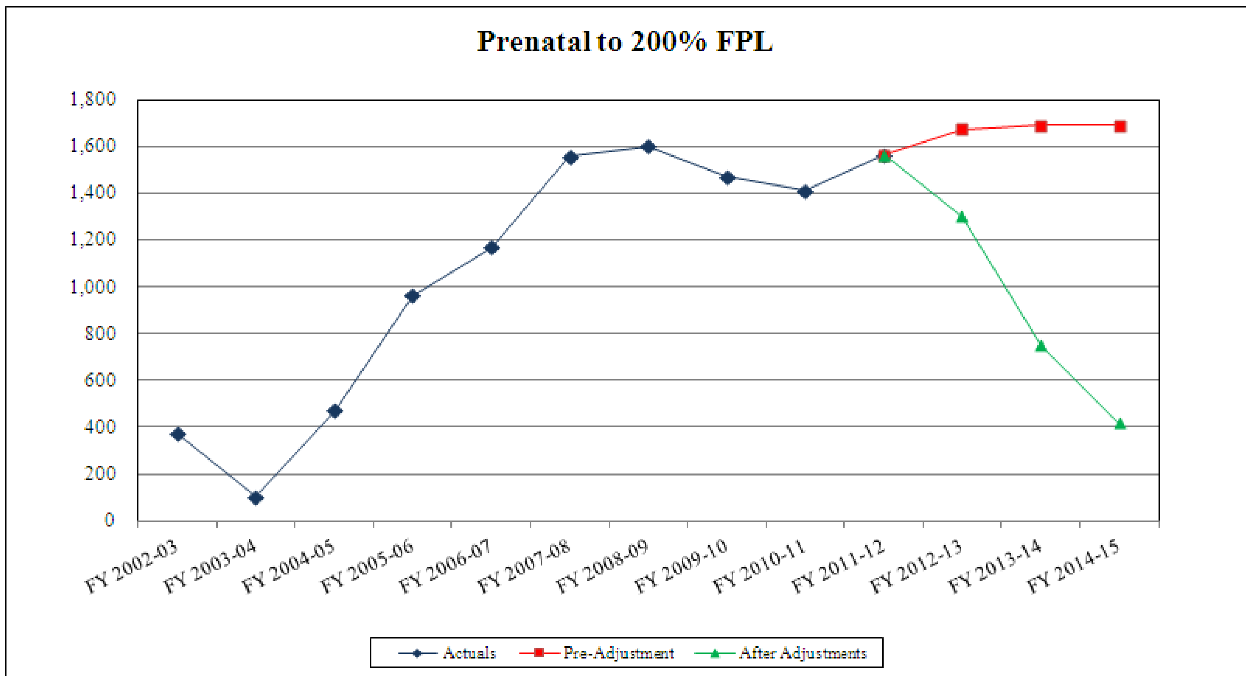
To estimate the FY 2013-14 per capita trends, the Department analyzed the historical growth in dental rates. Given the negative trend in adjusted claims cost for the base period for the FY 2012-13 rates, the Department has assumed that the growth rate for FY 2013-14 will be slightly lower than the average growth found in the literature, which averages at 4.0%. Thus, the projected FY 2013-14 per capita is $180.63, which is 3.0% higher than the FY 2012-13 estimate.

II. Description of Request Related to the Prenatal Program

Prenatal Caseload Projections (Exhibit C.7)

Prenatal to 200% FPL





- Caseload growth in Prenatal to 200% FPL in FY 2011-12 was higher than the Department's November 2011 forecast, in which annual caseload was projected to be 1,409 and average monthly growth was projected to be 0. The Prenatal to 200% FPL caseload for FY 2011-12 experienced growth similar to the Children to 200% FPL, increasing by an average of 1.43% per month. The Department believes

this may be related to the implementation of the federally required Income Eligibility Verification System (IEVS) in August 2011. Per Section 1137 of the Social Security Act, States must use IEVS to request information from other Federal and State agencies to verify applicants' income and resources. IEVS extracts wage information reported by employers to the Colorado Department of Labor and Employment each month to update family incomes for the previous quarter. Since individual and family incomes may vary frequently, even from month to month, the implementation of IEVS has resulted in an increased number of pregnant women in low-income FPL categories moving between Medicaid and CHP+ each month. The increase in CHP+ caseload in this category during the first part of calendar year 2012 suggests that the incomes of low-income families may have increased during that time period.

- The Department is modeling the FY 2012-13 forecast for the Prenatal to 200% FPL population on the monthly growth experienced between January 2012 and June 2012, during which large initial increases were followed by more moderate declines. Thus, this forecast is slightly higher than the Department's November 2011 forecast, and would yield average growth of 2 per month. The Department's forecast assumes that the FY 2012-13 trend will decrease slowly in out years as caseload in this eligibility group has been volatile for 3 years, yet has exhibited a slightly positive trend overall. Growth is forecasted to average 2 clients (0.12%) per month in FY 2012-13.
- The FY 2013-14 forecast for the Prenatal to 200% FPL assumes that the slow improvement in economic conditions will continue, resulting in lower caseload growth compared to FY 2012-13. The resulting average growth is 0.03%, or 1 per month.
- There is a bottom-line adjustment to the CHP+ prenatal caseload from SB 11-250, which increases Medicaid eligibility for pregnant women from 133% FPL to 185% FPL beginning in January 2013 to comply with federal mandate. This is expected to have a negative impact on CHP+ caseload as pregnant women who would otherwise be in CHP+ become eligible for Medicaid. This adjustment has been updated from the SB 11-250 estimate to account for the revised caseload forecasts and recent guidance from CMS. CMS has directed the Department to move all pregnant women who meet this income requirement in January 2013 into Medicaid immediately upon implementation, including the women who are enrolled in CHP+ at that time. This differs from the Department's initial assumption that new prenatal clients under 185% FPL would be enrolled in Medicaid upon implementation, while existing CHP+ clients would remain in CHP+ for the term of their pregnancy and the guaranteed 60 days of post-partum care. This has resulted in larger adjustments than previously estimated.
- Similar to the Children's caseload, another bottom-line adjustment to the Prenatal to 200% caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of MAGI in January 2014 as required by the ACA. States will be required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in health Exchanges, as well as Medicaid and federal CHIP programs. Due to differences in household size and income calculations that currently exist between Colorado's Medicaid and CHP+ programs, a number of clients with household incomes within the official Medicaid eligibility range are actually eligible for CHP+. In FY 2011-12, for example, 39.0% of clients in the Prenatal to 200% caseload reported family incomes within the existing Medicaid eligibility limit of 133% FPL and 88.7% reported family incomes under 185% FPL. The Department assumes that with the implementation of MAGI no clients with Medicaid-eligible incomes will remain in CHP+. The Department believes this will have a negative impact on the caseload for pregnant women whose incomes are documented at or below 185% FPL in CHP+ prior to the change. Although the exact effect of the implementation of MAGI is unknown at this time, the Department has included an adjustment to its caseload forecast for FY 2013-14 forward.

Prenatal to 200% FPL

	Actuals	Monthly Change	% Change
Jun-10	1,452	-	-
Jul-10	1,419	(33)	-2.27%
Aug-10	1,417	(2)	-0.14%
Sep-10	1,396	(21)	-1.48%
Oct-10	1,357	(39)	-2.79%
Nov-10	1,367	10	0.74%
Dec-10	1,370	3	0.22%
Jan-11	1,413	43	3.14%
Feb-11	1,415	2	0.14%
Mar-11	1,453	38	2.69%
Apr-11	1,452	(1)	-0.07%
May-11	1,443	(9)	-0.62%
Jun-11	1,409	(34)	-2.36%
Jul-11	1,468	59	4.19%
Aug-11	1,516	48	3.27%
Sep-11	1,490	(26)	-1.72%
Oct-11	1,507	17	1.14%
Nov-11	1,446	(61)	-4.05%
Dec-11	1,451	5	0.35%
Jan-12	1,528	77	5.31%
Feb-12	1,664	136	8.90%
Mar-12	1,682	18	1.08%
Apr-12	1,674	(8)	-0.48%
May-12	1,671	(3)	-0.18%
Jun-12	1,660	(11)	-0.66%

	Caseload	% Change	Level Change
FY 2002-03	372	-	-
FY 2003-04	101	-72.85%	(271)
FY 2004-05	472	367.33%	371
FY 2005-06	963	104.03%	491
FY 2006-07	1,169	21.39%	206
FY 2007-08	1,557	33.19%	388
FY 2008-09	1,598	2.63%	41
FY 2009-10	1,469	-8.07%	(129)
FY 2010-11	1,409	-4.08%	(60)
FY 2011-12	1,563	10.93%	154
FY 2012-13	1,673	7.04%	110
FY 2013-14	1,689	0.96%	16
FY 2014-15	1,690	0.06%	1

Monthly Average Growth Comparisons		
FY 2011-12 1st Half	7	0.53%
FY 2011-12 2nd Half	35	2.33%
November 2011 Forecast	0	0.00%
FY 2012-13 Forecast	2	0.12%
November 2011 Forecast	0	0.00%
FY 2013-14 Forecast	1	0.03%
November 2011 Forecast	0	0.00%

Actuals	Monthly Change	% Change
6-month average	35	2.33%
12-month average	21	1.43%
18-month average	16	1.12%
24-month average	9	0.60%

SB 11-250 Adjustment	
FY 2012-13	(372)
FY 2013-14	(749)
FY 2014-15	(750)

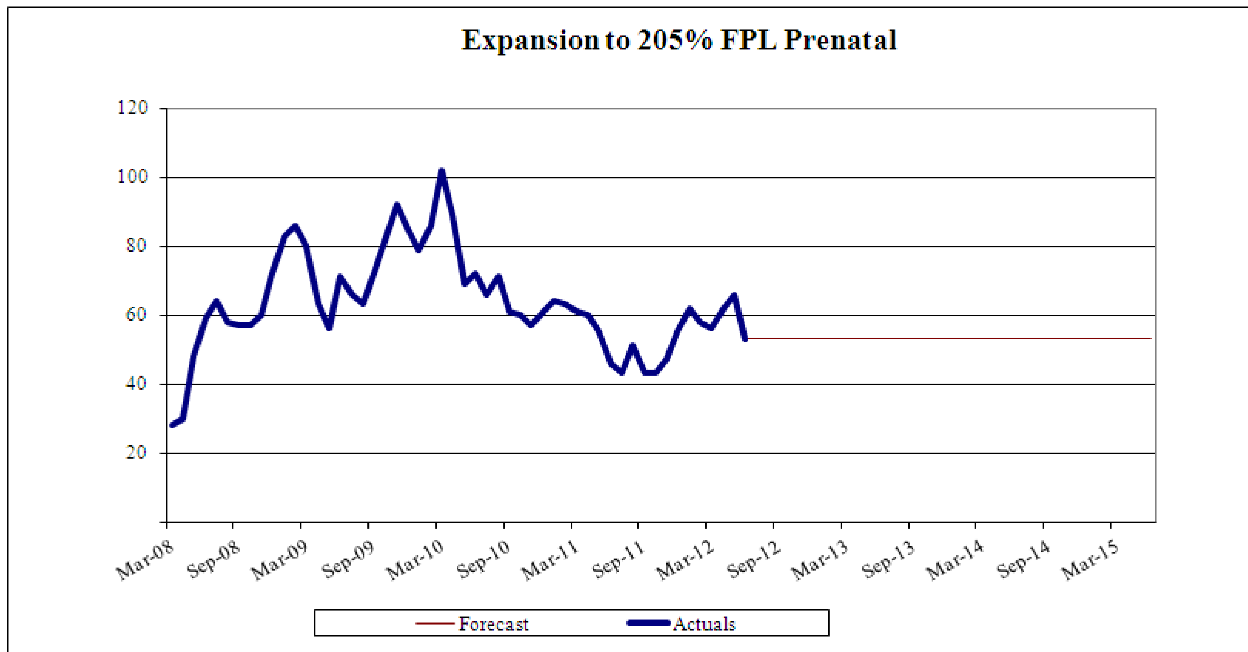
MAGI Adjustment	
FY 2012-13	0
FY 2013-14	(192)
FY 2014-15	(524)

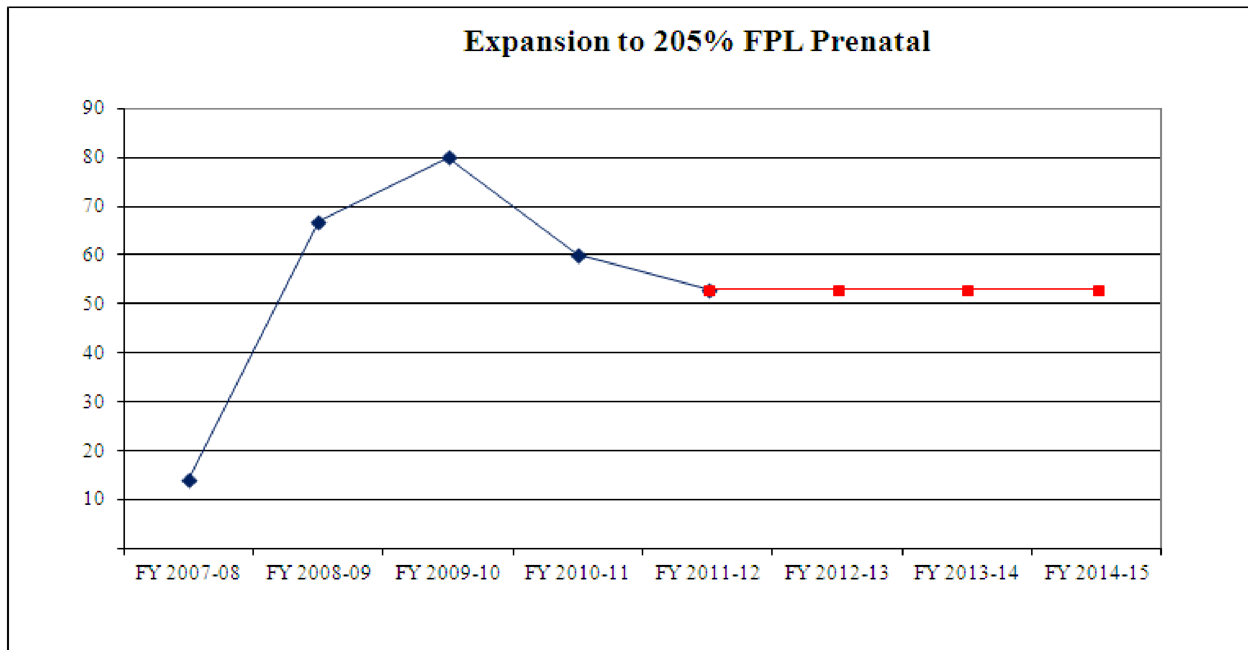
Base trend from June 2012 level			
FY 2012-13	1,660	0.78%	13

November 2011 Trend Selections			
FY 2011-12	1,409	0.00%	0
FY 2012-13	1,409	0.00%	0
FY 2013-14	1,409	0.00%	0

Projections After Adjustments			
FY 2012-13	1,301	-16.78%	(262)
FY 2013-14	748	-42.51%	(553)
FY 2014-15	416	-44.37%	(332)

Expansion to 205% Prenatal





- Along with the children's expansion to 205% FPL, this population was created through SB 07-097 and was implemented beginning March 1, 2008. Prenatal women in this population have family incomes between 201 and 205% of the federal poverty level.
- Growth in the Expansion to 205% FPL Prenatal in FY 2011-12 was higher than the Department's November 2011 forecast, in which annual caseload was projected to be 46 and average monthly growth was forecasted to be 0. The selected trend for FY 2012-13 for Expansion to 205% FPL Prenatal is the same as the Department's November 2011 forecast, and would result in average growth of 0 per month. This is based on the average monthly caseload decrease of 0.17% that was experienced between

January 2011 and June 2012 and increased monthly volatility during the first part of calendar year 2012.

- The Department's forecast assumes that the FY 2012-13 trend will continue in out-years, with zero growth on average.

Expansion to 205% FPL Prenatal

	Actuals	Monthly Change	% Change
Jun-10	72	3	4.35%
Jul-10	66	(6)	-8.33%
Aug-10	71	5	7.58%
Sep-10	61	(10)	-14.08%
Oct-10	60	(1)	-1.64%
Nov-10	57	(3)	-5.00%
Dec-10	61	4	7.02%
Jan-11	64	3	4.92%
Feb-11	63	(1)	-1.56%
Mar-11	61	(2)	-3.17%
Apr-11	60	(1)	-1.64%
May-11	55	(5)	-8.33%
Jun-11	46	(9)	-16.36%
Jul-11	43	(3)	-6.52%
Aug-11	51	8	18.60%
Sep-11	43	(8)	-15.69%
Oct-11	43	0	0.00%
Nov-11	47	4	9.30%
Dec-11	55	8	17.02%
Jan-12	62	7	12.73%
Feb-12	58	(4)	-6.45%
Mar-12	56	(2)	-3.45%
Apr-12	62	6	10.71%
May-12	66	4	6.45%
Jun-12	53	(13)	-19.70%

	Caseload	% Change	Level Change
FY 2007-08	14	-	-
FY 2008-09	67	378.57%	53
FY 2009-10	80	19.40%	13
FY 2010-11	60	-25.00%	(20)
FY 2011-12	53	-11.67%	(7)
FY 2012-13	53	0.00%	0
FY 2013-14	53	0.00%	0
FY 2014-15	53	0.00%	0

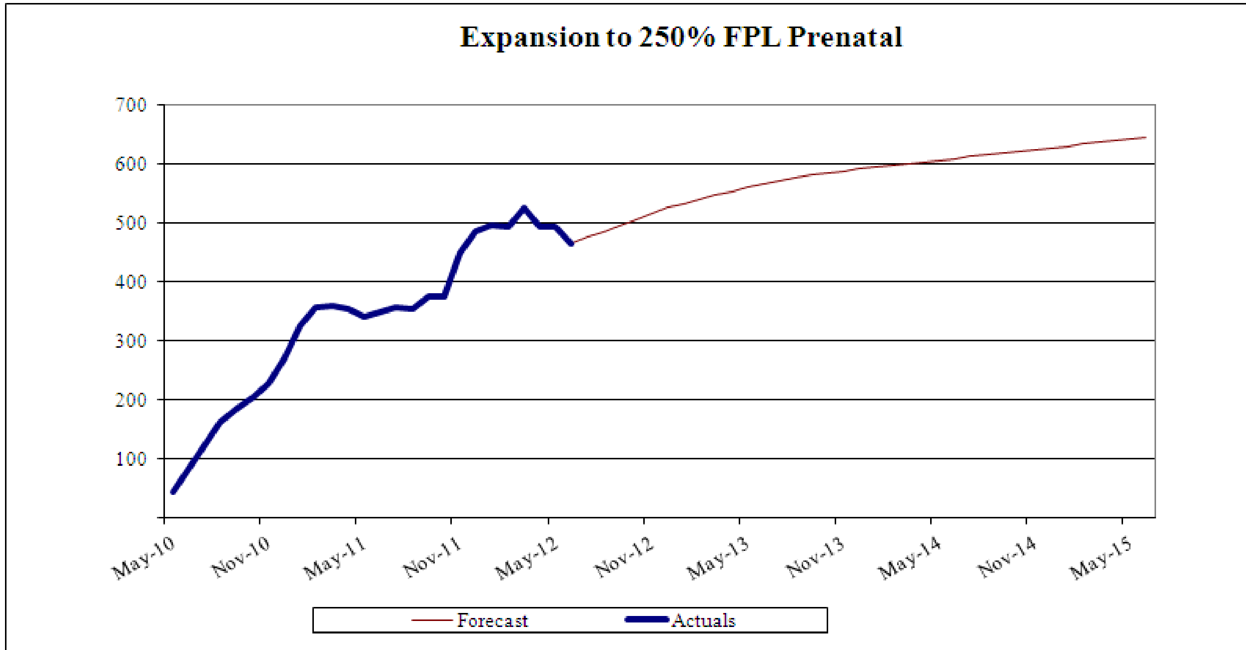
Monthly Average Growth Comparisons		
FY 2011-12 1st Half	2	3.79%
FY 2011-12 2nd Half	0	0.05%
November 2011 Forecast	0	0.00%
FY 2012-13 Forecast	53	0.00%
November 2011 Forecast	0	0.00%
FY 2013-14 Forecast	53	0.00%
November 2011 Forecast	0	0.00%

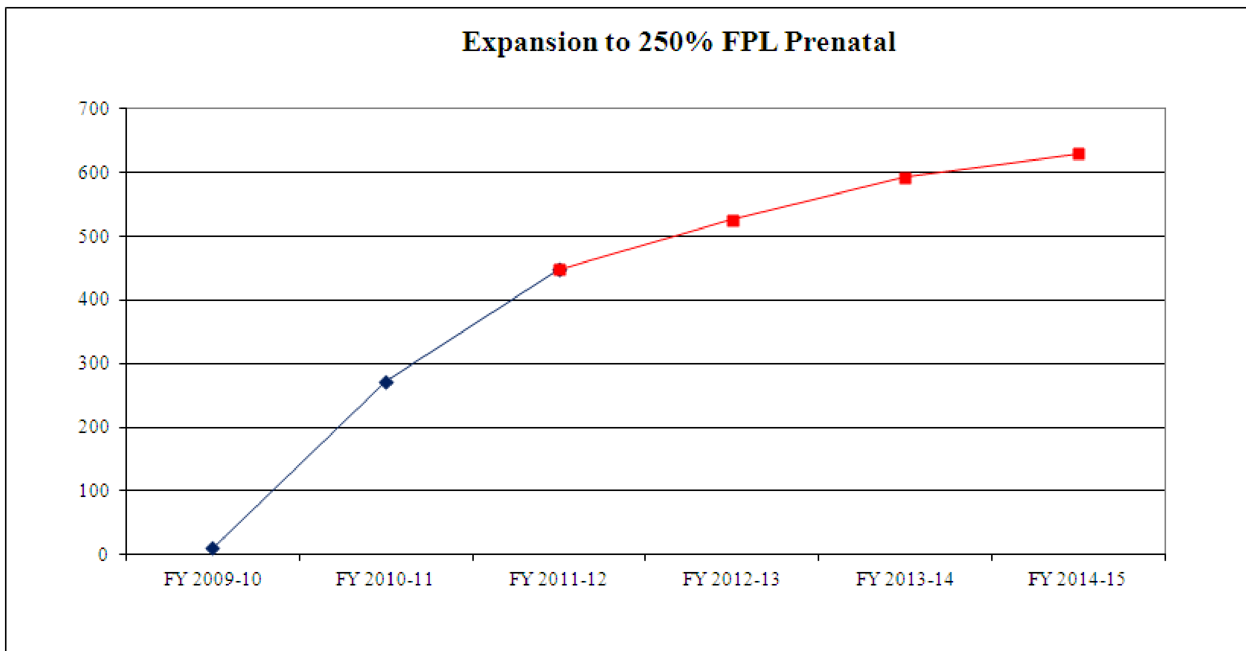
Actuals	Monthly Change	% Change
6-month average	0	0.05%
12-month average	1	1.92%
18-month average	0	-0.17%
24-month average	(1)	-0.73%

November 2011 Trend Selections			
FY 2011-12	46	-23.33%	(14)
FY 2012-13	46	0.00%	0
FY 2013-14	46	0.00%	0

Base trend from June 2012 level			
FY 2012-13	53	0.00%	0

Expansion to 250% FPL Prenatal





- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Pregnant women in this population have family incomes between 206 and 250% of the federal poverty level.
- Growth in FY 2011-12 was higher than the Department's November 2011 estimates in which annual caseload was projected to be 414 and average monthly growth was projected to be 10. The Department has increased its caseload growth forecast to account for this higher growth.
- The selected trend for FY 2012-13 for Expansion to 250% FPL Prenatal is higher than the Department's November 2011 forecast, and would result in average growth of 9 per month. This is

based on the average monthly growth between July 2011 and June 2012 and results in average growth of 1.66% per month in FY 2012-13.

- The FY 2013-14 forecast for the Expansion to 250% FPL Prenatal assumes that the slow improvement in economic conditions will continue, resulting in lower caseload growth compared to FY 2012-13. The average monthly growth is estimated at 4 (0.60%) in FY 2013-14.

Expansion to 250% Prenatal

	Actuals	Monthly Change	% Change
Jun-10	83	-	-
Jul-10	124	41	49.40%
Aug-10	162	38	30.65%
Sep-10	187	25	15.43%
Oct-10	206	19	10.16%
Nov-10	228	22	10.68%
Dec-10	270	42	18.42%
Jan-11	325	55	20.37%
Feb-11	357	32	9.85%
Mar-11	361	4	1.12%
Apr-11	355	(6)	-1.66%
May-11	342	(13)	-3.66%
Jun-11	349	7	2.05%
Jul-11	357	8	2.29%
Aug-11	355	(2)	-0.56%
Sep-11	377	22	6.20%
Oct-11	375	(2)	-0.53%
Nov-11	451	76	20.27%
Dec-11	487	36	7.98%
Jan-12	498	11	2.26%
Feb-12	494	(4)	-0.80%
Mar-12	525	31	6.28%
Apr-12	494	(31)	-5.90%
May-12	494	0	0.00%
Jun-12	466	(28)	-5.67%

Base trend from June 2012 level			
FY 2012-13	466	12.88%	60

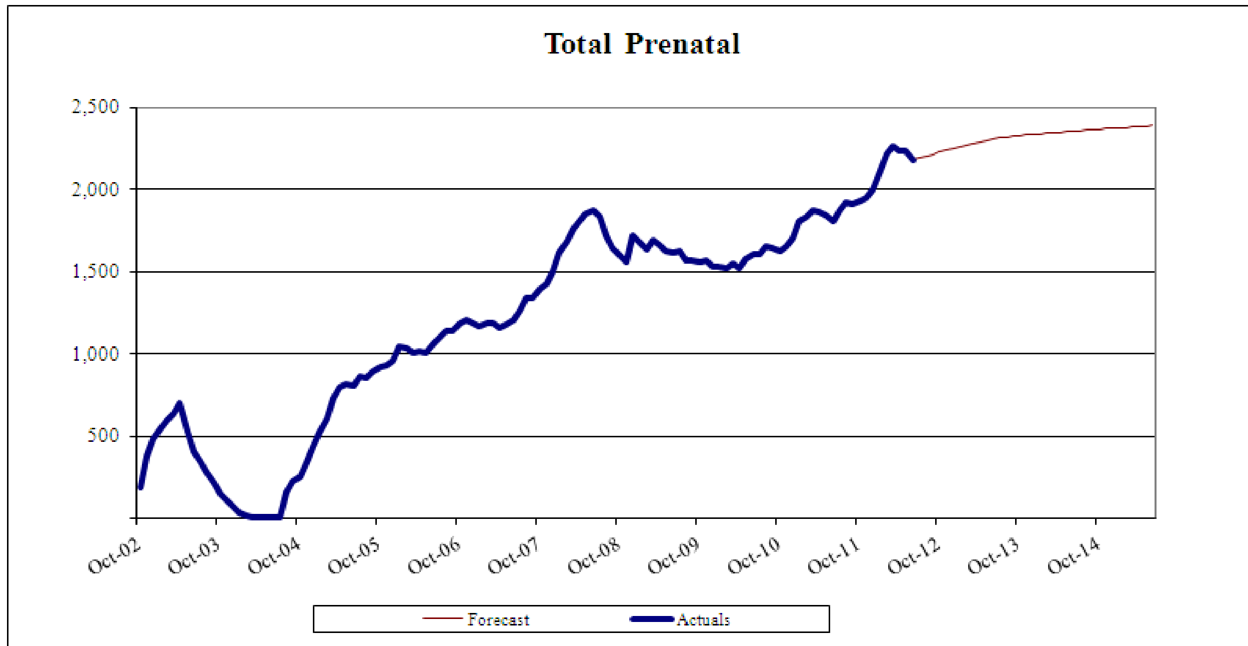
	Caseload	% Change	Level Change
FY 2009-10	11	-	-
FY 2010-11	272	2372.73%	261
FY 2011-12	448	64.71%	176
FY 2012-13	526	17.41%	78
FY 2013-14	593	12.74%	67
FY 2014-15	630	6.24%	37

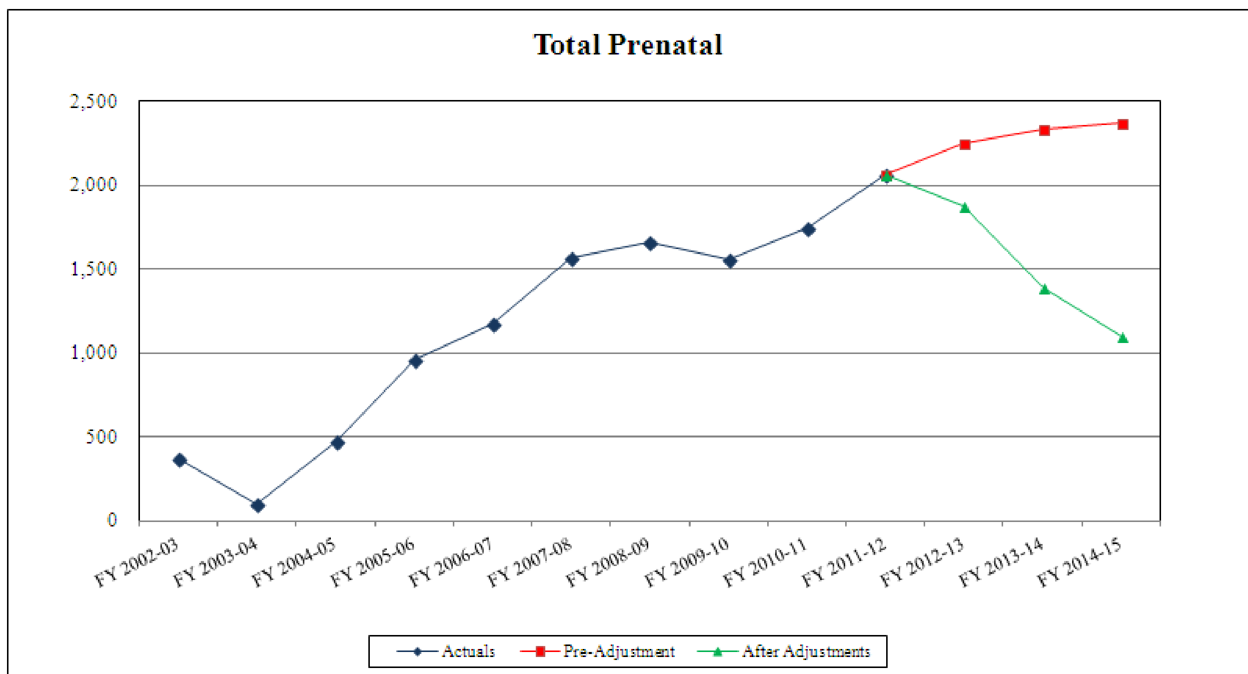
Monthly Average Growth Comparisons		
FY 2011-12 1st Half	23	5.94%
FY 2011-12 2nd Half	(4)	-0.64%
November 2011 Forecast	10	2.49%
FY 2012-13 Forecast	9	1.66%
November 2011 Forecast	5	1.01%
FY 2013-14 Forecast	4	0.60%
November 2011 Forecast	0	0.00%

Actuals	Monthly Change	% Change
6-month average	(4)	-0.64%
12-month average	10	2.65%
18-month average	11	3.33%
24-month average	16	8.11%

November 2011 Trend Selections			
FY 2011-12	414	52.21%	142
FY 2012-13	502	21.26%	88
FY 2013-14	529	5.38%	27

Total Prenatal





- The FY 2012-13 total prenatal caseload forecast is 2,252, a 9.11% increase over the FY 2011-12 caseload of 2,064. This forecast includes average increases of 11 (0.47%) per month.
- The Department estimates that the slow improvement in economic conditions will continue, resulting in lower growth in the CHP+ prenatal caseload in out-years. The FY 2013-14 caseload is projected to increase 3.69% to 2,335, and FY 2014-15 caseload is forecasted to grow 1.63% to 2,373. Total prenatal caseload is projected to increase by 0.17% (4 clients) per month in FY 2013-14 and 0.13% (3 clients) per month in FY 2014-15.

- As described in the CHP+ Prenatal to 200% FPL section, there is a bottom-line adjustment to the CHP+ prenatal caseload from SB 11-250, which increases Medicaid eligibility for pregnant women from 133% to 185% FPL beginning in January 2013. This is expected to have a negative impact on CHP+ caseload as pregnant women who would otherwise enroll in CHP+ become eligible for and enroll in Medicaid. This adjustment has been updated from the SB 11-250 estimate to account for the revised caseload forecasts and recent guidance from CMS that all pregnant women that fall under the new Medicaid income threshold be enrolled in Medicaid beginning in January 2013, including existing clients who are enrolled in CHP+ at the time of implementation. As a result, the Department's updated adjustment estimate is a larger negative than previously estimated.
- Another bottom-line adjustment to the CHP+ prenatal caseload accounts for anticipated changes in eligibility and enrollment resulting from the implementation of MAGI in January 2014 as required by the ACA. As described in the CHP+ Prenatal to 200% FPL section, the Department assumes that with the implementation of MAGI no clients with Medicaid-eligible incomes will remain in CHP+. The Department believes this will have a negative impact on the caseload for pregnant women whose incomes are documented at or below 185% FPL in CHP+ prior to this change. Although the exact effect of the implementation of MAGI is unknown at this time, the Department has adjusted its caseload forecast downwards for FY 2013-14 forward.
- The adjustment for SB 11-250 decreases the FY 2012-13 caseload projection to 1,880 which is a 8.93% decrease over FY 2011-12 caseload. The SB 11-250 and MAGI adjustments decrease the FY 2013-14 caseload projection to 1,394, which is a 25.85% decrease from the adjusted FY 2012-13 projection. Both adjustments also decrease the FY 2014-15 caseload projection to 1,099, which is a 21.15% decrease from the adjusted FY 2013-14 projection.

Total Prenatal

	Actuals	Monthly Change	% Change
Jun-10	1,607	-	-
Jul-10	1,609	2	0.12%
Aug-10	1,650	41	2.55%
Sep-10	1,644	(6)	-0.36%
Oct-10	1,623	(21)	-1.28%
Nov-10	1,652	29	1.79%
Dec-10	1,701	49	2.97%
Jan-11	1,802	101	5.94%
Feb-11	1,835	33	1.83%
Mar-11	1,875	40	2.18%
Apr-11	1,867	(8)	-0.43%
May-11	1,840	(27)	-1.45%
Jun-11	1,804	(36)	-1.96%
Jul-11	1,868	64	3.55%
Aug-11	1,922	54	2.89%
Sep-11	1,910	(12)	-0.62%
Oct-11	1,925	15	0.79%
Nov-11	1,944	19	0.99%
Dec-11	1,993	49	2.52%
Jan-12	2,088	95	4.77%
Feb-12	2,216	128	6.13%
Mar-12	2,263	47	2.12%
Apr-12	2,230	(33)	-1.46%
May-12	2,231	1	0.04%
Jun-12	2,179	(52)	-2.33%

	Caseload	% Change	Level Change
FY 2002-03	372	-	-
FY 2003-04	101	-72.85%	(271)
FY 2004-05	472	367.33%	371
FY 2005-06	963	104.03%	491
FY 2006-07	1,170	21.50%	207
FY 2007-08	1,570	34.19%	400
FY 2008-09	1,665	6.05%	95
FY 2009-10	1,560	-6.31%	(105)
FY 2010-11	1,741	11.60%	181
FY 2011-12	2,064	18.55%	323
FY 2012-13	2,252	9.11%	188
FY 2013-14	2,335	3.69%	83
FY 2014-15	2,373	1.63%	38

Monthly Average Growth Comparisons		
FY 2011-12 1st Half	32	1.68%
FY 2011-12 2nd Half	31	1.55%
November 2011 Forecast	10	0.54%
FY 2012-13 Forecast	11	0.47%
November 2011 Forecast	5	0.26%
FY 2013-14 Forecast	4	0.17%
November 2011 Forecast	0	0.00%

Actuals	Monthly Change	% Change
6-month average	31	1.55%
12-month average	31	1.62%
18-month average	27	1.42%
24-month average	24	1.30%

SB 11-250 Adjustments	
FY 2012-13	(372)
FY 2013-14	(749)
FY 2014-15	(750)

MAGI Adjustments	
FY 2012-13	0
FY 2013-14	(192)
FY 2014-15	(524)

Base trend from June 2012 level			
FY 2012-13	2,179	3.35%	73

November 2011 Trend Selections			
FY 2011-12	1,869	7.29%	127
FY 2012-13	1,957	4.71%	88
FY 2013-14	1,984	1.38%	27

Projections After Adjustments			
FY 2012-13	1,880	-8.93%	(184)
FY 2013-14	1,394	-25.85%	(486)
FY 2014-15	1,099	-21.15%	(295)

Prenatal Per Capita (Exhibit C.5)

All clients in the prenatal program are served by the self-funded program (SMCN) administered by Colorado Access and the costs of their services are billed in full directly to the State.

Similar to the SMCN children annual trend, the prenatal cost trend from FY 2009-10 to FY 2010-11 was negative, at 14.4%. As the actuary was developing rates for CHP+ during FY 2011-12, data from FY 2011-12 was not available for use in rate-setting. This is also similar to the negative trend experienced in the previous year. This trend is driven primarily by the change in the hospital reimbursement schedule that was effective on July 1, 2010. While the hospitals were paid 44% of billed charges in FY 2009-10, beginning in FY 2010-11 they are paid 135% of the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and 135% of the Colorado Medicaid Outpatient Cost-to-Charge ratio for outpatient services. This means that the program has essentially adopted the Medicaid reimbursement methodologies. Although the FY 2011-12 rates were adjusted to include the projected impact of this change, actual changes in hospital charges were not included in the base data until the FY 2012-13 rate-setting, which was able to incorporate data from FY 2010-11 when the reimbursement change was in effect. This change in reimbursement methodologies resulted in significant savings in the SMCN, which is reflected in the negative annual cost trend for FY 2010-11.

The contracted actuary also reviewed published studies to determine industry norms for current and projected health care cost trends, which ranged from 6.0% to 11.6%. To account for the larger than anticipated cost savings generated by the change in hospital reimbursement in the SMCN, the actuary set the unit cost base trend across services at 0.0%. The actuarially set combined utilization and unit cost base trend across services is 3.0% for FY 2012-13.

The FY 2012-13 prenatal per member per month rate is $930.32, which includes administrative costs of $24.22 for claims administration and case management. This is an 18.70% decrease from the final FY 2011-12 rate. The decrease is the result of fully accounting for the change in hospital reimbursement methodologies. The Department believes that once SB 11-250, which increases Medicaid eligibility for pregnant women from 133% to 185% FPL to comply with federal mandate, is implemented on January 1, 2013, the enrollment distribution of CHP+ prenatal clients will change as these women move into Medicaid. Although rates set for the various income groups will not change, the combined rate is expected to change as the decreased number of pregnant women with incomes between 134% and 185% FPL alters the distribution of the CHP+ prenatal population. The contracted actuary has estimated that the new combined per member per month rate beginning in January 2013 will change only slightly, to $927.03, based on anticipated changes in the enrollment distribution of CHP+ prenatal clients. As a result, the average prenatal per member per month rate for FY 2012-13 is $928.65.

The Department's FY 2012-13 forecasted per capita is based on the actuarially developed rate. This forecast assumes that the FY 2012-13 prenatal capitation rate is indeed in line with the costs incurred for these women. The negative growth forecasted for the FY 2012-13 per capita is mostly the result of the significant negative trend in the prenatal rate. The downward pressure on the per capita is mitigated by another factor, the permanent fix to the MMIS capitation issue. Although the Department is not making interim reconciliation payments to the SMCN, prenatal capitations will still be affected by the systems fix implemented in January 2013. As the MMIS is able to generate a more accurate number of capitations for the month, as well as retroactive capitations that were not generated in the previous five months for enrolled prenatal clients, expenditures that would have been incurred in the manual reconciliation 6 months out will be shifted to FY 2012-13. Due to the interaction of these factors, the Department estimates that the

prenatal per capita will experience a decrease of 6.48% over the FY 2011-12 per capita of $11,702.58 for a projected FY 2012-13 per capita of $10,944.36.

The Department assumes that the FY 2012-13 capitation rates have captured all relevant reimbursement and policy changes, so that the volatility experienced during recent years will even out and resume normal trends in FY 2013-14. Based on research and historical experience, the Department believes the prenatal capitation rate will grow by 3.0% in FY 2013-14. This is consistent with historical annual growth in capitation rates that has ranged from -17.35% to 33.06%. The Department believes that the fix for the capitation issue will result in expenditures that more closely follow caseload, allowing expenditures for the program to even out in FY 2013-14 forward. Thus, the per capita for FY 2013-14 is projected to increase to $13,337.05, an increase of 21.86% from the previous year. This per capita accounts for the correction in expenditures that is projected to occur in FY 2013-14 and only appears large when compared to the decreases experienced in the prior two years. In addition, the high growth rate is largely driven by the relatively low per capita in FY 2012-13 discussed above.

III. Other CHP+ Updates

The Department's estimates include only anticipated program expenditures to be incurred in FY 2012-13 forward. In recent conversations with CMS, the Department was notified that its CHP+ eligibility expansion for pregnant women from 206% to 250% FPL was not authorized in the Standard Terms and Conditions (STCs) outlined in its existing Section 1115 waiver. Due to political uncertainties around the time of the waiver's expiration date of October 1, 2009, CMS requested that the Department not immediately renew the waiver, which covered prenatal women in CHP+ up to 205% FPL. At that time, the Children's Health Insurance Program Reauthorization Act (CHIPRA) was being debated in Congress. Since the future provisions of the law were uncertain, CMS specifically requested that the Department not submit a renewal waiver until CHIPRA was passed. Since then, the Department has worked closely with CMS to implement a new waiver for the prenatal population. In the meantime, CMS approved monthly extensions of Colorado's waiver while the state implemented HB 09-1293 which expanded CHP+ eligibility from 205% to 250% FPL beginning in May 2010. Since receiving notice from CMS that the prenatal clients from 206% to 250% FPL that are not explicitly covered under the STCs of the expired waiver were not authorized to receive federal matching funds, the Department has been communicating with CMS to understand the policy and financial implications of this notice. A new Section 1115 waiver was approved effective August 1, 2012 that includes STCs that authorize pregnant women in CHP+ up to 250% FPL.

The Department has recently resolved an issue that has been pending since 2006. In its November 1, 2006 FY 2007-08 Budget Request DI-3 "Adjust Children's Basic Health Plan Medical Premium and Dental Costs for Caseload and Rate Changes," the Department notified the General Assembly of a potential liability regarding CHP+ administrative costs. When the federal government enacted the State Children's Health Insurance Plan in 1997, it stipulated that administrative costs up to 10% of total program expenditures would be matched by the federal government. CHP+ is the State of Colorado's version of the State Children's Health Insurance Plan, and in the early years the Department experienced administrative costs that were in excess of the 10% cap and was therefore entitled to claim the entire amount of federal matching funds available. In subsequent years, however, the Department continued to draw federal matching funds on 10% of its budgeted program expenditures, even though actual administrative costs as a portion of total expenditures decreased considerably. As a result, the Department received federal matching funds in excess of what it was entitled to for FY 2004-05 and FY 2005-06. The Department discovered this error in September 2006 and took immediate steps to correct the federal draw going forward. The Department has been working with the Department of Health and Human Services and the

Office of Inspector General on this issue since its discovery. In May 2012, the Office of Inspector General's final audit findings regarding the overdrawn federal funds for the CHP+ administration were published. The Department agreed to refund the federal government the entirety of the $2,837,860 incorrectly claimed as the federal share of CHP+ expenditures though FY 2005-2006. The Department made this payment with monies from the CHP+ Trust Fund in June 2012. This payment was not counted against FY 2011-12 CHP+ Administrative expenditures but rather as a prior period adjustment in the state's accounting system. This payment did, however, decrease the balance of the CHP+ Trust Fund by $2,837,860. This payment is thus included in Exhibit C.1 "Children's Basic Health Plan Trust Fund Analysis."

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medicare Modernization Act of 2003 State Contribution Payment

Priority Number: R-4

Dept. Approval by: John Bartholomew JB 10/26/12 Date

OSPB Approval by: [signature] 10/30/12 Date

- Decision Item FY 2013-14
- Base Reduction Item FY 2013-14
- Supplemental FY 2012-13
- Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$90,656,176	$0	$96,674,862	$14,603,355	$14,603,355
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$50,609,286	$0	$47,626,167	$14,603,355	$14,603,355
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$40,046,890	$0	$49,048,695	$0	$0
(5) Other Medical Services; Medicaid Modernization Act of 2003 State Contribution Payment	Total	$90,656,176	$0	$96,674,862	$14,603,355	$14,603,355
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$50,609,286	$0	$47,626,167	$14,603,355	$14,603,355
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$40,046,890	$0	$49,048,695	$0	$0

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

Cash or Federal Fund Name and COFRS Fund Number:

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: No: Not Required: ✓

Schedule 13s from Affected Departments:

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 Funding Request
November 1, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Signature Date

Department Priority: R-4
Medicare Modernization Act of 2003 State Contribution Payment

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
MMA State Contribution Payment	$14,603,355	$14,603,355	0.0

Request Summary:
This request is to fund the Medicare Modernization Act (MMA) of 2003 State Contribution Payment line item to $111,278,217 for FY 2013-14, which is a General Fund increase of $14,603,355 above the base request. This request is the combined result of a projected increase in the caseload of dual-eligible individuals in conjunction with an increase in the per-member per-month (PMPM) rate paid by the State as required by federal regulations. The Department also estimates the additional General Fund need in FY 2012-13 will be $6,677,986. This estimate is for informational purposes only.

Problem or Opportunity:
On January 1, 2006, the federal Centers for Medicare and Medicaid Services (CMS) assumed responsibility for the Medicare Part D prescription-drug benefit that replaced the Medicaid prescription-drug coverage for dual-eligible clients (individuals eligible for both Medicare and Medicaid). In lieu of the states' obligation to cover prescription drugs for this population, CMS began requiring states to pay a portion of what their anticipated dual-eligible drug cost would have been had this cost shift not occurred. These "clawback" payments, if left unpaid, are subject to automatic deduction – plus interest – from the federal funds the State receives for the Medicaid program.

Brief Background:
In January 2006, states began to pay CMS these clawback payments. The payments were calculated by taking 90% of the federal portion of each state's average PMPM dual-eligible drug benefit from calendar year 2003, inflated to 2006 using the average growth rate from the National Health Expenditure (NHE) per-capita drug expenditures. This inflated PMPM amount is then multiplied by the number of dual-eligible clients, including retroactive clients, back to January 2006. As each calendar year passes, the 90% factor is lowered by 1.67% each year – which is known as the phasedown percentage – until it reaches 75%, where it will remain beginning in 2015. In addition, CMS inflates each state's PMPM rates based on either NHE growth or actual growth in Part D expenditures.

For FY 2013-14, the Department estimates the clawback payment will total $111,278,217, which is $14,603,355 General Fund higher than the base request. This difference is a result of projected increases in caseload and the PMPM rate.

The Department would like to make note of the significant General Fund increase that this line

item will likely need beginning in FY 2014-15. As originally discussed in the Department's November 1, 2010 DI-6 "Cash Fund Insolvency Financing," since FY 2010-11, the Department has been utilizing federal funds received from the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) performance as General Fund offset in this line item. The performance bonuses are available to states through federal fiscal year 2013, with receipt of the final adjustment payment anticipated in August 2014. As shown in Table 3 of Appendix A in the Department's November 1, 2011 R-11 "CHIPRA Bonus Payment True-Up," the Department anticipates that the federal funds available to this line item will decrease from $49,048,695 in FY 2013-14 to $2,916,140 in FY 2014-15. This means that the difference of $46,132,555 will need to be appropriated as General Fund in FY 2014-15 solely due to the expiration of the performance bonus.

Proposed Solution:
The Department proposes this line item be funded as requested so the State can meet its obligation to the federal government and ensure that the amount of payment plus interest is not deducted from federal funds received for Medicaid.

Alternatives:
The MMA State Contribution Payment is a federal mandate. As such, the only alternative to paying the amount invoiced by CMS is to not pay and have the amount plus interest be deducted from federal funds received for Medicaid.

Anticipated Outcomes:
Approval of this request would allow the Department to meet its obligation to the federal government and ensure the Department would not have the amount of payment plus interest deducted from the federal funds received for the Medicaid program. Such a deduction could cause the Department to be under-funded to provide services and would necessitate a General Fund appropriation or program cuts to make up the difference, as Medicaid is an entitlement program in which the Department cannot cap enrollment.

Assumptions for Calculations:
The Department assumes the changes in the PMPM rate paid by the Department will be based on the formula established by CMS, which considers changes in annual growth of NHE prescription-drug per-capita estimates and are offset by the corresponding phasedown percentage rate. The Department further assumes the changes in dual-eligible caseload will follow a trend of 4.03% annual growth, as has been evidenced historically. Tables detailing these calculations are attached in Appendix A.

Consequences if not Funded:
If the Department does not receive the requested appropriation and subsequently cannot make the required federal payment, the Department is at risk of having the amount due for the clawback payment – plus interest – deducted from the federal funds received for the Medicaid program. Such a deduction could cause the Department to be under-funded to provide services and would necessitate a General Fund appropriation or program cuts to make up the difference, as Medicaid is an entitlement program in which the Department cannot cap enrollment.

Current Statutory Authority or Needed Statutory Change:
42 C.F.R. §423.910 (a) General rule: *Each of the 50 States and the District of Columbia is required to provide for payment to CMS a phased-down contribution to defray a portion of the Medicare drug expenditures for individuals whose projected Medicaid drug coverage is assumed by Medicare Part D.*

25.5-5-503, C.R.S. (2012) (1) *The state department is authorized to ensure the participation of Colorado medical assistance recipients, who are also eligible for medicare, in any federal prescription drug benefit enacted for medicare recipients. (2) Prescribed drugs shall not be a covered benefit under the medical assistance program for a recipient who is eligible for a prescription drug benefit program under medicare; ...*

Appendix A: Medicare Modernization Act of 2003 State Contribution Calculations

Using the prescribed methodology described below, the Department estimates the per-member per-month (PMPM) rate to be $139.44 for CY 2013 and $104.71 for CY 2014 as seen in Tables 1 and 2. However, the Department is cautious of the dramatic estimated drop in the CY 2014 rate. In order to be conservative in its forecast, the Department is opting to maintain the CY 2013 rate into CY 2014. Because CMS announces PMPM rates approximately three months prior to the rate taking effect, the Department will have more information regarding the CY 2014 rate at this time next year and will adjust the budget accordingly.

To estimate the CY 2013 PMPM rate (Table 1), the Department followed the procedure outlined by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) using the National Health Expenditure (NHE) estimates of per-capita drug-expenditures growth for the period 2006 to 2009 listed in CMS's NHE Projections from years 2010 and 2011. This estimate also includes the CY 2013 annual percentage increase in the average per-capita aggregate Part D expenditures from CMS. Applying this figure to the previous year's pure PMPM rate, the state share is taken into account, and that figure is then multiplied by the phasedown rate for CY 2013 to produce the final PMPM estimate.

Table 1: CY 2013 PMPM Rate		
From NHE Projections 2010-2020 (Table 11)		
	Estimated 2006 Per-Capita Prescription Drug Expenditures	$735
	Estimated 2009 Per-Capita Prescription Drug Expenditures	$813
	Percentage Growth	10.61%
From NHE Projections 2011-2021 (Table 11)		
	Estimated 2006 Per-Capita Prescription Drug Expenditures	$752
	Estimated 2009 Per-Capita Prescription Drug Expenditures	$836
	Percentage Growth	11.17%
Change in Percentage Growth		**5.28%**
From Announcement of CY 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies		
	Annual % Increase in Avg. Per Capita Aggregate Part D Expenditures for 2012 (Attachment V, Table III-1)	2.27%
FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2013		**7.55%**
2012 PMPM Rate Prior to FMAP and Phasedown		$331.03
FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2013		7.55%
Projected CY 2013 PMPM Rate Prior to FMAP and Phasedown		$356.02
FMAP State Share		50.00%
Projected CY 2013 PMPM Rate Prior to Phasedown		$178.01
CY 2013 Phasedown Percentage		78.33%
Projected CY 2013 PMPM Rate		**$139.44**

Sources: Centers for Medicare & Medicaid Services, NHE Projections 2010-2020, Table 11; Centers for Medicare & Medicaid Services, NHE Projections 2011-2021, Table 11; and Announcement of CY 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table III-1.

Using the same methodology to estimate the CY 2014 PMPM rate – only with NHE estimates of per-capita drug-expenditures growth for the period 2007 to 2010 and the CY 2014 annual percentage increase in the average per-capita aggregate Part D expenditures – the estimated CY 2014 rate is $104.71 (see Table 2 on the following page), which is significantly lower than the previous year's rate.

Table 2: CY 2014 PMPM Rate, Original Calculation		
From NHE Projections 2010-2020 (Table 11)		
	Estimated 2007 Per-Capita Prescription Drug Expenditures	$762
	Projected 2010 Per-Capita Prescription Drug Expenditures	$833
	Percentage Growth	9.32%
From NHE Projections 2011-2021 (Table 11)		
	Estimated 2007 Per-Capita Prescription Drug Expenditures	$784
	Estimated 2010 Per-Capita Prescription Drug Expenditures	$839
	Percentage Growth	7.02%
Change in Percentage Growth		**-24.68%**
From Announcement of CY 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies		
	Annual % Increase in Avg. Per Capita Aggregate Part D Expenditures for 2013 (Attachment V, Table III-2)	1.40%
FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2014		**-23.28%**
2013 PMPM Rate Prior to FMAP and Phasedown		$356.02
Final Percentage Change in Rate Prior to Applying Phasedown for CY 2014		-23.28%
Projected CY 2014 PMPM Rate Prior to FMAP and Phasedown		$273.14
FMAP State Share		50.00%
Projected CY 2014 PMPM Rate Prior to Phasedown		$136.57
CY 2014 Phasedown Percentage		76.67%
Projected CY 2014 PMPM Rate		**$104.71**

Sources: Centers for Medicare & Medicaid Services, NHE Projections 2010-2020, Table 11; Centers for Medicare & Medicaid Services, NHE Projections 2011-2021, Table 11; and Announcement of CY 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table III-2.

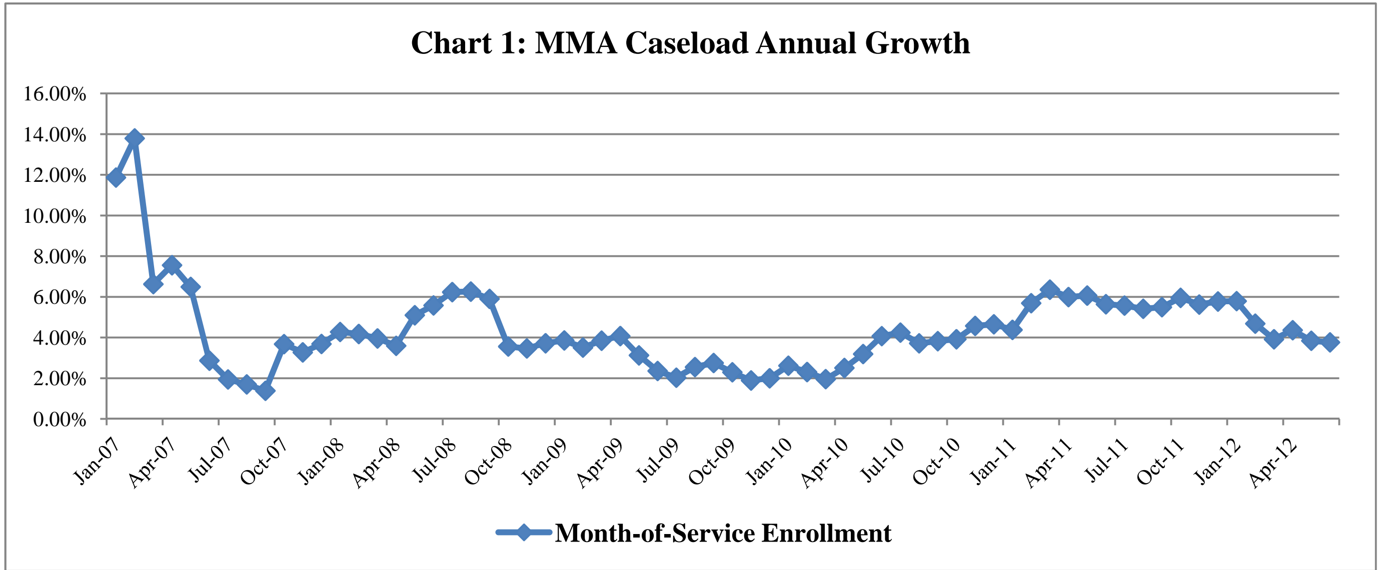
Earlier in 2012, a preliminary estimate of the CY 2014 PMPM rate was calculated using NHE projections from one year prior, and this estimate also indicated a significantly lower rate. As discussed above, the Department is electing to maintain the CY 2013 PMPM rate into CY 2014 for this request.

The Department notes the projection of PMPM rates is based on the growth in the NHE drug expenditures; however, federal law states the growth factor for 2007 and succeeding years will equal the annual percentage increase in average per-capita aggregate expenditures for covered Part D drugs in the United States for Part D-eligible individuals during the 12-month period ending in July of the previous year. Since actual expenditure data is not available for 2012 and beyond at the time of this request, the actual per-capita rate growth may differ from the Department's projection.

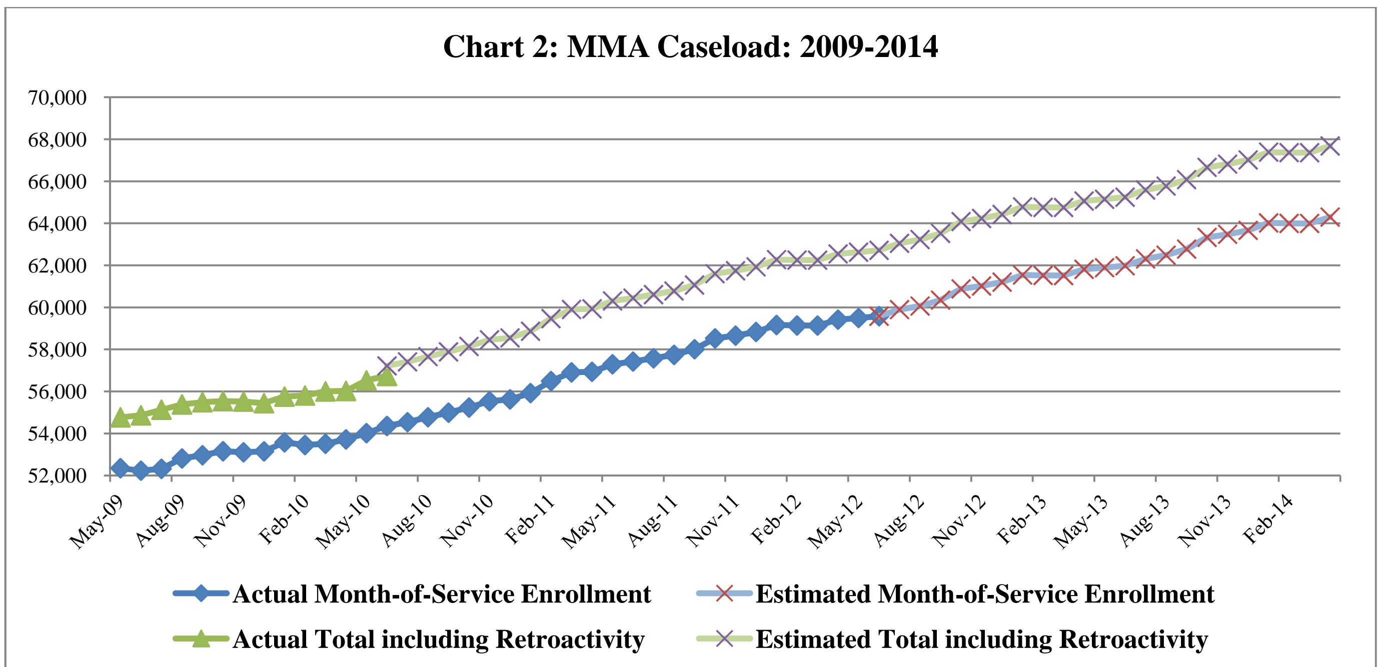
Caseload Calculation

To estimate caseload, the Department analyzed data from January 2006 through June 2012 and concluded a 4.03% historical trend, based upon an annual average over the past five years, is the most reasonable forecast method for the MMA clawback population. This method estimates caseload by increasing the figure from the same month during the previous year by 4.03%. Because clients are able to be retroactively enrolled and disenrolled for up to 24 months, retroactivity is also considered in this forecast. Historical data shows current month enrollment accounts for approximately 95% of the final caseload figure including retroactivity. This data also shows a decay rate that spreads the remaining 5% out over the first 12 retroactive months.

Chart 1, below, illustrates the complete history of annual growth of MMA caseload, comparing the growth in MMA enrollment for that month relative to enrollment for the same month in the previous year. Omitting the initial spike at the beginning of the program, annual caseload growth has been between approximately 2% and 6%, with an average annual growth rate of approximately 4%. Recent data is in line with this long-term trend; thus, the Department concludes the five-year annual average of 4.03% is reasonable to project MMA caseload growth for FY 2013-14.



The following chart (Chart 2) depicts MMA caseload totals, both for month-of-service enrollment and totals including retroactivity, as well as forecast estimates through FY 2013-14 for each. The forecast estimates are determined using the 4.03% historical average discussed above.



Due to a two-month delay between when the Department receives an invoice from CMS and when the invoice is paid, the amount paid in the July-through-June fiscal year are actually the invoices received between May and April. To improve the accuracy of the estimate for this line, the caseload projection table (Table 4, below) reflects this May-through-April period of time.

Table 4: FY 2013-14 Projected MMA Caseload and Expenditures				
	CY 2012	**CY 2013**	**CY 2014**	**FY 2013-14 TOTAL**
May 2013	651	64,497	0	65,148
June 2013	457	64,788	0	65,245
July 2013	328	65,260	0	65,588
August 2013	230	65,543	0	65,773
September 2013	165	65,916	0	66,081
October 2013	100	66,565	0	66,665
November 2013	67	66,751	0	66,818
December 2013	34	66,984	0	67,018
January 2014	0	3,370	64,021	67,391
February 2014	0	2,189	65,177	67,366
March 2014	0	1,516	65,847	67,363
April 2014	0	1,015	66,668	67,683
CY Client Total	2,032	534,394	261,713	
CY Rate	$132.41	$139.44	$139.44	
Expenditures	**$269,057**	**$74,515,899**	**$36,493,261**	**$111,278,217**

Based upon a 4.03% annual growth rate, the Department anticipates FY 2013-14 caseload will increase from 65,148 in May 2013 to 67,683 in April 2014 (see Table 4). As a result, the total projected expenditure for the Medicare Modernization Act of 2003 State Contribution Payment for FY 2013-14 is $111,278,217.

FY 2012-13 Revised Estimate

As noted in the Department's November 1, 2011 R-4, CMS released the National Health Expenditure Projections for 2010-2020 on July 26, 2011, which would have adjusted the estimated PMPM rates for CY 2012 and CY 2013. At the time of the submission of that request, the Department was analyzing the new NHE estimates to determine the impact these projections may have on the MMA State Contribution Payment line item, but noted that initial results indicated that MMA FY 2012-13 total expenditures could increase by as much as 6.5%. The estimated CY 2012 PMPM rate included in the Department's November 1, 2011 R-4 was $125.58. The actual PMPM rate determined by CMS for CY 2012 was $132.44, 5.4% higher than the Department's original estimate. Because the estimate for CY 2013 is based off the CY 2012 rate, the increase in the CY 2012 rate drives an increase in the estimated CY 2013 rate that is included in this request.

The difference between the Department's estimated PMPM rates and actual and updated estimates are shown in the following table on the next page (Table 5).

Table 5: PMPM Rate Estimate Comparisons		
	CY 2012	**CY 2013**
FY 2011-12 PMPM Rate Estimate		
November 1, 2011 Estimate	$125.58	-
Actual Rate	$132.41	-
% Difference	**5.44%**	-
FY 2012-13 PMPM Rate Estimate		
November 1, 2011 Estimate	$125.58	$128.49
November 1, 2012 Estimate	-	$139.44
Actual Rate	$132.41	-
% Difference	**5.44%**	**8.52%**

The caseload forecast for FY 2012-13 has also been revised, including accounting for the two-month delay between when invoices are received from CMS and when the invoices are paid. As a result of these adjustments, the Department estimates the need for an additional $6,677,986 General Fund for this line for FY 2012-13 to bring it in line with the revised expenditure estimate of $103,352,848 as detailed below in Table 6.

Table 6: FY 2012-13 Projected MMA Caseload and Expenditures				
	CY 2011	**CY 2012**	**CY 2013**	**FY 2012-13 TOTAL**
May 2012	627	62,000	0	62,627
June 2012	438	62,280	0	62,718
July 2012	316	62,734	0	63,050
August 2012	221	63,006	0	63,227
September 2012	159	63,364	0	63,523
October 2012	96	63,989	0	64,085
November 2012	64	64,167	0	64,231
December 2012	32	64,391	0	64,423
January 2013	0	3,239	61,543	64,782
February 2013	0	2,105	62,655	64,759
March 2013	0	1,457	63,298	64,755
April 2013	0	976	64,088	65,064
CY Client Total	1,953	513,708	251,584	
CY Rate	Varies*	$132.41	$139.44	
Expenditures	**$251,899**	**$68,020,076**	**$35,080,873**	**$103,352,848**

**CY 2011 Rates: CQ1 - $107.07; CQ2 - $111.98; CQ3 - $129.84; CQ4 - $129.84.*

Table 7 on the following page details the changes in this line item between the FY 2012-13 Long Bill appropriation and the FY 2013-14 request. As can be seen, the $14,603,355 request for FY 2013-14 represents a two year request – $6,677,986 to update the FY 2012-13 appropriation with revised estimates, and an additional $7,925,369 to get from the FY 2012-13 revised estimate to the FY 2013-14 projection.

Table 7: Building to FY 2013-14 Request			
	TF	**GF**	**FF**
FY 2012-13 Long Bill Appropriation	**$90,656,176**	**$50,609,286**	**$40,046,890**
Annualization of FY 2012-13 R-11 "CHIPRA Bonus Payment True-Up"	$0	($2,983,119)	$2,983,119
Correction for FY 2012-13 R-4 "MMA State Contribution Payment"	$6,018,686	$0	$6,018,686
FY 2012-13 Total with Corrections	**$96,674,862**	**$47,626,167**	**$49,048,695**
FY 2012-13 S-4 "MMA State Contribution Payment"	$6,677,986	$6,677,986	$0
FY 2012-13 Total with Corrections and Supplemental Request	**$103,352,848**	**$54,304,153**	**$49,048,695**
Annualization of FY 2012-13 S-4 "MMA State Contribution Payment"	($6,677,986)	($6,677,986)	$0
FY 2013-14 Base Request	**$96,674,862**	**$47,626,167**	**$49,048,695**
FY 2013-14 R-4 "MMA State Contribution Payment"	$14,603,355	$14,603,355	$0
FY 2013-14 November 1 Request	**$111,278,217**	**$62,229,522**	**$49,048,695**
Difference between FY 2013-14 Request and FY 2012-13 Revised Total	*$7,925,369*	*$7,925,369*	*$0*

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medicaid Management Information System Reprocurement

Priority Number: R-5

Dept. Approval by: John Bartholomew JB 10/26/12 Date

OSPB Approval by: Date

- Decision Item FY 2013-14
- Base Reduction Item FY 2013-14
- Supplemental FY 2012-13
- Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$0	$0	$0	$15,624,403	$33,177,576
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$1,439,072	$3,009,970
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$287,834	$607,258
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$13,897,497	$29,560,348
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, MMIS Reprocurement Contracts[a] *(new line item)*	Total	$0	$0	$0	$12,625,032	$30,177,141
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$1,165,817	$2,736,240
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$232,837	$552,209
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$11,226,378	$26,888,692
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, MMIS Reprocurement Contracted Staff[b] *(new line item)*	Total	$0	$0	$0	$2,999,371	$3,000,435
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$0	$0	$0	$273,255	$273,730
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$54,997	$55,049
	RF	$0	$0	$0	$0	$0
	FF	$0	$0	$0	$2,671,119	$2,671,656

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

FY 2013-14:

a Of this amount, $99,422 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S. and $133,415 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.

b Of this amount, $23,620 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S. and $31,377 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.

FY 2014-15:

a Of this amount, $221,802 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S. and $330,407 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.

b Of this amount, $22,053 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S. and $32,996 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Children's Basic Health Plan Trust Fund 11G, Hospital Provider Fee Cash Fund 24A, FF: Title XIX, Title XXI

Reappropriated Funds Source, by Department and Line Item Name: None

Approval by OIT? Yes: No: **Not Required:** ✓

Schedule 13s from Affected Departments: None

Other Information: None

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 Funding Request
November 1, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Signature Date

Department Priority: R-5
Medicaid Management Information System Reprocurement

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
MMIS Reprocurement	$15,624,403	$1,439,072	0.0

Request Summary:
In order to competitively bid and procure a new Medicaid Management Information System (MMIS) and corresponding Fiscal Agent services, the Department requests a funding increase in the following amounts:

- FY 2013-14: $15,624,403 total funds, comprised of $1,439,072 General Fund, $287,834 cash funds, and $13,897,497 federal funds;
- FY 2014-15: $33,177,576 total funds, comprised of $3,009,970 General Fund, $607,258 cash funds, and $29,560,348 federal funds;
- FY 2015-16: $32,143,637 total funds, comprised of $2,917,621 General Fund, $588,460 cash funds, and $28,637,556 federal funds; and,
- FY 2016-17: $23,991,872 total funds, comprised of $2,180,270 General Fund, $439,445 cash funds, and $21,372,157 federal funds.

Cumulatively, this request is for a funding increase for the period FY 2013-14 to FY 2016-17 of $104,937,488 total funds, comprised of $9,546,933 General Fund, $1,922,997 cash funds, and $93,467,558 federal funds.

Note that the Department intends for the combined ongoing operating cost of the new MMIS components to be no greater than the currently appropriated amounts for operations of current MMIS components.

Problem or Opportunity:
When the current MMIS and Fiscal Agent services contract ends in FY 2015-16, it must be competitively bid and reprocured in order to meet certain federal fiscal agent contracting requirements. Furthermore, the current highly outdated MMIS creates significant operational inefficiencies, limitations to the Department's ability to implement policy changes, and risks losing federal approval and federal financial participation (FFP), making reprocurement an opportunity to acquire a new, modern MMIS to address these problems.

Brief Background:
MMIS Purpose and Requirements
The MMIS itself is the hardware, software, and business process workflows that have been designed to meet the criteria for a "mechanized claim processing and information retrieval system" required by federal law to participate in the Medicaid program (see Section 1903(r) of the Social Security Act). The MMIS's core function

is to adjudicate and process the Department's medical claims and capitations for payment; it also provides other important functions including provider enrollment and management, certain client management functions, and analytics and reporting. Since the MMIS electronically processes approximately 97% of the Department's claims, its capabilities (and limitations) play a pivotal role in how the Department administers the Medicaid program.

The MMIS must meet the federal requirements issued by the Centers for Medicare and Medicaid Services (CMS) to qualify as an approved system and receive the enhanced FFP rates of 90% on Design, Development, and Implementation (DDI) costs, and 75% on operational costs. These requirements are outlined in Chapter 11 of the State Medicaid Manual (SMM), and also now include the recently issued Seven Standards and Conditions. The Seven Standards and Conditions focus primarily on progressing toward new, modern systems and processes and were built upon work that CMS, states and private industry have done over the last six years under the Medicaid Information Technology Architecture (MITA) initiative.

Current MMIS Overview

The current MMIS and Fiscal Agent services contract has been with Affiliated Computer Services, Inc., now Xerox, since December 1998. During this period, the MMIS and Fiscal Agent services contract was competitively bid and reprocured once, in which the incumbent vendor won the bid. The current contract's operational phase began in July 2007 using the same MMIS software as the prior contract and it expires June 30, 2015; at that time, it will be an 8-year-old contract. After 8 years, CMS has historically required the MMIS and Fiscal Agent services contract to be competitively bid and reprocured (SMM Section 2080.4); therefore, the Department must reprocure the MMIS and Fiscal Agent services by the end of the current contract to satisfy federal requirements and maintain enhanced FFP for DDI and operations. Before the current vendor, Blue Cross Blue Shield was the MMIS and Fiscal Agent services vendor for 12 years, using the same MMIS currently utilized by the Department.

The current MMIS is highly outdated, as it is over 20 years old (with some components being over 30 years old) and is based on a 1970's general mainframe design. Several of these components were modern when first designed (e.g. the MMIS is accessible by Department users through a Windows interface), but most interactions with outside parties (including providers) are now performed through outdated and difficult-to-configure processes. While the current MMIS is sufficient to process a high volume of claims, it lacks the enhanced capabilities of modern solutions. For example, modern MMIS solutions allow for system changes through configurable technology rather than long and costly programming efforts, allow for more effective web-based interfaces rather than mainframe file exchanges, and allow for alternative health benefit packages and provider reimbursement methodologies. Since the MMIS is central to administering the Medicaid program, the manual processes and workarounds that the Department has developed around these limitations create significant operating inefficiencies and restrictions to policy changes.

MMIS Reprocurement Preparation

To prepare for the competitive bid and reprocurement of the MMIS, the Department was appropriated $439,153 total funds in FY 2010-11 and $546,400 total funds in FY 2011-12 through the Department's FY 2010-11 BA-15 "MMIS Adjustments." (Note that the funding appropriated in BA-15 for FY 2010-11 was rolled forward to FY 2011-12 in the Department's FY 2010-11 Supplemental Bill, SB 11-139.) With the preparatory activities funded by BA-15 reaching completion, the Department now requests funding to proceed with the reprocurement.

With funding appropriated under BA-15, the Department hired the management consulting firm Public Knowledge, LLC to help determine the most effective strategy for an MMIS and

Fiscal Agent services reprocurement. To this end, Public Knowledge produced the *MMIS Procurement Analysis Report* in March 2012, which led to the solution proposed in this request. The report evaluated a wide range of reprocurement strategies based on thorough research of 35 other states' recent MMIS and Fiscal Agent services reprocurement experiences, Department staff and stakeholder input, CMS input, an independent literature review, and vendor demonstrations and feedback. Of particular value in the report was the research of other states' experiences; this research has allowed the Department to incorporate the hard-won lessons of other states' reprocurement failures and successes. States indicated that failed and delayed procurements were due to unclear requirements, project management weaknesses, an inability of the state to negotiate the contract terms and conditions, underestimated project schedules and many other factors that the Department has been careful to mitigate throughout the reprocurement process. These lessons are discussed in more detail at relevant points throughout the request.

Public Knowledge has also assisted the Department in creating a Request for Proposals (RFP) to solicit bids for the MMIS. Public Knowledge facilitated over 70 hours of group sessions with staff across the Department to develop detailed requirements and priorities to include in the RFP. These efforts helped mitigate the risk of unclear requirements seen in other states and ensure that the Department gets exactly what it is asking for and needs in the RFP. Public Knowledge is in the process of writing and reviewing the RFP with the Department at the time of developing this request.

Throughout these preparatory activities for the MMIS reprocurement, the Department has been working through a transparent process and engaging potential vendors. This has included holding a vendor fair in December 2011, releasing a draft RFP on August 1, 2012 for vendor comment and allowing considerable time for vendors to provide proposals prior to the scheduled April 1, 2013 award.

Proposed Solution:
To best meet the federal requirements to competitively bid and reprocure the MMIS and Fiscal Agent services contract and to address the substantial difficulties, inefficiencies, and risks posed by the current MMIS, the Department's proposed solution is to acquire a new, modern replacement MMIS. This proposed solution consists of a competitive bid and procurement for the MMIS and Fiscal Agent services to meet federal reprocurement deadlines, and replacing the current MMIS software with a modern MMIS, transferred and modified for use in Colorado, to address the current and future needs of the Department.

Alternatives:
In deciding upon the proposed reprocurement solution, the Department identified and considered four broad alternatives that aligned with the Department's visions and priorities, which were then researched and evaluated in the *MMIS Procurement Analysis Report* prepared by Public Knowledge. The four alternatives considered are:

1. Acquire a new MMIS (which ultimately became the Department's proposed solution);
2. Broker claims processing and administrator services through:
   a. A competitive procurement process, or
   b. An existing Department relationship;
3. Participate in a multi-state MMIS, and;
4. Keep the existing MMIS.

Each of the four identified alternatives encompasses a range of solutions and specific options. The following is a summary of the three alternatives that the Department ultimately did not recommend as the proposed solution. These three alternatives were deemed to be less effective, have higher long-term costs, and/or have higher risk than the proposed solution, as is discussed below.

Alternative two consists of contracting the services of vendors already processing claims in a commercial environment to process the Department's claims. While this approach could have very low implementation costs, long-term operational costs could be substantially higher than other alternatives and are at risk of not meeting CMS approval for enhanced FFP. To the Department's knowledge, CMS has never approved a broker claim approach, so the Department would need to investigate with CMS whether an enhanced match could be available. Alternative three consists of either leading or participating in a multi-state consortium to develop a multi-state MMIS. While this option would be encouraged by CMS due to its ability to leverage resources among states, it would be highly taxing to state resources and face prolonged implementation timelines and legal difficulties as a result of multi-state planning efforts. Finally, alternative four consists of a competitive bid and reprocurement of the MMIS and Fiscal Agent services, but keeping the same MMIS software currently used. This is what the Department did in its last MMIS reprocurement, and while this option would be the least expensive and resource-intensive to implement, it does not ameliorate the problems and risks associated with the current MMIS, including the risk of noncompliance with the Seven Standards and Conditions. Further, this option may still require costly system changes if the contract were to be transferred to a new vendor.

Anticipated Outcomes:

Justification of Proposed Solution

Of all the alternatives discussed in the previous section, the Department's proposed solution of acquiring a new MMIS is the most effective way to meet the federal requirements to competitively bid and reprocure the MMIS and Fiscal Agent services contract and to address the substantial difficulties and risks posed by the current MMIS. Each alternative underwent a structured evaluation process described in the *MMIS Procurement Analysis Report* that consisted of a written assessment of each alternative based on Department priorities and Public Knowledge's research, as well as a quantitative scoring process with Department staff and stakeholders using weighted criteria defined by the Department's procurement team. The solution now proposed in this request scored the highest of all other alternatives through this assessment process as shown in Figures 1A and 1B of the attached Appendix. After this assessment process, the solution was refined to best meet Department priorities and resource constraints using best practices and lessons learned from the 35 other states reported on by Public Knowledge, as well as feedback from vendors to the *Proposed Procurement Strategy*.

Although the proposed solution of acquiring a new, modern MMIS and Fiscal Agent services requires significant resources to implement, a modern MMIS will increase efficiencies, allow greater program flexibility, and ensure compliance with federal MMIS regulations. In addition to the technology implementation costs, the proposed solution also requires temporary staffing to assist the Department during the implementation phase to avoid the costs and delays of a failed procurement seen in other states. The temporary staffing is expected to be either at the Department or contracted out through a separate RFP process, provided through a temporary agency or a combination of both. The proposed solution is a proven approach and the traditional solution for most states in the past, meaning that unlike some alternatives, CMS approval of the solution is ensured along with the accompanying 90% FFP on Design, Development, and Implementation (DDI) costs, and 75% FFP on operational costs. The proposed solution also allows for great opportunity to meet modernization goals, addressing the limitations of the current MMIS and, based on Public Knowledge's research and vendor demonstrations, allows for faster and less costly system modifications (once the system is initially implemented) to accommodate future policy changes; such modern capabilities comply with CMS's Seven Standards and Conditions, and thus ensure continuing FFP in the future for the MMIS.

Details of Proposed Solution

In procuring a new MMIS, the Department proposes separating the MMIS into three components - releasing three separate RFPs - and designing each RFP based on the best practices and lessons learned in other states reported in the *MMIS Procurement Analysis Report* to most effectively serve the Department's needs. Multiple RFPs encourage a "best of breed" solution by capitalizing upon vendor strengths that may specialize in one area of the overall system, as well as minimize implementation time by utilizing overlapping implementations of the components. The three components are:

1. Core MMIS and Fiscal Agent services, which will include the Provider Web Portal, currently administered by a separate vendor from the MMIS;
2. Pharmacy Benefits Management System, and;
3. Business Intelligence functions, which includes the Statewide Data and Analytics Contractor, currently administered by a separate vendor from the MMIS.

Each of the RFPs will be structured to be objectives-based (i.e. specifying the "what," not the "how) in order to encourage vendor innovations. All procurement decisions will be evaluated against the guiding principles shown in Figure 2 of the attached Appendix to ensure that risks are mitigated appropriately, the procurement is successful, and there is minimal impact to clients, the provider community and other stakeholders.

The proposed solution also requires adequate oversight and project management throughout the DDI phase, including Independent Verification and Validation (IV&V) and temporary staffing. During this phase, the Department proposes a contractor for IV&V to provide independent, technical oversight of the MMIS contractor. The Department also proposes contracting for temporary staff at the Department during the DDI phase in order to ensure adequate Departmental oversight and resources for a successful procurement.

In addition to DDI, IV&V, and contracting costs, the Department also anticipates that certain commercial off-the-shelf products will be needed. These include, but are not limited to, analytics software, an electronic document management system, provider call center software, and project management software.

Timeline of Proposed Solution

The Department's anticipated timeline for the proposed solution is shown in Figure 3 of the attached Appendix, and there are several important things to note. The DDI phase of the three components spans from FY 2013-14 to FY 2016-17, during which time an IV&V contractor and the temporary staff will work. For each component, the DDI is split in two phases and the component begins operating at the conclusion of the first DDI phase. Note that the first six months of the MMIS design is for business process re-engineering, a process to ensure that process changes best reflect the needs of the Department and not the MMIS contractor. The Department's solution also will require approval from CMS for an extension of the current MMIS operating contract to allow for adequate time to implement the new MMIS.

The estimated timeline is largely based on the research of other state's experiences and is structured to ensure a realistic and adequate length of time is given to development activities. Many states have had delayed implementations or have severely underestimated the time required to implement. For instance, the recent Wisconsin MMIS implementation required 46 months instead of the 24 months originally estimated, the recent Washington implementation required 64 months instead of the 30 months originally estimated, and the recent Maine implementation required 30 months instead of the 24 months originally estimated.

Assumptions for Calculations:
All calculations and figures are included in the attached Appendix. The Department anticipates the total cost of the proposed solution to be $104,937,488 over four fiscal years, based on other states' recent MMIS reprocurements that were reported by Public Knowledge; this cost is shown itemized by fiscal year in Figure 4. For details of the anticipated temporary staffing needs, see Figures 5A and 5B. Note that the Department intends for the combined ongoing operating cost of the new MMIS components to be no greater than the currently appropriated amounts for operations of current MMIS components.

To finance the proposed solution, a number of assumptions have been made regarding federal matching rates and state financing. The Department anticipates that CMS will support all DDI costs with 90% FFP and commercial-off-the-shelf software products and training at 75% FFP and 50% FFP, respectively. The Department intends to house this request's funding in two new line items in order to keep the funding separate from current MMIS operating appropriations and to reflect the temporary nature of the funding. The Department assumes all funding to be financed with 97% Medicaid FFP and 3% CHP+ FFP (which is 65%) pursuant to the Department's approved cost allocation methodology with CMS. In addition, state funds will utilize Hospital Provider Fee Cash financing to reflect the proportion of HB 09-1293 expansion caseload under each program. See Figures 6A through 6D for an itemized summary of the financing across fiscal years and Figures 7A through 7F for an overall summary of the request by fiscal year.

Consequences if not Funded:
Without the funding presented in this request, the Department would likely have to pursue one of the alternative solutions presented above, all of which were assessed to be less effective, have higher long-term costs, and/or have higher risk than the proposed solution, as discussed in the *Alternatives* and *Anticipated Outcomes* sections.

In particular, although the alternative of keeping the current MMIS (possibly transferring to another vendor through the bidding process) is likely to be significantly less expensive to implement, it does nothing to address the substantial difficulties and risks posed by the current MMIS. For instance, the current MMIS is unable to implement Alternative Benefit Plans; thus, with the current MMIS, the Department would have to give any potential expansion populations under the federal Affordable Care Act full Medicaid benefits instead of alternative packages deemed appropriate by policy-makers. These alternative benefit packages are intended to be designed more like a commercial insurance plan, with limits on amount, duration, and scope of services. Such alternative benefit packages could better align benefits with health care needs of the population served at lower costs. Also, the current MMIS puts the Department at risk of losing enhanced FFP for MMIS operations because keeping a highly outdated MMIS contradicts the "MITA" condition of the Seven Standards and Conditions, which requires states to make measurable progress in maturity for business, architecture, and data.

If this request is not adequately funded, the state risks the high costs and lost investments of a failed or severely delayed procurement. In particular, although funding for temporary staff costs are high, Public Knowledge's research indicates that inadequate Department staff resources, either through a direct increase in staff or temporary, contract resources, are a key factor in failed or delayed MMIS procurements. The majority of all states directly contacted in Public Knowledge's study reiterated the importance of solid project governance, with a strong Project Management team and adequate staffing resources being a key factor. Maine, for example, recently implemented a new MMIS and cited its most fundamental lesson learned was the need for a strong, competent Project Management Team, both at the state and at the vendor. Arkansas was recently forced to cancel an MMIS reprocurement and is now beginning a new procurement citing

the need for fewer RFPs (their initial had 20), and a stronger project management approach using dedicated staff and a Project Management Office.

Impact to Other State Government Agency:
Not applicable.

Cash Fund Projections:
This request includes Cash Funds from the Children's Basic Health Plan Trust and the Hospital Provider Fee Cash Fund. For information on associated revenues, expenditures, and cash fund balances, please see the Schedule 9 "Cash Funds Report" in Section O of this Budget Request.

Relation to Performance Measures:
Federal mandate.

Current Statutory Authority or Needed Statutory Change:
The Department is the single state Medicaid agency and has authority to administer the MMIS through 25.5-4-204 (3), C.R.S. (2012) and §1903 (a) of the Social Security Act [42 U.S.C. 1396b].

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Additional FTE to Restore Functionality

Priority Number: R-6

Dept. Approval by: John Bartholomew 10/29/12
Date

OSPB Approval by: 10/30/12
Date

- [x] Decision Item FY 2013-14
- [ ] Base Reduction Item FY 2013-14
- [ ] Supplemental FY 2012-13
- [ ] Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$28,524,475	$0	$29,699,432	$704,341	$800,719
	FTE	326.2	0.0	326.6	7.4	9.0
	GF	$10,217,610	$0	$11,355,147	$352,172	$400,361
	GFE	$0	$0	$0	$0	$0
	CF	$2,519,384	$0	$2,560,455	$0	$0
	RF	$1,438,886	$0	$1,181,464	$0	$0
	FF	$14,348,595	$0	$14,602,366	$352,169	$400,358
(1) Executive Director's Office; (A) General Administration, Personal Services	Total	$22,593,922	$0	$23,641,039	$528,568	$644,865
	FTE	326.2	0.0	326.6	7.4	9.0
	GF	$7,971,021	$0	$9,149,778	$264,285	$322,433
	GFE	$0	$0	$0	$0	$0
	CF	$2,038,599	$0	$2,077,080	$0	$0
	RF	$1,176,645	$0	$1,069,555	$0	$0
	FF	$11,407,657	$0	$11,344,626	$264,283	$322,432
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	Total	$2,216,793	$0	$2,224,522	$39,789	$39,789
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$796,479	$0	$761,094	$19,895	$19,895
	GFE	$0	$0	$0	$0	$0
	CF	$174,652	$0	$167,467	$0	$0
	RF	$111,821	$0	$62,934	$0	$0
	FF	$1,133,841	$0	$1,233,027	$19,894	$19,894
(1) Executive Director's Office; (A) General Administration, Short-term Disability	Total	$33,497	$0	$39,933	$838	$1,023
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$12,334	$0	$13,650	$419	$512
	GFE	$0	$0	$0	$0	$0
	CF	$2,503	$0	$2,813	$0	$0
	RF	$1,309	$0	$611	$0	$0
	FF	$17,351	$0	$22,859	$419	$511
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	Total	$730,633	$0	$809,458	$17,050	$23,114
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$283,141	$0	$275,990	$8,525	$11,557
	GFE	$0	$0	$0	$0	$0
	CF	$53,468	$0	$57,223	$0	$0
	RF	$37,574	$0	$12,775	$0	$0
	FF	$356,450	$0	$463,470	$8,525	$11,557
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	Total	$627,713	$0	$730,907	$15,394	$21,668
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$242,160	$0	$249,158	$7,697	$10,834
	GFE	$0	$0	$0	$0	$0
	CF	$45,949	$0	$51,659	$0	$0
	RF	$33,280	$0	$11,679	$0	$0
	FF	$306,324	$0	$418,411	$7,697	$10,834

Department of Health Care Policy and Financing | **Schedule 13**
Request Title: Additional FTE to Restore Functionality | **Funding Request for the 2013-14 Budget Cycle**

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
(1) Executive Director's Office; (A) General Administration, Operating Expenses	Total	$1,625,353	$0	$1,557,009	$41,832	$8,550
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$715,356	$0	$708,358	$20,916	$4,275
	GFE	$0	$0	$0	$0	$0
	CF	$53,049	$0	$53,049	$0	$0
	RF	$78,257	$0	$23,910	$0	$0
	FF	$778,691	$0	$771,692	$20,916	$4,275
(1) Executive Director's Office; (A) General Administration, Leased Space	Total	$696,564	$0	$696,564	$60,870	$61,710
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$197,119	$0	$197,119	$30,435	$30,855
	GFE	$0	$0	$0	$0	$0
	CF	$151,164	$0	$151,164	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$348,281	$0	$348,281	$30,435	$30,855

Letternote Text Revision Required? Yes: ☐ No: ☑ If yes, describe the Letternote Text Revision:

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX
Reappropriated Funds Source, by Department and Line Item Name: N/A
Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑
Schedule 13s from Affected Departments: N/A
Other Information: N/A

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 Funding Request
November 1, 2012

John W. Hickenlooper
Governor

Sue Birch
Executive Director

Signature Date

Department Priority: R-6
Additional FTE to Restore Functionality

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
Additional FTE to Restore Functionality	$704,341	$352,172	7.4

Request Summary:

- The Department is committed to **improving external relations**, providing **timelier responses**, and presenting **more information with better data**.
- This **agency-wide** request will support senior Department staff, enabling timely, better informed interactions with stakeholders, legislators, and other partners.
- The Department acknowledges that internal problems exist, and this is **the Department's plan to address these issues**.
- **Changes have been made**, but the Department needs additional assistance.
- **All of the existing issues cannot be fixed without the approval of this request**.

As such, the Department requests an increase of $704,341 total funds, including $352,172 General Fund, in FY 2013-14, in order to hire additional employees to enable the Department to meet its objectives and restore core functionality as the administrator of the State's medical assistance programs and authority on health care. The Department's inadequate FTE level is impairing its ability to execute its mission to improve health care access and outcomes for the people it serves while demonstrating sound stewardship of financial resources, which has led to federal disallowances, audit findings, and inadequate customer service. Funds will be used specifically to cover the personal services, operating, and leased space expenses of new employees.

Problem or Opportunity:

Since the inception of the Department of Health Care Policy and Financing (the Department), the core function of the Department has changed. The Department has gone from simply a payer of the health care claims of those enrolled in the State's medical assistance programs to being expected to perform as a fully operational insurance plan. As such, the scope and complexity of the Department has changed significantly. Many new and complex programs and initiatives are being implemented, and in many cases the Department has either fully or partially absorbed the need for resources. The Department's current resources have become strained over time as the expectations of the public, the federal government, and the General Assembly have grown. In addition to new programs and initiatives, existing programs have grown significantly in both size and complexity; these changes together have diminished the Department's ability to adequately staff and manage programs effectively. By progressing from merely a payer of health care claims, to

being the State agency expected to bend the Medicaid cost curve, the Department is now in a position where additional resources are required in order to effectively operate.

Brief Background:

The understaffing problem the Department is struggling with can be traced back to the inception of the Department as the single State Medicaid agency. When the separation of the Department of Human Services and the Department occurred, the Department was simply a payer of the health care claims of those enrolled in the State's medical assistance programs. The Department was operational in nature, with little emphasis placed on policy and initiatives geared toward increasing quality and maintaining costs. Over time however, the core mission and the purpose of the Department has changed. Colorado is now becoming a national leader in health care, and the Department is expected to deliver innovative programs that will transform how the State delivers and pays for health care. These programs require vast amounts of knowledge, skill, and attention to administer. The Department's Accountable Care Collaborative (ACC) is an example of the kind of new, highly complex programs the Department is actively creating and implementing; another example would include HB 12-1281, "Medicaid Payment Reform Pilot Program." In addition to the implementation of elaborate new programs, the Department has also identified and implemented many efficiencies within the existing Medicaid program during the last four years of budget cuts. These represent some of the myriad of initiatives the Department is actively engaged in to transform the health care system in Colorado.

In addition to initiatives, the ways the Department interacts with stakeholders and the federal regulations surrounding the Department's programs have changed significantly. Historically, the Department only had limited participation and collaboration with stakeholder groups. Today, stakeholder relations are a critical piece of the Department's work. The Department consults and collaborates with stakeholders on nearly every project; in many cases, stakeholder participation is a requirement of both state and federal law. This collaborative process is important to ensure that policies being implemented meet the needs of both the Department and its clients. However, the Department believes that such stakeholder involvement has likely tripled the number of meetings required to implement any given policy, placing a significant burden on staff that are also tasked with the day-to-day operations to administer programs. Federal regulations are also much more numerous and strict today than they were in the past, leading to more federal fund disallowances and other findings as employees are finding it increasingly difficult to keep up with the additional regulatory pressures. Federal fund disallowances create a risk for the State, as the federal funds disallowed must be paid back with State funds, and often create a General Fund need which was not budgeted for. Federal fund disallowances could be caused by a multitude of things, such as not meeting federal timely filing requirements or other federal regulations on programs.

In FY 2003-04, the Department incurred $2.35 billion in Medicaid expenditures; by FY 2011-12, expenditures reached over $4.71 billion. These totals do not include Medicaid funds managed by the Department of Human Services (DHS), although the Department actively works with DHS staff to manage those funds as well. This expenditure growth is also placing additional pressure on Department staff to manage costs and conserve taxpayer resources, as Department expenditures have a "crowding out" effect on other areas of the State. This creates additional pressure for the people in charge of overseeing programs, as they must develop strategic plans to limit program growth without preventing clients from obtaining needed medical services and causing providers to stop accepting Medicaid clients. The Department has found that employees cannot function effectively when they are responsible for all areas of a program. When a single employee is responsible for the

operational, policy, and strategic aspects of program management, that person simply does not have enough time to devote to each required task, and this can lead to:

- audit findings,
- federal fund disallowances ranging from several hundred thousand to several million dollars depending on the size of the program,
- lawsuits,
- lost appeals,
- the inability to respond to legislative and other deadlines,
- difficulties with provider retention, and
- client frustration with the Medicaid program.

These types of problems create a lack of faith in the ability of State government to operate effectively. Further, these issues also place unsustainable pressure on the staff responsible for managing the programs; this has led to unacceptably high employee turnover, which further exacerbates the problem.

Over the past decade, the Department has grown in terms of the number of FTE. These additional FTE however, have generally been for new programs, and have not addressed the fundamental problem of having multiple roles for many of the Department's employees. In addition, for many programs, the Department has been underappropriated FTE or has simply absorbed the extra duties. For example, the Department requested three FTE to implement the ACC, however only 0.5 FTE was appropriated. The lack of resources was a major reason that the program took an additional 13 months to implement, and was much more difficult for those who did work on the program, many of whom simply absorbed the extra duties. Employees have also absorbed the duties associated with other programs and initiatives such as:

1) Intermediate Care Facility for Persons with an Intellectual Disability (ICF/ID) Program.
2) HB 10-1119, "SMART Government Act."

In these cases, FTE were not appropriated to perform the work required.

The Department is making internal efforts in order to free up some resources. In June and August 2012, the Department began two process improvement plans using LEAN coaching and training resources available from the Governor's Office of State Planning and Budgeting. The June project focused on reducing the time to hire new employees, and the August project focused on streamlining the service plan development process for Long Term Care waivers. As a result of these kinds of LEAN initiatives, the Department believes that it may be able to reassign some FTE from their current roles to other critical areas. For example, when the Department recently lost a budget analyst, the Budget Division was able to reassign those job duties to other analysts who had developed additional capacity; that capacity was a result of successful employee retention and process improvements in the Budget Division. However, most process improvements do not free up positions; rather they help reduce the workloads on already overburdened staff. The reassigned FTE and additional workloads that can be absorbed are not sufficient to address all of the needs discussed above.

Like other employers, the Department has also had to adapt to a new, 21st century workforce. This workforce is mobile, and does not typically stay within State employment for more than a few years. This creates an acute problem for the Department, because the sheer complexity of the Medicaid program and its regulations mean that employees take a full year to train to be effective at an operational level, and several years to fully train to be effective at a policy or strategic level. Because the Department is currently structured so that most programs are only supported by a single staff member, turnover causes the Department to lose critical knowledge that existing staff cannot replace. While the Department tries to cross-train staff, the volume of work is a serious constraint to having a workforce that is versed in multiple programs. Due to this, the Department must

create incentives for people to stay within the existing State personnel system. As new employees begin employment with the Department, it will generally be in a training capacity. As employees leave, these openings will create promotional opportunities for those in training, allowing the Department to promote from within, maintaining knowledge and experience. The Department however, requires an adequate level of FTE in order to operate in this manner, planning for it ahead of time, instead of reacting to loss regularly.

Proposed Solution:
The Department has identified nine positions that would assume some of the day-to-day responsibilities of administering the most critically understaffed Department programs. These positions will enable managers to focus on strategic management and planning, stakeholder relations, and improving services covered by Department programs. These positions will also increase the value received on program expenditures, and reduce the potential risks the Department faces due to inadequate staffing. The details of each position are presented in the accompanying table in the appendix.

Alternatives:
Over the last several years, the Department has considered or implemented alternatives for all requested positions. Alternatives include using temporary employees to address staffing needs, continuing to ask existing employees to take on additional tasks, and utilizing contractors to do work typically performed by permanent staff. These alternatives have failed to address the underlying root of the problem, and have led to serious consequences. Temporary employees can be hired to work for no more than six months, and their knowledge is lost when their contracts expire; further, it is very difficult to hire skilled professionals with relevant knowledge about the Colorado Medicaid program on a temporary basis. The Department has also employed contractors particularly to do research and policy analysis, but this work comes at a high cost and the Department retains only the final work product of the contractor.

Anticipated Outcomes:
The Department expects the requested FTE will address many of the problems discussed throughout this request. The additional FTE will allow managers and experienced staff the time required to strategically address areas that have been neglected due to restrictions imposed by inadequate staffing levels, including health care reform. Also, day-to-day operations will be performed more effectively, as these FTE will allow the Department to restructure program management to dedicate both policy and operational experts. The FTE will also help enhance partnerships both within the Department and in the community by providing resources to better manage current workloads while strategically involving external stakeholders as additional sources of input regarding current and anticipated programs.

The Department also expects to reduce many of the other problems that are associated with inadequate staffing levels. As discussed above, these include a reduced number of audit findings, increased stakeholder and provider satisfaction with the Department, and higher employee retention and morale. Employees will have a better career path, and productivity may also increase as a result.

This request also has the potential for significant savings. Savings could result from decreased client overutilization as the result of better oversight of programs, and many of the positions in this request have the potential to pay for themselves in this form of savings. Increased compliance with federal regulations will result in fewer federal fund disallowances, and increased resources dedicated to client, provider, and stakeholder issues may result in fewer lost appeals and lawsuits. These types of savings are difficult to quantify, both in terms of magnitude, and in terms of when reductions may occur. Therefore, the Department has not included a reduction in service expenditure in this request;

however, any savings will be captured through the regular budget process.

Assumptions for Calculations:

The Department request includes base salaries at the minimum salary of the designated class. The FTE Request form shows the calculations of class title base salary, PERA at 10.15% of base salary, AED at 3.60%, SAED at 3.25%, Medicare at 1.45%, STD at 0.177%, and Health-Life-Dental at $4,421.04 per employee. Operating expenses include $500 for regular operating expenses per FTE, $450 for telephone expenses, a one-time personal computer and office furniture charges of $1,230 and $3,473 respectively. It is estimated that leased space costs will be $60,870 total funds in FY 2013-14, and $61,710 total funds in FY 2014-15. This is calculated by multiplying the estimated cost per square foot for leased space by 3,000 square feet. Due to the larger increments required to acquire commercial leased space, and to keep Department staff in close proximity to each other, it is necessary to rent this much space for any additional FTE. This request also assumes that all positions would begin employment in August 2013.

Consequences if not Funded:

If this request is not funded, the lack of staff would continue to greatly inhibit the Department's ability to meet Department objectives and stakeholder expectations. The Department will continue to overburden current employees, high turnover will continue or increase, audit findings will persist without resources to address or prevent them, contractors will continue to be relied upon for critical functions, and the Department would become increasingly unable to keep pace with the health care needs of the citizens of Colorado.

Appendix: Descriptions of Requested Positions

POSITION TITLE	FTE	JOB CLASS	DESCRIPTION OF POSITION
Deputy Budget Director	1.0	Budget Analyst V	Currently, the Department's Finance Office Director, a member of the Executive Committee, simultaneously serves as the Budget Division Director. As the complexity of the Department's budget continues to grow, the Department requires a dedicated Deputy Budget Director to focus solely on the operational needs of the Budget Division, including the preparation of budget requests, schedules, legislative requests for information, and footnote reports. This would allow the current Budget Director to focus on the strategic direction of the Department and be more responsive to both internal and external stakeholders. The current responsibilities of being a director of both an office and an individual division has led to inefficiencies and inhibit the Department's ability to strategically link, from a finance perspective, the different aspects of not only the Finance office, but the Finance office with other areas of the Department.
Budget Analyst	1.0	Budget Analyst III	The Department's budget continues to grow more complex; there are large portions of the Medicaid and CHP+ programs that are funded through cash funds, and have different federal match rates. In order to meet the statutory deadlines in the budget process, the Department requires additional staff who are able to perform statistical and economic forecasting, as most individual programs require individual forecasts. For example, the Department's budget request for Medical Services Premiums is over 200 pages in length, and must be prepared twice per year to meet statutory budget deadlines. Accuracy is of paramount importance; a 1% error in the Medical Services Premiums forecast could cause a $15,000,000 General Fund impact. This position would assume a number of the forecasts that are currently being performed by other analysts; this would allow the Department to devote more time to research trend issues that could potentially cause large expenditure swings.
Recovery Officer	1.0	General Professional IV	The Department currently only has one individual generating adverse action letters, setting up case files, and tracking recovery payments received. A second FTE is needed to share the additional workload generated by Medicaid expansion as data analysts have been added and the number of recovery cases has grown. Inadequate staff in this section could cost the State money in the form of forgone recoveries. It could also cause the Department to become non-compliant with federal regulations, likely impacting federal financial participation rates (FFP). Losing enhanced FFP would prove extremely costly to the Department and State and should be avoided if possible.

POSITION TITLE	FTE	JOB CLASS	DESCRIPTION OF POSITION
Compliance Coordinator	1.0	General Professional IV	The complexity of the Medicaid and Child Health Plan *Plus* (CHP+) programs has created the need for an FTE to centralize the State Plan submission function, create rule drafts, and to assist with fiscal notes and other compliance related functions. Benefit managers are currently responsible for compliance functions related to their positions. Taking the compliance responsibilities away from benefit managers leaves more time for existing FTE to properly manage benefits, including coordinating stakeholder, provider, and client needs. A designated compliance FTE would also help prevent things from being missed, as benefit managers struggle to perform all current responsibilities. This position would reduce the risk of losing FFP, which is dependent upon the accuracy of the State Plan, and the Department's compliance with and implementation of audit recommendations.
Quality and Compliance Specialist	1.0	General Professional IV	This FTE is needed to complete data analysis, assess the effectiveness of projects, improve health outcomes, and impact reimbursement structures on health care services provided. Identifying and targeting quality improvement projects as they relate to value based purchasing, and development and monitoring of standards for quality care coordination would be the primary role of this position. Sufficient monitoring and quality improvement activities support health outcomes and overall quality, leading to improvement and lower reimbursements, potentially resulting in long-term savings.
Pharmacy Benefit Analyst	1.0	Pharmacist I	The Department currently has two pharmacists who handle client pharmacy related issues. They are responsible for a variety of projects, including expanding drugs covered by prior authorization, expanding Rx review, and expanding Smart PA, a prior authorization decision support system. Because pharmacy issues are frequently escalated to the Department, the pharmacists are frequently unable to handle any tasks beyond client and provider phone calls. An additional FTE with medical knowledge would provide a way to reallocate work, enabling more to be accomplished with the pharmacy benefit. The Pharmacist Assistant would work on a number of projects including health care reform, the Durable Medical Equipment (DME) programs, and other programs that provide safety to clients.
Eligible Provider and Hospital Attestation Processor	1.0	General Professional IV	Currently, there is no FTE assigned to assist in the processing of eligible provider and eligible hospital attestations for adopting, implementing, and upgrading Meaningful Use Incentive Payments. These duties are currently being worked on part time by four staff members, but it is difficult to meet the CMS mandated timeframe for these attestations. There are now indications that the number of attestations will begin to increase and the number of hours needed to process them will be more than current staff can handle.

POSITION TITLE	FTE	JOB CLASS	DESCRIPTION OF POSITION
Financial Reporting and Cash Management Unit Manager	1.0	Accountant IV	The Department's Controller Division has been experiencing an increasing amount of review and inquiries from CMS, and has been unable to provide timely responses to many of these due to other responsibilities. The Division also receives an increasing amount of audits being performed by the Office of the State Auditor (OSA) and the Office of Inspector General (OIG). This position's primary responsibilities will be to oversee the day-to-day activities of a Financial Reporting and Cash Management Unit to ensure accurate and timely production of deliverables and compliance with CMS, OIG, and OSA, saving the Department from potential penalties and fees. This position would also provide valuable support to the Accounting Manager and Controller as a resource for other ad hoc program requests.
Stakeholder Relations	1.0	General Professional IV	The increased importance of stakeholder relations in the Medicaid program has required Department policy staff to assume the responsibility of organizing stakeholder meetings and addressing comments and feedback. This has proven to be unsustainable. This FTE would provide facilitation for meetings with stakeholders or intradepartmental meetings as needed, and act as a general point of contact for the myriad of boards and committees that the Department is involved with. This FTE would manage and coordinate stakeholder relations and ensure that messaging to stakeholders is uniform and consistent. This person would be an expert in facilitation and public process management.

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Substance Use Disorder Benefit

Priority Number: R-7

Dept. Approval by: John Bartholomew 10/26/12 Date

OSPB Approval by: 10/30/12 Date

- ☑ Decision Item FY 2013-14
- Base Reduction Item FY 2013-14
- Supplemental FY 2012-13
- Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$4,304,134,650	$0	$4,348,450,732	$5,788,068	$9,081,619
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,194,629,067	$0	$1,238,046,775	$1,818,130	$2,740,119
	GFE	$312,202,624	$0	$312,202,624	$0	$0
	CF	$665,268,289	$0	$640,200,403	$42,035	$97,407
	RF	$3,215,340	$0	$1,215,340	$0	$0
	FF	$2,128,819,330	$0	$2,156,785,590	$3,927,903	$6,244,092
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	$5,940,552	$0	$5,902,552	$100,000	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,312,418	$0	$1,262,418	$50,000	$0
	GFE	$0	$0	$0	$0	$0
	CF	$437,500	$0	$468,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,190,634	$0	$4,171,634	$50,000	$0
(2) Medical Services Premiums	Total	$3,985,613,386	$0	$4,026,532,673	$415,440	($1,901,422)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,050,603,677	$0	$1,092,869,207	($11,820)	($953,140)
	GFE	$312,202,624	$0	$312,202,624	$0	$0
	CF	$651,181,857	$0	$626,082,971	($282)	($33,883)
	RF	$3,215,340	$0	$1,215,340	$0	$0
	FF	$1,968,409,888	$0	$1,994,162,531	$427,542	($914,399)
(3) Medicaid Mental Health Community Programs; Mental Health Capitation Payments	Total	$312,580,712	$0	$316,015,507	$5,272,628	$10,983,040
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$142,712,972	$0	$143,915,150	$1,779,950	$3,693,259
	GFE	$0	$0	$0	$0	$0
	CF	$13,648,932	$0	$13,648,932	$42,317	$131,290
	RF	$0	$0	$0	$0	$0
	FF	$156,218,808	$0	$158,451,425	$3,450,361	$7,158,491

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

(2) Medical Services Premiums Of this amount, ~~$482,144,867~~ $482,111,758 shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402 3 (4), C.R.S.;

(3) Medicaid Mental Health Community Programs: a Of this amount, ~~$13,614,743~~ $13,656,881 (H) shall be from the Hospital Provider Fee Cash Fund created in Section 25.5-4-402 3 (4), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund [24A], FF: Title XIX.

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: No: **Not Required:** ✓

Schedule 13s from Affected Departments:

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

FY 2013-14 Funding Request
November 1, 2012

Susan E. Birch
Executive Director

Signature Date

Department Priority: R-7
Substance Use Disorder Benefit

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
Substance Use Disorder Benefit	$5,788,068	$1,818,130	0.0

Request Summary:
The Department of Health Care Policy and Financing and the Department of Human Services are submitting a series of coordinated requests to strengthen Colorado's behavioral health system. Collectively, the Departments are submitting requests to expand the Medicaid substance use disorder benefit; establish a comprehensive statewide behavioral health crisis care system for persons, families, and communities; expand community services for individuals with behavioral health needs to help avoid institutional placement; and, increase the number of available beds for individuals who have determined by the court to be Incompetent to Proceed (ITP). Collectively, these requests address current and serious unmet needs in the state's behavioral health system.

The Department requests $5,788,068 total funds, $1,818,130 General Fund in FY 2013-14 and $9,081,619 total funds, $2,740,119 General Fund in FY 2014-15 to enhance its existing substance use disorder benefit by administering services through Behavioral Health Organizations (BHO), expanding limitations on current services and adding appropriate services to create a more robust program. A high percentage of individuals with mental health disorders have a co-occurring substance use disorder. Integrating substance use disorder services with the BHO benefit would provide clients with better care coordination and ensure they receive services necessary for recovery. Under the current fee-for-service structure, substance use disorder services are unmanaged and providers are unable to design comprehensive treatment programs as a result of the limited benefit offered by the Department. By expanding these services, the BHOs would be able to create a complete care program to aid clients in their recovery from addiction.

Problem or Opportunity:
The current Medicaid substance use disorder benefit operates in a fee-for-service environment which offers little client support outside of the acute care provider as the client recovers. In addition, providers are very limited in the services that can be offered to clients under the current benefit. Many of the substance use disorder services have caps on the number of units that can be provided and the services available for treatment are not inclusive of many evidence-based successful benefits such as medication assisted treatment and peer support. The Department believes that moving the substance use disorder benefit under the BHO managed care framework, while also increasing

limits on services and adding appropriate services, would better treat substance use disorders and improve the overall health of the client.

Brief Background:
Prior to FY 2006-07 the Department offered substance use disorder treatment on a limited basis to pregnant women and recent mothers, up to one year postpartum, and clients who needed substance use disorder treatment when it was medically necessary to treat another covered condition. In 2005 the General Assembly passed HB 05-1015, which amended the Colorado Medical Assistance Act, section 25.5-5-202(1)(s)(I), C.R.S. (2012), and added substance use disorder treatment as a basic service available to all Medicaid clients.

In FY 2011-12 the Department spent $2,931,529 on substance use disorder services for approximately 6,786 clients. This was an increase in expenditure of approximately 33% from FY 2010-11. The Department anticipates the utilization of these services will continue to grow as clients become more aware of service availability and with the addition of the Adults without Dependent Children (AwDC) population which expanded the number of adults on Medicaid by 10,000 clients in FY 2011-12.

Proposed Solution:
The Department requests to move the existing substance use disorder benefit under the scope of the BHO contracts, increase the limit on the current services offered, and expand the services available to clients. The Department would increase limits on: assessments; detoxification services; behavioral health counseling; group counseling; case management; safety assessments; drug screenings; and provision of daily living needs. The Department would also add medication assisted treatment and peer advocate services to the list of covered benefits. A complete description of the services and proposed changes are shown in appendix A, table 4. Many of the services currently offered do not allow providers to create an effective treatment plan because they have unit caps which limit provider recommendations. The Department also believes that adding services to the benefit would better enable providers to treat clients and potentially create savings by improving the overall health of the client.

Anticipated Outcomes:
The Department believes moving the substance use disorder benefit to a full risk managed care program through the BHO contracts would result in a larger provider network and the addition of valuable care management for this population. Ensuring that clients have access to appropriate services and assistance in navigating the behavioral health system should result in increasing treatment of substance use disorders which could improve the overall health of the client.

In a study conducted by the Office of the State Auditor, a comparison was done between substance use disorder service costs and other medical costs for the same clients in FY 2006-07 through FY 2008-09. The auditors saw a reduction in medical costs for clients who had received substance use disorder services, but were not, however, able to determine whether the reduction in costs was a result of the treatment or other factors. While this study was not able to prove that substance use disorder treatment directly reduces other medical costs, the Department believes that providing treatment greatly improves the overall health of the client as it reduces clients' risks for a variety of health conditions and accidents and could therefore reduce costs. This view is supported by research from the National Center for Addiction and Substance Abuse at Columbia University, which has found that untreated addiction alone causes or contributes to more than 70 other diseases requiring hospitalization. In Washington, substance use disorder treatment was shown to save $311 per month in medical costs for Medicaid members. In California, substance use disorder treatment reduced ER visits by 39%, hospital stays by 35% and total medical costs by

26% (Substance Abuse and Mental Health Services Administration (SAMHSA)).

The Department anticipates that moving the substance use disorder benefit to the BHO contracts would improve health outcomes and recovery success through outreach and benefits management. These organizations specialize in behavioral health and are well trained and equipped to define and carry out substance use disorder outreach and treatment plans with clients. All Medicaid clients have access to behavioral health services through the BHOs. By providing substance use disorder services through these organizations, not only would more clients be referred to treatment through regular BHO visits, but care coordination would improve through case management. Clients would also be able to receive care in one location for multiple issues. The Department believes that concurrently treating underlying conditions leads to better outcomes than individual treatment of symptoms.

In addition to a more managed structure, the Department requests to increase the availability of current services and expand the substance use disorder benefit to include new services better aligned to serve the needs of clients. The Department has already received a number of recommendations for program improvements through a focused study conducted by Signal Behavioral Health Network in 2010 designed to make program recommendations for the AwDC population. This study included 24 subject matter experts, some of which currently act as providers for the Department. The recommendations primarily discussed ways to improve the substance use disorder service package by expanding the current benefit and proposed new services that would improve client outcomes.

By expanding current limitations on benefits and adding services to better meet the need of the clients, the Department anticipates the BHOs would create care plans to sufficiently aid clients in recovery. A more robust program would overcome some of the service limitation issues that current fee-for-service providers experience. For example, allowing 52 urinalysis units, as opposed to the current benefit of 36, would allow the BHOs to monitor substance use on a weekly basis. This change could help improve client accountability and success in the recovery process.

The Department intends to utilize the Benefits Collaborative process, as well as the Signal recommendations to encourage further stakeholder involvement in creating an effective substance use disorder benefit. The Benefits Collaborative serves as the Department's formal coverage standard development process. The Benefits Collaborative is a stakeholder driven process for ensuring that benefit coverage standards are: based on the best available clinical evidence; outline the appropriate amount, duration, and scope of Medicaid services; set reasonable limits upon those services; and, promote the health and functioning of Medicaid clients.

Beyond direct health outcomes, research by the National Center for Addiction and Substance Abuse at Columbia University has found that health-related costs represent only 26 cents of every dollar spent on substance use disorder. The other 74 cents goes to Justice, Education, Child/Family Services and other costs. By providing treatment to individuals with substance use disorders, the overall burden to State government for related costs may be reduced.

Alternatives:

The Department considered substance use disorder service limitation and additional benefits in the fee-for-service environment. However, given other states' experience and recommendations from stakeholders, the Department believes a managed care structure through the BHOs would result in overall better health outcomes and lower total costs of care for these clients.

Assumptions for Calculations:
The Department assumes the benefit would be implemented January 1, 2014. To be consistent with annual BHO rate setting and to allow the Department enough time to update the 1915(b) waiver and make appropriate rule changes the Department believes this timeline to be the most appropriate for implementing this request.[1]

The Department requests $100,000 for actuarial consulting services to assist the Department in calculating an add-on substance use disorder treatment rate that is actuarially sound. Adding the existing fee-for-service substance use disorder benefit and two new services to the BHO contract, as well as expanding the limits of existing services, will require the Department to calculate an actuarially sound rate using existing data, data collected by the Division of Behavioral Health, and other sources. The Department will require actuarial assistance in developing a rate setting model and a risk sharing mechanism, validating the existing data, identifying supplemental data sources if needed, calculating the anticipated utilization increase, calculating trend, and certifying a substance use capitation rate.

The Department would utilize the Benefits Collaborative process to determine actual benefit changes. However, in order to estimate costs associated with the request, the Department utilized benefit recommendations from the stakeholders involved in the Signal report. The Department believes that these assumptions are reasonable to approximate the final benefit.

Should the Department obtain differing information from the Benefits Collaborative process and determine the change would require an adjustment to the budget, the Department would request funding through the normal budget process. The Department does, however, intend to design a program limited to the fiscal bounds of this request. While the details of the revised program may differ from the request, the Department does not anticipate the difference to be so great as to require additional funding. The BHOs have already demonstrated competencies in managing a statewide Medicaid benefit under significant budget constraints and the Department anticipates that they would be able to ensure that care is managed within established limits. The current BHO contracts contain an option clause to make substance use disorder a covered benefit; the Department would not need to use the procurement process to add this benefit to the contracts.

The Department anticipates that adding the substance use disorder benefit to the BHO contract would increase both the number of clients using services and the number of services each client receives. Providing case management through the BHOs would better align clients' needs for a more successful recovery program. Some of these needs would be met through increasing the maximum number of units allowed by the Department for particular services.

In addition, administering the program through the BHOs would not only increase utilization by providing outreach to potential clients but also by offering a larger provider network once a client is referred to the program. In FY 2009-10 the Department implemented the Screening, Brief Intervention and Referral to Treatment (SBIRT) program designed to identify clients with potential substance use disorders and refer them to treatment. Currently, primary care physicians must identify local substance use disorder treatment providers when they identify a need through SBIRT or otherwise. By moving treatment for substance use disorders to the BHO contracts, the referral becomes much easier for the providers and for the clients as they would be

[1] Please note that because the BHO contracts are scheduled to be reprocured in July 2014, it may not be possible to add this benefit to the BHO contracts prior to that date. If so, the Department assumes that it would administer an enhanced SUD benefit through the current fee-for-service delivery system until the benefit can be added to the BHO contracts. The Department would work with stakeholders to determine the best course of action, and use the regular budget process to account for any necessary changes to the implementation assumed in this request.

assigned a case manager at the beginning of the treatment process.

Due to the unique nature of this request the Department was unable to find specific information from other states' experience to help determine utilization assumptions of moving the substance use disorder benefit from the fee-for-service structure to managed care under the BHO contracts. As a result, the Department has made some broad assumptions about utilization. In estimating the impact of moving the substance use disorder services to the BHO contracts the Department assumes a 100% increase in utilization. The Department assumes that not all of the growth in clients utilizing services would be new clients. Many existing clients would remain in the program as they are allowed a larger mix of services for a longer time.

The Department assumes a 20% increase in the number of units per client as a result of this request. The Department believes that coordination through the BHO's case managers would increase the number of services each client receives as case managers assist in constructing treatment plans.

The Department assumes two new services would be added as a result of this request: medication-assisted treatment and peer support services. Medication-assisted treatment is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance use disorders, a combination of medication and behavioral therapies is most successful. Medication-assisted treatment is clinically driven with a focus on individualized patient care. To estimate costs for this service the Department estimated current per utilizer costs for medication-assisted treatment and estimated an increase in utilization, ramping up to twice as much as the current benefit in FY 2014-15.

Peer support services are an integral component of a recovery-oriented system of care (ROSC). Traditionally, recovery-oriented services have been viewed as activities that occur after a formal substance use treatment episode. However, this view has changed and recovery-oriented activities and approaches are part of the full continuum of care in partnership with other disciplines, such as mental health and primary care. Recovery management is shifting the substance use disorder treatment world from an acute care model, which treats medical conditions in an intensive short-term manner, to a chronic care approach reflecting a commitment to long-term supports and wellness. Recovery-oriented activities include providing a menu of traditional treatment services and alternative therapies, such as peer support services.

Providing medication-assisted treatment and peer support services aligns with best practices, SAMHSA supported treatment models, and SAMHSA sponsored state activities such as the Access to Recovery (ATR) and Bringing Recovery Support Systems to Scale (BRSS TACS) projects managed by the Office of Behavioral Health. To estimate costs for peer support services the Department assumed approximately one-third of clients would utilize the service at an average of 26 hours per year.

While the Department believes that there could be savings achieved through this proposal, the Department did not include savings associated with the request. The Department believes that providing substance use disorder treatment improves clients' overall health by reducing their risk for serious disease and accidents. However, because many diseases take years to develop and are unique to each person, the Department does not anticipate any short term savings from the substance use disorder benefit changes.

Consequences if not Funded:
If this request is not funded the Department would continue to operate the substance use disorder treatment program under a fee-for-service structure. However, Medicaid members will not benefit from the advantages of coordinated, whole-person care for substance use

disorders, and Colorado would not benefit from the potential improvements in client health, productivity, quality of life, and cost effectiveness offered by expanding and managing the benefit.

Impact to Other State Government Agency:
The Department is actively working with the Office of Behavioral Health (OBH) on the expansion of Medicaid's substance use disorder benefit. By adding a more robust substance use disorder treatment benefit to the BHO program, a number of OBH programs may be affected. OBH currently funds substance use disorder services to non-Medicaid populations with its federal block grant and other state funds, as well as certain substance use disorder services not covered by Medicaid as a wraparound benefit to Medicaid members.

OBH believes that shifting coverage of certain substance use disorder services to Medicaid may permit block grant or other state funding to be re-purposed to serve additional individuals within gap populations such as the non-Medicaid populations. It would also allow block grant funds to be used for gap services (such as recovery services and residential treatment) not included in Medicaid's expanded benefit or eligible to receive federal financial participation. While these changes would require planning and collaboration with both OBH and the Department, contractors, clients and advocates, OBH sees the expansion of Medicaid's substance use disorder benefit and management through the BHO program as an opportunity to create a statewide recovery-oriented system of care, and expand support recovery services for beneficiaries. The implementation of an expanded Medicaid substance use disorder benefit would not have a financial impact on OBH because its primary source of funding is a block grant.

The Department also believes that there may be future savings to other state agencies; substance use disorder is a contributing factor in many arrests and incarcerations. Reducing the rate of substance use disorder may also result in reductions to the number of individuals who are arrested and incarcerated, providing some relief for many aspects of the criminal justice system. While the Department does not assume any short term savings to other state agencies (such as the Department of Corrections), it is possible that a more robust Medicaid substance use disorder treatment benefit would help mitigate growth in the criminal justice system over the long term.

Cash Fund Projections:
This request includes Cash Funds from the Hospital Provider Fee Cash Fund. For information on associated revenues, expenditures, and cash fund balance, please see the Schedule 9 "Cash Funds Report" in Section O of this Budget Request.

Relation to Performance Measures:
This request will assist the Department in meeting its performance measures to improve health outcomes and better integrate physical and mental health services. Many studies have shown that providing substance use disorder treatment improves health outcomes of people by reducing their propensity for accident and serious disease. By expanding the substance use disorder benefit, the Department would improve clients' likelihood for recovery and potentially prevent health ailments over time. Further, providers would be able to refer clients to the BHOs to aid in substance use disorder recovery which, in turn, would enable clients to receive other mental health services.

Current Statutory Authority or Needed Statutory Change:
Colorado Medical Assistance Act, section 25.5-5-202, C.R.S. (2012). Basic services for the categorically needy - optional services
(1) Subject to the provisions of subsection (2) of this section, the following are services for which federal financial participation is available and which Colorado has selected to provide as optional services under the medical assistance program:
(s) (I) Outpatient substance abuse treatment

Schedule 13

Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Medicaid Dental Benefit for Adults

Priority Number: R-8

Dept. Approval by: John Bartholomew — JB 10/26/12 — Date

OSPB Approval by: Eric M [signature] 10/30/12 — Date

- ☑ Decision Item FY 2013-14
- ☐ Base Reduction Item FY 2013-14
- ☐ Supplemental FY 2012-13
- ☐ Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$4,050,146,429	$0	$4,089,731,769	$32,959,416	$52,786,189
	FTE	326.2	0.0	326.6	1.2	2.0
	GF	$1,067,895,074	$0	$1,110,969,303	($747,621)	($1,570,715)
	GFE	$312,202,624	$0	$312,202,624	$0	$0
	CF	$654,954,503	$0	$629,988,285	$13,693,726	$22,763,659
	RF	$4,570,570	$0	$2,409,133	$0	$0
	FF	$2,010,523,658	$0	$2,034,162,424	$20,013,311	$31,593,245
(1) Executive Director's Office; (A) General Administration, Personal Services	Total	$22,593,922	$0	$23,641,039	$82,577	$125,010
	FTE	326.2	0.0	326.6	1.2	2.0
	GF	$7,971,021	$0	$9,149,778	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$2,038,599	$0	$2,077,080	$41,289	$62,505
	RF	$1,176,645	$0	$1,069,555	$0	$0
	FF	$11,407,657	$0	$11,344,626	$41,288	$62,505
(1) Executive Director's Office; (A) General Administration, Operating Expenses	Total	$1,625,353	$0	$1,557,009	$10,514	$1,900
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$715,356	$0	$708,358	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$53,049	$0	$53,049	$5,257	$950
	RF	$78,257	$0	$23,910	$0	$0
	FF	$778,691	$0	$771,692	$5,257	$950
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	Total	$31,899,317	$0	$29,586,597	$1,707,678	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,379,650	$0	$6,016,590	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$1,566,666	$0	$1,660,853	$426,919	$0
	RF	$100,328	$0	$100,328	$0	$0
	FF	$23,852,673	$0	$21,808,826	$1,280,759	$0
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	Total	$8,414,451	$0	$8,414,451	$355,000	$355,000
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,225,370	$0	$2,225,370	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$114,332	$0	$114,332	$88,750	$88,750
	RF	$0	$0	$0	$0	$0
	FF	$6,074,749	$0	$6,074,749	$266,250	$266,250

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
(2) Medical Services Premiums	Total	$3,985,613,386	$0	$4,026,532,673	$30,803,647	$52,304,279
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,050,603,677	$0	$1,092,869,207	($747,621)	($1,570,715)
	GFE	$312,202,624	$0	$312,202,624	$0	$0
	CF	$651,181,857	$0	$626,082,971	$13,131,511	$22,611,454
	RF	$3,215,340	$0	$1,215,340	$0	$0
	FF	$1,968,409,888	$0	$1,994,162,531	$18,419,757	$31,263,540

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

Medical Services Premiums: Of this amount, ~~$482,144,867~~ $482,432,447 shall be from the **Hospital Provider Fee Cash Fund** created in Section 25.5-4-402.3 (4), C.R.S.,; and, $12,843,931 shall be from the **Unclaimed Property Trust Fund**, created in Section 38-13-116.5 (1) (a), C.R.S.

Cash or Federal Fund Name and COFRS Fund Number: CF: Hospital Provider Fee Cash Fund [22A]; Unclaimed Property Trust Fund [82A]. FF: Title XIX.

Reappropriated Funds Source, by Department and Line Item Name:
Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: N/A
Other Information: N/A

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2013-14 Funding Request
November 1, 2012

Signature　　　　　　　　　　　　Date

Department Priority: R-8
Medicaid Dental Benefit for Adults

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
Medicaid Dental Benefits for Adults	$32,959,418	($747,620)	1.2

Request Summary:
The Department requests $32,959,418 total funds, including a reduction of $747,620 General Fund, to provide a dental benefit for adults in the Medicaid program. This benefit would be subject to an annual $1,000 cap on services. Further, the Department requests legislative authority to use funding from the Unclaimed Property Trust Fund. This funding will become available when the CoverColorado program is phased out as a result of federal requirements in the Affordable Care Act that health insurers must cover pre-existing conditions.

Problem or Opportunity:
Oral health is a critical aspect of an individual's overall health status, but the Department does not generally provide dental coverage for adults, except for emergency services. With funding potentially becoming available from the CoverColorado program, the Department has the unique opportunity to meet unmet medical need by providing a dental benefit for adults without a General Fund impact.

Brief Background:
The Department currently provides a comprehensive dental benefit to children 21 years of age and under who are eligible through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. For clients over 21 years old, the Department generally reimburses for emergency dental services only. Clients with certain allowable concurrent medical conditions – including neoplastic disease requiring chemotherapy or radiation, pre- and post-organ transplant, or pregnancy – can receive treatment for oral cavity conditions; however, preventive services and any restorative treatment for dental caries, tooth replacement procedures, and adjunct oral surgery procedures are not a benefit.

The Need for Dental Coverage
Research indicates that a lack of dental coverage can create costs for both emergency dental services and non-dental medical services. Studies show that the cost of providing preventive dental treatment is potentially 10 times less than the cost of managing symptoms of dental disease in emergency rooms. The Pew Center estimates that emergency department visits for preventable dental conditions increased 16% nationally between 2006 and 2009. According to researchers, untreated oral disease may increase a person's risk for acquiring or exacerbating some systematic/chronic diseases - including diabetes, heart disease, strokes, kidney disease, Alzheimer's disease, and even mental illness.

Furthermore, 90% of symptomatic diseases, including HIV and cancer, have oral health symptoms, making regular dental visits a critical tool in screening for and detecting many costly and life-threatening conditions. Early detection also manifests into lower treatment costs for the life-threatening illnesses. For instance, oral cancer treatment can cost 60% less in the earliest stages of the diseases than in the advanced stages.

Offering a dental benefit for adults would provide clients access to regular dental care and preventive dental services specifically, which can prevent minor oral conditions from developing into more complex conditions that would eventually require emergency and palliative care. Avoiding worsening health conditions with oral disease and detecting certain serious illnesses sooner would also lead to improved health outcomes.

Funding from the CoverColorado Program

CoverColorado is a non-profit unincorporated public entity created by the Colorado General Assembly to serve as the state's high-risk health insurance pool. Since its inception, CoverColorado has been available to any Colorado resident who is ineligible for health coverage through a public program and is unable to obtain health insurance or unable to obtain health insurance except at prohibitive rates or with restrictive exclusions. CoverColorado receives partial funding from the State's Unclaimed Property Trust Fund (UPTF), which is administered by the Department of Treasury. Through its Guaranteed Availability of Insurance Provision (section 2702), the Affordable Care Act will prohibit private insurers from denying coverage to individuals with pre-existing conditions, which will in turn eliminate the need for the CoverColorado program and potentially free up funds from the UPTF. The Guaranteed Availability of Insurance Provision will be implemented in October 2013, and CoverColorado anticipates having all members transitioned off the program by May 2014. Based upon the Department of Treasury's FY 2011-12 Joint Budget Committee Briefing Document, the Department anticipates the UPTF to generate revenue of $33 million annually, which would be used to fund this Medicaid dental benefit for adults.

Proposed Solution:

In order to expand access to care and improve health outcomes, the Department would utilize the available funding from the UPTF to develop a Medicaid dental benefit for adults, which would cover a range of services that would be determined through the Benefits Collaborative process. Due to the finite amount of funding available from the UPTF, the benefit would employ an annual per-client cap of $1,000. In order to track each client's service costs and ensure proper utilization, the Department anticipates that the benefit would be managed by a third party administrator under an administrative services organization (ASO) structure. The Department estimates that the benefit would be implemented in April 2014.

Alternatives:

A number of potential alternatives exist to the Department's proposed implementation plan. For example, the dental benefit could be designed without an annual per-client cap. This would enable clients to immediately receive all the covered dental services they require, but could also make the benefit so costly that it would require significantly larger expenditures from the General Fund to fund the benefit. Further, the program could be implemented without a third party administrator; this would likely increase service costs, and require additional administrative funding and staff for the Department to administer the program.

Anticipated Outcomes:

The Department anticipates that utilization of the dental benefit would improve clients' oral and physical health, reduce emergency dental procedure costs, lower costs associated with managing chronic health conditions, and save lives by detecting certain life-threatening conditions at an earlier stage.

The Department would continue to utilize the Benefits Collaborative process and build relationships with various dental stakeholder groups to define which services would be covered and how exceptions to the annual cap would be made. The Benefits Collaborative serves as the Department's formal coverage standard development process, and is a stakeholder-driven process for ensuring that benefit coverage standards: are based on the best available clinical evidence; outline the appropriate amount, duration, and scope of Medicaid services; set reasonable limits upon those services; and promote the health and functioning of Medicaid clients. Once the Benefits Collaborative has established the coverage standards, the Medicaid Director approves the standards and, if appropriate, the Department promulgates rules to the Medical Services Board.

The Department anticipates that the program will be managed by an administrative services contractor (ASO). An ASO would assume the general administration of the dental program, potentially including managing provider networks, claims processing and benefits management. A number of states including Tennessee, Virginia, Illinois, and Kansas, have implemented dental ASO programs in an attempt to streamline burdensome administration and improve dental outcomes. Through connections with these states and research into best practices, the Department believes implementing a dental ASO would be the most effective structure to improve health outcomes and reduce costs. A dental ASO would align with other Department initiatives such as the Accountable Care Collaborative by coordinating care, improving preventive services and reducing costs.

Assumptions for Calculations:

Based on the most recent caseload estimates and utilization rate, the Department estimates that 46,242 clients would receive services in FY 2013-14 and 88,669 would receive them in FY 2014-15. See Table 3.B for more details.

Based on the evidence available from other states that have implemented dental benefits, the Department assumes a overall utilization rate of 27%, although it would take a full 12 months to reach this level as clients gradually become aware of and utilize the benefit. See Table 3.B for more details.

The Department assumes that not all clients who utilize services would use the full amount available. Based on information provided by the North Carolina Division of Medical Assistance, which administers the state's Medicaid dental benefit for adults, the Department estimates that clients would utilize only $600 of the $1,000 cap on average.

Through the competitive bid process, the Department would procure an ASO as the program administrator, which would be required to have efficient processes in place to ensure accurate processing of claims, authorizations, and appeals. The Department assumes that the administrative costs of managing this benefit would be between $1 and $3 per member per month (PMPM). This estimate is based on current knowledge of administrative rates and could increase or decrease, depending on the vendor selected through the request for proposal (RFP) process. The Department may pay the vendor a fixed price per year, as opposed to a monthly fee based on the number of clients served; this would be determined through the RFP process.

Operationally, in order to implement a dental ASO program, the Department would be required to make changes to the Medicaid Management Information System (MMIS) at an estimated cost of $1,707,678 in FY 2013-14. Of this sum, $1,152,144 would be used to set up a monthly capitation payment process, while $555,534 would be used to establish the $1,000 annual per client cap in the MMIS.[1]

[1] Please note that the Department has also requested the same $1,152,144 total funds in request R-9 "Dental ASO for Children"; should both requests be approved, the Department would only need a single appropriation of

The Department currently has only one dental benefit administrator, who manages the existing dental program. Given the scope of this proposed benefit, the Department would require additional staff resources to adequately manage this benefit. Therefore, the Department requests 1.0 FTE at the General Professional IV level to provide dental benefit management such as promulgating rules, coordinating stakeholder feedback, and writing any necessary waivers. This position would be the Department's official benefit manager for the adult dental program, and would start July 1, 2013 in order to begin the stakeholder outreach and benefit design processes.

The Department also requests 1.0 FTE at the General Professional II level to oversee the benefit's daily administration. The FTE would assist the dental benefit manager in managing provider, client, and ASO concerns that have been escalated to Department staff. This position would also resolve complaints, claims processing issues, and client appeals, enabling the benefit manager to facilitate higher level policy analysis and decision-making. This position would start March 1, 2014 for training purposes in anticipating of the program's April 1, 2014 start date.

The Department anticipates that implementation of an adult dental benefit would offset current dental expenditures for adults, disabled, and elderly individuals. In FY 2011-12, the Department spent roughly $11 million on dental expenditures for emergency services and services provided to individuals with concurrent medical conditions. Research has shown that preventive dental services reduce emergency dental expenditures, but it is not clear how quickly emergency services are reduced or by how much. The Department assumes a 15% reduction in FY 2013-14 and a 30% reduction in FY 2014-15 in emergency dental expenditures, which the Department considers to be reasonable and conservative estimates. See Table 2.A and 2.B for more details. The Department is not assuming any savings from systematic or chronic conditions that are no longer potentially being affected by oral disease, as it is difficult to estimate the magnitude of such savings and the time frame on which those savings may occur. Any savings the Department realizes would be accounted for through the normal budget process.

Consequences if not Funded:
If this request is not funded, the Department would avoid accruing non-emergency dental expenditures, but clients would continue to suffer from poor oral health and the exacerbation of certain health conditions, resulting in the Department spending additional money to cover emergency dental services and management of exacerbated health conditions.

Cash Fund Projections:
This request includes Cash Funds from the UPTF and Hospital Provider Fee Cash Fund. For information on associated revenues, expenditures, and cash fund balances, please see the Schedule 9 "Cash Funds Report" in Section O of this Budget Request.

Relation to Performance Measures:
This request would assist the Department in meeting its performance measures to increase access to health care, improve health outcomes, and contain health care costs. The implementation of an adult dental benefit would increase access to dental care, prevent complications from oral diseases and concurrent conditions, and avoid the need for more costly interventions resulting from advanced oral disease or aggravated concurrent conditions.

Current Statutory Authority or Needed Statutory Change:
In order to implement and fund this benefit, the Department needs statutory authorization to provide dental coverage to adult Medicaid clients, as well as to utilize the funds in the Unclaimed Property Trust Fund.

$1,152,144, to make changes necessary to establish the capitation rate process for both ASO benefits.

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Dental ASO for Children

Priority Number: R-9

Dept. Approval by: John Bartholomew JB 10/26/12 Date

OSPB Approval by: [signature] 10/30/12 Date

- ☑ Decision Item FY 2013-14
- Base Reduction Item FY 2013-14
- Supplemental FY 2012-13
- Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$4,022,439,721	$0	$4,061,167,999	$576,072	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,059,359,976	$0	$1,101,323,301	$0	$0
	GFE	$312,202,624	$0	$312,202,624	$0	$0
	CF	$652,835,384	$0	$627,830,685	$0	$0
	RF	$3,315,668	$0	$1,315,668	$0	$0
	FF	$1,994,726,069	$0	$2,018,495,721	$576,072	$0
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Information Technology Contracts	Total	$31,899,317	$0	$29,586,597	$1,152,144	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$6,379,650	$0	$6,016,590	$288,036	$0
	GFE	$0	$0	$0	$0	$0
	CF	$1,566,666	$0	$1,660,853	$0	$0
	RF	$100,328	$0	$100,328	$0	$0
	FF	$23,852,673	$0	$21,808,826	$864,108	$0
(2) Medical Services Premiums	Total	$3,985,613,386	$0	$4,026,532,673	($576,072)	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,050,603,677	$0	$1,092,869,207	($288,036)	$0
	GFE	$312,202,624	$0	$312,202,624	$0	$0
	CF	$651,181,857	$0	$626,082,971	$0	$0
	RF	$3,215,340	$0	$1,215,340	$0	$0
	FF	$1,968,409,888	$0	$1,994,162,531	($288,036)	$0

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments:

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 Funding Request
November 1, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Signature Date

Department Priority: R-9
Dental ASO for Children

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
Dental ASO for Children	$576,072	$0	0.0

Request Summary:
The Department requests permission in FY 2013-14 to implement a dental administrative services organization (ASO) for the Medicaid children's dental benefit. The Department would ensure that the cost to pay the provider would be offset by savings realized from the ASO's services, so that the program is at least General Fund neutral. This program would allow the Department to better deliver and manage dental services for children and increase the available provider network while increasing savings through the reduction of preventable and costly restorative services. In addition, the proposed change would align the Colorado dental benefit for children with the Department's care coordination efforts such as the Accountable Care Collaborative, and also with best practices in other state Medicaid programs. The Department estimates that the program would begin April 2014.

Problem or Opportunity:
In FY 2011-12, the Department spent approximately $109,050,000 on dental services through fee-for-service and payments to federally qualified health centers; this amount represents nearly a 93% increase in expenditure since FY 2007-08. Because dental services for children are federally mandated, the Department's only option to reduce long term expenditure trends is through proper benefit management. The Department's dental benefit is currently managed only through utilization controls and a single program administrator. These resources are not sufficient to make outreach to clients to encourage proper utilization, recruit a provider network, or critically evaluate the program to make necessary programmatic changes.

Brief Background:
Dental services for children are federally mandated as outlined in sections 1905(r)(3) and 1905(r)(5) of the Social Security Act. Improving oral health is also one of the Governor's 10 winnable battles; children are recognized as one of the most high-risk groups for poor dental care which can lead to missed school days and low achievement. In line with the Governor's objective, the Department has focused on improving the delivery of cost effective, appropriate dental services and benefits to clients.

The Department believes improvements to the program such as numerous dental policy work groups and the authorization of dental procedures to be performed by physicians during a child's routine check-up have improved the percentage of children receiving preventive care. For example, in FY 2010-11 approximately 50% of

Medicaid children received a preventive dental service; this percentage is higher than the national average of about 40% of Medicaid children receiving preventive dental care. Further, based on FY 2009-10 statistics, the percentage of Medicaid children receiving dental sealants in Colorado was about 16% while the national average was approximately 14% of clients. However, in FY 2010-11, nearly 180,000 Medicaid children in Colorado did not receive preventive care; this can eventually lead to more expensive costs as their teeth need restoration.

Proposed Solution:
The Department believes that in order to continue to improve the number of children receiving preventive dental services, thereby reducing costs in restoration, a dental administrative services organization (ASO) is needed to conduct outreach, evaluate data and make policy recommendations to the Department. This request would allow the Department to improve dental health outcomes and benefits management through a coordinated management framework. Through the competitive bid process, the Department would ensure that payments to the contractor are no more than the estimated savings to be achieved under the program, therefore ensuring a General Fund neutral implementation.

A number of states including Tennessee, Virginia, Illinois, and Kansas, have implemented dental ASO programs in an attempt to streamline burdensome administration and improve dental outcomes. Through connections with these states and research into best practices the Department believes implementing a dental ASO would continue Colorado's efforts to improve dental care for children while improving health outcomes and reducing costs. A dental ASO would align with other Department initiatives such as the Accountable Care Collaborative by coordinating care, improving preventive services and reducing costs.

An outside contractor would have the ability to assist the Department in policy review and outreach which in turn would improve dental health outcomes in Medicaid children and reduce costs. An ASO model would also assist the Department by having a vendor responsible for data analytics to better monitor the dental program. Many current ASO providers in other states have access to sophisticated data analytics which enable them to see patterns per procedure code or tooth level to monitor outliers. The Department anticipates the advanced analytics of a dental ASO would allow the Department to better manage the benefit.

In selecting an ASO and making benefit changes the Department would utilize information gathered from a study to be conducted by the Caring for Colorado Foundation. The Department has agreed to an external independent and comprehensive review of Colorado's Medicaid dental program to provide guidance on benefit design, efficiencies and cost savings, optimal staffing, best practices, strategic direction and model design. The review will be facilitated by the Caring for Colorado Foundation and the reviewer will work under the direction and guidance of a stakeholder group of their selection with the cooperation and participation of the Department. The group anticipates completion of the review and recommendations to the Department by approximately November 2012.

In addition, the Department would continue to utilize the Benefits Collaborative process and build relationships with various dental stakeholder groups to make additional policy recommendations. The Benefits Collaborative serves as the Department's formal coverage standard development process. The Benefits Collaborative is a stakeholder driven process for ensuring that benefit coverage standards are: based on the best available clinical evidence; outline the appropriate amount, duration, and scope of Medicaid services; set reasonable limits upon those services; and, promote the health and functioning of Medicaid clients.

Benefits Collaborative groups focusing on dental began in 2008 and in order to be as transparent and inclusive as possible, the Department has made a dedicated commitment to identifying all possible stakeholders with an interest in helping Colorado Medicaid shape its coverage standards. Since the Benefits Collaborative aims to produce evidence-based policies guided by best practices, a diverse group of stakeholders including

providers, administrators, clients, advocates, and policy makers, have been invited to participate. The Department intends to continue to involve stakeholders in the Benefits Collaborative when reviewing the Caring for Colorado study results as well as in assistance in drafting a request for proposal (RFP) for the ASO.

Although the Department would solicit input on many program details through the stakeholder process, there would be a number of required features. Through the competitive bid process, the Department would procure a program administrator, which would be required to have efficient processes in place to ensure accurate processing of claims, authorizations, and appeals. Further, the administrator would be required to have programs in place to educate enrollees about their dental benefits and the importance of maintaining dental appointments with an emphasis on prevention. Finally, the administrator would be required to have adequate local presence to accommodate provider outreach initiatives, as well as relations staff who must be knowledgeable about Medicaid dental programs and can offer the support to both clients and providers.

Given the experience of other states, the Department anticipates that this type of ASO model would attract multiple bidders through the competitive procurement process. The Department would be able to score the vendors based on weights assigned to qualifications, experience, and price to ensure the purchase of services that best meet its needs and limited budget.

The Department believes that given the outreach and benefits management responsibility of the vendor, the Department would be able to realize savings. The costs of providing a client with preventive services such as dental prophylaxis and sealants are significantly less than the costs of fillings, extractions, and crowns. The Department anticipates that the ASO vendor would be able to increase the number of clients receiving preventive services and therefore reduce costly restorative work or emergency room visits. Therefore, the Department intends to set the monthly payment amount to the vendor based on proposed savings likely achieved through the reduction in restorative and intervention services as well as hospital visits for dental purposes. The Department would require that the savings achieved through these reductions directly offset the costs associated with vendor payment and necessary administrative costs, resulting in budget neutrality. Any further savings achieved would be accounted for during the regular budget process.

Additionally, an ASO structure is conducive to the deployment of both incentives and penalties. Through implementation of performance incentives such as shared savings, with payments linked to outcomes, the state and the administrator have aligned goals. This approach reduces risk of service overutilization as an ASO would encourage its provider network to only utilize necessary and proper services while trying to provide the most comprehensive and cost effective care.

Operationally, in order to implement a dental ASO program, the Department would be required to make changes to the Medicaid Management Information System (MMIS) at the cost of $1,152,144 in FY 2013-14. These changes would be necessary to pay the ASO contractor a monthly premium per client. Because the program would be required to be budget neutral, the Department would take these costs into consideration when determining the monthly payment to the contractor.

The Department requests $576,072 total funds for implementation. Because the administrative budget and services budgets are contained in different appropriations and receive different federal match rates, the Department requests an increase of $1,152,144 to its appropriation for Information Technology Contracts and a decrease of $576,072 to its appropriation for Medical Services Premiums. While the resulting total funds request is $576,072, the total request is General Fund neutral.

After reviewing feedback from the Caring for Colorado Study and Benefits Collaborative process and making necessary system changes,

the Department anticipates a new program could be implemented by April 2014. However, the Benefits Collaborative process would begin immediately, so that when the ASO vendor begins providing services, savings to offset the administrative and system change costs can still occur within the first year of the request.

Once clients are enrolled, the Department anticipates the cost associated with reimbursing an administrative vendor and enrolling clients in the program would be offset by savings. Should the Department determine that implementing a dental ASO for Medicaid children would incur additional costs, the Department would go through the regular budget process to request additional funding prior to implementing the program.

Notably, the Department has not requested an FTE to administer this program. This is because the Department has requested additional dental staff in request R-8, "Medicaid Dental Benefit for Adults" and additional staff to address other Department needs in R-6, "Additional FTE to Restore Functionality." With those resources, the Department would be able to absorb the additional workload from this program. However, without the additional resources, it is unlikely the Department would be able to implement this program on the timeframe identified in this request.

Anticipated Outcomes:
The Department anticipates a dental ASO for Medicaid children would improve dental health outcomes for children through outreach and benefits management while decreasing costs for restorative and intervention care. The Department believes the additional cost of providing administrative services would be offset by savings realized through benefits management. Further, the Department believes that by encouraging preventive services, there will also be long-term savings to the state through reduced Medicaid costs, and also long-term benefits to the affected clients.

Assumptions for Calculations:
The Department assumes that the program implementation would be at least General Fund neutral. This would be achieved through the RFP process, where any administrative costs including system changes and the payment to the ASO would be required to be offset with proposed savings. The Department would use the calculated administrative costs and estimated savings to determine the maximum payment that could be made to the vendor.

Consequences if not Funded:
Should the proposal not be funded, the Department would continue to operate the program with its current resources. Under this framework, the Department does not believe that it would be able to encourage positive outcomes, or avoid unnecessary long terms costs that could be avoided with proper benefit management. Without intervention the Department believes dental expenditure could continue to grow an average of 21% a year, as was observed from FY 2007-08 through FY 2011-12.

Relation to Performance Measures:
This request will assist the Department in meeting its performance measures to improve health outcomes and contain health care costs. For example, an ASO would be able to improve the percentage of Medicaid children receiving preventive dental services which would improve health outcomes as well as reduce costs associated with restorative work.

Current Statutory Authority or Needed Statutory Change:
Medicaid dental services for children are mandated in Section 1905(r)(3) and 1905(r)(5) of the Social Security Act. These sections specifically require both dental preventive care and coverage of medically necessary services whether or not such services are covered under the state plan.

Schedule 13

Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Leased Space Rent Increase and True-up

Priority Number: R-10

Dept. Approval by: John Bartholomew JB 10/26/12
Date

OSPB Approval by: [signature] 10/31/12
Date

- ✓ Decision Item FY 2013-14
- Base Reduction Item FY 2013-14
- Supplemental FY 2012-13
- Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$696,564	$0	$696,564	$92,115	$120,194
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$197,119	$0	$197,119	$92,402	$104,999
	GFE	$0	$0	$0	$0	$0
	CF	$151,164	$0	$151,164	($46,344)	($44,901)
	RF	$0	$0	$0	$0	$0
	FF	$348,281	$0	$348,281	$46,057	$60,096
(1) Executive Director's Office; (A) General Administration, Leased Space	Total	$696,564	$0	$696,564	$92,115	$120,194
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$197,119	$0	$197,119	$92,402	$104,999
	GFE	$0	$0	$0	$0	$0
	CF	$151,164	$0	$151,164	($46,344)	($44,901)
	RF	$0	$0	$0	$0	$0
	FF	$348,281	$0	$348,281	$46,057	$60,096

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

For FY 2012-13

Of this amount, ~~$2,535,659~~ $2,489,315 shall be from the Hospital Provider Fee Cash Fund ..

Cash or Federal Fund Name and COFRS Fund Number: CF, Hospital Provider Fee Cash Fund (24A); FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name: None.

Approval by OIT? Yes: No: Not Required: ✓

Schedule 13s from Affected Departments: None.

Other Information: None.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 Funding Request
November 1, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Signature Date

Department Priority: R-10
Leased Space Rent Increase and True-up

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
Leased Space	$92,115	$92,402	0.0

Request Summary:
The Department requests an increase of $92,115 total funds, comprised of $92,402 General Fund in FY 2013-14 to cover the shortage in the leased space appropriation. Similarly, the Department requests an increase of $120,194 total funds, comprised of $104,999 General Fund in FY 2014-15 to cover the shortage in the leased space appropriation.

Problem or Opportunity:
The current FY 2013-14 appropriation is $696,564 total funds for leased space the Department occupies at 225 East 16th Avenue, Denver, CO 80203. This is insufficient to cover the projected leased space expenditures as rental rates and operating expenses for which the Department is liable have increased. This request will ensure the Department continues to have the adequate space necessary to continue to administer the Medicaid and Child Health Plan Plus programs, as well as a variety of other programs for Colorado's low-income families, the elderly, and persons with disabilities.

Brief Background:
The Department rents several units at 225 East 16th Avenue, including units 120, 220, 350, 650, 690, 900, 1050, and B200, a basement training room. Leases for units 120, 220, and 650 have been renewed effective July 1, 2012, with the rates for units 120 and 220 increasing from $16.77 per square foot per the old lease terms, to $21.00 per square foot when the new leases took effect July 1, 2012. The annual rate in suite 650 remains at $21.00 per square foot, unchanged from the old lease terms.

Lease terms for units at 225 East 16th Avenue are also subject to additional rent payments. Additional rent is calculated as the Department's proportionate share of actual building operating expenses. Proportionate share is defined in the lease as the number of square feet in the Department's leased units divided by the total rentable square footage available for lease in the building. The leases limit annual operating expense increases to 107% of base year operating expenses plus the previous year's additional rent payable. The base year is normally the calendar year following the signing of the lease. No refund is provided to the Department if operating expenses fall below the base year level. Operating expenses covered in additional rent calculations include supplies, obtaining and providing energy for the building, water, sanitary, and storm drainage services, janitorial and security services, general maintenance and

repairs, and several other expressly noted items. Some of the additional rents stem from improvements initiated by building management to obtain LEED certification with the ultimate goal of reducing operating costs passed to tenants in out years. The Department received notice of the additional rent in December 2011 and has worked to determine the appropriateness of the charges and liability of the Department. In April 2012, after a thorough review, the Department concluded the charges were appropriate and the Department is liable.

Three units at 225 East 16th Avenue, 350, 1050, and the basement training room, are currently funded using federal funds through a Health Resources and Services Administration (HRSA) grant. HRSA is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable. The grant was extended in FY 2011-12 and is now set to expire August 31, 2013. The Department will continue using HRSA funds to fund the units currently funded by HRSA for FY 2012-13, and for the two months HRSA funding will be available in FY 2013-14.

This request will also serve to true-up the hospital provider fee funding appropriated to the line item. Currently, hospital provider fee funding is appropriated to this line item directly from the original fiscal note developed for HB 09-1293, however the actual need has been found to be less than that originally forecasted. This request will make the hospital provider fee more efficient by ensuring that the appropriate level of fee is being assessed on hospitals for leased space.

Currently, the Department's leased space appropriation for FY 2012-13 and the base request for FY 2013-14 remains unchanged from the FY 2011-12 appropriation of $696,564. However, in going from FY 2011-12 to FY 2012-13, the Department was appropriated an additional 11.9 FTE as a result of the annualizations of HB 12-1339, "Colorado Benefits Management System Project," HB 12-1281, "Medicaid Payment Reform Pilot Project," and SB 12-060, "Improve Medicaid Fraud Prosecution." As a result of these three bills, the Department requests $84,747 total funds, comprised of $31,111 General Fund in FY 2013-14 to provide the space to house these new employees. Similarly, the Department requests $103,040 total funds, comprised of $38,115 General Fund in FY 2014-15 to provide the space to house these new employees.

Proposed Solution:
The Department requests an increase of $92,115 total funds, comprised of $92,402 General Fund in FY 2013-14 to cover the shortage in the leased space appropriation. Similarly, the Department requests an increase of $120,194 total funds, comprised of $104,999 General Fund in FY 2014-15 to cover the shortage in the leased space appropriation.

The Department will also be submitting a supplemental request for FY 2012-13 related to this issue.

Alternatives:
The Department has examined comparable space in the vicinity of the capitol complex. Department research indicates that first year lease rates at comparable space in the vicinity of the capitol complex run from $21.00 to $26.00 per square foot. The proximity of 225 East 16th Avenue to 1570 Grant Street makes day-to-day business manageable, the rent is reasonable given department needs and available space, and it is expected current additional rents will result in slower operating expense growth in future years. It is for these reasons the Department has decided to remain at 225 East 16th Avenue.

Anticipated Outcomes:
This request will enable Department staff to continue serving the health care needs of Colorado citizens enrolled in Medicaid, CHP+, and many other health based programs for eligible Coloradans.

Assumptions for Calculations:
To estimate the funding need for this request, negotiated rental rates from signed leases were used, in addition to projected additional rents for operating expenses. For FY 2014-15, rental rates were forecasted using the weighted average rental increase as experienced with the most recent rent renewals executed on June 27th, 2012. Operating expense increases were forecasted using the maximum increase that can be allowed under the contract, as discussed previously. Hospital provider fee funds are applied by multiplying the appropriated 51 hospital provider fee FTE, the average loaded cost per square foot, and 204 rentable square feet per FTE, which is based on The Colorado Standards for Measuring Overall Space Use Efficiency in Leased Office Spaces. The annual base rent of units funded through the leased space appropriation (all units at 225 E. 16th Avenue excluding HRSA units) were summed and then reduced for property taxes and increased by projected additional rents for operating expenses to determine the Department's projected liability. Please refer to Tables 1 – 6 in Appendix A for the calculations of the funding need.

Consequences if not Funded:
If this request is not approved, it would critically impair the Department's ability to meet its objectives. The Department would be required to use funding appropriated in other administrative line items to fund the leased space need, which would put a strain on other areas of the budget.

Cash Fund Projections:
This request includes Cash Funds from the Hospital Provider Fee Cash Fund. For information on associated revenues, expenditures, and cash fund balance, please see the Schedule 9 "Cash Funds Report" in Section O of this Budget Request.

Current Statutory Authority or Needed Statutory Change:
24-1-107 C.R.S. (2012) allows the head of a principal department to structure the internal organization of the Department.

Appendix A: Tables and Calculations

Table 1: Summary of 225 E 16th Ave Leased Space by Unit

FY 2013-14	SUMMARY BY FLOOR							FUNDING SPLIT				
Units	Square Feet	Price/ Sq Ft	Prop. Tax Adjustment	Annual Rent	Annual Tax Adjustment	Annual Addt'l Rent	Total Rent	GF	CF	RF	FF	Grant Funded
120	7,239	$21.00	($2.41)	$152,019	($17,446)	$10,207	$144,780	$72,390	$0	$0	$72,390	$0
220	5,817	$21.00	($2.41)	$122,157	($14,019)	$8,202	$116,340	$58,170	$0	$0	$58,170	$0
350	1,770	$21.57	($2.59)	$38,179	($4,584)	$2,655	$36,250	$15,104	$0	$0	$15,104	$6,042
650	8,347	$21.00	($2.41)	$175,287	($20,116)	$11,769	$166,940	$83,470	$0	$0	$83,470	$0
690	2,440	$21.00	($2.59)	$51,240	($6,320)	$1,489	$46,409	$23,205	$0	$0	$23,204	$0
900	10,846	$22.25	($2.66)	$241,324	($28,850)	$16,029	$228,503	$114,252	$0	$0	$114,251	$0
1050	2,676	$21.57	($2.59)	$57,722	($6,931)	$4,014	$54,805	$22,836	$0	$0	$22,835	$9,134
B200	765	$15.00	($2.59)	$11,475	($1,981)	$1,148	$10,642	$4,434	$0	$0	$4,434	$1,774
Storage	80	$12.00	$0	$960	$0	$0	$960	$480	$0	$0	$480	$0
TOTAL	**39,980**	**$21.27**	**($2.51)**	**$850,363**	**($100,247)**	**$55,513**	**$805,629**	**$394,341**	**$0**	**$0**	**$394,338**	**$16,950**
Provider Fee Adjustment								($104,820)	$104,820	$0	$0	$0
Net Total							**$805,629**	**$289,521**	**$104,820**	**$0**	**$394,338**	**$16,950**

Table 2: Summary of 225 E 16th Ave Leased Space by Funding Source

FY 2013-14	SUMMARY BY FLOOR							FUNDING SPLIT				
Units	Square Feet	Price/ Sq Ft	Prop. Tax Adjustment	Annual Rent	Annual Tax Adjustment	Annual Addt'l Rent	Total Rent	GF	CF	RF	FF	Grant Funded
B200, 350, 1050	5,211	$20.61	($2.59)	$107,376	($13,496)	$7,817	$101,697	$42,374	$0	$0	$42,373	$16,950
120, 220, 650, 690, 900, Storage	34,769	$21.37	($2.50)	$742,987	($86,751)	$47,696	$703,932	$351,967	$0	$0	$351,965	$0
Provider Fee Adjustment								($104,820)	$104,820	$0	$0	$0
Net Total	**39,980**	**$21.27**	**($2.51)**	**$850,363**	**($100,247)**	**$55,513**	**$805,629**	**$289,521**	**$104,820**	**$0**	**$394,338**	**$16,950**

Table 3: Derivation of FY 2013-14 Request Amount

Row	Description	TF	GF	CF	RF	FF	Grant Funded	Notes
A	Leased Space Appropriation	$713,514	$197,119	$151,164	$0	$348,281	$16,950	FY 2013-14 Base Request
B	Estimated Expenditure	$805,629	$394,341	$0	$0	$394,338	$16,950	Tables 1 and 2: Units 120, 220, 350, 650, 690, 900, 1050, B200, and Storage
C	HB 09-1293 Adjustment	$0	($104,820)	$104,820	$0	$0	$0	Tables 1 and 2: Provider Fee Adjustment
D	HRSA Adjustment	$16,950	$0	$0	$0	$0	$16,950	Tables 1 and 2: Grant Funded Funding Split
E	Total Projected Leased Space Expenditure	$805,629	$289,521	$104,820	$0	$394,338	$16,950	Row B + Row C
F	Projected Under/(Over) Expenditure	($92,115)	($92,402)	$46,344	$0	($46,057)	$0	Row A - Row E
	Total Request Amount	**$92,115**	**$92,402**	**($46,344)**	**$0**	**$46,057**	**$0**	

Table 4: Summary of 225 E 16th Ave Leased Space by Unit

FY 2014-15	SUMMARY BY FLOOR							FUNDING SPLIT				
Units	Square Feet	Price/ Sq Ft	Prop. Tax Adjustment	Annual Rent	Annual Tax Adjustment	Annual Addt'l Rent	Total Rent	GF	CF	RF	FF	Grant Funded
120	7,239	$21.47	($2.63)	$155,455	($19,023)	$10,386	$146,818	$73,409	$0	$0	$73,409	$0
220	5,817	$21.47	($2.63)	$124,918	($15,286)	$8,346	$117,978	$58,989	$0	$0	$58,989	$0
350	1,770	$22.06	($2.82)	$39,042	($4,999)	$2,701	$36,744	$18,372	$0	$0	$18,372	$0
650	8,347	$21.47	($2.63)	$179,249	($21,935)	$11,975	$169,289	$84,645	$0	$0	$84,644	$0
690	2,440	$21.47	($2.82)	$52,398	($6,891)	$1,515	$47,022	$23,511	$0	$0	$23,511	$0
900	10,846	$22.75	($2.90)	$246,777	($31,458)	$16,310	$231,629	$115,815	$0	$0	$115,814	$0
1050	2,676	$22.06	($2.82)	$59,026	($7,557)	$4,084	$55,553	$27,777	$0	$0	$27,776	$0
B200	765	$15.34	($2.82)	$11,735	($2,160)	$1,168	$10,743	$5,372	$0	$0	$5,371	$0
Storage	80	$12.27	$0.00	$982	$0	$0	$982	$491	$0	$0	$491	$0
Total	**39,980**	**$21.75**	**($2.73)**	**$869,582**	**($109,309)**	**$56,485**	**$816,758**	**$408,381**	**$0**	**$0**	**$408,377**	**$0**
Provider Fee Adjustment								($106,263)	$106,263	$0	$0	$0
Net Total							**$816,758**	**$302,118**	**$106,263**	**$0**	**$408,377**	**$0**

Table 5: Summary of 225 E 16th Ave Leased Space by Funding Source

FY 2014-15	SUMMARY BY FLOOR							FUNDING SPLIT				
Units	Square Feet	Price/ Sq Ft	Prop. Tax Adjustment	Annual Rent	Annual Tax Adjustment	Annual Addt'l Rent	Total Rent	GF	CF	RF	FF	Grant Funded
All Units listed above	39,980	$21.75	($2.73)	869,582	($109,309)	$56,485	$816,758	$408,381	$0	$0	$408,377	$0
Portion of All								($106,263)	$106,263	$0	$0	$0
Net Total	**39,980**	**$21.75**	**($2.73)**	**$869,582**	**($109,309)**	**$56,485**	**$816,758**	**$302,118**	**$106,263**	**$0**	**$408,377**	**$0**

Table 6: Derivation of FY 2014-15 Request Amount

Row	Description	TF	GF	CF	RF	FF	Grant Funded	Notes
A	Leased Space Appropriation	$713,514	$197,119	$151,164	$0	$348,281	$0	Continuation from FY 2013-14 Base Request
B	Estimated Expenditure	$816,758	$408,381	$0	$0	$408,377	$0	Tables 1 and 2: Units 120, 220, 350, 650, 690, 900, 1050, B200, and Storage
C	HB 09-1293 Adjustment	$0	($106,263)	$106,263	$0	$0	$0	Tables 1 and 2: Provider Fee Adjustment
D	HRSA Adjustment	$0	$0	$0	$0	$0	$0	HRSA Grant Expired.
E	Total Projected Leased Space Expenditure	$816,758	$302,118	$106,263	$0	$408,377	$0	Row B + Row C
F	Projected Under/(Over) Expenditure	($103,244)	($104,999)	$44,901	$0	($60,096)	$0	Row A - Row E
	Total Request Amount	**$120,194**	**$104,999**	**($44,901)**	**$0**	**$60,096**	**$0**	

Schedule 13

Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: HB 12-1281 Departmental Differences Reconciliation

Priority Number: R-11

Dept. Approval by: John Bartholomew 10/26/12 Date

OSPB Approval by: 10/30/12 Date

- [x] Decision Item FY 2013-14
- [ ] Base Reduction Item FY 2013-14
- [ ] Supplemental FY 2012-13
- [ ] Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$43,501,296	$0	$44,563,780	$1,096,749	$995,244
	FTE	326.2	0.0	326.6	3.0	0.0
	GF	$14,600,814	$0	$15,783,428	$497,661	$446,908
	GFE	$0	$0	$0	$0	$0
	CF	$2,730,341	$0	$2,799,822	$0	$0
	RF	$1,254,902	$0	$1,093,465	$0	$0
	FF	$24,915,239	$0	$24,887,065	$599,088	$548,336
(1) Executive Director's Office; (A) General Administration, Personal Services	Total	$22,593,922	$0	$23,641,039	$238,414	$240,539
	FTE	326.2	0.0	326.6	3.0	0.0
	GF	$7,971,021	$0	$9,149,778	$119,207	$120,269
	GFE	$0	$0	$0	$0	$0
	CF	$2,038,599	$0	$2,077,080	$0	$0
	RF	$1,176,645	$0	$1,069,555	$0	$0
	FF	$11,407,657	$0	$11,344,626	$119,207	$120,270
(1) Executive Director's Office; (A) General Administration, Operating Expenses	Total	$1,625,353	$0	$1,557,009	($1,741)	($1,741)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$715,356	$0	$708,358	($870)	($870)
	GFE	$0	$0	$0	$0	$0
	CF	$53,049	$0	$53,049	$0	$0
	RF	$78,257	$0	$23,910	$0	$0
	FF	$778,691	$0	$771,692	($871)	($871)
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	$5,940,552	$0	$5,902,552	$390,000	$390,000
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,312,418	$0	$1,262,418	$195,000	$195,000
	GFE	$0	$0	$0	$0	$0
	CF	$437,500	$0	$468,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,190,634	$0	$4,171,634	$195,000	$195,000
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach	Total	$4,927,018	$0	$5,048,729	$267,220	$163,590
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,376,649	$0	$2,437,504	$133,610	$81,795
	GFE	$0	$0	$0	$0	$0
	CF	$86,861	$0	$86,861	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,463,508	$0	$2,524,364	$133,610	$81,795

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	Total	$8,414,451	$0	$8,414,451	$202,856	$202,856
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,225,370	$0	$2,225,370	$50,714	$50,714
	GFE	$0	$0	$0	$0	$0
	CF	$114,332	$0	$114,332	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$6,074,749	$0	$6,074,749	$152,142	$152,142

Letternote Text Revision Required? Yes: ☐ No: ☑ **If yes, describe the Letternote Text Revision:** N/A

Cash or Federal Fund Name and COFRS Fund Number: N/A

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: N/A

Other Information: N/A

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 Funding Request
November 1, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Signature Date

Department Priority: R-11
HB 12-1281 Departmental Differences Reconciliation

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
HB 12-1281 Departmental Differences Reconciliation	$1,096,749	$497,661	3.0

Request Summary:
The Department requests 3.0 FTE, $1,096,749 total funds, $497,661 General Fund in FY 2013-14 for the implementation of HB 12-1281, which requires the Department to accept and evaluate payment reform pilot project proposals. This request reflects the annualization of the Department's June 20, 2012 emergency supplemental request, which was approved by the Joint Budget Committee.

Problem or Opportunity:
The Department is requesting the incremental difference between the level of funding appropriated in HB 12-1281 and the level of funding indicated in the Department's fiscal note as necessary for the implementation of the bill. The Department was granted the Departmental Difference for FY 2012-13 through the emergency supplemental process. Consequently, this request reconciles only the Departmental Difference in FY 2013-14 and subsequent years.

Brief Background:
While funding was appropriated for the implementation of HB 12-1281, the amount of funding is less than the Department indicated would be needed to successfully implement the bill. The Departmental Difference is discussed in the HB 12-1281 fiscal note, and the Department has included a comparison of the differences in table 1 of Appendix A. This request represents the incremental difference between funds appropriated and funds needed to successfully implement HB 12-1281.

The Departmental Difference is primarily the result of a difference in assumptions regarding the cost and amount of actuarial services needed and the amount of analysis the Department will need to conduct for each pilot program proposal. It is the Department's experience that even established rate setting methodologies, such as HMO rate setting, require significant external actuarial contribution and dedicated internal resources. The pilot programs will not be using established rate setting methodologies; without the requested resources to develop sound reimbursement methodologies, the state would be put at financial risk.

Since the passage of the bill, the Department has been contacted by several current care coordination organizations that have expressed their intent to submit multiple payment reform pilot program proposals. In particular, two vendors have told the Department that they plan to submit as many as four proposals each; the

original fiscal note assumed that the Department would only evaluate four proposals total. While the Department has not yet established criteria for the solicitation of proposals, it is clear that there is much interest in payment pilot programs. The Department does not believe that it will be able to successfully implement selected pilot programs with the base FY 2013-14 resources.

Resources Requested

The Departmental Differences section of the fiscal note included differences for both actuarial funding and personnel costs. The appropriation for HB 12-1281 provided less funding for actuarial work, and provided fewer FTE, than the Department requested.

The fiscal note estimated that the Department would require 60 hours of actuarial services at a rate of $250 per hour; the Department received a total appropriation of $60,000 for actuarial services. However, the Department anticipates that the level of actuarial involvement required to evaluate and implement proposals will be significantly higher than estimated by Legislative Council Staff. The Department anticipates that the process to determine the pilot programs will take at least 9 months of negotiations, with rigorous analysis of the proposals to ensure compliance with federal law. On average, the Department currently spends roughly $90,000 in actuary funding for *each* of its three risk-based Medicaid managed care programs, despite the fact that each of the programs is well established and has been operational for at least a decade. Given this experience, the Department does not believe that multiple new programs, which may have never been tested in a Medicaid system before, can be evaluated with the current appropriation.

The fiscal note stated that the Department would need two 0.5 FTE (0.4 FTE each in the first year): one General Professional IV, and one Rate/Financial Analyst II. The Department's analysis identified the need for 4.0 FTE (1.7 FTE in the first year), including one General Professional V, two General Professional IVs, and one Rate/Financial Analyst II.

The Department has hired two staff, the General Professional V and Rate/Financial Analyst II. The staff are responsible for the assessment of program methodologies, operational impacts, and estimation of fiscal impact. This includes extensive collaboration with actuaries to deconstruct the proposals, develop a comprehensive understanding of how the proposals can be incorporated within the Medicaid system, and ultimately determining feasibility of implementation. While these staff will not be determining the specific proposals, they will need to assess what risk any proposal puts to the state and to ensure that a proposal is, at a minimum, budget neutral. Stakeholder engagement will also be a key responsibility. Stakeholder engagement is both a federal requirement and necessary to ensure a viable program. Further, the stakeholder outreach process will result in multiple iterations of the aforementioned responsibilities. Following selection and implementation of the programs, these FTE will be responsible for retrospective analysis of the programs, validation of budget neutrality, and continued stakeholder engagement.

Beginning in April 2013, the two additional staff will be hired to manage the specific contracts and handle day-to-day operations. It is important to recognize the operational complexity introduced when implementing new programs. These FTE will be responsible for a host of responsibilities including, but not limited to following: client enrollment/disenrollment, dispute resolution, customer outreach, policy issues that go beyond the scope of the provider contracts, stakeholder communication in addition to that provided by the other FTE, county outreach, monthly reporting requirements, performance monitoring, and contract management.

The four FTE fill two distinct roles, technical and operational, both of which are critical to the successful implementation of HB 12-1281.

Proposed Solution:
In order for the Department to successfully comply with the requirements of the bill, the Department requests the full annualization of its June 20, 2012 emergency supplemental request.

Alternatives:
The Department does not believe there is an alternative to funding the legislatively required activities if it is to comply in a manner that does not introduce financial risk to the state.

Anticipated Outcomes:
With the funding requested, the Department will be able to select, implement, and evaluate payment reform proposals as directed by HB 12-1281.

Assumptions for Calculations:
Assumptions and calculations are shown in the attached appendix in Table 1, Table 2, and Table 3. Additional assumptions are mentioned in the background narrative.

Consequences if not Funded:
The Department is not able to absorb a project of this magnitude within the current appropriation. This is also why the actuarial request needs to be fully funded. Although HB 12-1281 directs the Department to implement pilot programs, all managed care contracts implemented pursuant to this bill must comply with all applicable federal managed care laws and regulations, without exception. These regulations contain numerous and complicated requirements on rate setting, access to care, and state oversight. If the Department is not able to establish programs that comply with these regulations, the Department is at significant risk of losing federal funding for this program. Further, the loss of federal funds may occur retroactively, putting the state at significant, and unacceptable, risk of paying the federal government back with money from the General Fund.

Current Statutory Authority or Needed Statutory Change:
Colorado Medical Assistance Act, section 25.5-5-415 to 25.5-5-416, C.R.S. (2012) grants authority for the implementation of the payment reform pilots.

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Customer Service Technology Improvements

Priority Number: R-12

Dept. Approval by: John Bartholomew — 10/26/12 Date

OSPB Approval by: 10/30/12 Date

- [x] Decision Item FY 2013-14
- [ ] Base Reduction Item FY 2013-14
- [ ] Supplemental FY 2012-13
- [ ] Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$5,940,552	$0	$5,902,552	$1,800,000	$180,000
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,312,418	$0	$1,262,418	$900,000	$90,000
	GFE	$0	$0	$0	$0	$0
	CF	$437,500	$0	$468,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,190,634	$0	$4,171,634	$900,000	$90,000
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	Total	$5,940,552	$0	$5,902,552	$1,800,000	$180,000
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,312,418	$0	$1,262,418	$900,000	$90,000
	GFE	$0	$0	$0	$0	$0
	CF	$437,500	$0	$468,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,190,634	$0	$4,171,634	$900,000	$90,000

Letternote Text Revision Required? Yes: [ ] No: [x] **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

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

Approval by OIT? Yes: No: Not Required:

Schedule 13s from Affected Departments:

Other Information:

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 Funding Request
November 1, 2012

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

Signature Date

Department Priority: R-12
Customer Service Technology Improvements

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
Customer Service Technology Improvements	$1,800,000	$900,000	0.0

Request Summary:
The Department is requesting $1,800,000, including $900,000 General Fund, to fund technological improvements for the Department's Customer Contact Center.

Problem or Opportunity:
Medicaid caseload has increased by roughly 60% over the last four years, with no additional investment in the Department's Customer Contact Center. With only 10 full-time equivalent (FTE) representatives, the Department's Customer Contact Center fields nearly 13% more calls than the industry average per employee. This low staffing level combined with technological inadequacies results in poor client experiences as highlighted by low performance scores. For example, between July 2011 and March 2012, approximately 52% of the Department's clients abandoned their calls, while the health care industry's average call abandonment rate is only 4%; the Department's clients waited an average of 19.5 minutes to receive an answer to their inquiry, while the health care industry's average wait time is 33 seconds.

Increased demand for customer services will likely exacerbate these deficiencies as Medicaid caseload continues to grow and the health care system becomes more complex. With Medicaid caseload expected to continue to increase by more than 150,000 clients over the next two fiscal years and potentially more than 400,000 individuals applying for health insurance through the Colorado Health Benefit Exchange that will be implemented by early 2014 – many of whom will mistakenly call the Department's Customer Contact Center for assistance - the stresses on the Department's Customer Contact Center will continue to compound.

In FY 2011-12, the Customer Contact Center utilized a consultant to provide recommended improvements, which included developing clear performance standards and tailoring staff schedules to match call volumes, as well as upgrading technological capabilities. In April 2012, the Customer Service Center began implementing a series of improvements to its internal processes to address inadequacies. For example, management implemented more concrete performance standards, held additional training sessions, and staggered staff scheduling to coincide with patterns in call volume, resulting in an improved capacity to manage call volume. In July, the Customer Contact Center's call abandonment rate dropped to 30% (an improvement of 22 percentage points) and the

average time spent waiting to receive an answer dropped to 8.6 minutes (a 56% improvement).

Despite these improvements, the Customer Contact Center's performance scores still remain well below industry standards. The Center lacks the technology to route calls, directly monitor call quality, or enable self-service for callers. This technological functionality was presented by the Department's consultant as an industry norm to improve performance measures and the callers' experiences.

One of the Customer Contact Center's central deficiencies is the inability to transfer clients to outside organizations, such as regional care collaborative organizations, county departments of human/social services, or transportation vendors. When the Customer Contact Center is unable to directly assist a caller, they can only provide the correct party's phone number, rather than directly transferring the caller to that entity. If a client needs assistance with more than one issue, they will likely need to call the Customer Contact Center numerous times to obtain the phone numbers of all of the parties who can assist them.

The Customer Contact Center also lacks technology to track and log information regarding individual calls and produce summarized statistics, such as the top reasons for client calls. This information would assist the Customer Contact Center in tailoring training, adding additional information to the Department's website, or provide frequently requested information that could be played during hold times, similar to techniques used in private industry.

Brief Background:
The Department's Customer Contact Center acts as a major focal point for callers who require assistance with questions about eligibility, benefits, and enrollment, or who need help in navigating the Department's programs. While the intent of the Department's Customer Contact Center is to be a resource to individuals and families who are applying for or are enrolled in Medicaid, it also receives inquiries during the application process that need to be referred to outside agencies or parties, such as questions regarding programs that are managed by other state departments. The Department's Customer Contact Center currently has 10 FTE representatives that handle more than 110,000 calls per year, or an average of over 11,000 calls per FTE. This compares to an average call volume of approximately 9,500 in the health care industry.

The Department's Customer Contact Center currently limits correspondence with clients to telephone and email, with no web-based assistance offered. The Customer Contact Center currently utilizes an antiquated database to track call history and a hyperlinked Word document to provide Representatives with operating procedures for various situations. These resources are slow to operate, cumbersome to navigate, and cannot be integrated with other programs. The multiple programs that provide information to assist in answering client inquiries – such as the Medicaid Management Information System (MMIS) and the Colorado Benefits Management System (CBMS) – operate independently of either the database or the Word document, resulting in longer call times as Representatives gather relevant information from each source and manually integrate it to form a complete response.

Proposed Solution:
The Department is requesting funding to expand the role that the phone system plays in providing high-quality customer service. Phone system automation, initiated by both voice and data input recognition, would allow a greater range of flexibility to callers and allow more data to be gained accurately in the event that a caller wants to speak with a Representative. By automating a response based on the input of a caller's zip code, Customer Contact Center staff could offer the phone numbers for local services, such as the county department of human/social services, regional care collaborative organization, and

transportation vendors. Interactive Voice Response (IVR) would provide the ability to obtain a greater level of details from clients about their needs so that calls can be routed to the correct party immediately. In the event that a client needs to be transferred to an outside organization, the requested technology would enable a Customer Contact Center Representative to contact that outside organization directly, introduce the client and explain their situation, and then transfer the client, all while the client remains on the line. This process ensures more efficient problem resolution and greater client satisfaction compared to the Customer Contact Center's current procedure of verbally providing the client with the outside organization's phone number and then ending the call. The Department will also add automated services to allow clients to request medical ID card replacements and provide connections to appropriate vendors. Call trigger functionality would also help seamlessly transfer clients to the Colorado Health Benefits Exchange and PEAK Help Desks in an "any door is the right door" fashion.

The Department is also requesting funding to establish a website dedicated solely to the needs of Colorado Medicaid clients, which will be overseen by the Customer Contact Center. This would increase client exposure to relevant information and provide quick access to new content as well as to content already available on the Department's website. Live chat functionality would be available from this website, giving clients another avenue to reach Medicaid customer service and potentially reducing the Center's call volume. The Department is investigating the addition of features like functional links to vendors for services such as non-emergent medical transportation (offering the ability to schedule or cancel transportation appointments) or the ability to request replacement medical ID cards, which would further reduce the call volume at the Customer Contact Center and lead to improved client satisfaction and self-sufficiency.

As part of this request, the Department would also implement a customer relations management (CRM) system that would allow for the integration of existing silos of information (MMIS, CBMS, Contact Tracking Database, and possibly others) and bring the data together in one accessible format, helping ensure that complete and accurate information is conveyed to clients upon initial contact. CRM software encompasses every aspect of customer interaction with the Customer Contact Center and is a widely implemented model for managing interactions with clients. Such software helps to direct clients to the individual who can best help them with their current problem, and is an effective method to increase accountability and efficiency within the Department.

Based on industry research, the Department has estimated that these technological improvements will cost approximately $1,800,000. The Department is committed to procuring these services for the lowest possible cost, but based on industry research, this request represents the upper bound estimate. If the contract is procured for less, the Department will work with the Office of State Planning and Budgeting through the normal budgetary process to submit a negative supplemental and revert any unused funds.

Alternatives:
If this request is not funded, the Customer Contact Center will continue to make non-technological management and training improvements to achieve higher quality customer service, but these improvements are limited in scope and effectiveness. To ensure that the Customer Contact Center has the capacity to handle the influx of calls that the implementation of the Colorado Health Benefit Exchange will likely produce in 2014, the Customer Contact Center must upgrade its technological capacities.

Anticipated Outcomes:
The Department anticipates that these improvements will result in lower call volume per FTE, shorter hold times, lower call abandonment rates, and clients obtaining assistance from

outside organizations in a more timely and efficient manner. All of these components will be critical to the Customer Contact Center's ability to manage the influx of applicants and clients in 2014.

Assumptions for Calculations:
Based on research of industry standards and costs, the Department is requesting total funds of $1,800,000 to implement the improvements outlined, with anticipated on-going maintenance and support costs of approximately $180,000 annually. The Department will procure these services through a competitive bidding process by issuing Requests for Proposals (RFPs). The Department is not providing detailed cost estimates for each of the improvements outlined above so as not to influence the competitive process. The Department is requesting this funding assuming the regular 50% Federal Financial Participation (FFP) for Medicaid administration. However, some of this funding may qualify for 75% FFP as commercial off-the-shelf software or 90% FFP for custom modifications under the State's Eligibility Determination System Implementation Advanced Planning Document that was recently submitted to the Centers for Medicare and Medicaid Services (CMS) for approval.

Consequences if not Funded:
Clients continue to receive insufficient customer service if these problems are not addressed. Annual double-digit caseload growth in Medicaid and the implementation of the Colorado Health Benefit Exchange in 2014 will likely exacerbate these deficiencies as Medicaid caseload continues to grow and the health care system becomes more complex.

Schedule 13

Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: 1.5% Provider Rate Increase

Priority Number: R-13

Dept. Approval by: John Bartholomew [signature] 10/26/12 Date

OSPB Approval by: [signature] 10/30/12 Date

☑ Decision Item FY 2013-14
☐ Base Reduction Item FY 2013-14
☐ Supplemental FY 2012-13
☐ Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$3,989,761,014	$0	$4,030,680,301	$33,116,630	$36,586,647
	FTE	0.0	0.0	$0	0.0	0.0
	GF	$1,052,677,492	$0	$1,094,943,022	$14,578,983	$15,990,776
	GFE	$312,202,624	$0	$312,202,624	$0	$0
	CF	$651,181,857	$0	$626,082,971	$1,227,138	$932,784
	RF	$3,215,340	$0	$1,215,340	$0	$0
	FF	$1,970,483,701	$0	$1,996,236,344	$17,310,509	$19,663,087
(2) Medical Services Premiums	Total	$3,985,613,386	$0	$4,026,532,673	$33,054,416	$36,514,097
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$1,050,603,677	$0	$1,092,869,207	$14,547,876	$15,954,501
	GFE	$312,202,624	$0	$312,202,624	$0	$0
	CF	$651,181,857	$0	$626,082,971	$1,227,138	$932,784
	RF	$3,215,340	$0	$1,215,340	$0	$0
	FF	$1,968,409,888	$0	$1,994,162,531	$17,279,402	$19,626,812
(3) Medicaid Mental Health Community Programs; Medicaid Mental Health Fee for Services Payments	Total	$4,147,628	$0	$4,147,628	$62,214	$72,550
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,073,815	$0	$2,073,815	$31,107	$36,275
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,073,813	$0	$2,073,813	$31,107	$36,275

Letternote Text Revision Required? Yes: ☑ No: ☐ **If yes, describe the Letternote Text Revision: See Table 1c.**

Cash or Federal Fund Name and COFRS Fund Number: Hospital Provider Fee Cash Fund (24A), BCCP Cash Fund (15D), Unclaimed Property Trust Fund (82A), FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: N/A

Other Information: N/A

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

John W. Hickenlooper
Governor

Susan E. Birch
Executive Director

FY 2013-14 Funding Request
November 1, 2012

Signature 10/23/12
Date

Department Priority: R-13
1.5% Provider Rate Increase

Summary of Incremental Funding Change for FY 2013-14	Total Funds	General Fund	FTE
1.5% Provider Rate Increase	$33,116,630	$14,578,983	0.0

Request Summary:
The Department requests $33,116,630 total funds, including $14,578,983 in General Fund, in FY 2013-14 to increase reimbursement to most providers by 1.5%.

Problem or Opportunity:
During the recent economic recession, the state imposed multiple provider rate reductions to create General Fund relief. Continuation of the rate reductions not only perpetuates the financial strain on providers, but could also potentially put clients' access to health care at risk.

Brief Background:
Since FY 2008-09, the state has shared the burden of the economic crisis with health care providers. The following is a list of select budget reduction items implemented since FY 2008-09: FY 2009-10 BA-33: "Provider Volume and Rate Reductions", FY 2010-11 ES-2: "Medicaid Program Reductions", FY 2010-11 ES-6: "Medicaid Provider Reductions", FY 2010-11 BRI-6: "Medicaid Program Reductions", and FY 2011-12 BA-9: "Medicaid Budget Balancing Reductions". Each request contained either targeted or across-the-board reductions to rates that impacted multiple provider types.

Maintaining the magnitude of rate reductions that has accumulated in the last four years (which varies by provider type) is not sustainable. Without sufficient reimbursement, it is difficult to expand the Medicaid provider network sufficiently to cover the needs of the growing population. In particular, this is true for rural areas throughout Colorado.

Insufficient access to health care can negatively impact long-term costs as clients' conditions are exacerbated due to lack of care. The Department believes it is necessary to provide a degree of relief to providers after four years of reductions to alleviate the financial pressure on businesses, risk to client care, and risk of growing long-term costs.

Proposed Solution:
The Department requests to increase provider rates by 1.5% for services impacted by rate reductions in recent years.

Alternatives:
The current level of reimbursement can be maintained.

Anticipated Outcomes:
By implementing the provider rate increase, the financial strain and risk to client access that

accompanied several years' worth of rate reductions will be reduced.

Assumptions for Calculations:
The Department assumes all provider types impacted by rate reductions since FY 2008-09 would be impacted by the rate increase with the exception of class I nursing facilities, pharmacies, and services provided under the home and community based services (HCBS) waiver for children with autism.

Rate reductions impacting class I nursing facilities were implemented through statutory changes as one-time, limited duration impacts. Under current statute, in FY 2013-14, expenditure for this service will return to the level it would have been absent rate reductions, and thus should not qualify for a rate increase.

Pharmaceutical reimbursement is transitioning to a methodology that reflects the actual costs of purchasing and dispensing medications. Under this methodology, the Department has little flexibility to augment rates due to federal constraints. Further, pharmaceutical reimbursement is unique in that the reimbursement methodology is directly tied to a moving price statistic that increases reimbursement as provider costs increase. As a result, even though pharmacies were impacted by rate reductions like other provider types, pharmacies saw increases to reimbursement as costs increased that other provider types (reimbursed on a fee schedule) did not.

Rates for services provided under the HCBS waiver for children with autism were not reduced in prior years because of the cap on client expenses. Rate reductions would have reduced total client expenditures, and thus allowed for additional services to be provided under the cap. Because the Department did not reduce rates for these services, the Department would not apply this proposed rate increase to these services.

See Appendix A for detailed calculations.

Consequences if not Funded:
Provider reimbursement will remain at current levels.

Cash Fund Projections:
This request includes Cash Funds from the Hospital Provider Fee Cash Fund, Breast and Cervical Cancer Prevention and Treatment Fund, and Unclaimed Property Trust Fund. For information on associated revenues, expenditures, and cash fund balances, please see the Schedule 9 "Cash Funds Report" in Section O of this Budget Request.

Relation to Performance Measures:
Performance Measure 3 – Increase the number of providers participating in Medicaid.
Adequate provider reimbursement is pivotal to achieving this strategic goal.

R-13 Provider Rate Increase
Appendix A: Calculations and Assumptions

Table 1a: FY 2013-14 - Amounts Eligible for Rate Increase by Funding Source (Includes Budget Actions Not Yet Approved)

Service Category	Total Funds	General Fund	Cash Fund	Federal Funds
Acute Care	$1,717,576,987	$744,326,785	$67,713,370	$905,536,832
Community Based Long Term Care	$345,089,671	$171,673,124	$838,046	$172,578,501
PACE	$75,330,414	$37,665,207	$0	$37,665,207
Service Management	$34,411,528	$16,952,700	$126,532	$17,332,296
FY 2013-14 R-7 Substance Abuse Benefit	$415,440	($11,820)	($282)	$427,542
FY 2013-14 R-8 Dental Benefit	$30,803,647	($747,621)	$13,131,511	$18,419,757
Total Medical Service Premiums	$2,203,627,687	$969,858,375	$81,809,177	$1,151,960,135
Impact of 1.5% Rate Increase	**$33,054,416**	**$14,547,876**	**$1,227,138**	**$17,279,402**
Mental Health Fee-for-service	$4,147,628	$2,073,814	$0	$2,073,814
Impact of 1.5% Rate Increase	**$62,214**	**$31,107**	**$0**	**$31,107**
Total Impact of Rate Increase	**$33,116,630**	**$14,578,983**	**$1,227,138**	**$17,310,509**

Table 1b: FY 2014-15 - Amounts Eligible for Rate Increase by Funding Source (Includes Budget Actions Not Yet Approved)

Service Category	Total Funds	General Fund	Cash Fund	Federal Funds
Acute Care	$1,868,653,780	$809,797,215	$38,664,567	$1,020,191,998
Community Based Long Term Care	$388,491,487	$193,264,397	$943,447	$194,283,643
PACE	$89,019,409	$44,509,705	$0	$44,509,704
Service Management	$37,705,579	$18,585,958	$0	$19,119,621
FY 2013-14 R-7 Substance Abuse Benefit	($1,901,422)	($953,140)	($33,883)	($914,399)
FY 2013-14 R-8 Dental Benefit	$52,304,279	($1,570,715)	$22,611,454	$31,263,540
Total Medical Service Premiums	$2,434,273,112	$1,063,633,420	$62,185,585	$1,308,454,107
Impact of 1.5% Rate Increase	**$36,514,097**	**$15,954,501**	**$932,784**	**$19,626,812**
Mental Health - Fee-for-service	$4,836,640	$2,418,320	$0	$2,418,320
Impact of 1.5% Rate Increase	**$72,550**	**$36,275**	**$0**	**$36,275**
Total Impact of Rate Increase	**$36,586,647**	**$15,990,776**	**$932,784**	**$19,663,087**

Table 1c: Impact by Cash Fund with 1.5% Increase (Medical Services Premiums Only)

Fiscal Year	Hospital Provider Fee Fund	Breast and Cervical Cancer Prevention and Treatment Fund	Unclaimed Property Trust Fund	Total Cash Fund Impact
Percentages	82.72%	1.58%	15.70%	100%
FY 2013-14	$1,015,107	$19,372	$192,659	$1,227,138
FY 2014-15	$771,612	$14,726	$146,446	$932,784

(1) The increase to rates will not impact the contribution amount from the Medicaid Buy-in Fund.

Schedule 13

Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - Developmental Disabilities Services for New Resources

Priority Number: NP R-1

Dept. Approval by: John Bartholomew [signature] 10/26/12 Date

OSPB Approval by: [signature] 10/29/12 Date

- ☑ Decision Item FY 2013-14
- ☐ Base Reduction Item FY 2013-14
- ☐ Supplemental FY 2012-13
- ☐ Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$340,502,802	$0	$344,574,272	$13,055,339	$25,585,912
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$170,251,400	$0	$172,287,135	$6,527,670	$12,792,956
	GFE	$0	$0	$0	$0	$0
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$170,251,401	$0	$172,287,136	$6,527,669	$12,792,956
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding, Community Services for People with Developmental Disabilities, Program Costs	Total	$340,502,802	$0	$344,574,272	$13,055,339	$25,585,912
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$170,251,400	$0	$172,287,135	$6,527,670	$12,792,956
	GFE	$0	$0	$0	$0	$0
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$170,251,401	$0	$172,287,136	$6,527,669	$12,792,956

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: Colorado Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - Technical Changes for Developmental Disabilities Programs

Priority Number: NP R-2

Dept. Approval by: John Bartholomew [signature] 10/26/12
Date

OSPB Approval by: [signature] 10/24/12
Date

- Decision Item FY 2013-14
- Base Reduction Item FY 2013-14
- Supplemental FY 2012-13
- Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$388,485,839	$0	$392,376,087	$0	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$192,375,264	$0	$194,320,388	$0	$0
	GFE	$0	$0	$0	$0	$0
	CF	$1	$0	$1	$0	$0
	RF	$1,867,655	$0	$1,867,655	$0	$0
	FF	$194,242,919	$0	$196,188,043	$0	$0
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding, Community Services for People with Developmental Disabilities, Program Costs	Total	$340,502,802	$0	$344,574,272	$301,732	$301,732
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$170,251,400	$0	$172,287,135	$150,866	$150,866
	GFE	$0	$0	$0	$0	$0
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$170,251,401	$0	$172,287,136	$150,866	$150,866
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding, Regional Centers	Total	$47,983,037	$0	$47,801,815	($301,732)	($301,732)
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$22,123,864	$0	$22,033,253	($150,866)	($150,866)
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$1,867,655	$0	$1,867,655	$0	$0
	FF	$23,991,518	$0	$23,900,907	($150,866)	($150,866)

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: No: Not Required: ✓

Schedule 13s from Affected Departments: Colorado Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - Early Intervention Services Caseload Growth and Associated Case Management

Priority Number: NP R-3

Dept. Approval by: John Bartholomew JB 10/26/12 Date

OSPB Approval by: [signature] 10/24/12 Date

- [x] Decision Item FY 2013-14
- [ ] Base Reduction Item FY 2013-14
- [ ] Supplemental FY 2012-13
- [ ] Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$340,502,802	$0	$344,574,272	$1,635,843	$1,635,843
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$170,251,400	$0	$172,287,135	$817,922	$817,922
	GFE	$0	$0	$0	$0	$0
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$170,251,401	$0	$172,287,136	$817,921	$817,921
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding, Community Services for People with Developmental Disabilities, Program Costs	Total	$340,502,802	$0	$344,574,272	$1,635,843	$1,635,843
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$170,251,400	$0	$172,287,135	$817,922	$817,922
	GFE	$0	$0	$0	$0	$0
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$170,251,401	$0	$172,287,136	$817,921	$817,921

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:
Approval by OIT? Yes: No: **Not Required:** ✓
Schedule 13s from Affected Departments: Colorado Department of Human Services
Other Information:

Schedule 13

Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Capitol Complex Building Upgrade, Repair, and Replacement

Priority Number: NP R-4

Dept. Approval by: John Bartholomew [signature] 10/31/12
Date

OSPB Approval by: [signature] 10/31/12
Date

- ☑ Decision Item FY 2013-14
- ☐ Base Reduction Item FY 2013-14
- ☐ Supplemental FY 2012-13
- ☐ Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$394,600	$0	$461,336	$28,985	$28,985
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$197,300	$0	$230,668	$14,493	$14,493
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$197,300	$0	$230,668	$14,492	$14,492
(1) Executive Director's Office; (A) General Administration, Capitol Complex Leased Space	Total	$394,600	$0	$461,336	$28,985	$28,985
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$197,300	$0	$230,668	$14,493	$14,493
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$197,300	$0	$230,668	$14,492	$14,492

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX
Reappropriated Funds Source, by Department and Line Item Name: None.
Approval by OIT? Yes: ☐ No: ☐ **Not Required:** ☑
Schedule 13s from Affected Departments: Department of Personnel and Administration
Other Information: None.

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: Employee Engagement Survey Adjustment

Priority Number: NP R-5

Dept. Approval by: John Bartholomew JB 10/26/12 Date

OSPB Approval by: [signature] 10/30/12 Date

- ☑ Decision Item FY 2013-14
- ☐ Base Reduction Item FY 2013-14
- ☐ Supplemental FY 2012-13
- ☐ Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	**Total**	$84,444	$0	$130,028	$3,463	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$42,222	$0	$65,014	$1,732	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$42,222	$0	$65,014	$1,731	$0
(1) Executive Director's Office; (A) General Administration, Payment to Risk Management and Property Funds	Total	$84,444	$0	$130,028	$3,463	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$42,222	$0	$65,014	$1,732	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$42,222	$0	$65,014	$1,731	$0

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX
Reappropriated Funds Source, by Department and Line Item Name: None.
Approval by OIT? Yes: ☐ No: ☐ Not Required: ☑
Schedule 13s from Affected Departments: Department of Personnel and Administration
Other Information: None.

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: OIT Enterprise Asset Management

Priority Number: NP R-6

Dept. Approval by: John Bartholomew JB 10/26/12 Date

OSPB Approval by: [signature] 10/30/12 Date

- ☑ Decision Item FY 2013-14
- ☐ Base Reduction Item FY 2013-14
- ☐ Supplemental FY 2012-13
- ☐ Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$1,001,906	$0	$846,006	$6,260	$1,425
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$496,930	$0	$415,693	$3,130	$713
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$4,046	$0	$4,046	$0	$0
	FF	$500,930	$0	$426,267	$3,130	$712
(1) Executive Director's Office; (A) General Administration, Purchases of Services from Computer Center	Total	$1,001,906	$0	$846,006	$6,260	$1,425
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$496,930	$0	$415,693	$3,130	$713
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$4,046	$0	$4,046	$0	$0
	FF	$500,930	$0	$426,267	$3,130	$712

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name: None.

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

Schedule 13s from Affected Departments: Governor's Office of Information Technology

Other Information: None.

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - 1.5% Community Provider Rate Increase

Priority Number: NP R-7

Dept. Approval by: John Bartholomew [signature] 10/26/12 Date

OSPB Approval by: [signature] 10/29/12 Date

- [x] Decision Item FY 2013-14
- [ ] Base Reduction Item FY 2013-14
- [ ] Supplemental FY 2012-13
- [ ] Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$358,544,843	$0	$362,616,313	$5,663,452	$5,663,452
	FTE	0.0	0.0	0.0	0.0	0 0
	GF	$179,272,421	$0	$181,308,156	$2,831,728	$2,831,728
	GFE	$0	$0	$0	$0	$0
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$179,272,421	$0	$181,308,156	$2,831,724	$2,831,724
(6) Department of Human Services Medicaid-Funded Programs; (D) Division of Child Welfare - Medicaid Funding, Child Welfare Services	Total	$14,293,272	$0	$14,293,272	$214,399	$214,399
	FTE	0.0	0.0	0.0	0 0	0.0
	GF	$7,146,636	$0	$7,146,636	$107,200	$107,200
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$7,146,636	$0	$7,146,636	$107,199	$107,199
(6) Department of Human Services Medicaid-Funded Programs; (F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding, Residential Treatment for Youth (H.B. 99-1116)	Total	$116,840	$0	$116,840	$1,753	$1,753
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$58,420	$0	$58,420	$877	$877
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$58,420	$0	$58,420	$876	$876
(6) Department of Human Services Medicaid-Funded Programs; (F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding, Alcohol and Drug Abuse Division, High Risk Pregnant Women Program	Total	$1,999,146	$0	$1,999,146	$29,987	$29,987
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$999,573	$0	$999,573	$14,994	$14,994
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$999,573	$0	$999,573	$14,993	$14,993
(6) Department of Human Services Medicaid-Funded Programs; (G) Services for People with Disabilities - Medicaid Funding, Community Services for People with Developmental Disabilities, Program Costs	Total	$340,502,802	$0	$344,574,272	$5,393,507	$5,393,507
	FTE	0.0	0.0	0.0	0 0	0 0
	GF	$170,251,400	$0	$172,287,135	$2,696,754	$2,696,754
	GFE	$0	$0	$0	$0	$0
	CF	$1	$0	$1	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$170,251,401	$0	$172,287,136	$2,696,753	$2,696,753

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - OIT - Enterprise Asset Management

Priority Number: NP R-8

Dept. Approval by: John Bartholomew [signature] 10/26/12 Date

OSPB Approval by: [signature] 10/29/12 Date

- [x] Decision Item FY 2013-14
- [ ] Base Reduction Item FY 2013-14
- [ ] Supplemental FY 2012-13
- [ ] Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$500,820	$0	$483,399	$1,532	$348
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$250,410	$0	$241,699	$766	$174
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$250,410	$0	$241,700	$766	$174
(6) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology Services - Medicaid Funding, Other Office of Information Technology Services Line Items	Total	$500,820	$0	$483,399	$1,532	$348
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$250,410	$0	$241,699	$766	$174
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$250,410	$0	$241,700	$766	$174

Letternote Text Revision Required? Yes: [ ] No: [x] **If yes, describe the Letternote Text Revision:**

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

Approval by OIT? Yes: [ ] No: [ ] **Not Required:** [x]

Schedule 13s from Affected Departments: Colorado Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - DPA - Capitol Complex Building Upgrade, Repair, and Replacement

Priority Number: NP R-9

Dept. Approval by: John Bartholomew 10/26/12 Date

OSPB Approval by: 10/29/12 Date

- ☑ Decision Item FY 2013-14
- ☐ Base Reduction Item FY 2013-14
- ☐ Supplemental FY 2012-13
- ☐ Budget Amendment FY 2013-14

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$4,824,525	$0	$4,818,003	$1,460	$1,460
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,412,263	$0	$2,409,002	$730	$730
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,412,262	$0	$2,409,001	$730	$730
(6) Department of Human Services Medicaid-Funded Programs; (C) Office of Operations - Medicaid Funding	Total	$4,824,525	$0	$4,818,003	$1,460	$1,460
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$2,412,263	$0	$2,409,002	$730	$730
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$2,412,262	$0	$2,409,001	$730	$730

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: Colorado Department of Human Services

Other Information:

Schedule 13
Funding Request for the 2013-14 Budget Cycle

Department: Health Care Policy and Financing

Request Title: DHS - DPA - Employee Engagement Survey Adjustment

Priority Number: NP R-10

Dept. Approval by: John Bartholomew 10/26/12 Date

OSPB Approval by: 10/29/12 Date

- ☑ **Decision Item FY 2013-14**
- ☐ **Base Reduction Item FY 2013-14**
- ☐ **Supplemental FY 2012-13**
- ☐ **Budget Amendment FY 2013-14**

Line Item Information		FY 2012-13		FY 2013-14		FY 2014-15
		1	2	3	4	5
	Fund	Appropriation FY 2012-13	Supplemental Request FY 2012-13	Base Request FY 2013-14	Funding Change Request FY 2013-14	Continuation Amount FY 2014-15
Total of All Line Items	Total	$15,276,074	$0	$16,999,667	$7,736	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,638,037	$0	$8,500,172	$3,868	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$7,638,037	$0	$8,499,495	$3,868	$0
(6) Department of Human Services Medicaid-Funded Programs; (A) Executive Director's Office - Medicaid Funding	Total	$15,276,074	$0	$16,999,667	$7,736	$0
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$7,638,037	$0	$8,500,172	$3,868	$0
	GFE	$0	$0	$0	$0	$0
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$7,638,037	$0	$8,499,495	$3,868	$0

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

Cash or Federal Fund Name and COFRS Fund Number: FF: Title XIX.

Reappropriated Funds Source, by Department and Line Item Name:

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

Schedule 13s from Affected Departments: Colorado Department of Human Services

Other Information:

Schedule 10
Summary of FY 2013-14 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: November 1, 2012
Number of Funding Requests: 13
Number of Non Prioritized Items: 10

Schedule 10 Priority	Nov. 1, 2012 Priority	Title	IT Request	Total Request (FY 2013-14)	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Total Impact				**$474,998,375**	**11.6**	**$134,308,021**	**$0**	**$31,788,508**	**$0**	**$308,901,846**
FY 2013-14 Funding Requests										
1	R-1	Medical Services Premiums	No	$255,256,258	0.0	$78,363,224	$0	($1,837,669)	$0	$178,730,703
2	R-2	Medicaid Mental Health Community Programs	No	$32,384,988	0.0	$10,284,849	$0	($1,313,268)	$0	$23,413,407
3	R-3	Children's Basic Health Plan Medical and Dental Costs	No	$60,591,910	0.0	$1,923,755	$0	$19,735,056	$0	$38,933,099
4	R-4	Medicare Modernization Act of 2003 State Contribution Payment	No	$14,603,355	0.0	$14,603,355	$0	$0	$0	$0
5	R-5	Medicaid Management Information System Reprocurement	No	$15,624,403	0.0	$1,439,072	$0	$287,834	$0	$13,897,497
6	R-6	Additional FTE to Restore Functionality	No	$704,341	7.4	$352,172	$0	$0	$0	$352,169
7	R-7	Subtance Use Disorder Benefit	No	$5,788,068	0.0	$1,818,130	$0	$42,035	$0	$3,927,903
8	R-8	Medicaid Dental Benefit for Adults	No	$32,959,416	1.2	($747,621)	$0	$13,693,726	$0	$20,013,311
9	R-9	Dental ASO for Children	No	$576,072	0.0	$0	$0	$0	$0	$576,072
10	R-10	Leased Space Rent Increase and True-up	No	$92,115	0.0	$92,402	$0	($46,344)	$0	$46,057
11	R-11	HB 12-1281 Departmental Differences Reconciliation	No	$1,096,749	3.0	$497,661	$0	$0	$0	$599,088
12	R-12	Customer Service Technology Improvements	No	$1,800,000	0.0	$900,000	$0	$0	$0	$900,000
13	R-13	1.5% Provider Rate Increase	No	$33,116,630	0.0	$14,578,983	$0	$1,227,138	$0	$17,310,509
FY 2013-14 Funding Requests				**$454,594,305**	**11.6**	**$124,105,982**	**$0**	**$31,788,508**	**$0**	**$298,699,815**
Funding Requests R-1 through R-4				**$362,836,511**	**0.0**	**$105,175,183**	**$0**	**$16,584,119**	**$0**	**$241,077,209**
All Other Funding Requests				**$91,757,794**	**11.6**	**$18,930,799**	**$0**	**$15,204,389**	**$0**	**$57,622,606**

Schedule 10
Summary of FY 2013-14 Change Requests

Department Name: Health Care Policy and Financing
Submission Date: November 1, 2012
Number of Funding Requests: 13
Number of Non Prioritized Items: 10

Schedule 10 Priority	Nov. 1, 2012 Priority	Title	IT Request	Total Request (FY 2013-14)	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Total Impact				**$474,998,375**	**11.6**	**$134,308,021**	**$0**	**$31,788,508**	**$0**	**$308,901,846**
FY 2013-14 Non-Prioritized Funding Requests										
1	NP-R1	DHS - Developmental Disabilities Services for New Resources	No	$13,055,339	0.0	$6,527,670	$0	$0	$0	$6,527,669
2	NP-R2	DHS - Technical Changes for Developmental Disabilities Programs	No	$0	0.0	$0	$0	$0	$0	$0
3	NP-R3	DHS - Early Intervention Services Caseload Growth and Associated Case Management	No	$1,635,843	0.0	$817,922	$0	$0	$0	$817,921
4	NP-R4	Capitol Complex Building Upgrade, Repair, and Replacement	No	$28,985	0.0	$14,493	$0	$0	$0	$14,492
5	NP-R5	Employee Engagement Survey Adjustment	No	$3,463	0.0	$1,732	$0	$0	$0	$1,731
6	NP-R6	OIT Enterprise Asset Management	Yes	$6,260	0.0	$3,130	$0	$0	$0	$3,130
7	NP-R7	DHS - 1.5% Community Provider Rate Increase	No	$5,663,452	0.0	$2,831,728	$0	$0	$0	$2,831,724
8	NP-R8	DHS - OIT - Enterprise Asset Management	No	$1,532	0.0	$766	$0	$0	$0	$766
9	NP-R9	DHS - DPA - Capitol Complex Building Upgrade, Repair, and Replacement	No	$1,460	0.0	$730	$0	$0	$0	$730
10	NP-R10	DHS - DPA - Employee Engagement Survey Adjustment	No	$7,736	0.0	$3,868	$0	$0	$0	$3,868
FY 2013-14 Non-Prioritized Funding Requests				**$20,404,070**	**0.0**	**$10,202,039**	**$0**	**$0**	**$0**	**$10,202,031**

TABLE OF CONTENTS

Exhibits for the Medical Services Premiums Budget Request

Exhibit	Description
Exhibit A	Calculation of Request, Calculation of Fund Splits
Exhibit B	Medicaid Caseload Forecast
Exhibit C	History and Projections of Per Capita Costs
Exhibit D	Cash Funds Report
Exhibit E	Summary of Total Requested Expenditure by Service Group, Comparison of Request to Long Bill Appropriation and Special Bills
Exhibit F	Acute Care, Breast and Cervical Cancer Program Per Capita Detail, Antipsychotic Drug Expenditure and Pharmacy Enhanced Rebates, Family Planning Enhanced Match Calculation, Indian Health Services
Exhibit G	Community Based Long Term Care, Half-Year Expenditure Split, Colorado Choice Transitions
Exhibit H	Long Term Care and Insurance Summary; Class I Nursing Facilities Request, Footnotes, and Supplemental Payments; Class II Nursing Facilities; Program for All-Inclusive Care for the Elderly (PACE); Supplemental Medicare Insurance Benefit (SMIB); Health Insurance Buy-In (HIBI)
Exhibit I	Service Management - Summary; Single Entry Points; Disease Management; Prepaid Inpatient Health Plan Administration
Exhibit J	Hospital Provider Fee Financing
Exhibit K	Upper Payment Limit Financing
Exhibit L	Department Recoveries
Exhibit M	Expenditure History by Aid Category and Service Category
Exhibit N	Expenditure History by Service Category
Exhibit O	Comparison of Budget Requests, Appropriations and Expenditure for Prior Years
Exhibit P	Global Reasonableness; Expenditure and Caseload History; Estimate of Expenditures with Prior Year Cash Flow Pattern (Reference Only)

Exhibit A - Summary of Request

Calculation of Request

FY 2012-13

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$3,994,685,293	$1,055,118,623	$312,202,624	$651,202,864	$3,215,340	$1,972,945,842
HB 12-1340 "Nursing Facility Reduction Per Diem Rate"	($9,024,676)	($4,512,338)	$0	$0	$0	($4,512,338)
SB 12-060 "Improve Medicaid Fraud Prosecution"	($54,156)	($2,608)	$0	($24,470)	$0	($27,078)
SB 12-159 "Evaluation Children With Autism Medicaid Waiver"	$6,925	$0	$0	$3,463	$0	$3,462
FY 2012-13 Total Spending Authority	**$3,985,613,386**	**$1,050,603,677**	**$312,202,624**	**$651,181,857**	**$3,215,340**	**$1,968,409,888**
Total Projected FY 2012-13 Expenditures	$3,997,155,681	$1,044,314,977	$312,202,624	$663,769,785	$3,215,340	$1,973,652,955
FY 2012-13 Requested Change from Appropriation	**$11,542,295**	**($6,288,700)**	**$0**	**$12,587,928**	**$0**	**$5,243,067**
Percent Change	0.29%	-0.60%	0.00%	1.93%	0.00%	0.27%

Exhibit A - Summary of Request

Calculation of Request

FY 2013-14

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation Plus Special Bills	$3,985,613,386	$1,050,603,677	$312,202,624	$651,181,857	$3,215,340	$1,968,409,888
Bill Annualizations						
Annualization of FY 2012-13 Long Bill (HB 12-1335)	($3,256,585)	($1,535,870)	$0	($96,662)	$0	($1,624,053)
SB 08-118 Annualization "Transfer for Medicaid Disease Management"	$0	$2,000,000	$0	$0	($2,000,000)	$0
HB 10-1146 Annualization "State-funded Public Assistance Programs"	($102,745)	($51,373)	$0	$0	$0	($51,372)
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	$26,454,555	$9,259,094	$0	$0	$0	$17,195,461
SB 11-212 Annualization "Use Provider Fee Offset GF Medicaid"	$0	$25,000,000	$0	($25,000,000)	$0	$0
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	$8,803,834	$3,081,341	$0	$0	$0	$5,722,493
HB 12-1340 Annualization "Nursing Facility Reduction Per Diem Rate"	$9,024,676	$4,512,338	$0	$0	$0	$4,512,338
SB 12-060 Annualization "Improve Medicaid Fraud Prosecution"	($4,448)	$0	$0	($2,224)	$0	($2,224)
Total Annualizations	$40,919,287	$42,265,530	$0	($25,098,886)	($2,000,000)	$25,752,643
FY 2013-14 Base Amount	**$4,026,532,673**	**$1,092,869,207**	**$312,202,624**	**$626,082,971**	**$1,215,340**	**$1,994,162,531**
Total Projected FY 2013-14 Expenditures	$4,281,788,931	$1,171,232,431	$312,202,624	$624,245,302	$1,215,340	$2,172,893,234
FY 2013-14 Request	**$255,256,258**	**$78,363,224**	**$0**	**($1,837,669)**	**$0**	**$178,730,703**
Percent Change from FY 2012-13 Base	6.34%	7.17%	0.00%	-0.29%	0.00%	8.96%

Calculation of Request

FY 2014-15

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Appropriation Plus Special Bills	$4,026,532,673	$1,092,869,207	$312,202,624	$626,082,971	$1,215,340	$1,994,162,531
Bill Annualizations						
HB 08-1373 "Breast and Cervical Cancer Fund"	$0	$1,315,972	$0	($1,315,972)	$0	$0
Total Annualizations	$0	$1,315,972	$0	($1,315,972)	$0	$0
FY 2014-15 Total Spending Authority	**$4,026,532,673**	**$1,094,185,179**	**$312,202,624**	**$624,766,999**	**$1,215,340**	**$1,994,162,531**
Total Projected FY 2014-15 Expenditures	$4,447,257,384	$1,238,323,573	$312,202,624	$591,293,163	$1,215,340	$2,304,222,684
FY 2014-15 Requested Change From Appropriation	**$420,724,711**	**$144,138,394**	**$0**	**($33,473,836)**	**$0**	**$310,060,153**
Percent Change	10.45%	13.17%	0.00%	-5.36%	0.00%	15.55%

Exhibit A - Summary of Request

Calculation of Fund Splits
FY 2012-13

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
Acute Care Services							
Base Acute	$1,968,113,314	$984,056,657	$0	$0	$984,056,657	50.00%	
Breast and Cervical Cancer Program	$10,301,457	$1,195,085	$1,195,085	$1,215,340	$6,695,947	65.00%	State fund sources vary; see Exhibit F
Family Planning	$11,795,916	$1,160,689	$18,903	$0	$10,616,324	90.00%	CF: Local Funds
Home Health Telemedicine Services	$312,575	$136,120	$40,335	$0	$136,120	50.00%	CF: Home Health Telemedicine Cash Fund
Indian Health Service	$1,499,130	$0	$0	$0	$1,499,130	100.00%	
Affordable Care Act Drug Rebate Offset	($14,428,315)	$0	$0	$0	($14,428,315)	0.00%	
SB 11-008: "Aligning Medicaid Eligibility for Children" Adjustment	$2,833,686	$991,790	$0	$0	$1,841,896	65.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid" Adjustment	$2,997,688	$1,049,191	$0	$0	$1,948,497	65.00%	
Physicians to 100% of Medicare: 100% Federally Funded Portion	$4,950,838	$0	$0	$0	$4,950,838	100.00%	
Acute Care Services Sub-Total	$1,988,376,289	$988,589,532	$1,254,323	$1,215,340	$997,317,094		
Community Based Long Term Care Services							
Base Community Based Long Term Care	$369,743,798	$184,871,899	$0	$0	$184,871,899	50.00%	
Children with Autism Waiver Services	$1,060,466	$0	$530,233	$0	$530,233	50.00%	CF: Colorado Autism Treatment Fund
Community Based Long Term Care Sub-Total	$370,804,264	$184,871,899	$530,233	$0	$185,402,132		
Long Term Care and Insurance							
Base Class I Nursing Facilities	$543,064,320	$271,532,160	$0	$0	$271,532,160	50.00%	
Base Class II Nursing Facilities	$4,027,425	$2,013,712	$0	$0	$2,013,713	50.00%	
PACE	$91,349,933	$45,674,966	$0	$0	$45,674,967	50.00%	
Supplemental Medicare Insurance Benefit (SMIB)	$122,123,622	$70,493,926	$0	$0	$51,629,696	50.00%*	Approximately 15.5% of Total is State-Only
Health Insurance Buy-In	$2,951,465	$1,475,732	$0	$0	$1,475,733	50.00%	
Long Term Care and Insurance Sub-Total	$763,516,765	$391,190,496	$0	$0	$372,326,269		
Service Management							
Base Service Management	$72,786,851	$36,393,425	$0	$0	$36,393,426	50.00%	
Tobacco Tax Funded Disease Management	$500,000	$0	$0	$250,000	$250,000	50.00%	RF: Transfer from DPHE
Tobacco Quit line	$1,278,166	$0	$639,083		$639,083	50.00%	CF: Tobacco Education Fund
Coordinated Care for People with Disabilities Program	$405,000	$0	$202,500	$0	$202,500	50.00%	CF: Coordinated Care for People with Disabilities Fund
Service Management Sub-Total	$74,970,017	$36,393,425	$841,583	$250,000	$37,485,009		
Expansion Population Financing							
Expansion Adults to 100% FPL	$0	($54,505,756)	$54,505,756	$0	$0	50.00%	CF: Hospital Provider Fee Cash Fund
Disabled Buy-In	$0	($12,416,090)	$14,053,695	$0	($1,637,605)	50.00%*	CF: Hospital Provider Fee Cash Fund and Medicaid Buy-In Fund *Federal Match Applies Only to State Share
Adults without Dependent Children	$0	($45,169,907)	$45,169,907	$0	$0	50.00%	CF: Hospital Provider Fee Cash Fund
Expansion Populations Sub-Total	$0	($112,091,753)	$113,729,358	$0	($1,637,605)		
FY 2012-13 Estimate of Total Expenditures for Medical Services to Clients	**$3,197,667,335**	**$1,488,953,599**	**$116,355,497**	**$1,465,340**	**$1,590,892,899**		

Exhibit A - Summary of Request

Calculation of Fund Splits
FY 2012-13

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
Financing							
Upper Payment Limit Financing	$4,768,240	($5,238,837)	$4,768,240	$0	$5,238,837	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($18,251,106)	$36,502,212	$0	($18,251,106)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$13,250,000	$0	$6,625,000	$0	$6,625,000	50.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$682,374,883	$0	$341,187,440	$0	$341,187,443	50.00%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$83,842,713	$0	$41,921,356	$0	$41,921,357	50.00%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$6,383,916	($335,996)	$3,359,956	$0	$3,359,956	50.00%	CF: Certification of Public Expenditure
Memorial Hospital High Volume Payment	$4,968,594	$0	$2,290,025	$0	$2,678,569	53.91%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($67,829,559)	$67,829,559	$0	$0	N/A	CF: Health Care Expansion Fund
Cash Funds Financing(1)	$0	($44,680,500)	$42,930,500	$1,750,000	$0	N/A	CF: Various, see narrative
Provider Settlements	$3,900,000	$3,900,000	$0	$0	$0	N/A	
Financing Sub-Total	$799,488,346	($132,435,998)	$547,414,288	$1,750,000	$382,760,056		
Total Projected FY 2012-13 Expenditures(2)	**$3,997,155,681**	**$1,356,517,601**	**$663,769,785**	**$3,215,340**	**$1,973,652,955**		

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

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

(2) Of the General Fund total, $312,202,624 is General Fund Exempt.

Exhibit A - Summary of Request

Calculation of Fund Splits
FY 2013-14

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
Acute Care Services							
Base Acute	$2,108,673,180	$1,054,336,590	$0	$0	$1,054,336,590	50.00%	
Breast and Cervical Cancer Program	$10,852,352	$1,291,492	$1,291,491	$1,215,340	$7,054,029	65.00%	State fund sources vary; see Exhibit F
Family Planning	$13,051,290	$1,291,802	$13,327	$0	$11,746,161	90.00%	CF: Local Funds
Home Health Telemedicine Services	$312,576	$156,288	$0	$0	$156,288	50.00%	CF not available (see narrative)
Indian Health Service	$1,566,440	$0	$0	$0	$1,566,440	100.00%	
Affordable Care Act Drug Rebate Offset	($14,428,315)	$0	$0	$0	($14,428,315)	0.00%	
SB 11-008: "Aligning Medicaid Eligibility for Children" Adjustment	$18,317,437	$6,411,103	$0	$0	$11,906,334	65.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid" Adjustment	$6,052,494	$2,118,373	$0	$0	$3,934,121	65.00%	
Physicians to 100% of Medicare: 100% Federally Funded Portion	$12,872,970	$0	$0	$0	$12,872,970	100.00%	
Acute Care Services Sub-Total	$2,157,270,424	$1,065,605,648	$1,304,818	$1,215,340	$1,089,144,618		
Community Based Long Term Care Services							
Base Community Based Long Term Care	$407,201,893	$203,600,946	$0	$0	$203,600,947	50.00%	
Children with Autism Waiver Services	$1,078,252	$0	$539,126	$0	$539,126	50.00%	CF: Colorado Autism Treatment Fund
Community Based Long Term Care Sub-Total	$408,280,145	$203,600,946	$539,126	$0	$204,140,073		
Long Term Care and Insurance							
Base Class I Nursing Facilities	$575,444,276	$287,722,138	$0	$0	$287,722,138	50.00%	
Class II Nursing Facilities	$4,721,954	$2,360,977	$0	$0	$2,360,977	50.00%	
PACE	$105,376,882	$52,688,441	$0	$0	$52,688,441	50.00%	
Supplemental Medicare Insurance Benefit (SMIB)	$137,477,718	$80,717,538	$0	$0	$56,760,180	50.00%*	Approximately 17.5% of Total is State-Only
Health Insurance Buy-In	$5,986,956	$2,993,478	$0	$0	$2,993,478	50.00%	
Long Term Care and Insurance Sub-Total	$829,007,786	$426,482,572	$0	$0	$402,525,214		
Service Management							
Base Service Management	$76,626,808	$38,313,404	$0	$0	$38,313,404	50.00%	
Tobacco Quit line	$1,185,736	$0	$592,868	$0	$592,868	50.00%	CF: Tobacco Education Fund
Coordinated Care for People with Disabilities Program	$405,000	$0	$202,500	$0	$202,500	50.00%	CF: Coordinated Care for People with Disabilities Fund
Service Management Sub-Total	$78,217,544	$38,313,404	$795,368	$0	$39,108,772		
Expansion Population Financing							
Expansion Adults to 100%	$0	($31,103,705)	$31,103,705	$0	$0	N/A	CF: Hospital Provider Fee Cash Fund
Enhanced Federal Match for Expansion Adults to 100%	$0	($31,103,705)	$0	$0	$31,103,705	75.00%	100% FMAP as of January 1, 2014
Disabled Buy-In	$0	($32,181,984)	$36,178,474	$0	($3,996,490)	50.00%*	CF: Hospital Provider Fee Cash Fund and Medicaid Buy-In Fund *Federal Match Applies Only to State Share
Adults without Dependent Children	$0	($23,192,022)	$23,192,022	$0	$0	N/A	CF: Hospital Provider Fee Cash Fund
Enhanced Federal Match for AWDC effective January 1, 2014	$0	($23,192,022)	$0	$0	$23,192,022	75.00%	100% FMAP as of January 1, 2014
Expansion Populations Sub-Total	$0	($140,773,438)	$90,474,201	$0	$50,299,237		
FY 2013-14 Estimate of Total Expenditures for Medical Services to Clients	**$3,472,775,899**	**$1,593,229,132**	**$93,113,513**	**$1,215,340**	**$1,785,217,914**		
Financing							
Upper Payment Limit Financing	$5,162,991	($5,162,991)	$5,162,991	$0	$5,162,991	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($19,585,726)	$39,171,453	$0	($19,585,727)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$10,600,000	$0	$5,300,000	$0	$5,300,000	50.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$695,431,946	$0	$347,715,973	$0	$347,715,973	50.00%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$86,274,152	$0	$43,137,076	$0	$43,137,076	50.00%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$6,575,349	($346,071)	$3,460,710	$0	$3,460,710	50.00%	CF: Certification of Public Expenditure
Memorial Hospital High Volume Payment	$4,968,594	$0	$2,484,297	0	$2,484,297	50.00%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($66,768,789)	$66,768,789	$0	$0	N/A	CF: Health Care Expansion Fund
Cash Funds Financing[1]	$0	($17,930,500)	$17,930,500	$0	$0	N/A	CF: Various, see narrative
Financing Sub-Total	$809,013,032	($109,794,077)	$531,131,789	$0	$387,675,320		
Total Projected FY 2013-14 Expenditures[2]	**$4,281,788,931**	**$1,483,435,055**	**$624,245,302**	**$1,215,340**	**$2,172,893,234**		

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

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

(2) Of the General Fund total, $312,202,624 is General Fund Exempt.

Exhibit A - Summary of Request

Calculation of Fund Splits
FY 2014-15

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
Acute Care Services							
Base Acute	$2,206,771,184	$1,103,385,592	$0	$0	$1,103,385,592	50.00%	
Breast and Cervical Cancer Program	$10,992,241	$2,631,944	$0	$1,215,340	$7,144,957	65.00%	State fund sources vary; see Exhibit F
Family Planning	$13,312,316	$1,317,452	$13,780	$0	$11,981,084	90.00%	CF: Local Funds
Home Health Telemedicine Services	$312,576	$156,288	$0	$0	$156,288	50.00%	CF not available (see narrative)
Indian Health Service	$1,636,774	$0	$0	$0	$1,636,774	100.00%	
Affordable Care Act Drug Rebate Offset	($16,525,144)	$0	$0	$0	($16,525,144)	0.00%	
SB 11-008: "Aligning Medicaid Eligibility for Children" Adjustment	$20,745,330	$7,260,865	$0	$0	$13,484,465	65.00%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid" Adjustment	$5,843,790	$2,045,326	$0	$0	$3,798,464	65.00%	
Physicians to 100% of Medicare: 100% Federally Funded Portion	$6,436,485	$0	$0	$0	$6,436,485	100.00%	
Acute Care Services Sub-Total	$2,249,525,552	$1,116,797,467	$13,780	$1,215,340	$1,131,498,965		
Community Based Long Term Care Services							
Base Community Based Long Term Care	$436,414,878	$218,207,439	$0	$0	$218,207,439	50.00%	
Children with Autism Waiver Services	$1,060,466	$0	$530,233	$0	$530,233	50.00%	CF: Colorado Autism Treatment Fund
Community Based Long Term Care Sub-Total	$437,475,344	$218,207,439	$530,233	$0	$218,737,672		
Long Term Care and Insurance							
Base Class I Nursing Facilities	$585,690,896	$292,845,448	$0	$0	$292,845,448	50.00%	
Class II Nursing Facilities	$5,129,104	$2,564,552	$0	$0	$2,564,552	50.00%	
PACE	$119,267,943	$59,633,971	$0	$0	$59,633,972	50.00%	
Supplemental Medicare Insurance Benefit (SMIB)	$154,259,903	$91,768,107	$0	$0	$62,491,796	50.00%*	Approximately 19% of total is State-Only
Health Insurance Buy-In	$6,548,142	$3,274,071	$0	$0	$3,274,071	50.00%	
Long Term Care and Insurance Sub-Total	$870,895,988	$450,086,149	$0	$0	$420,809,839		
Service Management							
Base Service Management	$78,486,990	$39,243,495	$0	$0	$39,243,495	50.00%	
Tobacco Quit line	$1,290,945	$0	$645,473		$645,472	50.00%	
Coordinated Care for People with Disabilities Program	$405,000	$0	$202,500	$0	$202,500	50.00%	CF: Coordinated Care for People with Disabilities Fund
Service Management Sub-Total	$80,182,935	$39,243,495	$847,973	$0	$40,091,467		
Expansion Population Financing							
Expansion Adults to 100%	$0	($65,096,604)	$0	$0	$65,096,604	100.00%	100% FMAP as of January 1, 2014
Disabled Buy-In	$0	($50,582,059)	$56,653,409	$0	($6,071,350)	50.00%*	CF: Hospital Provider Fee Cash Fund and Medicaid Buy-In Fund *Federal Match Applies Only to State Share
Adults Without Dependent Children	$0	($47,651,851)	$0	$0	$47,651,851	100.00%	100% FMAP as of January 1, 2014
Expansion Populations Sub-Total	$0	($163,330,514)	$56,653,409	$0	$106,677,105		
FY 2014-15 Estimate of Total Expenditures for Medical Services to Clients	**$3,638,079,819**	**$1,661,004,036**	**$58,045,395**	**$1,215,340**	**$1,917,815,048**		
Financing							
Upper Payment Limit Financing	$5,327,524	($5,327,524)	$5,327,524	$0	$5,327,524	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($21,017,943)	$42,035,887	$0	($21,017,944)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$10,600,000	$0	$5,300,000	$0	$5,300,000	50.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$695,431,946	$0	$347,715,973	$0	$347,715,973	50.00%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$86,274,152	$0	$43,137,076	$0	$43,137,076	50.00%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$6,575,349	($346,071)	$3,460,710	$0	$3,460,710	50.00%	CF: Certification of Public Expenditure
Memorial Hospital High Volume Payment	$4,968,594	$0	$2,484,297	$0	$2,484,297	50.00%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($65,855,801)	$65,855,801	$0	$0	N/A	CF: Health Care Expansion Fund
Cash Funds Financing[1]	$0	($17,930,500)	$17,930,500	$0	$0	N/A	CF: Various, see narrative
Financing Sub-Total	$809,177,565	($110,477,839)	$533,247,768	$0	$386,407,636		
Total Projected FY 2014-15 Expenditures[2]	**$4,447,257,384**	**$1,550,526,197**	**$591,293,163**	**$1,215,340**	**$2,304,222,684**		

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

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

(2) Of the General Fund total, $312,202,624 is General Fund Exempt.

Exhibit B - Medicaid Caseload

Final Request

Official Medicaid Caseload Actuals and Projection without Retroactivity from REX01/COLD (MARS) 474701 Report

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 1995-96 Actuals	31,321	4,261	44,736	-	36,690	-	-	-	-	113,439	8,376	7,223	4,100	3,937	254,083
FY 1996-97 Actuals	32,080	4,429	46,090	-	33,250	-	-	-	-	110,586	9,261	5,476	4,610	4,316	250,098
FY 1997-98 Actuals	32,664	4,496	46,003	-	27,179	-	-	-	-	103,912	10,453	4,295	5,032	4,560	238,594
Percent Change	1.82%	1.51%	-0.19%	-	-18.26%	-	-	-	-	-6.04%	12.87%	-21.57%	9.15%	5.65%	-4.60%
FY 1998-99 Actuals	33,007	4,909	46,310	-	22,852	-	-	-	-	102,074	11,526	5,017	5,799	6,104	237,598
Percent Change	1.05%	9.19%	0.67%	-	-15.92%	-	-	-	-	-1.77%	10.26%	16.81%	15.24%	33.86%	-0.42%
FY 1999-00 Actuals	33,135	5,092	46,386	-	23,515	-	-	-	-	109,816	12,474	6,174	9,065	7,597	253,254
Percent Change	0.39%	3.73%	0.16%	-	2.90%	-	-	-	-	7.58%	8.22%	23.06%	56.32%	24.46%	6.59%
FY 2000-01 Actuals	33,649	5,157	46,046	-	27,081	-	-	-	-	123,221	13,076	6,561	12,451	8,157	275,399
Percent Change	1.55%	1.28%	-0.73%	-	15.16%	-	-	-	-	12.21%	4.83%	6.27%	37.35%	7.37%	8.74%
FY 2001-02 Actuals	33,916	5,184	46,349	-	33,347	-	-	-	-	143,909	13,121	7,131	4,028	8,428	295,413
Percent Change	0.79%	0.52%	0.66%	-	23.14%	-	-	-	-	16.79%	0.34%	8.69%	-67.65%	3.32%	7.27%
FY 2002-03 Actuals	34,704	5,431	46,647	-	40,798	-	-	-	47	169,311	13,967	7,823	4,084	8,988	331,800
Percent Change	2.32%	4.76%	0.64%	-	22.34%	-	-	-	-	17.65%	6.45%	9.70%	1.39%	6.64%	12.32%
FY 2003-04 Actuals	34,329	5,548	46,789	-	47,562	-	-	-	105	195,279	14,914	8,398	4,793	9,842	367,559
Percent Change	-1.08%	2.15%	0.30%	-	16.58%	-	-	-	123.40%	15.34%	6.78%	7.35%	17.36%	9.50%	10.78%
FY 2004-05 Actuals	35,780	6,082	47,929	-	57,140	-	-	-	87	222,472	15,795	5,984	5,150	9,605	406,024
Percent Change	4.23%	9.63%	2.44%	-	20.14%	-	-	-	-17.14%	13.93%	5.91%	-28.74%	7.45%	-2.41%	10.46%
FY 2005-06 Actuals	36,207	6,042	47,855	-	58,885	-	-	-	188	214,158	16,460	5,119	6,212	11,092	402,218
Percent Change	1.19%	-0.66%	-0.15%	-	3.05%	-	-	-	116.09%	-3.74%	4.21%	-14.46%	20.62%	15.48%	-0.94%
FY 2006-07 Actuals	35,888	6,059	48,799	-	50,687	5,162	-	-	228	205,390	16,724	5,182	5,201	12,908	392,228
Percent Change	-0.88%	0.28%	1.97%	-	-13.92%	-	-	-	21.28%	-4.09%	1.60%	1.23%	-16.27%	16.37%	-2.48%
FY 2007-08 Actuals	36,284	6,146	49,933	-	44,555	8,918	-	-	270	204,022	17,141	6,288	4,191	14,214	391,962
Percent Change	1.10%	1.44%	2.32%	-	-12.10%	1	-	-	18.42%	-0.67%	2.49%	21.34%	-19.42%	10.12%	-0.07%
FY 2008-09 Actuals	37,619	6,447	51,355	-	49,147	12,727	-	-	317	235,129	18,033	6,976	3,987	15,075	436,812
% Change from FY 2007-08	3.68%	4.90%	2.85%	-	10.31%	0	-	-	17.41%	15.25%	5.20%	10.94%	-4.87%	6.06%	11.44%
FY 2009-10 Actuals	38,487	7,049	53,264	-	57,661	17,178	3,238	-	425	275,672	18,381	7,830	3,693	15,919	498,797
% Change from FY 2008-09	2.31%	9.34%	3.72%	-	17.32%	34.97%	-	-	34.07%	17.24%	1.93%	12.24%	-7.37%	5.60%	14.19%
FY 2010-11 Actuals	38,921	7,767	56,285	-	60,960	20,154	27,167	-	531	302,410	18,393	7,868	3,213	17,090	560,759
% Change from FY 2009-10	1.13%	10.19%	5.67%	-	5.72%	17.32%	739.01%	-	24.94%	9.70%	0.07%	0.49%	-13.00%	7.36%	12.42%
FY 2011-12 Actuals	39,740	8,383	59,434	52	68,689	24,535	35,461	1,134	597	334,633	18,034	7,630	2,770	18,871	619,963
% Change from FY 2010-11	2.10%	7.93%	5.59%	-	12.68%	21.74%	30.53%	-	12.43%	10.66%	-1.95%	-3.02%	-13.79%	10.42%	10.56%
FY 2012-13 Projection	40,364	8,874	61,140	2,183	73,483	28,615	42,531	10,000	621	363,786	17,994	8,211	2,801	20,932	681,535
% Change from FY 2011-12	1.57%	5.86%	2.87%	4098.08%	6.98%	16.63%	19.94%	781.83%	4.02%	8.71%	-0.22%	7.62%	1.12%	10.92%	9.93%
FY 2013-14 Projection	41,195	9,356	62,620	5,465	77,326	30,573	47,351	10,000	655	401,411	18,057	8,801	2,827	22,776	738,413
% Change from FY 2011-12	2.06%	5.43%	2.42%	150.34%	5.23%	6.84%	11.33%	0.00%	5.48%	10.34%	0.35%	7.18%	0.93%	8.81%	8.35%
FY 2014-15 Projection	42,081	9,822	63,935	8,367	78,958	31,414	49,210	10,000	680	426,907	18,209	9,157	2,861	24,780	776,381
% Change from FY 2011-12	2.15%	4.98%	2.10%	53.10%	2.11%	2.75%	3.93%	0.00%	3.82%	6.35%	0.84%	4.04%	1.20%	8.80%	5.14%
FY 2012-13 Appropriation	40,820	8,948	62,098	2,208	77,455	26,498	42,381	10,000	679	367,649	18,159	7,546	2,529	20,503	687,473
Difference between the Total FY 2012-13 Projection and Appropriation	(456)	(74)	(958)	(25)	(3,972)	2,117	150	0	(58)	(3,863)	(165)	665	272	429	(5,938)

Exhibit B - Medicaid Caseload

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Medicaid Caseload Adjustments															
SB 11-008 Aligning Medicaid Eligibility for Children	-	-	-	-	-	-	-	-	-	2,449	-	-	-	-	2,449
SB 11-250 Eligibility for Pregnant Women in Medicaid	-	-	-	-	-	-	-	-	-	-	-	372	-	-	372
Total FY 2012-13 Adjustments	-	-	-	-	-	-	-	-	-	2,449	-	372	-	-	2,821
SB 11-008 Aligning Medicaid Eligibility for Children	-	-	-	-	-	-	-	-	-	16,320	-	-	-	-	16,320
SB 11-250 Eligibility for Pregnant Women in Medicaid	-	-	-	-	-	-	-	-	-	-	-	749	-	-	749
Affordable Care Act- MAGI Conversion	-	-	-	-	-	-	-	-	-	5,434	-	192	-	-	5,626
Total FY 2013-14 Adjustments	-	-	-	-	-	-	-	-	-	21,754	-	941	-	-	22,695
SB 11-008 Aligning Medicaid Eligibility for Children	-	-	-	-	-	-	-	-	-	18,887	-	-	-	-	18,887
SB 11-250 Eligibility for Pregnant Women in Medicaid	-	-	-	-	-	-	-	-	-	-	-	750	-	-	750
Affordable Care Act- MAGI Conversion	-	-	-	-	-	-	-	-	-	15,189	-	524	-	-	15,713
Total FY 2014-15 Adjustments	-	-	-	-	-	-	-	-	-	34,076	-	1,274	-	-	35,350

Exhibit B - Medicaid Caseload

Prior to Adjustments - Not Official Department Request

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

Prior to Adjustments

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 1995-96 Actuals	31,321	4,261	44,736	-	36,690	-	-	-	-	113,439	8,376	7,223	4,100	3,937	254,083
FY 1996-97 Actuals	32,080	4,429	46,090	-	33,250	-	-	-	-	110,586	9,261	5,476	4,610	4,316	250,098
FY 1997-98 Actuals	32,664	4,496	46,003	-	27,179	-	-	-	-	103,912	10,453	4,295	5,032	4,560	238,594
Percent Change	1.82%	1.51%	-0.19%	-	-18.26%	-	-	-	-	-6.04%	12.87%	-21.57%	9.15%	5.65%	-4.60%
FY 1998-99 Actuals	33,007	4,909	46,310	-	22,852	-	-	-	-	102,074	11,526	5,017	5,799	6,104	237,598
Percent Change	1.05%	9.19%	0.67%	-	-15.92%	-	-	-	-	-1.77%	10.26%	16.81%	15.24%	33.86%	-0.42%
FY 1999-00 Actuals	33,135	5,092	46,386	-	23,515	-	-	-	-	109,816	12,474	6,174	9,065	7,597	253,254
Percent Change	0.39%	3.73%	0.16%	-	2.90%	-	-	-	-	7.58%	8.22%	23.06%	56.32%	24.46%	6.59%
FY 2000-01 Actuals	33,649	5,157	46,046	-	27,081	-	-	-	-	123,221	13,076	6,561	12,451	8,157	275,399
Percent Change	1.55%	1.28%	-0.73%	-	15.16%	-	-	-	-	12.21%	4.83%	6.27%	37.35%	7.37%	8.74%
FY 2001-02 Actuals	33,916	5,184	46,349	-	33,347	-	-	-	-	143,909	13,121	7,131	4,028	8,428	295,413
Percent Change	0.79%	0.52%	0.66%	-	23.14%	-	-	-	-	16.79%	0.34%	8.69%	-67.65%	3.32%	7.27%
FY 2002-03 Actuals	34,704	5,431	46,647	-	40,798	-	-	-	47	169,311	13,967	7,823	4,084	8,988	331,800
Percent Change	2.32%	4.76%	0.64%	-	22.34%	-	-	-	-	17.65%	6.45%	9.70%	1.39%	6.64%	12.32%
FY 2003-04 Actuals	34,329	5,548	46,789	-	47,562	-	-	-	105	195,279	14,914	8,398	4,793	9,842	367,559
% Change from FY 2002-03	-1.08%	2.15%	0.30%	-	16.58%	-	-	-	123.40%	15.34%	6.78%	7.35%	17.36%	9.50%	10.78%
FY 2004-05 Actuals	35,780	6,082	47,929	-	57,140	-	-	-	87	222,472	15,795	5,984	5,150	9,605	406,024
% Change from FY 2003-04	4.23%	9.63%	2.44%	-	20.14%	-	-	-	-17.14%	13.93%	5.91%	-28.74%	7.45%	-2.41%	10.46%
FY 2005-06 Actuals	36,207	6,042	47,855	-	58,885	-	-	-	188	214,158	16,460	5,119	6,212	11,092	402,218
% Change from FY 2004-05	1.19%	-0.66%	-0.15%	-	3.05%	-	-	-	116.09%	-3.74%	4.21%	-14.46%	20.62%	15.48%	-0.94%
FY 2006-07 Actuals	35,888	6,059	48,799	-	50,687	5,162	-	-	228	205,390	16,724	5,182	5,201	12,908	392,228
% Change from FY 2005-06	-0.88%	0.28%	1.97%	-	-13.92%	-	-	-	21.28%	-4.09%	1.60%	1.23%	-16.27%	16.37%	-2.48%
FY 2007-08 Actuals	36,284	6,146	49,933	-	44,555	8,918	-	-	270	204,022	17,141	6,288	4,191	14,214	391,962
% Change from FY 2006-07	1.10%	1.44%	2.32%	-	-12.10%	72.76%	-	-	18.42%	-0.67%	2.49%	21.34%	-19.42%	10.12%	-0.07%
FY 2008-09 Actuals	37,619	6,447	51,355	-	49,147	12,727	-	-	317	235,129	18,033	6,976	3,987	15,075	436,812
% Change from FY 2007-08	3.68%	4.90%	2.85%	-	10.31%	42.71%	-	-	17.41%	15.25%	5.20%	10.94%	-4.87%	6.06%	11.44%
FY 2009-10 Actuals	38,487	7,049	53,264	-	57,661	17,178	3,238	-	425	275,672	18,381	7,830	3,693	15,919	498,797
% Change from FY 2008-09	2.31%	9.34%	3.72%	-	17.32%	34.97%	-	-	34.07%	17.24%	1.93%	12.24%	-7.37%	5.60%	14.19%
FY 2010-11 Actuals	38,921	7,767	56,285	-	60,960	20,154	27,167	-	531	302,410	18,393	7,868	3,213	17,090	560,759
% Change from FY 2009-10	1.13%	10.19%	5.67%	-	5.72%	17.32%	739.01%	-	24.94%	9.70%	0.07%	0.49%	-13.00%	7.36%	12.42%
FY 2011-12 Actuals	39,740	8,383	59,434	52	68,689	24,535	35,461	1,134	597	334,633	18,034	7,630	2,770	18,871	619,963
% Change from FY 2010-11	2.10%	7.93%	5.59%	-	12.68%	21.74%	30.53%	-	12.43%	10.66%	-1.95%	-3.02%	-13.79%	10.42%	10.56%
FY 2012-13 Projection [1]	40,364	8,874	61,140	2,183	73,483	28,615	42,531	10,000	621	361,337	17,994	7,839	2,801	20,932	678,714
% Change from FY 2011-12	1.57%	5.86%	2.87%	4098.08%	6.98%	16.63%	19.94%	781.83%	4.02%	7.98%	-0.22%	2.74%	1.12%	10.92%	9.48%
FY 2013-14 Projection [1]	41,195	9,356	62,620	5,465	77,326	30,573	47,351	10,000	655	379,657	18,057	7,860	2,827	22,776	715,718
% Change from FY 2011-12	2.06%	5.43%	2.42%	150.34%	5.23%	6.84%	11.33%	0.00%	5.48%	5.07%	0.35%	0.27%	0.93%	8.81%	5.45%
FY 2014-15 Projection [1]	42,081	9,822	63,935	8,367	78,958	31,414	49,210	10,000	680	392,831	18,209	7,883	2,861	24,780	741,031
% Change from FY 2011-12	2.15%	4.98%	2.10%	53.10%	2.11%	2.75%	3.93%	0.00%	3.82%	3.47%	0.84%	0.29%	1.20%	8.80%	3.54%
FY 2012-13 Appropriation	40,820	8,948	62,098	2,208	77,455	26,498	42,381	10,000	679	367,649	18,159	7,546	2,529	20,503	687,473
Difference between the Total FY 2012-13 Projection and Appropriation	(456)	(74)	(958)	(25)	(3,972)	2,117	150	0	(58)	(3,863)	(165)	665	272	429	(5,938)

[1] Medicaid Caseload forecast without adjustments.

Exhibit B - Medicaid Caseload Forecast

MEDICAID CASELOAD FY 2006-07 without RETROACTIVITY

FY 2006-07	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2006	36,264	5,927	48,080	-	57,372	1,008	-	-	202	215,937	16,499	5,074	6,703	12,145	405,211	-	-
August 2006	36,356	5,989	48,443	-	56,033	2,051	-	-	211	216,226	16,574	4,852	6,364	12,316	405,415	204	0.05%
September 2006	36,113	6,032	48,576	-	54,433	3,051	-	-	220	214,255	16,524	4,761	6,011	12,443	402,419	(2,996)	-0.74%
October 2006	36,088	6,067	48,747	-	53,443	4,620	-	-	226	209,565	16,576	4,950	5,761	12,536	398,579	(3,840)	-0.95%
November 2006	35,939	6,113	48,736	-	50,988	5,325	-	-	232	205,572	16,554	5,002	5,226	12,693	392,380	(6,199)	-1.56%
December 2006	36,195	6,141	48,498	-	49,733	5,592	-	-	236	202,812	16,595	5,070	4,864	12,879	388,615	(3,765)	-0.96%
January 2007	35,947	6,102	48,829	-	49,624	6,124	-	-	231	202,963	16,683	5,181	4,798	12,905	389,387	772	0.20%
February 2007	35,929	6,116	48,948	-	48,952	6,395	-	-	228	202,656	16,761	5,353	4,690	13,060	389,088	(299)	-0.08%
March 2007	35,664	6,064	49,044	-	48,235	6,607	-	-	228	201,549	16,849	5,422	4,514	13,213	387,389	(1,699)	-0.44%
April 2007	35,526	6,083	48,903	-	47,717	7,030	-	-	241	200,833	16,962	5,526	4,547	13,547	386,915	(474)	-0.12%
May 2007	35,186	6,028	49,337	-	46,245	7,042	-	-	236	196,757	17,007	5,437	4,501	13,493	381,269	(5,646)	-1.46%
June 2007	35,448	6,048	49,449	-	45,470	7,104	-	-	246	195,549	17,100	5,561	4,437	13,669	380,081	(1,188)	-0.31%
Year-to-Date Average	**35,888**	**6,059**	**48,799**	**-**	**50,687**	**5,162**	**-**	**-**	**228**	**205,390**	**16,724**	**5,182**	**5,201**	**12,908**	**392,229**		

MEDICAID CASELOAD FY 2007-08 without RETROACTIVITY

FY 2007-08	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2007	35,532	6,073	49,590	-	45,453	7,273	-	-	255	197,420	17,003	5,551	4,475	13,821	382,446	2,365	0.62%
August 2007	35,624	6,091	49,768	-	45,363	7,187	-	-	260	198,001	16,915	5,691	4,330	13,988	383,218	772	0.20%
September 2007	35,916	6,124	49,743	-	44,739	7,160	-	-	267	197,134	16,877	5,448	4,148	14,064	381,620	(1,598)	-0.42%
October 2007	36,104	6,141	49,853	-	46,590	7,110	-	-	273	201,710	16,968	5,479	4,136	14,105	388,469	6,849	1.79%
November 2007	36,059	6,127	49,889	-	45,100	8,364	-	-	261	201,378	16,995	5,759	4,069	14,144	388,145	(324)	-0.08%
December 2007	36,126	6,150	49,741	-	43,665	8,783	-	-	268	200,121	17,042	5,896	4,032	14,028	385,852	(2,293)	-0.59%
January 2008	36,329	6,158	49,785	-	43,491	9,268	-	-	268	201,816	17,050	6,233	4,007	14,066	388,471	2,619	0.68%
February 2008	36,418	6,128	49,891	-	43,344	9,755	-	-	272	203,657	17,117	6,827	4,026	14,212	391,647	3,176	0.82%
March 2008	36,702	6,145	49,989	-	43,723	9,949	-	-	282	206,695	17,208	7,035	4,130	14,333	396,191	4,544	1.16%
April 2008	36,771	6,188	50,237	-	44,037	10,395	-	-	280	210,620	17,358	7,142	4,178	14,479	401,685	5,494	1.39%
May 2008	36,897	6,203	50,358	-	44,349	10,775	-	-	280	213,554	17,537	7,191	4,371	14,628	406,143	4,458	1.11%
June 2008	36,932	6,227	50,351	-	44,802	10,995	-	-	270	216,154	17,620	7,200	4,389	14,700	409,640	3,497	0.86%
Year-to-Date Average	**36,284**	**6,146**	**49,933**	**-**	**44,555**	**8,918**	**-**	**-**	**270**	**204,022**	**17,141**	**6,288**	**4,191**	**14,214**	**391,961**		

MEDICAID CASELOAD FY 2008-09 without RETROACTIVITY

FY 2008-09	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2008	36,961	6,249	50,565	-	45,318	11,236	-	-	277	218,619	17,588	7,286	4,258	14,768	413,125	3,485	0.85%
August 2008	37,127	6,317	50,671	-	45,954	11,335	-	-	283	221,736	17,761	7,270	4,136	14,821	417,411	4,286	1.04%
September 2008	37,273	6,369	50,864	-	46,099	11,794	-	-	275	223,167	17,736	7,027	4,052	14,898	419,554	2,143	0.51%
October 2008	37,441	6,386	51,201	-	46,589	11,836	-	-	282	225,486	17,864	6,932	4,005	14,933	422,955	3,401	0.81%
November 2008	37,591	6,399	51,406	-	47,013	12,008	-	-	290	228,186	17,977	6,773	3,889	14,980	426,512	3,557	0.84%
December 2008	37,530	6,361	51,298	-	48,042	12,142	-	-	304	230,447	18,033	6,689	3,884	15,053	429,783	3,271	0.77%
January 2009	37,814	6,367	51,452	-	49,155	12,486	-	-	314	234,744	18,022	6,847	3,954	15,194	436,349	6,566	1.53%
February 2009	37,769	6,438	51,494	-	50,023	12,730	-	-	331	237,345	18,144	6,910	3,885	15,205	440,274	3,925	0.90%
March 2009	37,942	6,539	51,640	-	51,530	13,190	-	-	339	242,805	18,265	6,959	3,988	15,293	448,490	8,216	1.87%
April 2009	37,947	6,597	51,695	-	52,740	14,346	-	-	355	249,444	18,328	6,995	3,984	15,268	457,699	9,209	2.05%
May 2009	37,989	6,654	51,862	-	53,134	14,619	-	-	373	252,943	18,327	6,973	3,919	15,240	462,033	4,334	0.95%
June 2009	38,044	6,691	52,107	-	54,171	14,996	-	-	383	256,630	18,348	7,045	3,892	15,249	467,556	5,523	1.20%
Year-to-Date Average	**37,619**	**6,447**	**51,355**	**-**	**49,147**	**12,727**	**-**	**-**	**317**	**235,129**	**18,033**	**6,976**	**3,987**	**15,075**	**436,812**		

Exhibit B - Medicaid Caseload Forecast

MEDICAID CASELOAD FY 2009-10 without RETROACTIVITY

FY 2009-10	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2009	38,058	6,774	52,315	-	55,087	15,269	-	-	393	259,609	18,285	7,745	3,930	15,434	472,899	5,343	1.14%
August 2009	38,306	6,863	52,573	-	55,937	15,530	-	-	395	263,415	18,325	7,849	3,835	15,522	478,550	5,651	1.19%
September 2009	38,346	6,945	52,710	-	56,489	15,703	-	-	402	266,381	18,200	7,775	3,724	15,513	482,188	3,638	0.76%
October 2009	38,480	6,985	52,847	-	57,359	16,115	-	-	406	270,514	18,169	7,713	3,650	15,638	487,876	5,688	1.18%
November 2009	38,387	6,986	52,982	-	57,595	16,362	-	-	418	272,453	17,992	7,674	3,644	15,743	490,236	2,360	0.48%
December 2009	38,410	7,025	53,000	-	58,381	16,739	-	-	411	275,867	18,371	7,627	3,632	15,846	495,309	5,073	1.03%
January 2010	38,452	7,047	53,255	-	59,210	17,193	-	-	416	279,000	18,400	7,796	3,610	15,954	500,333	5,024	1.01%
February 2010	38,432	7,049	53,298	-	59,700	17,514	-	-	431	279,898	18,467	7,779	3,550	16,076	502,194	1,861	0.37%
March 2010	38,597	7,152	53,629	-	61,190	18,096	-	-	449	283,625	18,486	7,996	3,768	16,212	509,200	7,006	1.40%
April 2010	38,727	7,212	53,904	-	61,702	18,490	-	-	452	285,746	18,552	8,054	3,831	16,308	512,978	3,778	0.74%
May 2010	38,754	7,228	54,164	-	55,110	20,694	18,253	-	455	285,779	18,651	8,039	3,615	16,285	527,027	14,049	2.74%
June 2010	38,900	7,326	54,493	-	54,173	18,435	20,607	-	466	285,778	18,678	7,903	3,522	16,495	526,776	(251)	-0.05%
Year-to-Date Average	**38,487**	**7,049**	**53,264**	**-**	**57,661**	**17,178**	**3,238**	**-**	**425**	**275,672**	**18,381**	**7,829**	**3,693**	**15,919**	**498,797**		

MEDICAID CASELOAD FY 2010-11 without RETROACTIVITY

FY 2010-11	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2010	39,382	7,395	54,740	-	55,213	18,556	21,446	-	471	287,674	18,628	7,909	3,492	16,539	531,445	4,669	0.89%
August 2010	38,648	7,492	55,032	-	56,687	19,176	24,193	-	493	290,871	18,455	8,014	3,378	16,634	539,073	7,628	1.44%
September 2010	38,774	7,562	55,223	-	56,852	19,403	25,071	-	503	291,592	18,451	7,971	3,231	16,652	541,285	2,212	0.41%
October 2010	38,901	7,602	55,508	-	57,801	19,490	26,016	-	505	294,155	18,464	7,985	3,080	16,794	546,301	5,016	0.93%
November 2010	39,009	7,682	55,804	-	58,276	20,002	26,924	-	511	296,482	18,597	7,891	3,049	16,941	551,168	4,867	0.89%
December 2010	38,769	7,721	55,937	-	59,591	20,182	27,596	-	526	299,499	18,510	7,764	3,023	17,002	556,120	4,952	0.90%
January 2011	38,813	7,781	56,417	-	62,929	19,895	27,188	-	532	304,042	18,386	7,806	3,116	17,210	564,115	7,995	1.44%
February 2011	38,823	7,870	56,671	-	63,025	20,522	28,323	-	535	307,032	18,200	7,677	3,161	17,249	569,088	4,973	0.88%
March 2011	38,939	7,966	57,103	-	64,697	20,877	28,968	-	556	312,300	18,244	7,881	3,271	17,390	578,192	9,104	1.60%
April 2011	38,861	7,987	57,385	-	64,673	21,090	29,451	-	569	312,603	18,280	7,864	3,274	17,399	579,436	1,244	0.22%
May 2011	38,981	8,051	57,608	-	65,402	21,194	30,102	-	587	315,116	18,279	7,830	3,255	17,546	583,951	4,515	0.78%
June 2011	39,154	8,089	57,986	-	66,369	21,458	30,724	-	589	317,551	18,221	7,828	3,229	17,727	588,925	4,974	0.85%
Year-to-Date Average	**38,921**	**7,767**	**56,285**	**-**	**60,960**	**20,154**	**27,167**	**-**	**531**	**302,410**	**18,393**	**7,868**	**3,213**	**17,090**	**560,759**	**5,179**	**0.94%**

MEDICAID CASELOAD FY 2011-12 without RETROACTIVITY

FY 2011-12	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL[1]	Monthly Growth	Monthly Growth Rate
July 2011	39,341	8,133	58,294	-	65,372	22,184	31,920	-	587	319,065	18,125	7,810	3,089	17,923	591,843	2,918	0.50%
August 2011	39,537	8,222	58,712	-	66,406	22,112	32,462	-	586	322,779	18,084	7,786	2,973	18,046	597,705	5,862	0.99%
September 2011	39,600	8,280	58,937	-	67,613	22,388	33,152	-	590	325,673	18,119	7,628	2,774	18,156	602,910	5,205	0.87%
October 2011	39,697	8,328	59,159	-	68,677	22,985	33,838	-	592	328,632	18,096	7,558	2,657	18,314	608,533	5,623	0.93%
November 2011	39,789	8,343	59,298	-	68,638	23,803	34,915	-	602	332,183	18,077	7,371	2,543	18,584	614,146	5,613	0.92%
December 2011	39,843	8,355	59,384	-	70,628	24,150	34,886	-	606	336,053	18,172	7,333	2,591	18,798	620,799	6,653	1.08%
January 2012	39,742	8,373	59,709	-	68,831	24,692	35,481	-	603	336,096	17,968	7,445	2,617	18,985	620,542	(257)	1.08%
February 2012	39,800	8,401	59,635	-	69,644	25,224	35,962	-	604	339,523	17,863	7,594	2,636	19,220	626,106	5,564	1.08%
March 2012	39,849	8,445	59,847	51	71,278	26,040	37,141	-	604	341,274	17,930	7,734	2,852	19,466	632,511	6,405	1.08%
April 2012	39,837	8,507	59,970	133	67,739	26,578	37,902	-	596	341,546	17,944	7,705	2,846	19,396	630,699	(1,812)	1.08%
May 2012	39,924	8,600	60,167	202	68,601	26,980	38,955	5,860	597	344,523	18,012	7,744	2,844	19,640	642,649	11,950	1.08%
June 2012	39,923	8,605	60,091	240	70,837	27,283	38,921	7,753	601	348,253	18,022	7,846	2,818	19,929	651,122	8,473	1.08%
Year-to-Date Average	**39,740**	**8,383**	**59,434**	**52**	**68,689**	**24,535**	**35,461**	**1,134**	**597**	**334,633**	**18,034**	**7,630**	**2,770**	**18,871**	**619,964**	**5,183**	**0.98%**

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

(1) Due to rounding, the average monthly totals may differ slightly from annual totals reported elsewhere.

Exhibit C - History and Projections of Per Capita Costs

Per Capita Costs - Cash Based

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 1995-96	$11,438.90	$8,020.74	$6,216.02	-	$2,612.84	-	-	-	-	$1,253.09	$2,391.78	$5,922.44	$3,364.90	$1,544.32	$3,901.23
FY 1996-97	$13,535.28	$8,388.91	$7,164.80	-	$3,174.99	-	-	-	-	$1,233.89	$2,413.14	$6,856.06	$3,872.40	$1,520.98	$4,509.91
FY 1997-98	$13,297.59	$8,457.61	$7,186.27	-	$3,036.03	-	-	-	-	$1,375.75	$2,177.83	$6,743.66	$3,687.26	$1,369.92	$4,631.18
Percent Change	-1.76%	0.82%	0.30%	-	-4.38%	-	-	-	-	11.50%	-9.75%	-1.64%	-4.78%	-9.93%	2.69%
FY 1998-99	$14,049.96	$9,886.63	$7,796.82	-	$3,129.24	-	-	-	-	$1,466.08	$2,023.98	$6,272.97	$3,576.18	$1,013.41	$4,950.52
Percent Change	5.66%	16.90%	8.50%	-	3.07%	-	-	-	-	6.57%	-7.06%	-6.98%	-3.01%	-26.02%	6.90%
FY 1999-00	$15,040.64	$10,793.96	$8,772.23	-	$3,440.54	-	-	-	-	$1,544.54	$2,203.23	$5,430.89	$3,273.65	$917.32	$5,166.43
Percent Change	7.05%	9.18%	12.51%	-	9.95%	-	-	-	-	5.35%	8.86%	-13.42%	-8.46%	-9.48%	4.36%
FY 2000-01	$15,311.41	$11,851.80	$9,792.12	-	$3,277.51	-	-	-	-	$1,570.78	$2,351.36	$4,801.64	$2,966.03	$959.04	$5,143.57
Percent Change	1.80%	9.80%	11.63%	-	-4.74%	-	-	-	-	1.70%	6.72%	-11.59%	-9.40%	4.55%	-0.44%
FY 2001-02	$16,837.64	$11,821.86	$10,033.18	-	$3,125.56	-	-	-	-	$1,532.60	$2,530.78	$4,760.42	$9,774.69	$963.28	$5,202.22
Percent Change	9.97%	-0.25%	2.46%	-	-4.64%	-	-	-	-	-2.43%	7.63%	-0.86%	229.55%	0.44%	1.14%
FY 2002-03	$16,269.83	$11,909.35	$11,071.22	-	$3,425.30	-	-	-	$30,399.56	$1,346.59	$2,689.77	$5,435.44	$11,932.93	$882.68	$4,977.91
Percent Change	-3.37%	0.74%	10.35%	-	9.59%	-	-	-	-	-12.14%	6.28%	14.18%	22.08%	-8.37%	-4.31%
FY 2003-04	$17,917.49	$13,642.60	$11,967.29	-	$3,853.40	-	-	-	$25,417.70	$1,188.86	$3,019.91	$7,534.30	$11,504.23	$961.96	$5,010.73
Percent Change	10.13%	14.55%	8.09%	-	12.50%	-	-	-	-16.39%	-11.71%	12.27%	38.61%	-3.59%	8.98%	0.66%
FY 2004-05	$18,024.54	$13,297.64	$11,432.79	-	$3,224.86	-	-	-	$28,627.25	$1,314.92	$2,908.66	$6,405.47	$8,682.52	$1,137.99	$4,662.42
Percent Change	0.60%	-2.53%	-4.47%	-	-16.31%	-	-	-	12.63%	10.60%	-3.68%	-14.98%	-24.53%	18.30%	-6.95%
FY 2005-06	$18,452.47	$14,387.34	$11,705.52	-	$3,315.44	-	-	-	$36,225.53	$1,439.11	$2,969.74	$7,695.99	$8,904.59	$1,204.54	$4,928.66
Percent Change	2.37%	8.19%	2.39%	-	2.81%	-	-	-	26.54%	9.44%	2.10%	20.15%	2.56%	5.85%	5.71%
FY 2006-07	$18,730.43	$14,802.45	$11,695.80	-	$3,925.23	$1,467.77	-	-	$24,376.09	$1,610.83	$3,211.25	$9,215.49	$10,470.57	$1,313.15	$5,222.57
Percent Change	1.51%	2.89%	-0.08%	-	18.39%	-	-	-	-32.71%	11.93%	8.13%	19.74%	17.59%	9.02%	5.96%
FY 2007-08	$19,415.43	$16,324.25	$13,065.11	-	$4,260.90	$2,132.72	-	-	$26,305.08	$1,781.99	$3,738.66	$8,532.40	$12,797.32	$1,333.66	$5,681.77
Percent Change	3.66%	10.28%	11.71%	-	8.55%	45.30%	-	-	7.91%	10.63%	16.42%	-7.41%	22.22%	1.56%	8.79%
FY 2008-09	$20,680.18	$17,708.89	$14,233.44	-	$4,244.04	$2,489.04	-	-	$22,261.37	$1,837.39	$3,747.29	$8,654.00	$14,858.01	$1,254.95	$5,742.83
Percent Change	6.51%	8.48%	8.94%	-	-0.40%	16.71%	-	-	-15.37%	3.11%	0.23%	1.43%	16.10%	-5.90%	1.07%
FY 2009-10	$19,455.97	$15,862.64	$13,373.23	-	$3,658.12	$2,337.91	$689.29	-	$20,511.28	$1,632.88	$3,536.01	$8,401.86	$12,655.02	$1,213.77	$4,975.87
Percent Change	-5.92%	-10.43%	-6.04%	-	-13.81%	-6.07%	-	-	-7.86%	-11.13%	-5.64%	-2.91%	-14.83%	-3.28%	-13.36%
FY 2010-11	$20,336.39	$17,105.76	$14,635.16	-	$3,741.31	$2,848.31	$2,316.20	-	$19,033.37	$1,711.49	$4,014.76	$8,894.53	$14,661.32	$1,428.00	$5,063.72
Percent Change	4.53%	7.84%	9.44%	-	2.27%	21.83%	236.03%	-	-7.21%	4.81%	13.54%	5.86%	15.85%	17.65%	1.77%
FY 2011-12	$20,300.66	$16,955.03	$14,209.99	$8,877.60	$3,531.55	$2,695.27	$2,423.80	$2,185.53	$17,216.60	$1,569.28	$3,783.82	$8,354.70	$15,148.44	$1,298.38	$4,717.85
Percent Change	-0.18%	-0.88%	-2.91%	-	-5.61%	-5.37%	4.65%	-	-9.55%	-8.31%	-5.75%	-6.07%	3.32%	-9.08%	-6.83%
FY 2012-13 Projection	$20,841.97	$16,951.36	$14,495.68	$10,567.71	$3,506.78	$2,695.39	$2,563.11	$9,033.98	$16,604.86	$1,497.07	$3,801.26	$8,139.14	$16,172.30	$1,290.61	$4,691.86
Percent Change	2.67%	-0.02%	2.01%	19.04%	-0.70%	0.00%	5.75%	313.35%	-3.55%	-4.60%	0.46%	-2.58%	6.76%	-0.60%	-0.55%
FY 2013-14 Projection	$21,900.50	$17,473.44	$15,179.99	$10,909.60	$3,584.31	$2,774.89	$2,627.50	$9,276.81	$16,578.82	$1,451.46	$3,929.79	$8,163.27	$17,702.33	$1,378.11	$4,703.02
Percent Change	5.08%	3.08%	4.72%	3.24%	2.21%	2.95%	2.51%	2.69%	-0.16%	-3.05%	3.38%	0.30%	9.46%	6.78%	0.24%
FY 2014-15 Projection	$22,334.60	$17,564.97	$15,454.78	$11,162.31	$3,549.62	$2,786.70	$2,645.67	$9,530.37	$16,175.95	$1,419.41	$3,954.01	$7,874.89	$18,725.38	$1,462.87	$4,685.95
Percent Change	1.98%	0.52%	1.81%	2.32%	-0.97%	0.43%	0.69%	2.73%	-2.43%	-2.21%	0.62%	-3.53%	5.78%	6.15%	-0.36%

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

See narrative for a description of events that alter trends.

Exhibit C - History and Projections of Per Capita Costs

Per Capita Costs - Adjusted for Payment Delays

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 1995-96	$11,438.90	$8,020.74	$6,216.02	-	$2,612.84	-	-	-	-	$1,253.09	$2,391.78	$5,922.44	$3,364.90	$1,544.32	$3,901.23
FY 1996-97	$13,535.28	$8,388.91	$7,164.80	-	$3,174.99	-	-	-	-	$1,233.89	$2,413.14	$6,856.06	$3,872.40	$1,520.98	$4,509.91
FY 1997-98	$13,297.59	$8,457.61	$7,186.27	-	$3,036.03	-	-	-	-	$1,375.75	$2,177.83	$6,743.66	$3,687.26	$1,369.92	$4,631.18
Percent Change	-1.76%	0.82%	0.30%	-	-4.38%	-	-	-	-	11.50%	-9.75%	-1.64%	-4.78%	-9.93%	2.69%
FY 1998-99	$14,049.96	$9,886.63	$7,796.82	-	$3,129.24	-	-	-	-	$1,466.08	$2,023.98	$6,272.97	$3,576.18	$1,013.41	$4,950.52
Percent Change	5.66%	16.90%	8.50%	-	3.07%	-	-	-	-	6.57%	-7.06%	-6.98%	-3.01%	-26.02%	6.90%
FY 1999-00	$15,040.64	$10,793.96	$8,772.23	-	$3,440.54	-	-	-	-	$1,544.54	$2,203.23	$5,430.89	$3,273.65	$917.32	$5,166.43
Percent Change	7.05%	9.18%	12.51%	-	9.95%	-	-	-	-	5.35%	8.86%	-13.42%	-8.46%	-9.48%	4.36%
FY 2000-01	$15,311.41	$11,851.80	$9,792.12	-	$3,277.51	-	-	-	-	$1,570.78	$2,351.36	$4,801.64	$2,966.03	$959.04	$5,143.57
Percent Change	1.80%	9.80%	11.63%	-	-4.74%	-	-	-	-	1.70%	6.72%	-11.59%	-9.40%	4.55%	-0.44%
FY 2001-02	$16,837.64	$11,821.86	$10,033.18	-	$3,125.56	-	-	-	-	$1,532.60	$2,530.78	$4,760.42	$9,774.69	$963.28	$5,202.22
Percent Change	9.97%	-0.25%	2.46%	-	-4.64%	-	-	-	-	-2.43%	7.63%	-0.86%	229.55%	0.44%	1.14%
FY 2002-03	$16,269.83	$11,909.35	$11,071.22	-	$3,425.30	-	-	-	$30,399.56	$1,346.59	$2,689.77	$5,435.44	$11,932.93	$882.68	$4,977.91
Percent Change	-3.37%	0.74%	10.35%	-	9.59%	-	-	-	-	-12.14%	6.28%	14.18%	22.08%	-8.37%	-4.31%
FY 2003-04	$17,917.49	$13,642.60	$11,967.29	-	$3,853.40	-	-	-	$25,417.70	$1,188.86	$3,019.91	$7,534.30	$11,504.23	$961.96	$5,010.73
Percent Change	10.13%	14.55%	8.09%	-	12.50%	-	-	-	-16.39%	-11.71%	12.27%	38.61%	-3.59%	8.98%	0.66%
FY 2004-05	$18,024.54	$13,297.64	$11,432.79	-	$3,224.86	-	-	-	$28,627.25	$1,314.92	$2,908.66	$6,405.47	$8,682.52	$1,137.99	$4,662.42
Percent Change	0.60%	-2.53%	-4.47%	-	-16.31%	-	-	-	12.63%	10.60%	-3.68%	-14.98%	-24.53%	18.30%	-6.95%
FY 2005-06	$18,452.47	$14,387.34	$11,705.52	-	$3,315.44	-	-	-	$36,225.53	$1,439.11	$2,969.74	$7,695.99	$8,904.59	$1,204.54	$4,928.66
Percent Change	2.37%	8.19%	2.39%	-	2.81%	-	-	-	26.54%	9.44%	2.10%	20.15%	2.56%	5.85%	5.71%
FY 2006-07	$18,730.43	$14,802.45	$11,695.80	-	$3,925.23	$1,467.77	-	-	$24,376.09	$1,610.83	$3,211.25	$9,215.49	$10,470.57	$1,313.15	$5,222.57
Percent Change	1.51%	2.89%	-0.08%	-	18.39%	-	-	-	-32.71%	11.93%	8.13%	19.74%	17.59%	9.02%	5.96%
FY 2007-08	$19,415.43	$16,324.25	$13,065.11	-	$4,260.90	$2,132.72	-	-	$26,305.08	$1,781.99	$3,738.66	$8,532.40	$12,797.32	$1,333.66	$5,681.77
Percent Change	3.66%	10.28%	11.71%	-	8.55%	45.30%	-	-	7.91%	10.63%	16.42%	-7.41%	22.22%	1.56%	8.79%
FY 2008-09	$20,680.18	$17,708.89	$14,233.44	-	$4,244.04	$2,489.04	-	-	$22,261.37	$1,837.39	$3,747.29	$8,654.00	$14,858.01	$1,254.95	$5,742.83
Percent Change	6.51%	8.48%	8.94%	-	-0.40%	16.71%	-	-	-15.37%	3.11%	0.23%	1.43%	16.10%	-5.90%	1.07%
FY 2009-10	$19,767.99	$16,303.29	$13,773.18	-	$3,810.34	$2,392.59	$952.90	-	$21,192.52	$1,691.68	$3,669.73	$8,704.60	$13,125.32	$1,225.15	$5,116.67
Percent Change	-4.41%	-7.94%	-3.23%	-	-10.22%	-3.88%	0.00%	-	-4.80%	-7.93%	-2.07%	0.58%	-11.66%	-2.37%	-10.90%
FY 2010-11	$20,027.85	$16,705.85	$14,256.68	-	$3,597.33	$2,801.70	$2,284.78	-	$18,488.13	$1,657.89	$3,881.13	$8,593.25	$14,120.76	$1,417.39	$4,938.48
Percent Change	1.31%	2.47%	3.51%	-	-5.59%	17.10%	139.77%	-	-12.76%	-2.00%	5.76%	-1.28%	7.58%	15.69%	-3.48%
FY 2011-12	$20,300.66	$16,955.03	$14,209.99	$8,877.60	$3,531.55	$2,695.27	$2,423.80	$2,185.53	$17,216.60	$1,569.28	$3,783.82	$8,354.70	$15,148.44	$1,298.38	$4,717.85
Percent Change	-0.18%	-0.88%	-2.91%	-	-5.61%	-5.37%	4.65%	-	-9.55%	-8.31%	-5.75%	-6.07%	3.32%	-9.08%	-6.83%
FY 2012-13 Projection	$20,841.97	$16,951.36	$14,495.68	$10,567.71	$3,506.78	$2,695.39	$2,563.11	$9,033.98	$16,604.86	$1,497.07	$3,801.26	$8,139.14	$16,172.30	$1,290.61	$4,691.86
Percent Change	2.67%	-0.02%	2.01%	19.04%	-0.70%	0.00%	5.75%	313.35%	-3.55%	-4.60%	0.46%	-2.58%	6.76%	-0.60%	-0.55%
FY 2013-14 Projection	$21,900.50	$17,473.44	$15,179.99	$10,909.60	$3,584.31	$2,774.89	$2,627.50	$9,276.81	$16,578.82	$1,451.46	$3,929.79	$8,163.27	$17,702.33	$1,378.11	$4,703.02
Percent Change	5.08%	3.08%	4.72%	3.24%	2.21%	2.95%	2.51%	2.69%	-0.16%	-3.05%	3.38%	0.30%	9.46%	6.78%	0.24%
FY 2014-15 Projection	$22,334.60	$17,564.97	$15,454.78	$11,162.31	$3,549.62	$2,786.70	$2,645.67	$9,530.37	$16,175.95	$1,419.41	$3,954.01	$7,874.89	$18,725.38	$1,462.87	$4,685.95
Percent Change	1.98%	0.52%	1.81%	2.32%	-0.97%	0.43%	0.69%	2.73%	-2.43%	-2.21%	0.62%	-3.53%	5.78%	6.15%	-0.36%

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

See narrative for a description of events that alter trends.

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

Exhibit D - Cash Funds Report

Cash Funds Report

Cash Fund	FY 2012-13			FY 2013-14			FY 2014-15		
	Spending Authority	Request	Change	Base Spending Authority	Request	Change	Base Spending Authority	Request	Change
Cash Funds									
Certified Funds	$12,436,615	$17,043,221	$4,606,606	$12,436,615	$16,407,998	$3,971,383	$12,436,615	$16,572,531	$4,135,916
Local Funds	$40,869	$18,903	($21,966)	$40,869	$13,327	($27,542)	$40,869	$13,780	($27,089)
Hospital Provider Fee Cash Fund	$482,144,867	$492,341,588	$10,196,721	$457,094,420	$445,897,194	($11,197,226)	$457,094,420	$407,926,682	($49,167,738)
Medicaid Buy-In Fund	$4,531,955	$3,275,210	($1,256,745)	$4,531,955	$7,992,980	$3,461,025	$4,531,955	$12,142,700	$7,610,745
Tobacco Tax Cash Fund	$2,230,500	$2,230,500	$0	$2,230,500	$2,230,500	$0	$2,230,500	$2,230,500	$0
Health Care Expansion Fund	$67,872,147	$67,829,559	($42,588)	$67,872,147	$66,768,789	($1,103,358)	$67,872,147	$65,855,801	($2,016,346)
Breast and Cervical Cancer Prevention and Treatment Fund	$1,484,910	$1,195,085	($289,825)	$1,484,910	$1,291,491	($193,419)	$168,938	$0	($168,938)
Colorado Autism Treatment Fund	$882,088	$530,233	($351,855)	$882,088	$539,126	($342,962)	$882,088	$530,233	($351,855)
Coordinated Care for People with Disabilities Fund	$268,200	$202,500	($65,700)	$268,200	$202,500	($65,700)	$268,200	$202,500	($65,700)
Nursing Facility Cash Fund	$43,381,505	$41,921,356	($1,460,149)	$43,381,505	$43,137,076	($244,429)	$43,381,505	$43,137,076	($244,429)
Home Health Telemedicine Fund	$40,335	$40,335	$0	$40,335	$0	($40,335)	$40,335	$0	($40,335)
Comprehensive Primary and Preventive Care Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Pediatric Specialty Hospital Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tobacco Education Program Fund	$686,735	$639,083	($47,652)	$640,520	$592,868	($47,652)	$640,520	$645,473	$4,953
Health Disparities Grant Program Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Supplemental Old Age Pension Health and Medical Care Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prevention, Early Detection, and Treatment Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Department Recoveries	$35,181,131	$36,502,212	$1,321,081	$35,178,907	$39,171,453	$3,992,546	$35,178,907	$42,035,887	$6,856,980
Total Cash Funds	**$651,181,857**	**$663,769,785**	**$12,587,928**	**$626,082,971**	**$624,245,302**	**($1,837,669)**	**$624,766,999**	**$591,293,163**	**($33,473,836)**
Reappropriated Funds - Transfers from the Department of Public Health and Environment									
(9) Prevention Services Division; (A) Prevention Programs, (1) Programs and Administration	$2,000,000	$2,000,000	$0	$0	$0	$0	$0	$0	$0
(9) Prevention Services Division; (A) Prevention Programs, (3) Chronic Disease and Cancer Prevention Grants Program	$1,215,340	$1,215,340	$0	$1,215,340	$1,215,340	$0	$1,215,340	$1,215,340	$0
Total Reappropriated Funds	**$3,215,340**	**$3,215,340**	**$0**	**$1,215,340**	**$1,215,340**	**$0**	**$1,215,340**	**$1,215,340**	**$0**

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

Exhibit D - Cash Funds Report

Cash Funds Spending Authority by Source of Authority
FY 2012-13

Spending Authority	FY 2012-13 Long Bill Appropriation (HB 12-1335)	HB 12-1340 "Nursing Facility Reduction Per Diem Rate"	SB 12-060 "Improve Medicaid Fraud Prosecution"	SB 12-159 "Evaluation Children With Autism Medicaid Waiver"	Total
Certified Funds	$12,436,615	$0	$0	$0	$12,436,615
Local Funds	$40,869	$0	$0	$0	$40,869
Hospital Provider Fee Cash Fund	$482,144,867	$0	$0	$0	$482,144,867
Medicaid Buy-In Fund	$4,531,955	$0	$0	$0	$4,531,955
Tobacco Tax Cash Fund	$2,230,500	$0	$0	$0	$2,230,500
Health Care Expansion Fund	$67,872,147	$0	$0	$0	$67,872,147
Breast and Cervical Cancer Prevention and Treatment Fund	$1,484,910	$0	$0	$0	$1,484,910
Colorado Autism Treatment Fund	$878,625	$0	$0	$3,463	$882,088
Coordinated Care for People with Disabilities Fund	$268,200	$0	$0	$0	$268,200
Nursing Facility Cash Fund	$43,381,505	$0	$0	$0	$43,381,505
Home Health Telemedicine Fund	$40,335	$0	$0	$0	$40,335
Comprehensive Primary and Preventive Care Fund	$0	$0	$0	$0	$0
Pediatric Specialty Hospital Fund	$0	$0	$0	$0	$0
Tobacco Education Program Fund	$686,735	$0	$0	$0	$686,735
Health Disparities Grant Program Fund	$0	$0	$0	$0	$0
Supplemental Old Age Pension Health and Medical Care Fund	$0	$0	$0	$0	$0
Prevention, Early Detection, and Treatment Fund	$0	$0	$0	$0	$0
Primary Care Fund	$0	$0	$0	$0	$0
Department Recoveries	$35,205,601	$0	($24,470)	$0	$35,181,131
Total Cash Funds	**$651,202,864**	**$0**	**($24,470)**	**$3,463**	**$651,181,857**

Revised Totals for Letternotes and Appropriation Clauses
FY 2012-13

FY 2012-13 Request	FY 2012-13 Long Bill Appropriation (HB 12-1335)	HB 12-1340 "Nursing Facility Reduction Per Diem Rate"	SB 12-060 "Improve Medicaid Fraud Prosecution"	SB 12-159 "Evaluation Children With Autism Medicaid Waiver"	Total
Certified Funds	**$17,043,221**	$0	$0	$0	$17,043,221
Local Funds	**$18,903**	$0	$0	$0	$18,903
Hospital Provider Fee Cash Fund	**$492,341,588**	$0	$0	$0	$492,341,588
Medicaid Buy-In Fund	**$3,275,210**	$0	$0	$0	$3,275,210
Tobacco Tax Cash Fund	$2,230,500	$0	$0	$0	$2,230,500
Health Care Expansion Fund	**$67,829,559**	$0	$0	$0	$67,829,559
Breast and Cervical Cancer Prevention and Treatment Fund	**$1,195,085**	$0	$0	$0	$1,195,085
Colorado Autism Treatment Fund	**$526,770**	$0	$0	$3,463	$530,233
Coordinated Care for People with Disabilities Fund	**$202,500**	$0	$0	$0	$202,500
Nursing Facility Cash Fund	**$41,921,356**	$0	$0	$0	$41,921,356
Home Health Telemedicine Fund	$40,335	$0	$0	$0	$40,335
Comprehensive Primary and Preventive Care Fund	$0	$0	$0	$0	$0
Pediatric Specialty Hospital Fund	$0	$0	$0	$0	$0
Tobacco Education Program Fund	**$639,083**	$0	$0	$0	$639,083
Health Disparities Grant Program Fund	$0	$0	$0	$0	$0
Supplemental Old Age Pension Health and Medical Care Fund	$0	$0	$0	$0	$0
Prevention, Early Detection, and Treatment Fund	$0	$0	$0	$0	$0
Primary Care Fund	$0	$0	$0	$0	$0
Department Recoveries	**$36,526,682**	$0	($24,470)	$0	$36,502,212
Total Cash Funds	$663,790,792	$0	($24,470)	$3,463	$663,769,785

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

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2012-13	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Acute Care	**$94,526,851**	**$71,100,876**	**$576,445,254**	**$20,362,545**	**$248,197,073**	**$73,445,003**	**$103,858,631**	**$87,859,292**	**$10,301,457**	**$526,161,249**	**$58,370,428**	**$66,110,165**	**$45,257,115**	**$6,380,350**	**$1,988,376,289**
Community Based Long Term Care															
Base CBLTC	$126,331,371	$24,978,800	$140,258,929	$0	$2,973	$6,204	$22,019	$0	$0	$7,948	$119,541	$0	$0	$279,396	$292,007,181
Hospice	$33,319,091	$3,078,361	$7,324,018	$651,236	$76,360	$52,706	$82,392	$39,368	$0	$129,197	$1,238	$1,965	$0	$98,410	$44,854,342
Private Duty Nursing	$1,978,222	$146,628	$22,735,634	$0	$0	$0	$0	$0	$0	$661,136	$8,421,121	$0	$0	$0	$33,942,741
Subtotal CBLTC	**$161,628,684**	**$28,203,789**	**$170,318,581**	**$651,236**	**$79,333**	**$58,910**	**$104,411**	**$39,368**	**$0**	**$798,281**	**$8,541,900**	**$1,965**	**$0**	**$377,806**	**$370,804,264**
Long Term Care															
Class I Nursing Facilities	$428,414,076	$34,964,656	$79,273,409	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$412,179	$543,064,320
Class II Nursing Facilities	$0	$940,754	$3,086,671	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,027,425
PACE	$79,949,447	$7,888,312	$3,512,174	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$91,349,933
Subtotal Long Term Care	**$508,363,523**	**$43,793,722**	**$85,872,254**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$412,179**	**$638,441,678**
Insurance															
Supplemental Medicare Insurance Benefit	$62,781,854	$3,821,373	$33,409,561	$2,054,562	$216,812	$0	$0	$0	$0	$0	$0	$0	$0	$19,839,460	$122,123,622
Heath Insurance Buy-In	$5,506	$16,944	$2,857,162	$0	$24,765	$0	$0	$0	$0	$33,088	$5,451	$8,549	$0	$0	$2,951,465
Subtotal Insurance	**$62,787,360**	**$3,838,317**	**$36,266,723**	**$2,054,562**	**$241,577**	**$0**	**$0**	**$0**	**$0**	**$33,088**	**$5,451**	**$8,549**	**$0**	**$19,839,460**	**$125,075,087**
Service Management															
Single Entry Points	$12,563,256	$2,679,600	$11,733,705	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$26,976,561
Disease Management	$93,384	$66,293	$549,838	$395	$234,603	$63,345	$82,131	$2,367	$10,162	$507,479	$58,690	$62,639	$41,489	$5,351	$1,778,166
Prepaid Inpatient Health Plan	$1,302,414	$743,768	$5,079,583	$571	$8,936,096	$3,561,303	$4,966,337	$2,438,788	$0	$17,113,172	$1,423,363	$649,895	$0	$0	$46,215,290
Subtotal Service Management	**$13,959,054**	**$3,489,661**	**$17,363,126**	**$966**	**$9,170,699**	**$3,624,648**	**$5,048,468**	**$2,441,155**	**$10,162**	**$17,620,651**	**$1,482,053**	**$712,534**	**$41,489**	**$5,351**	**$74,970,017**
Medical Services Total	**$841,265,472**	**$150,426,365**	**$886,265,938**	**$23,069,309**	**$257,688,682**	**$77,128,561**	**$109,011,510**	**$90,339,815**	**$10,311,619**	**$544,613,269**	**$68,399,832**	**$66,833,213**	**$45,298,604**	**$27,015,146**	**$3,197,667,335**
Caseload	40,364	8,874	61,140	2,183	73,483	28,615	42,531	10,000	621	363,786	17,994	8,211	2,801	20,932	681,535
Medical Services Per Capita	$20,841.97	$16,951.36	$14,495.68	$10,567.71	$3,506.78	$2,695.39	$2,563.11	$9,033.98	$16,604.86	$1,497.07	$3,801.26	$8,139.14	$16,172.30	$1,290.61	$4,691.86
Financing	$209,309,142	$37,426,489	$220,505,380	$5,739,707	$64,113,646	$19,189,796	$27,122,361	$22,476,792	$2,565,559	$135,501,265	$17,018,065	$16,628,286	$11,270,416	$6,721,442	$795,588,346
Grand Total Medical Services Premiums	**$1,050,574,614**	**$187,852,854**	**$1,106,771,318**	**$28,809,016**	**$321,802,328**	**$96,318,357**	**$136,133,871**	**$112,816,607**	**$12,877,178**	**$680,114,534**	**$85,417,897**	**$83,461,499**	**$56,569,020**	**$33,736,588**	**$3,993,255,681**
Total Per Capita	$26,027.51	$21,168.90	$18,102.25	$13,196.98	$4,379.28	$3,366.01	$3,200.82	$11,281.66	$20,736.20	$1,869.55	$4,747.02	$10,164.18	$20,196.01	$1,611.72	$5,859.21

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2013-14	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Acute Care	**$97,292,919**	**$76,567,877**	**$610,484,206**	**$52,468,703**	**$267,154,574**	**$80,955,628**	**$118,981,918**	**$90,363,233**	**$10,852,352**	**$563,174,604**	**$60,319,969**	**$71,097,093**	**$50,016,833**	**$7,540,515**	**$2,157,270,424**
Community Based Long Term Care															
Base CBLTC	**$139,377,846**	**$27,558,407**	**$154,743,729**	**$0**	**$3,280**	**$6,845**	**$24,293**	**$0**	**$0**	**$8,769**	**$131,886**	**$0**	**$0**	**$308,250**	**$322,163,305**
Hospice	**$34,969,461**	**$3,332,331**	**$7,701,846**	**$1,673,912**	**$82,502**	**$57,818**	**$94,182**	**$40,420**	**$0**	**$146,370**	**$1,276**	**$2,162**	**$0**	**$109,942**	**$48,212,222**
Private Duty Nursing	**$2,483,446**	**$163,717**	**$25,563,609**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$739,373**	**$8,954,473**	**$0**	**$0**	**$0**	**$37,904,618**
Subtotal CBLTC	**$176,830,753**	**$31,054,455**	**$188,009,184**	**$1,673,912**	**$85,782**	**$64,663**	**$118,475**	**$40,420**	**$0**	**$894,512**	**$9,087,635**	**$2,162**	**$0**	**$418,192**	**$408,280,145**
Long Term Care															
Class I Nursing Facilities	$453,958,065	$37,049,407	$84,000,049	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$436,755	$575,444,276
Class II Nursing Facilities	$0	$1,102,987	$3,618,967	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,721,954
PACE	$91,610,888	$9,586,806	$4,179,188	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$105,376,882
Subtotal Long Term Care	**$545,568,953**	**$47,739,200**	**$91,798,204**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$436,755**	**$685,543,112**
Insurance															
Supplemental Medicare Insurance Benefit	$68,130,573	$4,284,141	$36,353,982	$5,477,299	$242,963	$0	$0	$0	$0	$0	$0	$0	$0	$22,988,760	$137,477,718
Heath Insurance Buy-In	$11,168	$34,374	$5,796,161	$0	$50,239	$0	$0	$0	$0	$67,124	$10,546	$17,344	$0	$0	$5,986,956
Subtotal Insurance	**$68,141,741**	**$4,318,515**	**$42,150,143**	**$5,477,299**	**$293,202**	**$0**	**$0**	**$0**	**$0**	**$67,124**	**$10,546**	**$17,344**	**$0**	**$22,988,760**	**$143,464,674**
Service Management															
Single Entry Points	$12,928,847	$2,977,036	$12,397,833	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$28,303,716
Disease Management	$62,272	$44,206	$366,649	$263	$156,440	$42,240	$54,768	$1,578	$6,777	$338,403	$39,136	$41,770	$27,666	$3,568	$1,185,736
Prepaid Inpatient Health Plan	$1,365,682	$780,182	$5,365,059	$794	$9,470,572	$3,774,150	$5,259,660	$2,362,857	$0	$18,157,468	$1,503,020	$688,648	$0	$0	$48,728,092
Subtotal Service Management	**$14,356,801**	**$3,801,424**	**$18,129,541**	**$1,057**	**$9,627,012**	**$3,816,390**	**$5,314,428**	**$2,364,435**	**$6,777**	**$18,495,871**	**$1,542,156**	**$730,418**	**$27,666**	**$3,568**	**$78,217,544**
Medical Services Total	**$902,191,167**	**$163,481,471**	**$950,571,278**	**$59,620,971**	**$277,160,570**	**$84,836,681**	**$124,414,821**	**$92,768,088**	**$10,859,129**	**$582,632,111**	**$70,960,306**	**$71,847,017**	**$50,044,499**	**$31,387,790**	**$3,472,775,899**
Caseload	41,195	9,356	62,620	5,465	77,326	30,573	47,351	10,000	655	401,411	18,057	8,801	2,827	22,776	738,413
Medical Services Per Capita	$21,900.50	$17,473.44	$15,179.99	$10,909.60	$3,584.31	$2,774.89	$2,627.50	$9,276.81	$16,578.82	$1,451.46	$3,929.79	$8,163.27	$17,702.33	$1,378.11	$4,703.02
Financing	$210,173,196	$38,084,416	$221,443,760	$13,889,218	$64,566,940	$19,763,435	$28,983,503	$21,611,124	$2,529,728	$135,729,164	$16,530,814	$16,737,381	$11,658,297	$7,312,056	$809,013,032
Grand Total Medical Services Premiums	**$1,112,364,363**	**$201,565,887**	**$1,172,015,038**	**$73,510,189**	**$341,727,510**	**$104,600,116**	**$153,398,324**	**$114,379,212**	**$13,388,857**	**$718,361,275**	**$87,491,120**	**$88,584,398**	**$61,702,796**	**$38,699,846**	**$4,281,788,931**
Total Per Capita	$27,002.41	$21,544.02	$18,716.31	$13,451.09	$4,419.31	$3,421.32	$3,239.60	$11,437.92	$20,441.00	$1,789.59	$4,845.27	$10,064.98	$21,826.25	$1,699.15	$5,798.64

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2014-15	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Acute Care	**$97,407,731**	**$80,168,597**	**$627,090,050**	**$81,894,058**	**$270,175,801**	**$83,634,713**	**$124,721,675**	**$92,898,634**	**$10,992,241**	**$586,138,111**	**$60,797,400**	**$71,348,795**	**$53,543,851**	**$8,713,895**	**$2,249,525,552.00**
Community Based Long Term Care															
Base CBLTC	**$150,007,798**	**$29,660,208**	**$166,545,594**	**$0**	**$3,530**	**$7,367**	**$26,146**	**$0**	**$0**	**$9,438**	**$141,945**	**$0**	**$0**	**$331,759**	**$346,733,785**
Hospice	**$35,794,670**	**$3,507,582**	**$7,884,433**	**$2,569,581**	**$84,467**	**$59,566**	**$98,139**	**$40,527**	**$0**	**$156,080**	**$1,290**	**$2,255**	**$0**	**$119,933**	**$50,318,523**
Private Duty Nursing	**$2,344,406**	**$175,909**	**$27,621,539**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$795,459**	**$9,485,723**	**$0**	**$0**	**$0**	**$40,423,036**
Subtotal CBLTC	**$188,146,874**	**$33,343,699**	**$202,051,566**	**$2,569,581**	**$87,997**	**$66,933**	**$124,285**	**$40,527**	**$0**	**$960,977**	**$9,628,958**	**$2,255**	**$0**	**$451,692**	**$437,475,344**
Long Term Care															
Class I Nursing Facilities	$462,041,447	$37,709,126	$85,495,791	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$444,532	$585,690,896
Class II Nursing Facilities	$0	$1,198,092	$3,931,012	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,129,104
PACE	$103,379,535	$11,133,265	$4,755,143	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$119,267,943
Subtotal Long Term Care	**$565,420,982**	**$50,040,483**	**$94,181,946**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$444,532**	**$710,087,943**
Insurance															
Supplemental Medicare Insurance Benefit	$74,113,494	$4,789,468	$39,527,069	$8,930,146	$264,196	$0	$0	$0	$0	$0	$0	$0	$0	$26,635,530	$154,259,903
Heath Insurance Buy-In	$12,217	$37,602	$6,340,421	$0	$54,956	$0	$0	$0	$0	$73,427	$10,546	$18,973	$0	$0	$6,548,142
Subtotal Insurance	**$74,125,711**	**$4,827,070**	**$45,867,490**	**$8,930,146**	**$319,152**	**$0**	**$0**	**$0**	**$0**	**$73,427**	**$10,546**	**$18,973**	**$0**	**$26,635,530**	**$160,808,045**
Service Management															
Single Entry Points	$13,305,076	$3,307,487	$13,099,550	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$29,712,113
Disease Management	$66,847	$48,771	$394,141	$440	$167,789	$45,606	$60,052	$1,683	$7,404	$377,249	$41,568	$45,758	$29,466	$4,171	$1,290,945
Prepaid Inpatient Health Plan	$1,389,000	$787,057	$5,416,352	$794	$9,520,389	$3,794,082	$5,287,195	$2,362,857	$0	$18,407,501	$1,520,078	$694,572	$0	$0	$49,179,877
Subtotal Service Management	**$14,760,923**	**$4,143,315**	**$18,910,043**	**$1,234**	**$9,688,178**	**$3,839,688**	**$5,347,247**	**$2,364,540**	**$7,404**	**$18,784,750**	**$1,561,646**	**$740,330**	**$29,466**	**$4,171**	**$80,182,935**
Medical Services Total	**$939,862,221**	**$172,523,164**	**$988,101,095**	**$93,395,019**	**$280,271,128**	**$87,541,334**	**$130,193,207**	**$95,303,701**	**$10,999,645**	**$605,957,265**	**$71,998,550**	**$72,110,353**	**$53,573,317**	**$36,249,820**	**$3,638,079,819**
Caseload	42,081	9,822	63,935	8,367	78,958	31,414	49,210	10,000	680	426,907	18,209	9,157	2,861	24,780	776,381
Medical Services Per Capita	$22,334.60	$17,564.97	$15,454.78	$11,162.31	$3,549.62	$2,786.70	$2,645.67	$9,530.37	$16,175.95	$1,419.41	$3,954.01	$7,874.89	$18,725.38	$1,462.87	$4,685.95
Financing	$209,043,083	$38,372,405	$219,772,319	$20,772,814	$62,337,585	$19,470,844	$28,957,425	$21,197,341	$2,446,528	$134,776,324	$16,013,835	$16,038,702	$11,915,716	$8,062,644	$809,177,565
Grand Total Medical Services Premiums	**$1,148,905,304**	**$210,895,569**	**$1,207,873,414**	**$114,167,833**	**$342,608,713**	**$107,012,178**	**$159,150,632**	**$116,501,042**	**$13,446,173**	**$740,733,589**	**$88,012,385**	**$88,149,055**	**$65,489,033**	**$44,312,464**	**$4,447,257,384**
Total Per Capita	$27,302.23	$21,471.75	$18,892.21	$13,645.01	$4,339.13	$3,406.51	$3,234.11	$11,650.10	$19,773.78	$1,735.12	$4,833.46	$9,626.41	$22,890.26	$1,788.24	$5,728.19

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

Item	Long Bill and Special Bills	R-1 Request (November 2012)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Acute Care					
Base Acute Cost	$2,078,446,960	$2,020,438,750	($58,008,210)		Exhibit F
Bottom Line Impacts					
SB 10-117 OTC MEDS	($149,755)	($74,878)	$74,877	Delayed Program Implementation	Exhibit F
Physicians to 100% of Medicare: 100% Federally Funded Portion	$4,950,838	$4,950,838	$0		Exhibit F
Physicians to 100% of Medicare: GF and FF Portion Due to Rate Decreases Since 2009	$1,347,828	$1,347,828	$0		Exhibit F
Managed Care Organization Reconciliation Annualization	$5,386,882	$5,386,882	$0		Exhibit F
Accountable Care Collaborative Savings	($12,418,568)	($23,227,707)	($10,809,139)	Anticipated Program Expansion	Exhibit F
FY 2010-11 BRI-1: "Client Overutilization"	($823,650)	($823,650)	$0		Exhibit F
FY 2011-12 BRI-5: "State Allowable Cost Expansion"	($166,666)	($166,666)	$0		Exhibit F
FY 2011-12 BRI-5: "Reduce Rates for Diabetes Supplies"	($150,066)	($150,066)	$0		Exhibit F
FY 2011-12 BRI-5: "Reduce Payment for Uncomplicated C-Section"	($811,545)	($811,545)	$0		Exhibit F
FY 2011-12 BRI-5: "Reduce Payments for Renal Dialysis"	($183,455)	($183,455)	$0		Exhibit F
FY 2011-12 BRI-5: "Deny Payment of Hospital Readmissions 48 hrs"	($320,094)	($320,094)	$0		Exhibit F
FY 2011-12 BRI-5: "Prior Authorize Certain Radiology"	($3,720,409)	($3,720,409)	$0		Exhibit F
FY 2011-12 BRI-5: Limit Acute Home Health Services to 60 days	($286,551)	($286,551)	$0		Exhibit F
FY 2011-12 BRI-5: "HMO Impact to Rates"	($81,968)	($81,968)	$0		Exhibit F
FY 2011-12 BA-9: "0.75% Provider Rate Reduction"	($2,904,019)	($2,904,019)	$0		Exhibit F
FY 2011-12 BA-9: "Limit Fluoride Application Benefit"	($6,101)	($6,101)	$0		Exhibit F
FY 2011-12 BA-9: "Limit Dental Prophylaxis Benefit"	($31,892)	($31,892)	$0		Exhibit F
FY 2011-12 BA-9: "Limit Oral Hygiene Instruction"	($835,251)	($835,251)	$0		Exhibit F
FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	($400,840)	($416,301)	($15,461)	Delayed Program Implementation	Exhibit F
FY 2011-12 BA-9: "Home Health Billing Changes"	($636,809)	($636,809)	$0		Exhibit F
Estimated Impact of Increasing PACE Enrollment	($1,337,761)	($1,129,116)	$208,645	Revised Pace Enrollment Estimates	Exhibit F
Annualization of HB 10-1005 Telemedicine	$182,336	$182,336	$0		Exhibit F
SB 11-177: "Sunset of Pregnancy Prevention Program"	$157,953	($51,940)	($209,893)	Lower than Anticipated Provider Enrollment	Exhibit F
Annualization of SB 10-167: "Colorado False Claims Act - NCCI"	($838,800)	($838,800)	$0		Exhibit F
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($3,340,516)	($2,643,760)	$696,756	Delayed Contract Execution	Exhibit F
Annualization of SB 10-167: "Colorado False Claims Act - PARIS"	($215,404)	($215,404)	$0		Exhibit F
Annualization of SB 10-167: "Colorado False Claims Act - RX COB"	($351,262)	($321,990)	$29,272	Implementation of Systems Changes Delayed	Exhibit F
Annualization of FY 2010-11 BRI-1: "Prevention and Benefits for Enhanced Value (P-BEV) and BA#12: Evidence Guided Utilization Review (EGUR)"	($382,297)	($382,297)	$0		Exhibit F
Annualization of FY 2010-11 BRI-2: "Coordinated Payment and Payment Reform"	($275,000)	($275,000)	$0		Exhibit F
Annualization of FY 2009-10 BA-33: "Prior Authorization of Anti-Convulsants"	($60,000)	($60,000)	$0		Exhibit F
Annualization of FY 2009-10 BRI-1: "Pharmacy Efficiencies - Auto PA"	($1,217,310)	($1,217,310)	$0		Exhibit F
ACA 4107 Smoking Cessation Counseling for Pregnant Women	($95,976)	($95,976)	$0		Exhibit F
Community Choice Transitions	$105,758	$24,406	($81,352)	Revised Enrollment Assumptions	Exhibit F
FY 2012-13 R-6: "Preterm Labor Prevention"	($1,034,351)	($1,034,351)	$0		Exhibit F
FY 2012-13 R-6: "Synagis Prior Authorization Review"	($208,519)	($208,519)	$0		Exhibit F

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

Item	Long Bill and Special Bills	R-1 Request (November 2012)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
FY 2012-13 R-6: "Expansion of Physician Administered Drug Rebate Program'	($679,656)	($679,656)	$0		Exhibit F
FY 2012-13 R-6: "Reimbursement Rate Alignment for Developmental Screenings"	($472,127)	($472,127)	$0		Exhibit F
FY 2012-13 R-6: "Physician Administered Drug Pricing and Unit Limits"	($57,167)	($57,167)	$0		Exhibit F
FY 2012-13 R-6: "Public Transportation Utilization"	$406,024	$406,024	$0		Exhibit F
FY 2012-13 R-6: "Seroquel Restrictions"	($1,236,962)	($1,236,962)	$0		Exhibit F
FY 2012-13 R-6: "Dental Efficiency"	($820,798)	($410,399)	$410,399	Delayed Program Implementation	Exhibit F
FY 2012-13 R-6: "Augmentative Communication Devices"	($492,000)	($451,000)	$41,000	Delayed Program Implementation	Exhibit F
FY 2012-13 R-6: "DME Preferred Provider"	($1,150,732)	($575,366)	$575,366	Delayed Program Implementation	Exhibit F
FY 2012-13 R-6: "Pharmacy Rate Methodology Transition'	$0	($7,000,000)	($7,000,000)	JBC Did Not Take Savings for This Initiative	Exhibit F
FY 2012-13 R-5: "FQHC/RHC Gainsharing"	($1,138,623)	($1,138,623)	$0		Exhibit F
FY 2012-13 R-5: "BHO Gainsharing"	($797,121)	($797,121)	$0		Exhibit F
FY 2012-13 R-5: ACC gainsharing	$0	$0	$0		Exhibit F
SB 12-060 "Improve Medicaid Fraud Prosecution"	($52,705)	($52,705)	$0		Exhibit F
SB 11-008: "Aligning Medicaid Eligibility for Children'	$0	($906,730)	($906,730)	Revised Per Capita Assumptions	Exhibit F
Total Acute Care	**$2,050,801,853**	**$1,988,376,289**	**($62,425,564)**		

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

Item	Long Bill and Special Bills	R-1 Request (November 2012)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Community Based Long Term Care					
Base CBLTC Cost	$358,189,181	$370,952,696	$12,763,515		Exhibit G
Bottom Line Impacts					
Annualization of FY 2011-12 BA-9: Medicaid Reductions - 0.50% Rate Reduction	($361,468)	($361,468)	$0		Exhibit G
Annualization of BRI-5: Medicaid Reductions - Cap CDASS Wage Rates	($1,204,144)	($1,204,144)	$0		Exhibit G
Annualization of HB 10-1146 State-funded Public Assistance Programs	$376,827	$376,827	$0		Exhibit G
Annualization of HB 09-1047 Alternative Therapies for Clients with Spinal Cord Injuries	$187,440	$187,440	$0		Exhibit G
SB 12-159 "Evaluate Children With Autism Medicaid Waiver"	$6,925	$6,925	$0		Exhibit G
Colorado Choice Transitions	$1,910,160	$484,520	($1,425,640)	Revised Implementation Assumptions	Exhibit G
Total Community Based Long Term Care	**$359,466,389**	**$370,804,264**	**$11,337,875**		
Long Term Care and Insurance					
Class I Nursing Facilities					
Base Class I Nursing Facility Cost	$539,586,490	$551,280,783	$11,694,293		Exhibit H
Bottom Line Impacts					
Hospital Back Up Program	$4,258,324	$4,571,186	$312,862	Revised Caseload Assumptions	Exhibit H
Recoveries from Department Overpayment Review	($2,076,753)	($2,139,323)	($62,570)	Trend Revision	Exhibit H
Savings from days incurred in FY 2011-12 and paid in FY 2012-13 under SB 11-215	($723,874)	($734,144)	($10,270)	Estimate Revision	Exhibit H
HB 12-1340 1.5% rate reduction Effective July 1, 2012	($9,024,676)	($9,397,068)	($372,392)	Revised Rate and Days Forecast	Exhibit H
Colorado Choice Transitions	($2,240,829)	($517,114)	$1,723,715	Delayed Program Implementation	Exhibit H
Total Class I Nursing Facilities	**$529,778,682**	**$543,064,320**	**$13,285,638**		
Class II Nursing Facilities					
Base Class II Nursing Facilities Cost	$5,216,775	$4,027,425	($1,189,350)		Exhibit H
Bottom Line Impacts					
Census Increases in FY 2012-13	$0	$666,420	$666,420	FY 2011-12 Claims Reflected a Lower Census Than is Expected in FY 2012-13	Exhibit H
Total Class II Nursing Facilities	**$5,216,775**	**$4,027,425**	**($1,189,350)**		

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

Item	Long Bill and Special Bills	R-1 Request (November 2012)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Program of All Inclusive Care for the Elderly (PACE)					
Base PACE Cost	$89,649,719	$91,349,933	$1,700,214		Exhibit H
Total Program of All-Inclusive Care for the Elderly	**$89,649,719**	**$91,349,933**	**$1,700,214**		
Supplemental Medicare Insurance Benefit (SMIB)					
Base SMIB Cost	$120,810,425	$122,123,622	$1,313,197		Exhibit H
Bottom Line Impacts					
Contractor to Enroll More Clients in Medicare	$0	$180,000	$180,000	Department Initiative to Increase Medicare Enrollment	Exhibit H
Total Supplemental Medicare Insurance Benefit	**$120,810,425**	**$122,123,622**	**$1,313,197**		
Health Insurance Buy-In Program (HIBI)					
Base HIBI Cost	$1,280,937	($97,598)	($1,378,535)		Exhibit H
Bottom Line Impacts					
Annualization of SB 10-167	$2,442,612	$3,049,063	$606,451	Delayed Program Implementation	Exhibit H
Total Health Insurance Buy-In Program	**$3,723,549**	**$2,951,465**	**($772,084)**		
Total Long Term Care and Insurance	**$749,179,150**	**$763,516,765**	**$14,337,615**		
Service Management					
Single Entry Points (SEP)					
Single Entry Points (SEP) Base	$26,976,561	$26,976,561	$0		Exhibit I
Total Single Entry Points	**$26,976,561**	**$26,976,561**	**$0**		
Disease Management					
Base Disease Management	$1,077,316	$494,791	($582,525)		Exhibit I
Bottom Line Impacts					
Smoking Quit line	$796,154	$796,154	$0		Exhibit I
Total Disease Management	**$1,873,470**	**$1,778,166**	**($95,304)**		
Prepaid Inpatient Health Plan Administration					
Estimated FY 2010-11 Base Expenditures	$37,074,823	$44,947,426	$7,872,603		Exhibit I
Bottom Line Impacts					
Estimated Contract Payment to PIHP for Cost Avoidance	$1,267,864	$1,267,864	$0		Exhibit I
Total Prepaid Inpatient Health Plan Administration	**$38,342,687**	**$46,215,290**	**$7,872,603**		
Total Service Management	**$67,192,718**	**$74,970,017**	**$7,777,299**		
Grand Total Services	**$3,226,640,110**	**$3,197,667,335**	**($28,972,775)**		
Bottom Line Financing					
Upper Payment Limit Financing	$4,111,163	$4,768,240	$657,077		Exhibit K
Department Recoveries Adjustment	$0	$0	$0		Exhibit A
Denver Health Outstationing	$5,485,699	$13,250,000	$7,764,301		Exhibit A
Hospital Provider Fee Supplemental Payments	$651,089,802	$682,374,883	$31,285,081		Exhibit J
Nursing Facility Provider Fee Supplemental Payments	$86,763,011	$83,842,713	($2,920,298)		Exhibit H
Physician Supplemental Payments	$7,161,512	$6,383,916	($777,596)		Exhibit A
Memorial Hospital High Volume Supplemental Payments	$4,362,089	$4,968,594	$606,505		Exhibit A
Cash Funds Financing	$0	$0	$0		Exhibit A
Provider Settlements	$0	$3,900,000	$3,900,000	New Information Regarding Pending Settlements	Exhibit A
Total Bottom Line Financing	**$758,973,276**	**$799,488,346**	**$40,515,070**		

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

Item	Long Bill and Special Bills	R-1 Request (November 2012)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Grand Total[1]	**$0**	**$0**	**$0**		
Total Acute Care	$2,050,801,853	$1,988,376,289	($62,425,564)		
Total Community Based Long Term Care	$359,466,389	$370,804,264	$11,337,875		
Total Class I Nursing Facilities	$529,778,682	$543,064,320	$13,285,638		
Total Class II Nursing Facilities	$5,216,775	$4,027,425	($1,189,350)		
Total Program of All-Inclusive Care for the Elderly	$89,649,719	$91,349,933	$1,700,214		
Total Supplemental Medicare Insurance Benefit	$120,810,425	$122,123,622	$1,313,197		
Total Health Insurance Buy-In Program	$3,723,549	$2,951,465	($772,084)		
Total Single Entry Point	$26,976,561	$26,976,561	$0		
Total Disease Management	$1,873,470	$1,778,166	($95,304)		
Total Prepaid Inpatient Health Plan Administration	$38,342,687	$46,215,290	$7,872,603		
Total Bottom Line Financing	$758,973,276	$799,488,346	$40,515,070		
Grand Total[1]	**$3,985,613,386**	**$3,997,155,681**	**$11,542,295**		

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

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills FY 2013-14

Item	Base Spending Authority	R-1 Request (November 2012)	Difference	Description of Difference from Base Request
Acute Care				
Base Acute Cost	$2,077,066,303	$2,122,406,582	$45,340,279	Increasing Caseload and Per Capita Costs
Bottom Line Impacts				
SB 10-117: "OTC Medications"	($34,526)	($109,403)	($74,877)	Savings Shifted From Prior Year Due to Implementation Timing
Physicians to 100% of Medicare: 100% Federally Funded Portion	$7,922,133	$7,922,133	$0	
Physicians to 100% of Medicare: GF and FF Portion Due to Rate Decreases Since 2009	$1,886,959	$1,886,959	$0	
Accountable Care Collaborative Savings	$0	($2,634,481)	($2,634,481)	Anticipated Program Expansion
Estimated Impact of Increasing PACE Enrollment	($1,357,426)	($1,966,624)	($609,198)	Increasing Enrollment in PACE Program
Annualization of SB 10-167: "Colorado False Claims Act - RX COB"	$0	($29,272)	($29,272)	Savings Shifted From Prior Year Due to Implementation Timing
Annualization of SB 10-167: "Colorado False Claims Act - HIBI'	$0	($3,596,647)	($3,596,647)	Savings Shifted From Prior Year Due to Implementation Timing
ACA 4107 Smoking Cessation Counseling for Pregnant Women	($16,426)	($16,426)	$0	
Community Choice Transitions	$97,623	$128,130	$30,507	
FY 2010-11 BRI-1: "Client Overutilization"	$0	($274,550)	($274,550)	Savings Shifted From Prior Year Due to Implementation Timing
FY 2011-12 BA-9: "Limit Physical and Occupational Therapy'	$0	($138,766)	($138,766)	Savings Shifted From Prior Year Due to Implementation Timing
FY 2012-13 R-6: "Dental Efficiency"	$0	($1,449,199)	($1,449,199)	Savings Shifted From Prior Year Due to Implementation Timing
FY 2012-13 R-6: "Augmentative Communication Devices"	$0	($41,000)	($41,000)	Savings Shifted From Prior Year Due to Implementation Timing
FY 2012-13 R-6: "Pharmacy Rate Methodology Transition"	$0	($7,000,000)	($7,000,000)	JBC Did Not Take Savings for This Initiative
FY 2012-13 R-5: "FQHC/RHC Gainsharing"	($1,005,024)	($1,005,024)	$0	
FY 2012-13 R-5: "BHO Gainsharing"	($1,262,243)	($1,262,243)	$0	
53 Pay Periods in FY 2013-14	$0	$32,659,616	$32,659,616	Adjustment Added for Additional Pay Period in FY 2013-14
SB 11-008: "Aligning Medicaid Eligibility for Children'	$0	($4,794,336)	($4,794,336)	Revised Per Capita Estimates
Total Bottom Line Impacts	$6,231,070	$17,431,921	$11,200,851	
Total Acute Care	**$2,083,297,373**	**$2,157,270,424**	**$73,973,051**	

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills FY 2013-14

Item	Base Spending Authority	R-1 Request (November 2012)	Difference	Description of Difference from Base Request
Community Based Long Term Care				
Base CBLTC Cost	$357,717,470	$400,210,876	$42,493,406	
Bottom Line Impacts				
Annualization of HB 09-1047 Alternative Therapies for Clients with Spinal Cord Injuries	($14,305)	($14,305)	$0	
Annualization of SB 12-159 "Evaluate Children With Autism Medicaid Waiver"	$0	$0	$0	
Adjustment for 53 pay periods	$0	$4,897,511	$4,897,511	Adjustment Added to Account for Additional Pay Period in FY 2013-14
Colorado Choice Transitions	$1,763,224	$3,171,758	$1,408,534	Delayed Implementation Shifted Costs Between Fiscal Years
Total Community Based Long Term Care	**$359,466,389**	**$408,280,145**	**$48,813,756**	
Long Term Care and Insurance				
Class I Nursing Facilities				
Base Class I Nursing Facility Cost	$541,239,898	$571,157,476	$29,917,578	
Bottom Line Impacts				
Hospital Back Up Program	$4,258,324	$4,571,186	$312,862	Revised Forecast
Recoveries from Department Overpayment Review	($2,180,694)	($2,218,264)	($37,570)	Revised Forecast
Savings from days incurred in FY 2012-13 and paid in FY 2013-14 under HB 12-1340	$0	($769,618)	($769,618)	Cash-flow Adjustment
Colorado Choice Transitions	($4,514,170)	($3,927,327)	$586,843	Delayed Implementation Shifted Savings Between Fiscal Years
Estimated Expenditures from Additional Payment Cycle	$0	$6,630,823	$6,630,823	Adjustment Added to Account for Additional Pay Period in FY 2013-14
Total Class I Nursing Facilities	**$538,803,358**	**$575,444,276**	**$36,640,918**	
Class II Nursing Facilities				
Base Class II Nursing Facilities	$5,216,775	$4,721,954	($494,821)	
Total Class II Nursing Facilities	**$5,216,775**	**$4,721,954**	**($494,821)**	
Program of All Inclusive Care for the Elderly (PACE)				
Base PACE Cost	$89,649,719	$0	($89,649,719)	
Total Program of All-Inclusive Care for the Elderly	**$89,649,719**	**$105,376,882**	**$15,727,163**	
Supplemental Medicare Insurance Benefit (SMIB)				
Base SMIB	$120,810,425	$137,477,718	$16,667,293	
Total Supplemental Medicare Insurance Benefit	**$120,810,425**	**$137,477,718**	**$16,667,293**	
Health Insurance Buy-In Program (HIBI)				
Base HIBI Cost	$3,723,549	$3,228,096	($495,453)	
Bottom Line Impacts				
Total Health Insurance Buy-In Program	**$3,723,549**	**$5,986,956**	**$2,263,407**	
Total Long Term Care and Insurance	**$874,489,274**	**$829,007,786**	**($45,481,488)**	

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills FY 2013-14

Item	Base Spending Authority	R-1 Request (November 2012)	Difference	Description of Difference from Base Request
Service Management				
Single Entry Points (SEP)				
FY 2012-13 Base Contracts	$26,976,561	$28,303,716	$1,327,155	
Total Single Entry Points	**$26,976,561**	**$28,303,716**	**$1,327,155**	
Disease Management				
Base Disease Management	$0	$0	$0	
Bottom Line Impacts				
Smoking Quit line	$1,281,040	$1,185,736	($95,304)	
Total Disease Management	**$1,281,040**	**$1,185,736**	**($95,304)**	
Prepaid Inpatient Health Plan Administration				
Estimated FY 2010-11 Base Expenditures	$37,482,129	$47,460,228	$9,978,099	
Bottom Line Impacts				
Estimated Contract Payment to PIHP for Cost Avoidance	$860,558	$1,267,864	$407,306	Revised Forecast
Total Prepaid Inpatient Health Plan Administration	**$38,342,687**	**$48,728,092**	**$10,385,405**	
Total Service Management	**$66,600,288**	**$78,217,544**	$11,617,256	
Grand Total Services	**$3,383,853,324**	**$3,472,775,899**	**$88,922,575**	
Bottom Line Financing				
Upper Payment Limit Financing	$4,111,163	$5,162,991	$1,051,828	Revised Forecast
Department Recoveries Adjustment	$0	$0	$0	
Denver Health Outstationing	$5,485,699	$10,600,000	$5,114,301	Revised Forecast
Hospital Provider Fee Supplemental Payments	$651,089,802	$695,431,946	$44,342,144	Revised Forecast
Nursing Facility Provider Fee Supplemental Payments	$86,763,011	$86,274,152	($488,859)	Revised Forecast
Physician Supplemental Payments	$7,161,512	$6,575,349	($586,163)	Revised Forecast
Memorial Hospital High Volume Supplemental Payments	$4,353,611	$4,968,594	$614,983	Revised Forecast
Cash Funds Financing[1]	$0	$0	$0	
Total Bottom Line Financing	**$758,964,798**	**$809,013,032**	**$50,048,234**	
Grand Total[2]	**$4,142,818,122**	**$4,281,788,931**	**$138,970,809**	
Total Acute Care	$2,083,297,373	$2,157,270,424	$73,973,051	
Total Community Based Long Term Care	$359,466,389	$408,280,145	$48,813,756	
Total Class I Nursing Facilities	$538,803,358	$575,444,276	$36,640,918	
Total Class II Nursing Facilities	$5,216,775	$4,721,954	($494,821)	
Total Program of All-Inclusive Care for the Elderly	$89,649,719	$105,376,882	$15,727,163	
Total Supplemental Medicare Insurance Benefit	$120,810,425	$137,477,718	$16,667,293	
Total Health Insurance Buy-In Program	$3,723,549	$5,986,956	$2,263,407	
Total Single Entry Point	$26,976,561	$28,303,716	$1,327,155	
Total Disease Management	$1,281,040	$1,185,736	($95,304)	
Total Prepaid Inpatient Health Plan Administration	$38,342,687	$48,728,092	$10,385,405	
Total Bottom Line Financing	$758,964,798	$809,013,032	$50,048,234	
Rounding Adjustment	($1)	$0	$1	
Grand Total[2]	**$4,026,532,673**	**$4,281,788,931**	**$255,256,258**	

Footnotes

(1) The Department has not received a FY 2014-15 appropriation as of this Budget Request. No annualizations are included.

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

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

Cash Based Actuals

ACUTE CARE	Adults 65 and Older (OAP-A) (4)	Disabled Adults 60 to 64 (OAP-B) (4)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$135,749,025	$46,119,779	$412,299,443	$0	$182,825,434	$0	$0	$0	$2,668,859	$229,743,284	$42,169,663	$63,935,230	$55,128,983	$2,089,094	$1,172,728,792
FY 2004-05	$134,189,229	$46,642,619	$385,860,624	$0	$191,063,780	$0	$0	$0	$2,490,150	$299,544,670	$42,706,006	$42,027,702	$44,696,256	$1,893,780	$1,191,114,826
FY 2005-06	$112,419,226	$45,351,381	$387,591,606	$0	$198,695,066	$0	$0	$0	$6,809,762	$312,707,761	$44,927,120	$41,011,299	$55,307,093	$2,067,371	$1,206,887,685
FY 2006-07	$83,410,163	$44,481,575	$383,750,038	$0	$196,349,132	$7,480,884	$0	$0	$5,555,696	$327,210,370	$49,460,226	$48,460,189	$54,457,447	$2,748,118	$1,203,363,838
FY 2007-08	$91,223,938	$50,717,725	$450,621,054	$0	$187,505,340	$18,427,719	$0	$0	$7,089,560	$360,156,073	$58,954,606	$54,344,094	$53,633,572	$3,330,605	$1,336,004,286
FY 2008-09	$102,239,226	$56,004,946	$492,622,774	$0	$206,446,267	$30,913,086	$0	$0	$7,043,287	$428,647,150	$61,714,145	$60,515,451	$59,182,087	$3,886,476	$1,509,214,896
FY 2009-10 (DA)	$94,978,885	$54,197,977	$489,172,778	$0	$218,768,176	$40,898,817	$3,085,476	$0	$9,006,411	$462,761,448	$60,444,300	$68,066,557	$48,429,084	$3,328,831	$1,553,138,739
FY 2010-11 (DA)	$97,388,620	$61,036,898	$529,213,760	$0	$218,112,253	$56,117,509	$61,707,804	$0	$9,817,196	$497,319,012	$62,802,717	$67,507,543	$45,331,275	$5,066,688	$1,711,421,275
FY 2011-12	$94,396,992	$67,010,397	$555,792,836	$398,462	$237,144,108	$64,030,894	$83,020,177	$2,393,150	$10,272,697	$512,975,400	$59,325,794	$63,318,002	$41,938,165	$5,407,941	$1,797,425,015
Estimated FY 2012-13	$94,526,851	$71,100,876	$576,445,254	$20,362,545	$248,197,073	$73,445,003	$103,858,631	$87,859,292	$10,301,457	$526,161,249	$58,370,428	$66,110,165	$45,257,115	$6,380,350	$1,988,376,289
Estimated FY 2013-14	$97,292,919	$76,567,877	$610,484,206	$52,468,703	$267,154,574	$80,955,628	$118,981,918	$90,363,233	$10,852,352	$563,174,604	$60,319,969	$71,097,093	$50,016,833	$7,540,515	$2,157,270,424
Estimated FY 2014-15	$97,407,731	$80,168,597	$627,090,050	$81,894,058	$270,175,801	$83,634,713	$124,721,675	$92,898,634	$10,992,241	$586,138,111	$60,797,400	$71,348,795	$53,543,851	$8,713,895	$2,249,525,552

Percent Change in Cash Based Actuals

ACUTE CARE	Adults 65 and Older (OAP-A) (4)	Disabled Adults 60 to 64 (OAP-B) (4)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-1.15%	1.13%	-6.41%	0.00%	4.51%	0.00%	0.00%	0.00%	-6.70%	30.38%	1.27%	-34.27%	-18.92%	-9.35%	1.57%
FY 2005-06	-16.22%	-2.77%	0.45%	0.00%	3.99%	0.00%	0.00%	0.00%	173.47%	4.39%	5.20%	-2.42%	23.74%	9.17%	1.32%
FY 2006-07	-25.80%	-1.92%	-0.99%	0.00%	-1.18%	0.00%	0.00%	0.00%	-18.42%	4.64%	10.09%	18.16%	-1.54%	32.93%	-0.29%
FY 2007-08	9.37%	14.02%	17.43%	0.00%	-4.50%	146.33%	0.00%	0.00%	27.61%	10.07%	19.20%	12.14%	-1.51%	21.20%	11.02%
FY 2008-09	12.07%	10.42%	9.32%	0.00%	10.10%	67.75%	0.00%	0.00%	-0.65%	19.02%	4.68%	11.36%	10.35%	16.69%	12.96%
FY 2009-10 (DA)	-7.10%	-3.23%	-0.70%	0.00%	5.97%	32.30%	0.00%	0.00%	27.87%	7.96%	-2.06%	12.48%	-18.17%	-14.35%	2.91%
FY 2010-11 (DA)	2.54%	12.62%	8.19%	0.00%	-0.30%	37.21%	1899.94%	0.00%	9.00%	7.47%	3.90%	-0.82%	-6.40%	52.21%	10.19%
FY 2011-12	-3.07%	9.79%	5.02%	0.00%	8.73%	14.10%	34.54%	0.00%	4.64%	3.15%	-5.54%	-6.21%	-7.49%	6.74%	5.03%
Estimated FY 2012-13	0.14%	6.10%	3.72%	5010.29%	4.66%	14.70%	25.10%	3571.28%	0.28%	2.57%	-1.61%	4.41%	7.91%	17.98%	10.62%
Estimated FY 2013-14	2.93%	7.69%	5.90%	157.67%	7.64%	10.23%	14.56%	2.85%	5.35%	7.03%	3.34%	7.54%	10.52%	18.18%	8.49%
Estimated FY 2014-15	0.12%	4.70%	2.72%	56.08%	1.13%	3.31%	4.82%	2.81%	1.29%	4.08%	0.79%	0.35%	7.05%	15.56%	4.28%

Per Capita Cost

ACUTE CARE	Adults 65 and Older (OAP-A) (4)	Disabled Adults 60 to 64 (OAP-B) (4)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$3,954.35	$8,312.87	$8,811.89	$0.00	$3,843.94	$0.00	$0.00	$0.00	$25,417.70	$1,176.49	$2,827.52	$7,613.15	$11,501.98	$212.26	$3,190.59
FY 2004-05	$3,750.40	$7,668.96	$8,050.67	$0.00	$3,343.78	$0.00	$0.00	$0.00	$28,622.42	$1,346.44	$2,703.77	$7,023.35	$8,678.88	$197.17	$2,933.61
FY 2005-06	$3,104.90	$7,506.02	$8,099.29	$0.00	$3,374.29	$0.00	$0.00	$0.00	$36,222.14	$1,460.17	$2,729.47	$8,011.58	$8,903.27	$186.38	$3,000.58
FY 2006-07	$2,324.18	$7,341.41	$7,863.89	$0.00	$3,873.76	$1,449.22	$0.00	$0.00	$24,367.09	$1,593.12	$2,957.44	$9,351.64	$10,470.57	$212.90	$3,068.02
FY 2007-08	$2,514.16	$8,252.15	$9,024.51	$0.00	$4,208.40	$2,066.35	$0.00	$0.00	$26,257.63	$1,765.28	$3,439.39	$8,642.51	$12,797.32	$234.32	$3,408.50
FY 2008-09	$2,717.76	$8,686.98	$9,592.50	$0.00	$4,200.59	$2,428.94	$0.00	$0.00	$22,218.57	$1,823.03	$3,422.29	$8,674.81	$14,843.76	$257.81	$3,455.07
FY 2009-10 (DA)	$2,467.82	$7,688.75	$9,183.93	$0.00	$3,794.04	$2,380.88	$952.90	$0.00	$21,191.56	$1,678.67	$3,288.41	$8,693.05	$13,113.75	$209.11	$3,113.77
FY 2010-11 (DA)	$2,502.21	$7,858.49	$9,402.39	$0.00	$3,577.96	$2,784.44	$2,271.43	$0.00	$18,488.13	$1,644.52	$3,414.49	$8,580.01	$14,108.71	$296.47	$3,051.97
FY 2011-12	$2,375.36	$7,993.61	$9,351.43	$7,662.73	$3,452.43	$2,609.78	$2,341.17	$2,110.36	$17,207.20	$1,532.95	$3,289.66	$8,298.56	$15,140.13	$286.57	$2,899.25
Estimated FY 2012-13	$2,341.86	$8,012.27	$9,428.28	$9,327.78	$3,377.61	$2,566.66	$2,441.95	$8,785.93	$16,588.50	$1,446.35	$3,243.88	$8,051.09	$16,157.48	$304.81	$2,917.50
Estimated FY 2013-14	$2,361.77	$8,183.83	$9,749.03	$9,600.86	$3,454.91	$2,647.95	$2,512.76	$9,036.32	$16,568.48	$1,402.99	$3,340.53	$8,078.07	$17,692.55	$331.07	$2,921.49
Estimated FY 2014-15	$2,314.77	$8,162.15	$9,808.24	$9,787.74	$3,421.77	$2,662.34	$2,534.48	$9,289.86	$16,165.06	$1,372.99	$3,338.87	$7,791.72	$18,715.08	$351.65	$2,897.45

Percent Change in Per Capita Cost

ACUTE CARE	Adults 65 and Older (OAP-A) (4)	Disabled Adults 60 to 64 (OAP-B) (4)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-5.16%	-7.75%	-8.64%	0.00%	-13.01%	0.00%	0.00%	0.00%	12.61%	14.45%	-4.38%	-7.75%	-24.54%	-7.11%	-8.05%
FY 2005-06	-17.21%	-2.12%	0.60%	0.00%	**0.91%**	0.00%	0.00%	0.00%	26.55%	8.45%	0.95%	14.07%	2.59%	-5.47%	2.28%
FY 2006-07	-25.14%	-2.19%	-2.91%	0.00%	14.80%	0.00%	0.00%	0.00%	-32.73%	9.11%	8.35%	16.73%	17.60%	14.23%	2.25%
FY 2007-08	8.17%	12.41%	14.76%	0.00%	8.64%	42.58%	0.00%	0.00%	7.76%	10.81%	16.30%	-7.58%	22.22%	10.06%	11.10%
FY 2008-09	8.10%	5.27%	6.29%	0.00%	-0.19%	17.55%	0.00%	0.00%	-15.38%	3.27%	-0.50%	0.37%	15.99%	10.02%	1.37%
FY 2009-10 (DA)	-9.20%	-11.49%	-4.26%	0.00%	-9.68%	-1.98%	0.00%	0.00%	-4.62%	-7.92%	-3.91%	0.21%	-11.65%	-18.89%	-9.88%
FY 2010-11 (DA)	1.39%	2.21%	2.38%	0.00%	-5.70%	16.95%	138.37%	0.00%	-12.76%	-2.03%	3.83%	-1.30%	7.59%	41.78%	-1.98%
FY 2011-12	-5.07%	1.72%	-0.54%	0.00%	-3.51%	-6.27%	3.07%	0.00%	-6.93%	-6.78%	-3.66%	-3.28%	7.31%	-3.34%	-5.00%
Estimated FY 2012-13	-1.41%	0.23%	0.82%	21.73%	-2.17%	-1.65%	4.30%	316.32%	-3.60%	-5.65%	-1.39%	-2.98%	6.72%	6.36%	0.63%
Estimated FY 2013-14	0.85%	2.14%	3.40%	2.93%	2.29%	3.17%	2.90%	2.85%	-0.12%	-3.00%	2.98%	0.34%	9.50%	8.62%	0.14%
Estimated FY 2014-15	-1.99%	-0.26%	0.61%	1.95%	-0.96%	0.54%	0.86%	2.81%	-2.43%	-2.14%	-0.05%	-3.54%	5.78%	6.22%	-0.82%

Per Capita Trends

Per Capita Trends	Adults 65 and Older (OAP-A) (4)	Disabled Adults 60 to 64 (OAP-B) (4)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Actual FY 2011-12 Per Capita	$2,375.36	$7,993.61	$9,351.43	$7,662.73	$3,452.43	$2,609.78	$2,341.17	$2,110.36	$17,207.20	$1,532.95	$3,289.66	$8,298.56	$15,140.13	$286.57	$2,899.25
Average of FY 2005-06 through FY 2009-10 (4)	-	-	-	-	2.90%	11.63%	-	-	-3.68%	4.74%	4.24%	4.76%	9.35%	1.99%	1.42%
Average of FY 2006-07 through FY 2009-10	-4.52%	1.00%	3.47%	0.00%	3.39%	14.54%	-	-	-11.24%	3.82%	5.06%	2.43%	**11.04%**	3.86%	1.21%
Average of FY 2007-08 through FY 2009-10	2.36%	2.06%	5.60%	0.00%	-0.41%	19.38%	-	0.00%	-4.08%	2.05%	3.96%	-2.33%	8.85%	0.40%	0.86%
Average of FY 2008-09 through FY 2009-10	-0.55%	-3.11%	1.02%	0.00%	-4.94%	7.79%	-	0.00%	-10.00%	-2.33%	-2.21%	0.29%	2.17%	-4.44%	-4.26%
Average of FY 2006-07 through FY 2010-11	-3.34%	1.24%	3.25%	0.00%	1.57%	15.02%	27.67%	3.00	-11.55%	2.65%	4.81%	1.69%	10.35%	11.44%	0.57%
Average of FY 2007-08 through FY 2010-11	2.12%	2.10%	4.79%	0.00%	-1.73%	18.78%	34.59%	0.00%	-6.25%	1.03%	3.93%	**-2.08%**	8.54%	10.74%	0.15%
Average of FY 2008-09 through FY 2010-11	0.10%	-1.34%	1.47%	0.00%	-5.19%	10.84%	46.12%	0.00%	-10.92%	-2.23%	-0.19%	-0.24%	3.98%	10.97%	-3.50%
Average of FY 2009-10 through FY 2010-11	-3.91%	-4.64%	-0.94%	0.00%	-7.69%	7.49%	69.19%	0.00%	-8.69%	-4.98%	-0.04%	-0.55%	-2.03%	11.45%	-5.93%
Average of FY 2007-08 through FY 2011-12	0.68%	2.02%	3.73%	0.00%	-2.09%	13.77%	28.29%	0.00%	-6.39%	-0.53%	2.41%	-2.32%	8.29%	7.93%	-0.88%
Average of FY 2008-09 through FY 2011-12	-1.20%	-0.57%	0.97%	0.00%	-4.77%	6.56%	35.36%	0.00%	-9.92%	-3.37%	-1.06%	-1.00%	4.81%	**7.39%**	-3.87%
Average of FY 2009-10 through FY 2011-12	-4.29%	-2.52%	-0.81%	0.00%	-6.30%	2.90%	47.15%	0.00%	-8.10%	-5.58%	-1.25%	-1.46%	1.08%	6.52%	-5.62%
Average of FY 2010-11 through FY 2011-12	-1.84%	1.97%	0.92%	0.00%	-4.61%	5.34%	70.72%	0.00%	-9.85%	-4.41%	0.09%	-2.29%	7.45%	19.22%	-3.49%

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

ACUTE CARE	Current Year Projection														
	Adults 65 and Older (OAP-A) [4]	Disabled Adults 60 to 64 (OAP-B) [4]	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Percentage Selected to Modify Per Capita [1]	0.70%	2.06%	2.38%	22.60%	0.91%	2.18%	8.21%	324.81%	-3.24%	-3.39%	1.97%	-1.64%	7.45%	7.39%	
Estimated FY 2012-13 Base Per Capita	$2,391.99	$8,158.28	$9,573.99	$9,394.55	$3,483.85	$2,666.67	$2,533.34	$8,964.98	$16,649.69	$1,480.98	$3,354.47	$8,162.46	$16,268.07	$307.75	$2,982.98
Estimated FY 2012-13 Eligibles	40,364	8,874	61,140	2,183	73,483	28,615	42,531	10,000	621	363,786	17,994	8,211	2,801	20,932	681,535
Estimated FY 2012-13 Base Expenditures	$96,550,284	$72,396,577	$585,353,749	$20,508,303	$256,003,750	$76,306,762	$107,745,484	$89,649,800	$10,339,457	$538,759,790	$60,360,333	$67,024,680	$45,566,864	$6,441,823	$2,033,007,656
Bottom Line Impacts															
SB 10-117 OTC MEDS	($1,587)	($4,278)	($30,387)	($645)	($9,597)	($3,370)	($4,123)	($988)	$0	($14,529)	($4,853)	($521)	$0	$0	($74,878)
Physicians to 100% of Medicare: 100% Federally Funded Portion	$59,332	$120,687	$921,747	$47,118	$869,497	$217,693	$283,915	$38,097	$0	$1,836,615	$174,502	$282,431	$99,140	$64	$4,950,838
Physicians to 100% of Medicare: GF and FF Portion Due to Rate Decreases Since 2009	$16,151	$32,856	$250,939	$12,828	$236,714	$59,265	$77,294	$10,372	$0	$500,005	$47,507	$76,890	$26,990	$17	$1,347,828
Managed Care Organization Reconciliation Annualization	$286,646	$297,573	$1,755,130	$11,534	$763,738	$240,626	$346,964	$0	$0	$1,599,530	$37,631	$47,510	$0	$0	$5,386,882
Accountable Care Collaborative Savings	($422,676)	($308,999)	($2,505,582)	($462)	($5,032,578)	($2,006,392)	($2,839,206)	($1,485,525)	$0	($7,536,335)	($750,575)	($339,377)	$0	$0	($23,227,707)
FY 2010-11 BRI-1: "Client Overutilization"	($47,042)	($30,116)	($249,790)	($7,604)	($106,580)	($28,777)	($37,312)	($9,485)	$0	($230,546)	($26,663)	($28,457)	($18,848)	($2,430)	($823,650)
FY 2011-12 BRI-5: "State Allowable Cost Expansion"	($2,538)	($9,523)	($67,636)	($1,437)	($21,361)	($7,500)	($9,177)	($2,199)	($994)	($32,340)	($10,802)	($1,159)	$0	$0	($166,666)
FY 2011-12 BRI-5: "Reduce Rates for Diabetes Supplies"	($29,425)	($8,561)	($79,786)	($373)	($4,847)	($1,834)	($2,069)	($281)	$0	($15,686)	($6,917)	($255)	$0	($32)	($150,066)
FY 2011-12 BRI-5: "Reduce Payment for Uncomplicated C-Section"	$0	$0	$0	$0	($317,796)	($54,878)	($73,429)	$0	$0	$0	$0	($160,474)	($204,968)	$0	($811,545)
FY 2011-12 BRI-5: "Reduce Payments for Renal Dialysis"	($19,762)	($7,468)	($55,782)	($3,675)	($26,100)	($4,586)	($6,312)	($3,826)	$0	($37,019)	($2,381)	$0	($16,544)	$0	($183,455)
FY 2011-12 BRI-5: "Deny Payment of Hospital Readmissions 48 hrs"	($11,592)	($13,030)	($97,328)	($6,412)	($45,540)	($8,002)	($11,013)	($6,675)	$0	($64,591)	($4,154)	($22,890)	($28,867)	$0	($320,094)
FY 2011-12 BRI-5: "Prior Authorize Certain Radiology"	($41,945)	($79,692)	($635,751)	($18,929)	($1,070,126)	($288,620)	($360,071)	($58,050)	$0	($663,221)	($157,754)	($333,200)	($13,021)	($29)	($3,720,409)
FY 2011-12 BRI-5: Limit Acute Home Health Services to 60 days	($39,471)	($13,230)	($206,580)	$0	($749)	($207)	($274)	($8)	$0	($7,252)	($18,401)	($89)	$0	($290)	($286,551)
FY 2011-12 BRI-5: "HMO Impact to Rates"	($4,362)	($4,528)	($26,706)	($176)	($11,621)	($3,661)	($5,279)	$0	$0	($24,339)	($573)	($723)	$0	$0	($81,968)
FY 2011-12 BA-9: "0.75% Provider Rate Reduction"	($149,583)	($106,184)	($880,707)	($26,810)	($375,777)	($101,463)	($131,553)	($33,441)	($16,278)	($812,859)	($94,007)	($100,333)	($66,455)	($8,569)	($2,904,019)
FY 2011-12 BA-9: "Limit Fluoride Application Benefit"	$0	$0	$0	$0	$0	$0	$0	$0	$0	($6,101)	$0	$0	$0	$0	($6,101)
FY 2011-12 BA-9: "Limit Dental Prophylaxis Benefit"	$0	$0	$0	$0	$0	$0	$0	$0	$0	($31,892)	$0	$0	$0	$0	($31,892)
FY 2011-12 BA-9: "Limit Oral Hygiene Instruction"	$0	$0	$0	$0	$0	$0	$0	$0	$0	($835,251)	$0	$0	$0	$0	($835,251)
FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	($5,127)	($10,895)	($91,557)	($5,426)	($84,123)	($27,179)	($33,894)	($8,728)	$0	($127,342)	($9,993)	($9,473)	($2,564)	$0	($416,301)
FY 2011-12 BA-9: "Home Health Billing Changes"	($87,719)	($29,402)	($459,087)	$0	($1,665)	($460)	($609)	($17)	$0	($16,115)	($40,892)	($197)	($1)	($645)	($636,809)
Estimated Impact of Increasing PACE Enrollment	($850,218)	($256,601)	($22,297)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1,129,116)
Annualization of HB 10-1005 Telemedicine	$25,117	$8,419	$131,449	$0	$477	$132	$174	$5	$0	$4,614	$11,708	$56	$0	$185	$182,336
SB 11-177: "Sunset of Pregnancy Prevention Program"	$0	$0	$0	$0	$0	$0	$0	$0	$0	($46,330)	($5,610)	$0	$0	$0	($51,940)
Annualization of SB 10-167: "Colorado False Claims Act - NCCI"	($43,206)	($30,670)	($254,384)	($7,744)	($108,540)	($29,307)	($37,998)	($9,659)	($4,702)	($234,787)	($27,153)	($28,980)	($19,195)	($2,475)	($838,800)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($136,175)	($96,668)	($801,778)	($24,408)	($342,100)	($92,370)	($119,764)	($30,444)	($14,819)	($740,010)	($85,582)	($91,342)	($60,499)	($7,801)	($2,643,760)
Annualization of SB 10-167: "Colorado False Claims Act - PARIS"	($11,096)	($7,876)	($65,326)	($1,989)	($27,873)	($7,526)	($9,758)	($2,480)	($1,207)	($60,293)	($6,973)	($7,442)	($4,929)	($636)	($215,404)
Annualization of SB 10-167: "Colorado False Claims Act - RX COB"	($6,826)	($18,398)	($130,669)	($2,776)	($41,268)	($14,490)	($17,729)	($4,247)	$0	($62,479)	($20,869)	($2,239)	$0	$0	($321,990)
Annualization of FY 2010-11 BRI-1: "Prevention and Benefits for Enhanced Value (P-BEV) and BA#12: Evidence Guided Utilization Review (EGUR)"	($8,103)	($21,844)	($155,143)	($3,295)	($48,997)	($17,204)	($21,050)	($5,043)	$0	($74,181)	($24,778)	($2,659)	$0	$0	($382,297)
Annualization of FY 2010-11 BRI-2: "Coordinated Payment and Payment Reform"	($123,168)	($20,100)	($82,809)	($1,585)	($1,173)	($2,238)	($4,646)	$0	$0	($194)	($129)	($304)	($15)	($38,639)	($275,000)
Annualization of FY 2009-10 BA-33: "Prior Authorization of Anti-Convulsants"	($1,273)	($3,428)	($24,349)	($517)	($7,690)	($2,700)	($3,304)	($791)	$0	($11,642)	($3,889)	($417)	$0	$0	($60,000)
Annualization of FY 2009-10 BRI-1: "Pharmacy Efficiencies - Auto PA"	($25,799)	($69,556)	($494,006)	($10,493)	($156,018)	($54,781)	($67,027)	($16,058)	$0	($236,209)	($78,897)	($8,466)	$0	$0	($1,217,310)
ACA 4107 Smoking Cessation Counseling for Pregnant Women	$0	$0	($3,091)	$0	($29,986)	($9,773)	($14,823)	$0	$0	($24,929)	($8,953)	($4,421)	$0	$0	($95,976)
Community Choice Transitions	$3,360	$1,127	$17,595	$0	$64	$18	$23	$1	$0	$618	$1,567	$8	$0	$25	$24,406
FY 2012-13 R-6: "Preterm Labor Prevention"	$0	$0	($33,312)	$0	($323,165)	($105,325)	($159,750)	$0	$0	($268,664)	($96,488)	($47,647)	$0	$0	($1,034,351)
FY 2012-13 R-6: "Synagis Prior Authorization Review"	($4,419)	($11,915)	($84,621)	($1,797)	($26,725)	($9,384)	($11,481)	($2,751)	$0	($40,461)	($13,515)	($1,450)	$0	$0	($208,519)
FY 2012-13 R-6: "Expansion of Physician Administered Drug Rebate Program"	($14,405)	($38,835)	($275,817)	($5,859)	($87,109)	($30,585)	($37,423)	($8,965)	$0	($131,881)	($44,050)	($4,727)	$0	$0	($679,656)
FY 2012-13 R-6: "Reimbursement Rate Alignment for Developmental Screenings"	$0	$0	$0	$0	$0	$0	$0	$0	$0	($431,161)	($40,966)	$0	$0	$0	($472,127)
FY 2012-13 R-6: "Physician Administered Drug Pricing and Unit Limits"	($1,211)	($3,266)	($23,199)	($493)	($7,327)	($2,573)	($3,148)	($754)	$0	($11,093)	($3,705)	($398)	$0	$0	($57,167)
FY 2012-13 R-6: "Public Transportation Utilization"	$83,974	$38,994	$202,547	$728	$15,364	$4,362	$5,061	$598	$0	$47,105	$5,085	$2,158	$48	$0	$406,024
FY 2012-13 R-6: "Seroquel Restrictions"	($26,216)	($70,679)	($501,981)	($10,663)	($158,537)	($55,665)	($68,109)	($16,317)	$0	($240,022)	($80,171)	($8,602)	$0	$0	($1,236,962)
FY 2012-13 R-6: "Dental Efficiency"	$0	$0	($19,749)	($224)	($16,461)	($4,859)	($5,865)	($1,250)	$0	($341,107)	($19,537)	($1,326)	($21)	$0	($410,399)
FY 2012-13 R-6: "Augmentative Communication Devices"	($88,432)	($25,730)	($239,784)	($1,121)	($14,568)	($5,511)	($6,217)	($844)	$0	($47,142)	($20,788)	($767)	$0	($96)	($451,000)
FY 2012-13 R-6: "DME Preferred Provider"	($112,816)	($32,825)	($305,907)	($1,430)	($18,586)	($7,031)	($7,931)	($1,077)	$0	($60,142)	($26,521)	($978)	$0	($122)	($575,366)
FY 2012-13 R-6: "Pharmacy Rate Methodology Transition"	($148,363)	($399,972)	($2,840,726)	($60,340)	($897,162)	($315,010)	($385,428)	($92,338)	$0	($1,358,291)	($453,688)	($48,682)	$0	$0	($7,000,000)
FY 2012-13 R-5: "FQHC/RHC Gainsharing"	($15,448)	($12,529)	($97,400)	($3,958)	($161,867)	($42,350)	($57,720)	($26,130)	$0	($638,960)	($22,599)	($59,662)	$0	$0	($1,138,623)
FY 2012-13 R-5: "BHO Gainsharing"	($16,894)	($45,547)	($323,486)	($6,871)	($102,164)	($35,872)	($43,890)	($10,515)	$0	($154,675)	($51,663)	($5,544)	$0	$0	($797,121)
SB 12-060 "Improve Medicaid Fraud Prosecution"	($1,116)	($3,012)	($21,389)	($454)	($6,755)	($2,372)	($2,902)	($695)	$0	($10,227)	($3,416)	($367)	$0	$0	($52,705)
SB 11-008: "Aligning Medicaid Eligibility for Children"	$0	$0	$0	$0	$0	$0	$0	$0	$0	($906,730)	$0	$0	$0	$0	($906,730)
Total Bottom Line Impacts	($2,023,433)	($1,295,701)	($8,908,495)	($145,758)	($7,806,677)	($2,861,759)	($3,886,853)	($1,790,508)	($38,000)	($12,598,541)	($1,989,905)	($914,515)	($309,749)	($61,473)	($44,631,367)
Estimated FY 2012-13 Expenditures	**$94,526,851**	**$71,100,876**	**$576,445,254**	**$20,362,545**	**$248,197,073**	**$73,445,003**	**$103,858,631**	**$87,859,292**	**$10,301,457**	**$526,161,249**	**$58,370,428**	**$66,110,165**	**$45,257,115**	**$6,380,350**	**$1,988,376,289**
Estimated FY 2012-13 Per Capita	$2,341.86	$8,012.27	$9,428.28	$9,327.78	$3,377.61	$2,566.66	$2,441.95	$8,785.93	$16,588.50	$1,446.35	$3,243.88	$8,051.09	$16,157.48	$304.81	$2,917.50
% Change over FY 2011-12 Per Capita	-1.41%	0.23%	0.82%	21.73%	-2.17%	-1.65%	4.30%	316.32%	-3.60%	-5.65%	-1.39%	-2.98%	6.72%	6.37%	0.63%

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

ACUTE CARE	Request Year Projection														
	Adults 65 and Older (OAP-A) (4)	**Disabled Adults 60 to 64 (OAP-B) (4)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Adults without Dependent Children (AwDC)**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Percentage Selected to Modify Per Capita(2)	0.70%	2.06%	2.38%	2.38%	0.91%	2.18%	2.03%	2.76%	-1.62%	-3.39%	1.97%	-1.64%	7.45%	7.39%	
Estimated FY 2013-14 Base Per Capita	$2,358.25	$8,177.32	$9,652.68	$9,549.78	$3,408.35	$2,622.61	$2,491.48	$9,028.25	$16,319.76	$1,397.32	$3,307.79	$7,919.05	$17,361.22	$327.34	$2,897.89
Estimated FY 2013-14 Eligibles	41,195	9,356	62,620	5,465	77,326	30,573	47,351	10,000	655	401,411	18,057	8,801	2,827	22,776	738,413
Estimated FY 2013-14 Base Expenditure	$97,148,109	$76,507,006	$604,450,822	$52,189,548	$263,554,072	$80,181,183	$117,974,233	$90,282,500	$10,689,443	$560,899,619	$59,728,764	$69,697,539	$49,080,169	$7,455,496	$2,139,838,503
Bottom Line Impacts															
SB 10-117: "OTC Medications"	($2,318)	($6,251)	($44,398)	($943)	($14,022)	($4,923)	($6,024)	($1,443)	$0	($21,229)	($7,091)	($761)	$0	$0	($109,403)
Physicians to 100% of Medicare: 100% Federally Funded Portion	$94,940	$193,119	$1,474,942	$75,397	$1,391,335	$348,344	$454,309	$60,961	$0	$2,938,878	$279,231	$451,935	$158,639	$103	$7,922,133
Physicians to 100% of Medicare: GF and FF Portion Due to Rate Decreases Since 2009	$22,612	$45,999	$351,314	$17,959	$331,400	$82,972	$108,211	$14,520	$0	$700,006	$66,510	$107,646	$37,786	$24	$1,886,959
Accountable Care Collaborative Savings	($47,568)	($34,772)	($281,956)	($52)	($566,321)	($225,781)	($319,499)	($187,806)	$0	($848,073)	($84,463)	($38,190)	$0	$0	($2,634,481)
Estimated Impact of Increasing PACE Enrollment	($974,321)	($656,662)	($335,641)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1,966,624)
Annualization of SB 10-167: "Colorado False Claims Act - RX COB"	($620)	($1,673)	($11,879)	($252)	($3,752)	($1,317)	($1,612)	($386)	$0	($5,680)	($1,897)	($204)	$0	$0	($29,272)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($267,561)	($131,510)	($1,090,762)	($33,205)	($465,403)	($125,663)	($162,930)	($41,417)	($20,160)	($1,006,731)	($116,428)	($124,264)	$0	($10,613)	($3,596,647)
ACA 4107 Smoking Cessation Counseling for Pregnant Women	$0	$0	($528)	$0	($5,132)	($1,673)	($2,537)	$0	$0	($4,267)	($1,532)	($757)	$0	$0	($16,426)
Community Choice Transitions	$17,649	$5,916	$92,371	$0	$335	$93	$122	$3	$0	$3,243	$8,228	$40	$0	$130	$128,130
FY 2010-11 BRI-1: "Client Overutilization"	($15,679)	($10,039)	($83,263)	($2,535)	($35,527)	($9,592)	($12,437)	($3,162)	$0	($76,849)	($8,888)	($9,486)	($6,283)	($810)	($274,550)
FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	($1,707)	($3,632)	($30,519)	($1,809)	($28,041)	($9,060)	($11,298)	($2,909)	$0	($42,447)	($3,331)	($3,158)	($855)	$0	($138,766)
FY 2012-13 R-6: "Dental Efficiency"	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1,449,199)	$0	$0	$0	$0	($1,449,199)
FY 2012-13 R-6: "Augmentative Communication Devices"	($8,038)	($2,339)	($21,799)	($102)	($1,324)	($501)	($565)	($77)	$0	($4,286)	($1,890)	($70)	$0	($9)	($41,000)
FY 2012-13 R-6: "DME Preferred Provider"	($166,068)	($48,318)	($450,298)	($2,106)	($27,358)	($10,349)	($11,675)	($1,585)	$0	($88,530)	($39,039)	($1,440)	$0	($180)	($846,946)
FY 2012-13 R-6: "Pharmacy Rate Methodology Transition"	($148,363)	($399,972)	($2,840,726)	($60,340)	($897,162)	($315,010)	($385,428)	($92,338)	$0	($1,358,291)	($453,688)	($48,682)	$0	$0	($7,000,000)
FY 2012-13 R-5: "FQHC/RHC Gainsharing"	($13,636)	($11,059)	($85,971)	($3,494)	($142,874)	($37,381)	($50,947)	($23,064)	$0	($563,988)	($19,948)	($52,662)	$0	$0	($1,005,024)
FY 2012-13 R-5: "BHO Gainsharing"	($26,752)	($72,123)	($512,241)	($10,881)	($161,777)	($56,803)	($69,501)	($16,650)	$0	($244,928)	($81,809)	($8,778)	$0	$0	($1,262,243)
53 Pay Periods in FY 2013-14	$1,682,240	$1,194,187	$9,904,738	$301,518	$4,226,125	$1,141,089	$1,479,496	$376,086	$183,069	$9,141,692	$1,057,240	$1,128,385	$747,377	$96,374	$32,659,616
SB 11-008: "Aligning Medicaid Eligibility for Children"	$0	$0	$0	$0	$0	$0	$0	$0	$0	($4,794,336)	$0	$0	$0	$0	($4,794,336)
Total Bottom Line Impacts	$144,810	$60,871	$6,033,384	$279,155	$3,600,502	$774,445	$1,007,685	$80,733	$162,909	$2,274,985	$591,205	$1,399,554	$936,664	$85,019	$17,431,921
Estimated FY 2013-14 Expenditure	**$97,292,919**	**$76,567,877**	**$610,484,206**	**$52,468,703**	**$267,154,574**	**$80,955,628**	**$118,981,918**	**$90,363,233**	**$10,852,352**	**$563,174,604**	**$60,319,969**	**$71,097,093**	**$50,016,833**	**$7,540,515**	**$2,157,270,424**
Estimated FY 2013-14 Per Capita	$2,361.77	$8,183.83	$9,749.03	$9,600.86	$3,454.91	$2,647.95	$2,512.76	$9,036.32	$16,568.48	$1,402.99	$3,340.53	$8,078.07	$17,692.55	$331.07	$2,921.49
% Change over FY 2012-13 Per Capita	0.85%	2.14%	3.40%	2.93%	2.29%	3.17%	2.90%	2.85%	-0.12%	-3.00%	2.98%	0.34%	9.50%	8.61%	0.14%

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

ACUTE CARE	Out Year Projection													
	Adults 65 and Older (OAP-A) (4)	Disabled Adults 60 to 64 (OAP-B) (4)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Percentage Selected to Modify Per Capita(3)	0.70%	2.06%	2.38%	2.38%	0.91%	2.18%	2.29%	3.27%	-0.81%	0.00%	1.97%	-1.64%	7.45%	7.39%	
Estimated FY 2014-15 Base Per Capita	$2,378.30	$8,352.42	$9,981.06	$9,829.36	$3,486.35	$2,705.68	$2,570.40	$9,331.59	$16,434.28	$1,402.99	$3,406.34	$7,945.59	$19,010.64	$355.54	$2,950.46
Estimated FY 2014-15 Eligibles	42,081	9,822	63,935	8,367	78,958	31,414	49,210	10,000	680	426,907	18,209	9,157	2,861	24,780	776,381
Estimated FY 2014-15 Base Expenditure	$100,081,242	$82,037,469	$638,139,071	$82,242,255	$275,275,223	$84,996,232	$126,489,187	$93,315,900	$11,175,310	$598,946,252	$62,026,045	$72,757,768	$54,389,441	$8,810,281	$2,290,681,676
Bottom Line Impacts															
Increased PACE Enrollment	($938,485)	($556,734)	($261,805)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1,757,024)
Physicians to 100% of Medicare: 100% Federally Funded Portion	($47,469)	($96,559)	($737,471)	($37,699)	($695,668)	($174,172)	($227,154)	($30,481)	$0	($1,469,439)	($139,616)	($225,968)	($79,320)	($51)	($3,961,067)
Physicians to 100% of Medicare: GF and FF Portion Due to Rate Decreases Since 2009	($11,307)	($22,999)	($175,657)	($8,979)	($165,700)	($41,486)	($54,106)	($7,260)	$0	($350,003)	($33,255)	($53,823)	($18,893)	($12)	($943,480)
Accountable Care Collaborative Savings	($1,013)	($741)	($6,005)	($1)	($12,062)	($4,809)	($6,805)	($3,440)	$0	($18,062)	($1,799)	($813)	$0	$0	($55,550)
Community Choice Transitions	$7,003	$2,348	$36,655	$0	$133	$37	$49	$1	$0	$1,287	$3,265	$16	$0	$51	$50,845
53 Pay Periods in FY 2013-14	($1,682,240)	($1,194,187)	($9,904,738)	($301,518)	($4,226,125)	($1,141,089)	($1,479,496)	($376,086)	($183,069)	($9,141,692)	($1,057,240)	($1,128,385)	($747,377)	($96,374)	($32,659,616)
SB 11-008: "Aligning Medicaid Eligibility for Children"	$0	$0	$0	$0	$0	$0	$0	$0	$0	($1,830,232)	$0	$0	$0	$0	($1,830,232)
Total Bottom Line Impacts	($2,673,511)	($1,868,872)	($11,049,021)	($348,197)	($5,099,422)	($1,361,519)	($1,767,512)	($417,266)	($183,069)	($12,808,141)	($1,228,645)	($1,408,973)	($845,590)	($96,386)	($41,156,124)
Estimated FY 2014-15 Expenditure	**$97,407,731**	**$80,168,597**	**$627,090,050**	**$81,894,058**	**$270,175,801**	**$83,634,713**	**$124,721,675**	**$92,898,634**	**$10,992,241**	**$586,138,111**	**$60,797,400**	**$71,348,795**	**$53,543,851**	**$8,713,895**	**$2,249,525,552**
Estimated FY 2014-15 Per Capita	$2,314.77	$8,162.15	$9,808.24	$9,787.74	$3,421.77	$2,662.34	$2,534.48	$9,289.86	$16,165.06	$1,372.99	$3,338.87	$7,791.72	$18,715.08	$351.65	$2,897.45
% Change over FY 2013-14 Per Capita	-1.99%	-0.26%	0.61%	1.95%	-0.96%	0.54%	0.86%	2.81%	-2.43%	-2.14%	-0.05%	-3.54%	5.78%	6.22%	-0.82%

Footnotes

(1) Percentage selected to modify Per Capita amounts for Estimated FY 2012-13: Where applicable, percentage selections have been bolded for clarification.	**OAP-A**	The per capita growth from FY 2003-04 to FY 2004-05	**Exp. Adults to 60%**	2.18% or a continuation of the forecasted growth for all expansion adults as reported in the February, 2011 forecast	**Foster Care**	One half the average per capita growth rate from FY 2007-08 through FY 2010-11
	OAP-B	The average per capita growth from FY 2007-08 through FY 2009-10	**Exp. Adults to 100%**	8.21% or the percentage necessary to achieve convergence to 95% of the Expansion to 60% population	**BC Adults**	One half the average per capita growth from FY 2006-07 through FY 2009-10
	AND/AB	The per capita growth from FY 2009-10 to FY 2010-11	**AWDC**	Weighted per capita equal to 90% of the AND/AB per capita and 10% of the AFDC-A per capita	**Non-Citizens**	The average per capita growth from FY 2005-06 through FY 2008-09
	Disabled Buy-in	Weighted average disabled populations per capita	**BCCP**	See EF-8	**Partial Dual Eligibles**	Average of FY 2007-08 through FY 2010-11
	AFDC-A	The per capita growth rate from FY 2005-06	**Elig. Children**	One half the per capita growth rate from FY 2009-10 to FY 2010-11		
(2) Percentage selected to modify Per Capita amounts for Estimated FY 2013-14: Where applicable, percentage selections have been italicized for clarification.	**OAP-A**	The per capita growth from FY 2003-04 to FY 2004-05	**Exp. Adults to 60%**	2.18% or a continuation of the forecasted growth for all expansion adults as reported in the February, 2011 forecast	**Foster Care**	One half the average per capita growth rate from FY 2007-08 through FY 2010-11
	OAP-B	The average per capita growth from FY 2007-08 through FY 2009-10	**Exp. Adults to 100%**	2.03% or the percentage necessary to achieve convergence to 95% of the Expansion to 60% population	**BC Adults**	One half the average per capita growth from FY 2006-07 through FY 2009-10
	AND/AB	The per capita growth from FY 2009-10 to FY 2010-11	**AWDC**	Weighted per capita equal to 90% of the AND/AB per capita and 10% of the AFDC-A per capita	**Non-Citizens**	The average per capita growth from FY 2005-06 through FY 2008-09
	Disabled Buy-in	Same per capita growth as AND/AB	**BCCP**	See EF-8	**Partial Dual**	Average of FY 2007-08 through FY 2010-11
	AFDC-A	The per capita growth rate from FY 2005-06	**Elig. Children**	One half the per capita growth rate from FY 2009-10 to FY 2010-11		
(3) Percentage selected to modify Per Capita amounts for Estimated FY 2014-15: Where applicable, percentage selections have been italicized for clarification.	**OAP-A**	The per capita growth from FY 2003-04 to FY 2004-05	**Exp. Adults to 60%**	2.18% or a continuation of the forecasted growth for all expansion adults as reported in the February, 2011 forecast	**Foster Care**	One half the average per capita growth rate from FY 2007-08 through FY 2010-11
	OAP-B	The average per capita growth from FY 2007-08 through FY 2009-10	**Exp. Adults to 100%**	2.29% or the percentage necessary to achieve convergence to 95% of the Expansion to 60% population	**BC Adults**	One half the average per capita growth from FY 2006-07 through FY 2009-10
	AND/AB	The per capita growth from FY 2009-10 to FY 2010-11	**AWDC**	Weighted per capita equal to 90% of the AND/AB per capita and 10% of the AFDC-A per capita	**Non-Citizens**	The average per capita growth from FY 2005-06 through FY 2008-09
	Disabled Buy-in	Same per capita growth as AND/AB	**BCCP**	See EF-8	**Partial Dual**	Average of FY 2007-08 through FY 2010-11
	AFDC-A	The per capita growth rate from FY 2005-06	**Elig. Children**	No per capita growth anticipated		

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

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

Month	Total[1]	Caseload	Monthly Per Capita	Rolling 3-Month Per Capita	Percent Change
October 2010	$731,130	505	$1,447.78	-	-
November 2010	$838,350	511	$1,640.61	-	-
December 2010	$641,895	526	$1,220.33	$4,308.72	-
January 2011	$858,219	532	$1,613.19	$4,474.13	3.84%
February 2011	$860,735	535	$1,608.85	$4,442.37	-0.71%
March 2011	$758,865	556	$1,364.87	$4,586.91	3.25%
April 2011	$842,553	569	$1,480.76	$4,454.48	-2.89%
May 2011	$977,078	587	$1,664.53	$4,510.16	1.25%
June 2011	$796,240	589	$1,351.85	$4,497.14	-0.29%
July 2011	$905,622	587	$1,542.80	$4,559.18	1.38%
August 2011	$1,098,058	586	$1,873.82	$4,768.47	4.59%
September 2011	$806,654	590	$1,367.21	$4,783.83	0.32%
October 2011	$840,959	592	$1,420.54	$4,661.57	-2.56%
November 2011	$777,937	602	$1,292.25	$4,080.00	-12.48%
December 2011	$948,163	606	$1,564.63	$4,277.42	4.84%
January 2012	$759,376	603	$1,259.33	$4,116.21	-3.77%
February 2012	$807,113	604	$1,336.28	$4,160.24	1.07%
March 2012	$896,406	604	$1,484.12	$4,079.73	-1.94%
April 2012	$931,643	596	$1,563.16	$4,383.56	7.45%
May 2012	$713,371	597	$1,194.93	$4,242.21	-3.22%
June 2012	$787,309	601	$1,310.00	$4,068.09	-4.10%
Selected Trend Factor[2]					
FY 2011-12 Totals[3]	$10,301,457	621	$16,588.50		**-3.24%**
FY 2012-13 Totals[3]	$10,852,352	655	$16,568.48		**-1.62%**
FY 2013-14 Totals[3]	$10,992,241	680	$16,165.06		**-0.81%**

Footnotes

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

(2) The selected trend factors were calculated using a regression model of the rolling 3-month per capita expenditures from April 2007 to June 2012. The model controls for caseload, time, and seasonality. The trend factor is the average of the rolling average percent changes of the predicted values from the regression model for each fiscal year, annualized to adjust for a full-year effect. The rate of decline is reduced in future years.

(3) The FY 2012-13, FY 2013-14, and FY 2014-15 totals are calculated on pages EF-2 through EF-4 and include bottom line impacts. Caseload totals are taken from Exhibit B.

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

Breast and Cervical Cancer Program Fund Splits

FY 2012-13 Fund Splits	Per Capita	Allocation	Caseload	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Medicaid Breast and Cervical Cancer Program Clients(5)		66.29%	412	$6,829,057	$1,195,085	$1,195,085	$0	$4,438,887
Health Care Expansion Breast and Cervical Cancer Program Clients(4)		33.71%	209	$3,472,400	$0	$0	$1,215,340	$2,257,060
Total	**$16,588.50**	**100.00%**	**621**	**$10,301,457**	**$1,195,085**	**$1,195,085**	**$1,215,340**	**$6,695,947**

FY 2013-14 Fund Splits	Per Capita	Allocation	Caseload	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Medicaid Breast and Cervical Cancer Program Clients(5)		68.00%	445	$7,379,952	$1,291,492	$1,291,491	$0	$4,796,969
Health Care Expansion Breast and Cervical Cancer Program Clients(4)		32.00%	210	$3,472,400	$0	$0	$1,215,340	$2,257,060
Total	**$16,568.48**	**100.00%**	**655**	**$10,852,352**	**$1,291,492**	**$1,291,491**	**$1,215,340**	**$7,054,029**

FY 2014-15 Fund Splits	Per Capita	Allocation	Caseload	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Medicaid Breast and Cervical Cancer Program Clients(6)		68.41%	465	$7,519,841	$2,631,944	$0	$0	$4,887,897
Health Care Expansion Breast and Cervical Cancer Program Clients(4)		31.59%	215	$3,472,400	$0	$0	$1,215,340	$2,257,060
Total	**$16,165.06**	**100.00%**	**680**	**$10,992,241**	**$2,631,944**	**$0**	**$1,215,340**	**$7,144,957**

(4) 24-22-117 (2) (d) (II), C.R.S. (2011). 35% RF from the Prevention, Early Detection, and Treatment fund, 65% FFP.

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

(6) The cash fund associated with this program sunsets July 1, 2014.

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

Cash Based Actuals

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2002-03	$4,664,387	$916,979	$17,700,825	$0	$519,527	$0	$0	$0	$2,839	$783,549	$3,789,992	$11,356	$0	$0	$28,389,454
FY 2003-04	$6,372,432	$1,298,597	$25,500,975	$0	$1,057,440	$0	$0	$0	$3,389	$1,296,760	$5,340,219	$29,882	$0	$0	$40,899,694
FY 2004-05	$6,629,621	$1,760,042	$28,042,949	$0	$1,378,076	$0	$0	$0	$3,654	$1,795,300	$6,321,954	$22,953	$0	$0	$45,954,548
FY 2005-06	$4,033,428	$1,685,933	$24,178,645	$0	$1,633,973	$0	$0	$0	$326	$1,935,729	$7,189,609	$22,633	$0	$0	$40,680,277
FY 2006-07	$479,529	$1,222,769	$19,965,507	$0	$2,000,023	$110,237	$0	$0	$183	$2,688,319	$7,814,333	$13,828	$0	$0	$34,294,729
FY 2007-08	$476,587	$1,416,439	$22,587,953	$0	$2,257,237	$326,303	$0	$0	$7,201	$3,116,761	$8,901,950	$23,191	$0	$0	$39,113,622
FY 2008-09	$574,003	$1,594,319	$22,596,632	$0	$3,156,992	$432,485	$0	$0	$13,539	$3,477,458	$8,956,851	$50,359	$0	$0	$40,852,638
FY 2009-10[1]	$624,336	$1,845,804	$23,477,770	$0	$3,457,524	$786,684	$66,514	$0	$31,055	$3,652,240	$8,663,502	$61,246	$0	$0	$42,666,675
FY 2010-11[1]	$528,892	$2,236,572	$27,074,670	$0	$3,220,104	$1,549,338	$469,727	$0	$41,477	$3,795,327	$8,465,862	$77,588	$0	$0	$47,459,557
FY 2011-12	$332,196	$2,736,142	$29,681,347	$3,181	$4,000,973	$1,331,911	$1,369,338	$51,852	$45,428	$4,356,981	$8,441,242	$76,112	$0	$0	$52,426,702

Percent Change in Cash Based Actuals

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	4.04%	35.53%	9.97%	0.00%	30.32%	0.00%	0.00%	0.00%	7.85%	38.44%	18.38%	-23.19%	0.00%	0.00%	12.36%
FY 2005-06	-39.16%	-4.21%	-13.78%	0.00%	18.57%	0.00%	0.00%	0.00%	-91.07%	7.82%	13.72%	-1.39%	0.00%	0.00%	-11.48%
FY 2006-07	-88.11%	-27.47%	-17.43%	0.00%	22.40%	0.00%	0.00%	0.00%	-44.00%	38.88%	8.69%	-38.90%	0.00%	0.00%	-15.70%
FY 2007-08	-0.61%	15.84%	13.13%	0.00%	12.86%	196.00%	0.00%	0.00%	3839.28%	15.94%	13.92%	67.71%	0.00%	0.00%	14.05%
FY 2008-09	20.44%	12.56%	0.04%	0.00%	39.86%	32.54%	0.00%	0.00%	88.02%	11.57%	0.62%	117.15%	0.00%	0.00%	4.45%
FY 2009-10	8.77%	15.77%	3.90%	0.00%	9.52%	81.90%	0.00%	0.00%	129.37%	5.03%	-3.28%	21.62%	0.00%	0.00%	4.44%
FY 2010-11	-15.29%	21.17%	15.32%	0.00%	-6.87%	96.95%	606.21%	0.00%	33.56%	3.92%	-2.28%	26.68%	0.00%	0.00%	11.23%
FY 2011-12	-37.19%	22.34%	9.63%	0.00%	24.25%	-14.03%	191.52%	0.00%	9.53%	14.80%	-0.29%	-1.90%	0.00%	0.00%	10.47%

Per Capita Cost

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$185.63	$234.07	$545.02	$0.00	$22.23	$0.00	$0.00	$0.00	$32.27	$6.64	$358.07	$3.56	$0.00	$0.00	$111.27
FY 2004-05	$185.29	$289.39	$585.09	$0.00	$24.12	$0.00	$0.00	$0.00	$42.01	$8.07	$400.25	$3.84	$0.00	$0.00	$113.18
FY 2005-06	$111.40	$279.04	$505.25	$0.00	$27.75	$0.00	$0.00	$0.00	$1.74	$9.04	$436.79	$4.42	$0.00	$0.00	$101.14
FY 2006-07	$13.36	$201.81	$409.14	$0.00	$39.46	$21.36	$0.00	$0.00	$0.80	$13.09	$467.25	$2.67	$0.00	$0.00	$87.44
FY 2007-08	$13.13	$230.47	$452.37	$0.00	$50.66	$36.59	$0.00	$0.00	$26.67	$15.28	$519.34	$3.69	$0.00	$0.00	$99.79
FY 2008-09	$15.26	$247.30	$440.01	$0.00	$64.24	$33.98	$0.00	$0.00	$42.71	$14.79	$496.69	$7.22	$0.00	$0.00	$93.52
FY 2009-10	$16.22	$261.85	$440.78	$0.00	$59.96	$45.80	$20.54	$0.00	$73.07	$13.25	$471.33	$7.82	$0.00	$0.00	$85.54
FY 2010-11	$13.59	$287.96	$481.03	$0.00	$52.82	$76.87	$17.29	$0.00	$78.11	$12.55	$460.28	$9.86	$0.00	$0.00	$84.63
FY 2011-12	$8.36	$326.39	$499.40	$61.17	$58.25	$54.29	$38.62	$45.72	$76.09	$13.02	$468.07	$9.98	$0.00	$0.00	$84.56

Percent Change in Per Capita Cost

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-0.18%	23.63%	7.35%	0.00%	8.50%	0.00%	0.00%	0.00%	30.18%	21.54%	11.78%	7.87%	0.00%	0.00%	1.72%
FY 2005-06	-39.88%	-3.58%	-13.65%	0.00%	15.05%	0.00%	0.00%	0.00%	-95.86%	12.02%	9.13%	15.10%	0.00%	0.00%	-10.64%
FY 2006-07	-88.01%	-27.68%	-19.02%	0.00%	42.20%	0.00%	0.00%	0.00%	-54.02%	44.80%	6.97%	-39.59%	0.00%	0.00%	-13.55%
FY 2007-08	-1.72%	14.20%	10.57%	0.00%	28.38%	71.30%	0.00%	0.00%	3233.75%	16.73%	11.15%	38.20%	0.00%	0.00%	14.12%
FY 2008-09	16.22%	7.30%	-2.73%	0.00%	26.81%	-7.13%	0.00%	0.00%	60.14%	-3.21%	-4.36%	95.66%	0.00%	0.00%	-6.28%
FY 2009-10	6.29%	5.88%	0.17%	0.00%	-6.66%	34.79%	0.00%	0.00%	71.08%	-10.41%	-5.11%	8.31%	0.00%	0.00%	-8.53%
FY 2010-11	-16.21%	9.97%	9.13%	0.00%	-11.91%	67.84%	-15.82%	0.00%	6.90%	-5.28%	-2.34%	26.09%	0.00%	0.00%	-1.06%
FY 2011-12	-38.48%	13.35%	3.82%	0.00%	10.28%	-29.37%	123.37%	0.00%	-2.59%	3.75%	1.69%	1.22%	0.00%	0.00%	-0.08%

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

Cash Based Actuals

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$5,090,144	$1,037,288	$20,369,563	$0	$844,658	$0	$0	$0	$2,707	$1,035,821	$4,265,638	$23,869	$0	$0	$32,669,688
FY 2004-05	$4,938,612	$1,311,110	$20,890,071	$0	$1,026,572	$0	$0	$0	$2,722	$1,337,375	$4,709,421	$17,098	$0	$0	$34,232,981
FY 2005-06	$2,687,488	$1,123,343	$16,110,320	$0	$1,088,722	$0	$0	$0	$217	$1,289,783	$4,790,463	$15,081	$0	$0	$27,105,417
FY 2006-07	$331,389	$845,022	$13,797,610	$0	$1,382,161	$76,182	$0	$0	$126	$1,857,823	$5,400,269	$9,556	$0	$0	$23,700,138
FY 2007-08	$354,695	$1,054,171	$16,810,867	$0	$1,679,927	$242,848	$0	$0	$5,359	$2,319,619	$6,625,191	$17,260	$0	$0	$29,109,937
FY 2008-09	$358,015	$994,403	$14,093,890	$0	$1,969,068	$269,748	$0	$0	$8,444	$2,168,948	$5,586,535	$31,410	$0	$0	$25,480,461
FY 2009-10	$359,915	$1,064,063	$13,534,393	$0	$1,993,183	$453,505	$38,344	$0	$17,902	$2,105,432	$4,994,309	$35,307	$0	$0	$24,596,353
FY 2010-11	$288,997	$1,222,105	$14,794,110	$0	$1,759,526	$846,587	$256,668	$0	$22,664	$2,073,838	$4,625,906	$42,396	$0	$0	$25,932,797
FY 2011-12	$181,304	$1,493,315	$16,199,299	$1,736	$2,183,626	$726,922	$747,348	$28,299	$24,793	$2,377,926	$4,607,008	$41,540	$0	$0	$28,613,116

Percent Change in Cash Based Actuals

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-2.98%	26.40%	2.56%	0.00%	21.54%	0.00%	0.00%	0.00%	0.55%	29.11%	10.40%	-28.37%	0.00%	0.00%	4.79%
FY 2005-06	-45.58%	-14.32%	-22.88%	0.00%	6.05%	0.00%	0.00%	0.00%	-92.03%	-3.56%	1.72%	-11.80%	0.00%	0.00%	-20.82%
FY 2006-07	-87.67%	-24.78%	-14.36%	0.00%	26.95%	0.00%	0.00%	0.00%	-41.94%	44.04%	12.73%	-36.64%	0.00%	0.00%	-12.56%
FY 2007-08	7.03%	24.75%	21.84%	0.00%	21.54%	218.77%	0.00%	0.00%	4153.17%	24.86%	22.68%	80.62%	0.00%	0.00%	22.83%
FY 2008-09	0.94%	-5.67%	-16.16%	0.00%	17.21%	11.08%	0.00%	0.00%	57.57%	-6.50%	-15.68%	81.98%	0.00%	0.00%	-12.47%
FY 2009-10	0.53%	7.01%	-3.97%	0.00%	1.22%	68.12%	0.00%	0.00%	112.01%	-2.93%	-10.60%	12.41%	0.00%	0.00%	-3.47%
FY 2010-11	-19.70%	14.85%	9.31%	0.00%	-11.72%	86.68%	569.38%	0.00%	26.60%	-1.50%	-7.38%	20.08%	0.00%	0.00%	5.43%
FY 2011-12	-37.26%	22.19%	9.50%	0.00%	24.10%	-14.13%	191.17%	0.00%	9.39%	14.66%	-0.41%	-2.02%	0.00%	0.00%	10.34%

Per Capita Cost

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$148.28	$186.97	$435.35	$0.00	$17.76	$0.00	$0.00	$0.00	$25.78	$5.30	$286.02	$2.84	$0.00	$0.00	$88.88
FY 2004-05	$138.03	$215.57	$435.85	$0.00	$17.97	$0.00	$0.00	$0.00	$31.29	$6.01	$298.16	$2.86	$0.00	$0.00	$84.31
FY 2005-06	$74.23	$185.92	$336.65	$0.00	$18.49	$0.00	$0.00	$0.00	$1.15	$6.02	$291.04	$2.95	$0.00	$0.00	$67.39
FY 2006-07	$9.23	$139.47	$282.74	$0.00	$27.27	$14.76	$0.00	$0.00	$0.55	$9.05	$322.91	$1.84	$0.00	$0.00	$60.42
FY 2007-08	$9.78	$171.52	$336.67	$0.00	$37.70	$27.23	$0.00	$0.00	$19.85	$11.37	$386.51	$2.74	$0.00	$0.00	$74.27
FY 2008-09	$9.52	$154.24	$274.44	$0.00	$40.06	$21.19	$0.00	$0.00	$26.64	$9.22	$309.80	$4.50	$0.00	$0.00	$58.33
FY 2009-10	$9.35	$150.95	$254.10	$0.00	$34.57	$26.40	$11.84	$0.00	$42.12	$7.64	$271.71	$4.51	$0.00	$0.00	$49.31
FY 2010-11	$7.43	$157.35	$262.84	$0.00	$28.86	$42.01	$9.45	$0.00	$42.68	$6.86	$251.50	$5.39	$0.00	$0.00	$46.25
FY 2011-12	$4.56	$178.14	$272.56	$33.38	$31.79	$29.63	$21.08	$24.96	$41.53	$7.11	$255.46	$5.44	$0.00	$0.00	$46.15

Percent Change in Per Capita Cost

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-6.91%	15.30%	0.11%	0.00%	1.18%	0.00%	0.00%	0.00%	21.37%	13.40%	4.24%	0.70%	0.00%	0.00%	-5.14%
FY 2005-06	-46.22%	-13.75%	-22.76%	0.00%	2.89%	0.00%	0.00%	0.00%	-96.32%	0.17%	-2.39%	3.15%	0.00%	0.00%	-20.07%
FY 2006-07	-87.57%	-24.98%	-16.01%	0.00%	47.49%	0.00%	0.00%	0.00%	-52.17%	50.33%	10.95%	-37.63%	0.00%	0.00%	-10.34%
FY 2007-08	5.96%	22.98%	19.07%	0.00%	38.25%	84.49%	0.00%	0.00%	3509.09%	25.64%	19.70%	48.91%	0.00%	0.00%	22.92%
FY 2008-09	-2.66%	-10.07%	-18.48%	0.00%	6.26%	-22.18%	0.00%	0.00%	34.21%	-18.91%	-19.85%	64.23%	0.00%	0.00%	-21.46%
FY 2009-10	-1.79%	-2.13%	-7.41%	0.00%	-13.70%	24.59%	0.00%	0.00%	58.11%	-17.14%	-12.30%	0.22%	0.00%	0.00%	-15.46%
FY 2010-11	-20.53%	4.24%	3.44%	0.00%	-16.52%	59.13%	-20.19%	0.00%	1.33%	-10.21%	-7.44%	19.51%	0.00%	0.00%	-6.21%
FY 2011-12	-38.63%	13.21%	3.70%	0.00%	10.15%	-29.47%	123.07%	0.00%	-2.69%	3.64%	1.57%	0.93%	0.00%	0.00%	-0.22%

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

Estimated Increase in Rebates Attributable to the Affordable Care Act

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	Percentage Change[(2)]
FY 2010-11[(1)]	$2,623,793	$2,663,517	$2,986,818	$2,724,952	$10,999,080	-
FY 2011-12[(1)]	$3,079,979	$3,164,919	$3,074,020	$3,278,629	$12,597,547	14.53%
FY 2012-13[(2)]	$3,527,584	$3,624,868	$3,520,759	$3,755,104	$14,428,315	14.53%
FY 2013-14[(2)]	$4,040,239	$4,151,661	$4,032,422	$4,300,822	$16,525,144	14.53%
FY 2014-15[(2)]	$4,627,396	$4,755,011	$4,618,443	$4,925,849	$18,926,699	14.53%

(1) Historical actuals have been restated as the Department has transitioned from an accrual-based reconciliation to cash-based reconciliation process in FY 2011-12 to prevent overstatement of federal funds only rebate revenue actually received by the state.

(2) The estimated FY 2012-13 growth rate is held constant for the request and out years and is equal the percentage change from FY 2010-11 to FY 2011-12.

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

Total Expenditure

Fiscal Year	Total Reported Expenditures	General Fund	Cash Funds [1]	Federal Funds (90% FMAP)	Change	% Change
FY 2000-01	$2,438,198	$243,820	$0	$2,194,378	($1,518,369)	-38.38%
FY 2001-02	$5,111,123	$511,112	$0	$4,600,011	$2,672,925	109.63%
FY 2002-03	$6,538,073	$653,807	$0	$5,884,266	$1,426,950	27.92%
FY 2003-04	$6,061,856	$606,186	$0	$5,455,670	($476,217)	-7.28%
FY 2004-05	$8,019,717	$801,972	$0	$7,217,745	$1,957,861	32.30%
FY 2005-06	$8,260,397	$826,040	$0	$7,434,357	$240,680	3.00%
FY 2006-07	$8,343,188	$834,319	$0	$7,508,869	$82,791	1.00%
FY 2007-08	$9,902,250	$990,225	$0	$8,912,025	$1,559,062	18.69%
FY 2008-09	$13,893,561	$1,389,356	$0	$12,504,205	$3,991,311	40.31%
FY 2009-10	$12,619,883	$1,261,988	$0	$11,357,895	($1,273,678)	-9.17%
FY 2010-11	$13,895,800	$1,389,580	$0	$12,506,220	$1,275,917	10.11%
FY 2011-12	$11,795,916	$1,160,689	$18,903	$10,616,324	($2,099,884)	-15.11%
FY 2012-13 Estimate[2]	$13,051,290	$1,291,803	$13,327	$11,746,160	$1,255,374	10.64%
FY 2013-14 Estimate[2]	$13,312,316	$1,317,452	$13,780	$11,981,084	$261,026	2.00%
FY 2014-15 Estimate[2]	$13,578,562	$1,343,609	$14,248	$12,220,705	$266,246	2.00%

[1] SB 11-177 extended and expanded the Teen Pregnancy and Dropout Prevention program. The Department receives local funds to provide services for the program. The cash fund expenditures in FY 2011-12, FY 2012-13, FY 2013-14, and FY 2014-15 represent the contributions -- actual and anticipated -- of this program.

[2] The FY 2012-13 estimate for total reported expenditures is the average of annual total reported expenditures for FY 2008-09 -- FY 2011-12. Estimates for FY 2013-14 and FY 2014-15 are the result of the application of the average growth rates for FY 2005-06 and FY 2006-07 to the previous year's estimated total reported expenditure.

Breakdown of Total Expenditure

Fiscal Year	Fee-for-Service Family Planning	Change in Fee-for-Service Expenditure	Percent Change in Fee-for-Service Expenditure	Managed Care Family Planning	Change in Managed Care Expenditure	Percent Change in Managed Care Expenditure
FY 2000-01	$2,438,198	($1,518,369)	-38.38%	$0	$0	0.00%
FY 2001-02	$2,763,372	$325,174	13.34%	$2,347,751	$2,347,751	0.00%
FY 2002-03	$3,094,894	$331,522	12.00%	$3,443,179	$1,095,428	100.00%
FY 2003-04	$4,058,413	$963,519	31.13%	$2,003,442	($1,439,737)	-41.81%
FY 2004-05	$6,902,883	$2,844,470	70.09%	$1,116,833	($886,609)	-44.25%
FY 2005-06	$7,013,966	$111,083	1.61%	$1,246,431	$129,598	11.60%
FY 2006-07	$7,431,084	$417,118	5.95%	$912,103	($334,328)	-26.82%
FY 2007-08	$9,139,367	$1,708,283	22.99%	$762,883	($149,220)	-16.36%
FY 2008-09	$13,472,771	$4,333,404	47.41%	$420,790	($342,093)	-44.84%
FY 2009-10	$12,533,203	($939,568)	-6.97%	$86,680	($334,110)	-79.40%
FY 2010-11	$12,375,827	($157,376)	-1.26%	$1,519,973	$1,433,293	1653.55%
FY 2011-12	$10,329,972	($2,045,855)	-16.53%	$1,465,943	($54,030)	-3.55%

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

Total Expenditure for Indian Health Service			
Fiscal Year	**Total Reported Expenditures: 100% FF**	**Change**	**% Change**
FY 2001-02	$100,299	$100,299	-
FY 2002-03	$511,451	$411,152	409.93%
FY 2003-04	$813,791	$302,340	59.11%
FY 2004-05	$922,761	$108,970	13.39%
FY 2005-06	$840,371	($82,390)	-8.93%
FY 2006-07	$899,521	$59,150	7.04%
FY 2007-08	$1,061,989	$162,468	18.06%
FY 2008-09	$1,534,327	$472,338	44.48%
FY 2009-10	$1,536,532	$2,205	0.14%
FY 2010-11	$1,672,353	$135,821	8.84%
FY 2011-12	$1,434,711	($237,642)	-14.21%
FY 2012-13 Estimated Total(1)	$1,499,130	$64,419	4.49%
FY 2013-14 Estimated Total(1)	$1,566,440	$67,311	4.49%
FY 2014-15 Estimated Total(1)	$1,636,774	$70,333	4.49%

(1) The trend for FY 2012-13, FY 2013-14, and FY 2014-15 is the average of the growth rates for FY 2009-10 and FY 2010-11.

Exhibit F - ACUTE CARE - Expenditure by Half-Year

FY 2011-12 July-December COFRS Total Actuals															
ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Physician Services & EPSDT	$1,827,938	$3,721,993	$27,588,875	$0	$26,163,326	$6,116,254	$8,186,695	$0	$0	$53,917,725	$5,260,980	$8,552,272	$3,185,827	$1,938	$144,523,823
Emergency Transportation	$58,217	$132,985	$1,050,433	$0	$583,358	$132,745	$154,893	$0	$0	$807,908	$108,965	$106,867	$44,155	$0	$3,180,526
Non-Emergency Medical Transportation	$986,931	$483,881	$2,478,453	$0	$185,591	$43,113	$53,065	$0	$0	$580,862	$70,738	$30,984	$955	$0	$4,914,573
Dental Services	$582,895	$137,606	$2,555,922	$0	$2,129,656	$547,886	$702,005	$0	$0	$43,463,649	$2,610,687	$185,506	$1,782	$0	$52,917,594
Family Planning	$0	$0	$7,166	$0	$69,513	$22,656	$34,362	$0	$0	$57,791	$20,755	$10,250	$0	$0	$222,493
Health Maintenance Organizations	$3,646,478	$3,540,861	$21,158,832	$0	$9,458,058	$2,716,063	$4,065,910	$0	$0	$19,016,005	$454,866	$612,606	$0	$0	$64,669,679
Inpatient Hospitals	$6,887,529	$7,343,286	$58,522,136	$0	$27,548,232	$4,757,139	$6,365,197	$0	$0	$39,881,082	$2,339,122	$13,910,731	$17,767,681	($12,548)	$185,309,587
Outpatient Hospitals	$1,439,631	$2,994,575	$25,298,006	$0	$22,559,226	$6,768,544	$8,648,462	$0	$0	$34,014,041	$2,850,961	$2,624,026	$584,184	$0	$107,781,656
Lab & X-Ray	$236,177	$425,968	$3,541,440	$0	$5,813,639	$1,532,229	$1,908,032	$0	$0	$3,571,283	$813,148	$1,797,553	$67,887	($47)	$19,707,309
Durable Medical Equipment	$9,472,628	$2,604,386	$24,837,658	$0	$1,461,328	$541,978	$607,153	$0	$0	$4,661,719	$2,269,344	$90,091	$0	$11,441	$46,557,726
Prescription Drugs	$3,629,896	$9,193,355	$65,740,485	$0	$20,378,113	$6,965,625	$8,294,003	$0	$0	$29,191,796	$10,391,284	$1,195,522	$0	$0	$154,980,079
Drug Rebate	($1,629,673)	($4,127,434)	($29,514,746)	$0	($9,148,926)	($3,127,276)	($3,723,663)	$0	$0	($13,105,904)	($4,665,255)	($536,740)	$0	$0	($69,579,617)
Rural Health Centers	$30,606	$126,749	$603,170	$0	$755,314	$258,700	$312,990	$0	$0	$2,744,845	$169,529	$152,302	$14,208	$0	$5,168,413
Federally Qualified Health Centers	$461,234	$536,096	$4,257,418	$0	$7,002,072	$1,711,267	$2,367,572	$0	$0	$28,071,118	$1,001,045	$2,542,573	$200,662	$0	$48,151,057
Co-Insurance (Title XVIII-Medicare)	$5,809,534	$967,030	$3,883,614	$0	$54,852	$104,669	$219,155	$0	$0	$13,070	$7,633	$16,763	$23	$1,810,497	$12,886,840
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$0	$5,377,394	$0	$0	$0	$0	$0	$5,377,394
Administrative Service Organizations - Services	$1,213,823	$1,451,664	$11,604,595	$0	$4,984,093	$1,347,051	$1,521,134	$0	$0	$5,314,760	$1,384,734	$1,481,212	$0	$0	$30,303,066
Other Medical Services	($1)	$0	($4)	$0	($2)	$0	($1)	$0	$0	($3)	$0	$0	$0	$0	($11)
Home Health	$11,893,229	$3,972,707	$60,221,569	$0	$214,110	$70,924	$88,859	$0	$0	$2,175,168	$5,710,699	$35,824	$0	$80,915	$84,464,004
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$46,547,073	$33,505,706	$283,835,020	$0	$120,211,552	$30,509,567	$39,805,824	$0	$5,377,394	$254,376,914	$30,799,233	$32,808,342	$21,867,365	$1,892,196	$901,536,186
Caseload	39,635	8,277	58,964	-	67,889	22,937	33,529	-	594	327,398	18,112	7,581	2,771	18,304	605,989
Half -Year Per Capita	$1,171.29	$3,997.02	$4,775.67	$0.00	$1,750.09	$1,243.52	$1,122.52	$0.00	$9,002.33	$760.17	$1,707.81	$4,300.20	$7,894.36	$100.27	$1,454.18

FY 2011-12 January-June COFRS Total Actuals															
ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Physician Services & EPSDT	$1,668,088	$3,389,329	$26,723,810	$65,386	$25,070,647	$6,711,036	$8,542,594	$254,561	$0	$54,302,364	$5,021,313	$8,089,602	$2,655,837	$1,849	$142,496,416
Emergency Transportation	$69,171	$151,088	$1,081,034	$133	$560,264	$140,315	$171,267	$26,001	$0	$791,530	$85,742	$60,723	$43,269	($5)	$3,180,532
Non-emergency Medical Transportation	$1,183,770	$523,960	$2,756,635	$443	$211,515	$69,633	$77,739	$1,752	$0	$636,627	$60,681	$24,791	$275	($228)	$5,547,593
Dental Services	$644,728	$190,966	$2,460,702	$1,339	$2,051,757	$686,355	$787,784	$36,007	$0	$41,627,679	$2,352,022	$151,283	$3,571	$0	$50,994,193
Family Planning	$0	$168	$9,706	$94	$112,078	$35,263	$54,537	$1,072	$0	$99,393	$31,846	$12,307	$0	$0	$356,464
Health Maintenance Organizations	$2,790,504	$3,141,489	$18,254,701	$6,100	$7,692,581	$2,687,469	$3,725,582	$0	$0	$16,903,336	$390,181	$454,289	$0	$0	$56,046,232
Inpatient Hospitals	$6,774,306	$7,996,804	$56,060,500	$177,773	$26,065,379	$4,663,383	$6,599,769	$891,142	$0	$36,160,105	$2,551,182	$13,036,855	$16,216,406	($574)	$177,193,030
Outpatient Hospitals	$1,515,403	$3,286,511	$27,483,911	$73,670	$25,937,359	$8,900,285	$10,891,311	$570,577	$0	$39,397,673	$2,909,968	$2,837,392	$894,130	$0	$124,698,190
Lab & X-Ray	$223,186	$446,775	$3,420,989	$4,882	$5,905,851	$1,628,593	$2,035,290	$72,092	$0	$3,691,978	$914,491	$1,851,482	$74,716	$369	$20,270,694
Durable Medical Equipment	$8,976,540	$2,763,495	$25,187,968	$5,509	$1,578,040	$607,765	$689,862	$19,968	$0	$5,173,476	$2,067,674	$69,903	$0	$8,526	$47,148,726
Prescription Drugs	$3,264,380	$9,392,985	$66,265,481	$66,035	$21,312,205	$7,672,600	$9,616,506	$486,584	$0	$33,926,739	$10,691,192	$1,066,675	$0	$0	$163,761,382
Drug Rebate	($1,610,176)	($4,606,904)	($32,519,240)	($31,032)	($10,442,738)	($3,751,712)	($4,693,080)	($228,662)	$0	($16,555,591)	($5,242,100)	($526,341)	$0	$0	($80,207,576)
Rural Health Centers	$29,307	$170,573	$629,814	$272	$849,312	$312,595	$337,772	$8,863	$0	$2,752,584	$141,433	$158,045	$8,933	$0	$5,399,503
Federally Qualified Health Centers	$484,161	$532,336	$4,048,304	$7,949	$6,801,064	$1,900,106	$2,554,451	$252,682	$0	$26,415,934	$926,089	$2,545,076	$171,107	$167	$46,639,426
Co-Insurance (Title XVIII-Medicare)	$10,872,405	$1,755,337	$7,332,042	$5,057	$104,049	$198,423	$410,168	$0	$0	$13,153	$9,821	$24,477	$1,950	$3,422,830	$24,149,712
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$0	$4,895,219	$0	$0	$0	$0	$0	$4,895,219
Administrative Service Organizations - Services	$595,120	$880,195	$6,469,492	$14,849	$2,912,637	$1,012,842	$1,346,464	$0	$0	$11,342,573	$947,495	$638,386	$0	$0	$26,160,053
Other Medical Services	$767	$590	$4,860	$3	$2,019	$556	$719	$21	$84	$4,259	$543	$504	$339	$42	$15,306
Home Health	$10,368,260	$3,488,992	$56,287,105	$0	$208,536	$45,820	$65,619	$490	$0	$1,914,673	$4,666,986	$14,211	$268	$82,769	$77,143,729
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$47,849,920	$33,504,689	$271,957,814	$398,462	$116,932,555	$33,521,327	$43,214,354	$2,393,150	$4,895,303	$258,598,485	$28,526,559	$30,509,660	$20,070,801	$3,515,745	$895,888,824
Caseload	39,846	8,489	59,903	104	69,488	26,133	37,394	2,269	601	341,869	17,957	7,678	2,769	19,439	633,938
Half -Year Per Capita	$1,200.88	$3,947.07	$4,539.96	$3,819.12	$1,682.77	$1,282.73	$1,155.66	$1,054.79	$8,147.52	$756.43	$1,588.65	$3,973.65	$7,248.83	$180.86	$1,413.21

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

Cash Based Actuals

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$68,586,556	$6,965,845	$47,097,650	$0	$4,471	$0	$0	$0	$0	$4,567	$92,418	$0	$0	$1	$122,751,508
FY 2004-05	$69,242,115	$7,002,255	$46,888,354	$0	$8,795	$0	$0	$0	$0	$27,352	$144,794	$97	$0	$224	$123,313,985
FY 2005-06	$73,871,969	$9,613,615	$55,885,763	$0	$38,653	$0	$0	$0	$0	$3,201	$1,113	$0	$0	$32,605	$139,446,919
FY 2006-07	$88,671,456	$11,964,141	$65,079,570	$0	$41,973	$5,134	$0	$0	$0	$264	$7,029	$0	$0	$269,817	$166,039,384
FY 2007-08	$98,761,506	$14,013,387	$75,665,199	$0	$42,945	$1,215	$0	$0	$0	$3,477	$24,363	$0	$0	$669,883	$189,181,976
FY 2008-09	$103,189,236	$16,600,418	$99,120,846	$0	$15,355	$1,400	$0	$0	$0	$50	$88,666	$0	$0	$242,445	$219,258,416
FY 2009-10 (DA)	$108,935,302	$17,849,185	$105,282,774	$0	$11,653	$7,691	$0	$0	$0	$0	$105,173	$0	$0	$194,576	$232,386,355
FY 2010-11 (DA)	$111,149,465	$20,210,586	$120,507,011	$0	$3,456	$28,638	$12,129	$0	$0	$3,327	$86,754	$0	$0	$142,108	$252,143,475
FY 2011-12	$117,679,185	$23,268,051	$130,652,872	$0	$2,769	$5,779	$20,511	$0	$0	$7,404	$111,354	$0	$0	$260,261	$272,008,186
Estimated FY 2012-13	$126,331,371	$24,978,800	$140,258,929	$0	$2,973	$6,204	$22,019	$0	$0	$7,948	$119,541	$0	$0	$279,396	$292,007,181
Estimated FY 2013-14	$139,377,846	$27,558,407	$154,743,729	$0	$3,280	$6,845	$24,293	$0	$0	$8,769	$131,886	$0	$0	$308,250	$322,163,305
Estimated FY 2014-15	$150,007,798	$29,660,208	$166,545,594	$0	$3,530	$7,367	$26,146	$0	$0	$9,438	$141,945	$0	$0	$331,759	$346,733,785

Percent Change in Cash Based Actuals

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	0.96%	0.52%	-0.44%	0.00%	96.72%	0.00%	0.00%	0.00%	0.00%	498.90%	56.67%	100.00%	0.00%	32623.62%	0.46%
FY 2005-06	6.69%	37.29%	19.19%	0.00%	339.50%	0.00%	0.00%	0.00%	0.00%	-88.30%	-99.23%	-100.00%	0.00%	14477.54%	13.08%
FY 2006-07	20.03%	24.45%	16.45%	0.00%	8.59%	100.00%	0.00%	0.00%	0.00%	-91.75%	531.54%	0.00%	0.00%	727.53%	19.07%
FY 2007-08	11.38%	17.13%	16.27%	0.00%	2.32%	-76.33%	0.00%	0.00%	0.00%	1217.17%	246.61%	0.00%	0.00%	148.27%	13.94%
FY 2008-09	4.48%	18.46%	31.00%	0.00%	-64.24%	15.22%	0.00%	0.00%	0.00%	-98.57%	263.94%	0.00%	0.00%	-63.81%	15.90%
FY 2009-10 (DA)	5.57%	7.52%	6.22%	0.00%	-24.11%	449.24%	0.00%	0.00%	0.00%	-100.00%	18.62%	0.00%	0.00%	-19.74%	5.99%
FY 2010-11 (DA)	2.03%	13.23%	14.46%	0.00%	-70.34%	272.37%	100.00%	0.00%	0.00%	100.00%	-17.51%	0.00%	0.00%	-26.97%	8.50%
FY 2011-12	5.87%	15.13%	8.42%	0.00%	-19.89%	-79.82%	69.11%	0.00%	0.00%	122.52%	28.36%	0.00%	0.00%	83.14%	7.88%
Estimated FY 2012-13	7.35%	7.35%	7.35%	0.00%	7.37%	7.35%	7.35%	0.00%	0.00%	7.35%	7.35%	0.00%	0.00%	7.35%	7.35%
Estimated FY 2013-14	10.33%	10.33%	10.33%	0.00%	10.33%	10.33%	10.33%	0.00%	0.00%	10.33%	10.33%	0.00%	0.00%	10.33%	10.33%
Estimated FY 2014-15	7.63%	7.63%	7.63%	0.00%	7.62%	7.63%	7.63%	0.00%	0.00%	7.63%	7.63%	0.00%	0.00%	7.63%	7.63%

Per Capita Cost

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$1,997.92	$1,255.56	$1,006.60	$0.00	$0.09	$0.00	$0.00	$0.00	$0.00	$0.02	$6.20	$0.00	$0.00	$0.00	$333.96
FY 2004-05	$1,935.22	$1,151.31	$978.29	$0.00	$0.15	$0.00	$0.00	$0.00	$0.00	$0.12	$9.17	$0.02	$0.00	$0.02	$303.71
FY 2005-06	$2,040.27	$1,591.13	$1,167.81	$0.00	$0.66	$0.00	$0.00	$0.00	$0.00	$0.01	$0.07	$0.00	$0.00	$2.94	$346.69
FY 2006-07	$2,470.78	$1,974.61	$1,333.63	$0.00	$0.83	$0.99	$0.00	$0.00	$0.00	$0.00	$0.42	$0.00	$0.00	$20.90	$423.32
FY 2007-08	$2,721.90	$2,280.08	$1,515.33	$0.00	$0.96	$0.14	$0.00	$0.00	$0.00	$0.02	$1.42	$0.00	$0.00	$47.13	$482.65
FY 2008-09	$2,743.01	$2,574.91	$1,930.11	$0.00	$0.31	$0.11	$0.00	$0.00	$0.00	$0.00	$4.92	$0.00	$0.00	$16.08	$501.95
FY 2009-10 (DA)	$2,830.44	$2,532.16	$1,976.62	$0.00	$0.20	$0.45	$0.00	$0.00	$0.00	$0.00	$5.72	$0.00	$0.00	$12.22	$465.89
FY 2010-11 (DA)	$2,855.77	$2,602.11	$2,141.01	$0.00	$0.06	$1.42	$0.45	$0.00	$0.00	$0.01	$4.72	$0.00	$0.00	$8.32	$449.65
FY 2011-12	$2,961.23	$2,775.62	$2,198.29	$0.00	$0.04	$0.24	$0.58	$0.00	$0.00	$0.02	$6.17	$0.00	$0.00	$13.79	$438.75
Estimated FY 2012-13	$3,129.80	$2,814.83	$2,294.06	$0.00	$0.04	$0.22	$0.52	$0.00	$0.00	$0.02	$6.64	$0.00	$0.00	$13.35	$428.45
Estimated FY 2013-14	$3,383.37	$2,945.53	$2,471.16	$0.00	$0.04	$0.22	$0.51	$0.00	$0.00	$0.02	$7.30	$0.00	$0.00	$13.53	$436.29
Estimated FY 2014-15	$3,564.74	$3,019.77	$2,604.92	$0.00	$0.04	$0.23	$0.53	$0.00	$0.00	$0.02	$7.80	$0.00	$0.00	$13.39	$446.60

Percent Change in Per Capita Cost

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-3.14%	-8.30%	-2.81%	0.00%	66.67%	0.00%	0.00%	0.00%	0.00%	500.00%	47.90%	100.00%	0.00%	100.00%	-9.06%
FY 2005-06	5.43%	38.20%	19.37%	0.00%	340.00%	0.00%	0.00%	0.00%	0.00%	-91.67%	-99.24%	-100.00%	0.00%	14600.00%	14.15%
FY 2006-07	21.10%	24.10%	14.20%	0.00%	25.76%	100.00%	0.00%	0.00%	0.00%	-100.00%	500.00%	0.00%	0.00%	610.88%	22.10%
FY 2007-08	10.16%	15.47%	13.62%	0.00%	15.66%	-85.86%	0.00%	0.00%	0.00%	100.00%	238.10%	0.00%	0.00%	125.50%	14.02%
FY 2008-09	0.78%	12.93%	27.37%	0.00%	-67.71%	-21.43%	0.00%	0.00%	0.00%	-100.00%	246.48%	0.00%	0.00%	-65.88%	4.00%
FY 2009-10 (DA)	3.19%	-1.66%	2.41%	0.00%	-35.48%	309.09%	0.00%	0.00%	0.00%	0.00%	16.26%	0.00%	0.00%	-24.00%	-7.18%
FY 2010-11 (DA)	0.89%	2.76%	8.32%	0.00%	-70.00%	215.56%	100.00%	0.00%	0.00%	100.00%	-17.48%	0.00%	0.00%	-31.91%	-3.49%
FY 2011-12	3.69%	6.67%	2.68%	0.00%	-33.33%	-83.10%	28.89%	0.00%	0.00%	100.00%	30.72%	0.00%	0.00%	65.75%	-2.42%
Estimated FY 2012-13	5.69%	1.41%	4.36%	0.00%	0.00%	-8.33%	-10.34%	0.00%	0.00%	0.00%	7.62%	0.00%	0.00%	-3.19%	-2.35%
Estimated FY 2013-14	8.10%	4.64%	7.72%	0.00%	0.00%	0.00%	-1.92%	0.00%	0.00%	0.00%	9.94%	0.00%	0.00%	1.35%	1.83%
Estimated FY 2014-15	5.36%	2.52%	5.41%	0.00%	0.00%	4.55%	3.92%	0.00%	0.00%	0.00%	6.85%	0.00%	0.00%	-1.03%	2.36%

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

Current Year Projections by Eligibility Category

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Elderly, Blind and Disabled Wavier	$119,297,940	$20,076,913	$99,980,751	$0	$2,903	$114	$18,126	$0	$0	$0	$74,361	$0	$0	$235,684	$239,686,792
Community Mental Health Supports Waiver	$3,967,961	$3,518,280	$20,406,138	$0	$0	$546	$3,469	$0	$0	$0	$11,593	$0	$0	$29,346	$27,937,333
Disabled Children's Waiver	$0	$0	$4,391,146	$0	$0	$0	$0	$0	$0	$1,005	$0	$0	$0	$0	$4,392,151
Persons Living with AIDS Waiver	$28,338	($1,877)	$503,909	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$8,378	$538,748
Consumer Directed Attendant Support-State Plan	$1,748,417	$294,245	$1,465,306	$0	$43	$2	$266	$0	$0	$0	$1,090	$0	$0	$3,454	$3,512,823
Brain Injury Waiver	$171,022	$881,540	$11,941,273	$0	$0	$5,344	$0	$0	$0	$0	$30,189	$0	$0	$171	$13,029,539
Children with Autism Waiver	$0	$0	$1,053,529	$0	$0	$0	$0	$0	$0	$6,937	$0	$0	$0	$0	$1,060,466
Children with Life Limiting Illness Waiver	$0	$0	$215,608	$0	$0	$0	$0	$0	$0	$0	$622	$0	$0	$0	$216,230
Alternative Therapies Waiver	$0	$0	$1,633,099	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,633,099
Estimated FY 2012-13 Total Expenditure	$125,213,678	$24,769,101	$141,590,759	$0	$2,946	$6,006	$21,861	$0	$0	$7,942	$117,855	$0	$0	$277,033	$292,007,181
Estimated FY 2012-13 Per Capita	$3,102.11	$2,791.20	$2,315.84	$0.00	$0.04	$0.14	$2.19	$0.00	$0.00	$0.02	$6.55	$0.00	$0.00	$13.23	$428.45
% Change over FY 2011-12 Per Capita	4.76%	0.56%	5.35%	0.00%	0.23%	-41.16%	276.91%	0.00%	0.00%	9.16%	6.15%	0.00%	0.00%	-4.03%	-2.35%

Request Year Projections by Eligibility Category

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Elderly, Blind and Disabled Wavier	$131,856,087	$22,190,351	$110,505,433	$0	$3,208	$126	$20,034	$0	$0	$0	$82,189	$0	$0	$260,494	$264,917,922
Community Mental Health Supports Waiver	$4,401,540	$3,902,723	$22,635,921	$0	$0	$606	$3,848	$0	$0	$0	$12,860	$0	$0	$32,553	$30,990,051
Disabled Children's Waiver	$0	$0	$5,357,013	$0	$0	$0	$0	$0	$0	$1,226	$0	$0	$0	$0	$5,358,239
Persons Living with AIDS Waiver	$30,030	($1,989)	$533,996	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$8,878	$570,915
Consumer Directed Attendant Support-State Plan	$1,799,619	$302,862	$1,508,218	$0	$44	$2	$274	$0	$0	$0	$1,122	$0	$0	$3,555	$3,615,696
Brain Injury Waiver	$180,065	$928,149	$12,572,640	$0	$0	$5,627	$0	$0	$0	$0	$31,785	$0	$0	$180	$13,718,446
Children with Autism Waiver	$0	$0	$1,071,199	$0	$0	$0	$0	$0	$0	$7,053	$0	$0	$0	$0	$1,078,252
Children with Life Limiting Illness Waiver	$0	$0	$231,670	$0	$0	$0	$0	$0	$0	$0	$669	$0	$0	$0	$232,339
Alternative Therapies Waiver	$0	$0	$1,681,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,681,445
Estimated FY 2013-14 Total Expenditure	$138,267,341	$27,322,096	$156,097,535	$0	$3,252	$6,361	$24,156	$0	$0	$8,279	$128,625	$0	$0	$305,660	$322,163,305
Estimated FY 2013-14 Per Capita	$3,356.41	$2,920.28	$2,492.77	$0.00	$0.04	$0.13	$2.42	$0.00	$0.00	$0.02	$7.12	$0.00	$0.00	$13.42	$436.29
% Change over FY 2012-13 Per Capita	8.20%	4.62%	7.64%	0.00%	4.90%	-4.87%	10.50%	0.00%	0.00%	-5.53%	8.76%	0.00%	0.00%	1.40%	1.83%

Out Year Projections by Eligibility Category

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Elderly, Blind and Disabled Wavier	$142,219,492	$23,934,431	$119,190,754	$0	$3,460	$136	$21,608	$0	$0	$0	$88,648	$0	$0	$280,968	$285,739,497
Community Mental Health Supports Waiver	$4,752,978	$4,214,333	$24,443,266	$0	$0	$654	$4,155	$0	$0	$0	$13,887	$0	$0	$35,152	$33,464,424
Disabled Children's Waiver	$0	$0	$6,371,745	$0	$0	$0	$0	$0	$0	$1,458	$0	$0	$0	$0	$6,373,203
Persons Living with AIDS Waiver	$30,779	($2,039)	$547,321	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$9,100	$585,161
Consumer Directed Attendant Support-State Plan	$1,785,696	$300,518	$1,496,548	$0	$44	$2	$272	$0	$0	$0	$1,113	$0	$0	$3,528	$3,587,721
Brain Injury Waiver	$183,640	$946,578	$12,822,272	$0	$0	$5,739	$0	$0	$0	$0	$32,416	$0	$0	$183	$13,990,828
Children with Autism Waiver	$0	$0	$1,053,529	$0	$0	$0	$0	$0	$0	$6,937	$0	$0	$0	$0	$1,060,466
Children with Life Limiting Illness Waiver	$0	$0	$241,428	$0	$0	$0	$0	$0	$0	$0	$697	$0	$0	$0	$242,125
Alternative Therapies Waiver	$0	$0	$1,690,360	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,690,360
Estimated FY 2014-15 Total Expenditure	$148,972,584	$29,393,821	$167,857,223	$0	$3,504	$6,531	$26,034	$0	$0	$8,395	$136,761	$0	$0	$328,931	$346,733,785
Estimated FY 2014-15 Per Capita	$3,540.14	$2,992.65	$2,625.44	$0.00	$0.04	$0.13	$2.60	$0.00	$0.00	$0.02	$7.51	$0.00	$0.00	$13.27	$446.60
% Change over FY 2013-14 Per Capita	5.47%	2.48%	5.32%	0.00%	-4.89%	-3.23%	7.63%	0.00%	0.00%	-3.03%	5.43%	0.00%	0.00%	-1.12%	2.36%

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

Cash Based Actuals by Waiver

COMMUNITY BASED LONG TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Alternative Therapies Waiver	TOTAL
FY 2003-04	$94,741,923	$15,030,947	$358,891	$562,218	$3,064,733	$8,992,797	$0	$0	$0	$122,751,508
FY 2004-05	$94,216,182	$13,019,463	$481,927	$458,451	$5,912,371	$9,225,591	$0	$0	$0	$123,313,985
FY 2005-06	$107,276,565	$14,984,173	$661,823	$472,783	$7,237,889	$8,813,686	$0	$0	$0	$139,446,919
FY 2006-07	$123,673,036	$17,246,320	$904,883	$503,530	$12,580,285	$11,112,528	$18,801	$0	$0	$166,039,384
FY 2007-08	$141,231,844	$20,409,887	$1,353,847	$595,406	$14,109,819	$10,785,587	$695,586	$0	$0	$189,181,976
FY 2008-09	$176,481,671	$22,958,866	$1,747,683	$592,744	$4,125,973	$12,028,236	$1,293,932	$29,312	$0	$219,258,416
FY 2009-10	$190,095,902	$23,040,614	$1,841,013	$598,542	$3,516,917	$11,596,421	$1,594,735	$102,210	$0	$232,386,355
FY 2010-11	$208,526,316	$24,587,535	$1,887,201	$550,397	$2,961,259	$12,182,916	$1,328,577	$119,273	$0	$252,143,475
FY 2011-12	$225,185,711	$25,934,255	$3,130,073	$516,036	$3,461,683	$12,587,131	$1,022,387	$170,910	$0	$272,008,186
Estimated FY 2012-13	$239,686,792	$27,937,333	$4,392,151	$538,748	$3,512,823	$13,029,539	$1,060,466	$216,230	$1,633,099	$292,007,181
Estimated FY 2013-14	$264,917,922	$30,990,051	$5,358,239	$570,915	$3,615,696	$13,718,446	$1,078,252	$232,339	$1,681,445	$322,163,305
Estimated FY 2014-15	$285,739,497	$33,464,424	$6,373,203	$585,161	$3,587,721	$13,990,828	$1,060,466	$242,125	$1,690,360	$346,733,785

Percent Change in Cash Based Actuals

COMMUNITY BASED LONG TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Alternative Therapies Waiver	TOTAL
FY 2004-05	-0.55%	-13.38%	34.28%	-18.46%	92.92%	2.59%	0.00%	0.00%	0.00%	0.46%
FY 2005-06	13.86%	15.09%	37.33%	3.13%	22.42%	-4.46%	0.00%	0.00%	0.00%	13.08%
FY 2006-07	15.28%	15.10%	36.73%	6.50%	73.81%	26.08%	100.00%	0.00%	0.00%	19.07%
FY 2007-08	14.20%	18.34%	49.62%	18.25%	12.16%	-2.94%	3599.64%	0.00%	0.00%	13.94%
FY 2008-09	24.96%	12.49%	29.09%	-0.45%	-70.76%	11.52%	86.02%	100.00%	0.00%	15.90%
FY 2009-10	7.71%	0.36%	5.34%	0.98%	-14.76%	-3.59%	23.25%	248.70%	0.00%	5.99%
FY 2010-11	9.70%	6.71%	2.51%	-8.04%	-15.80%	5.06%	-16.69%	16.69%	0.00%	8.50%
FY 2011-12	7.99%	5.48%	65.86%	-6.24%	16.90%	3.32%	-23.05%	43.29%	0.00%	7.88%
Estimated FY 2012-13	6.44%	7.72%	40.32%	4.40%	1.48%	3.51%	3.72%	26.52%	100.00%	7.35%
Estimated FY 2013-14	10.53%	10.93%	22.00%	5.97%	2.93%	5.29%	1.68%	7.45%	2.96%	10.33%
Estimated FY 2014-15	7.86%	7.98%	18.94%	2.50%	-0.77%	1.99%	-1.65%	4.21%	0.53%	7.63%

HCBS Waiver Enrollment[3]

COMMUNITY BASED LONG TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Alternative Therapies Waiver	TOTAL
FY 2007-08	15,790	1,775	1,253	34	0	201	48	11	0	19,112
FY 2008-09	16,680	1,923	1,267	34	0	210	68	56	0	20,238
FY 2009-10	17,587	2,060	1,250	37	41	211	67	98	0	21,351
FY 2010-11	18,539	2,187	1,177	38	39	217	64	130	0	22,391
FY 2011-12	19,652	2,351	1,121	40	36	221	63	167	0	23,651
Estimated FY 2012-13	20,648	2,494	1,113	42	34	225	65	200	67	24,888
Estimated FY 2013-14	21,765	2,640	1,109	44	32	229	65	200	67	26,151
Estimated FY 2014-15	22,942	2,785	1,105	46	30	233	65	200	67	27,473

Percent Change in Enrollment

COMMUNITY BASED LONG TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Alternative Therapies Waiver	TOTAL
FY 2008-09	5.64%	8.34%	1.12%	0.00%	0.00%	4.48%	41.67%	409.09%	0.00%	5.89%
FY 2009-10	5.44%	7.12%	-1.34%	8.82%	100.00%	0.48%	-1.47%	75.00%	0.00%	5.50%
FY 2010-11	5.41%	6.17%	-5.84%	2.70%	-4.88%	2.84%	-4.48%	32.65%	0.00%	4.87%
FY 2011-12	6.00%	7.50%	-4.76%	5.26%	-7.69%	1.84%	-1.56%	28.46%	0.00%	5.63%
Estimated FY 2012-13	5.07%	6.08%	-0.71%	5.00%	-5.56%	1.81%	3.17%	19.76%	100.00%	5.23%
Estimated FY 2013-14	5.41%	5.85%	-0.36%	4.76%	-5.88%	1.78%	0.00%	0.00%	0.00%	5.07%
Estimated FY 2014-15	5.41%	5.49%	-0.36%	4.55%	-6.25%	1.75%	0.00%	0.00%	0.00%	5.06%

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

Per Enrollee Cost

COMMUNITY BASED LONG TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Alternative Therapies Waiver	TOTAL
FY 2007-08	$8,944.39	$11,498.53	$1,080.48	$17,511.93	$0.00	$53,659.64	$14,491.37	$0.00	$0.00	$9,898.60
FY 2008-09	$10,580.44	$11,939.09	$1,379.39	$17,433.64	$0.00	$57,277.31	$19,028.42	$523.42	$0.00	$10,834.00
FY 2009-10	$10,808.89	$11,184.76	$1,472.81	$16,176.82	$85,778.47	$54,959.34	$23,802.01	$1,042.96	$0.00	$10,884.10
FY 2010-11	$11,247.98	$11,242.59	$1,603.40	$14,484.14	$75,929.72	$56,142.47	$20,759.02	$917.48	$0.00	$11,260.93
FY 2011-12	$11,458.67	$11,031.16	$2,792.21	$12,900.90	$96,157.86	$56,955.34	$16,228.37	$1,023.41	$0.00	$11,500.92
Estimated FY 2012-13	$11,608.23	$11,201.82	$3,946.23	$12,827.33	$103,318.32	$57,909.06	$16,314.86	$1,081.15	$24,374.61	$11,732.85
Estimated FY 2013-14	$12,171.74	$11,738.66	$4,831.60	$12,975.34	$112,990.50	$59,905.88	$16,588.49	$1,161.70	$25,096.19	$12,319.35
Estimated FY 2014-15	$12,454.86	$12,015.95	$5,767.60	$12,720.89	$119,590.70	$60,046.47	$16,314.86	$1,210.63	$25,229.25	$12,620.89

Percent Change in Per Enrollee Cost

COMMUNITY BASED LONG TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Alternative Therapies Waiver	TOTAL
FY 2008-09	18.29%	3.83%	27.66%	-0.45%	0.00%	6.74%	31.31%	0.00%	0.00%	9.45%
FY 2009-10	2.16%	-6.32%	6.77%	-7.21%	0.00%	-4.05%	25.09%	99.26%	0.00%	0.46%
FY 2010-11	4.06%	0.52%	8.87%	-10.46%	-11.48%	2.15%	-12.78%	-12.03%	0.00%	3.46%
FY 2011-12	1.87%	-1.88%	74.14%	-10.93%	26.64%	1.45%	-21.82%	11.55%	0.00%	2.13%
Estimated FY 2012-13	1.31%	1.55%	41.33%	-0.57%	7.45%	1.67%	0.53%	5.64%	0.00%	2.02%
Estimated FY 2013-14	4.85%	4.79%	22.44%	1.15%	9.36%	3.45%	1.68%	7.45%	2.96%	5.00%
Estimated FY 2014-15	2.33%	2.36%	19.37%	-1.96%	5.84%	0.23%	-1.65%	4.21%	0.53%	2.45%

Current Year Projection

COMMUNITY BASED LONG TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Alternative Therapies Waiver	TOTAL
FY 2011-12 Average HCBS Waiver Enrollment	19,652	2,351	1,121	40	36	221	63	167	0	23,651
Enrollment Trend Selected[1]	5.41%	6.08%	-0.67%	5.26%	-4.88%	1.84%	0.00%	19.76%	NA	
Bottom Line Impacts										
HB 09-1047 Alternative Therapies	(67)	0	0	0	0	0	0	0	67	0
FY 2012-13 Estimated Enrollment	**20,648**	**2,494**	**1,113**	**42**	**34**	**225**	**65**	**200**	**67**	**24,888**
FY 2011-12 Cost per Enrollee	$11,458.67	$11,031.16	$2,792.21	$12,900.90	$96,157.86	$56,955.34	$16,228.37	$1,023.41	$0.00	
Percentage Selected to Modify Per Enrollee[2]	2.16%	1.92%	41.50%	-0.45%	7.58%	1.80%	0.00%	5.77%	2.16%	
FY 2012-13 Estimate Cost Per Enrollee	**$11,706.08**	**$11,242.49**	**$3,951.11**	**$12,843.22**	**$103,446.14**	**$57,980.71**	**$16,228.37**	**$1,082.49**	**$0.00**	
Estimated FY 2012-13 Base Expenditures	**$241,707,140**	**$28,038,770**	**$4,397,585**	**$539,415**	**$3,517,169**	**$13,045,660**	**$1,054,844**	**$216,498**	**$0**	**$292,517,081**
Bottom Line Impacts										
Annualization of FY 2011-12 BA-9: Medicaid Reductions - 0.50% Rate Reduction	($298,681)	($34,648)	($5,434)	($667)	($4,346)	($16,121)	($1,303)	($268)	$0	($361,468)
Annualization of BRI-5: Medicaid Reductions - Cap CDASS Wage Rates	($1,078,979)	($125,165)	$0	$0	$0	$0	$0	$0	$0	($1,204,144)
Annualization of HB 10-1146 State-funded Public Assistance Programs	$376,827	$0	$0	$0	$0	$0	$0	$0	$0	$376,827
Annualization of HB 09-1047 Alternative Therapies for Clients with Spinal Cord Injuries	($1,445,659)	$0	$0	$0	$0	$0	$0	$0	$1,633,099	$187,440
SB 12-159 "Evaluate Children With Autism Medicaid Waiver"	$0	$0	$0	$0	$0	$0	$6,925	$0	$0	$6,925
Colorado Choice Transitions	$426,144	$58,376	$0	$0	$0	$0	$0	$0	$0	$484,520
Total Bottom Line Impacts	**($2,020,348)**	**($101,437)**	**($5,434)**	**($667)**	**($4,346)**	**($16,121)**	**$5,622**	**($268)**	**$1,633,099**	**($509,900)**
Estimated FY 2012-13 Expenditure	**$239,686,792**	**$27,937,333**	**$4,392,151**	**$538,748**	**$3,512,823**	**$13,029,539**	**$1,060,466**	**$216,230**	**$1,633,099**	**$292,007,181**
Estimated FY 2012-13 Per Enrollee	$11,608.23	$11,201.82	$3,946.23	$12,827.33	$103,318.32	$57,909.06	$16,314.86	$1,081.15	$24,374.61	$11,732.85
% Change over FY 2011-12 Per Enrollee	1.31%	1.55%	41.33%	-0.57%	7.45%	1.67%	0.53%	5.64%	0.00%	2.02%

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

Request Year Projection

Per Capita Trends	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Alternative Therapies Waiver	TOTAL
Estimated FY 2012-13 Average HCBS Waiver Enrollment	20,648	2,494	1,113	42	34	225	65	200	67	24,888
Enrollment Trend Selected[1]	5.41%	5.85%	-0.34%	5.26%	-4.88%	1.84%	0.00%	0.00%	0.00%	
FY 2013-14 Estimated Enrollment	**21,765**	**2,640**	**1,109**	**44**	**32**	**229**	**65**	**200**	**67**	**26,151**
FY 2012-13 Cost per Enrollee	$11,608.23	$11,201.82	$3,946.23	$12,827.33	$103,318.32	$57,909.06	$16,314.86	$1,081.15	$24,374.61	$11,732.85
Percentage Selected to Modify Per Enrollee [2]	2.16%	1.92%	20.75%	-0.45%	7.58%	1.80%	0.00%	5.77%	2.16%	
FY 2013-14 Estimate Cost Per Enrollee	**$11,858.87**	**$11,416.42**	**$4,765.17**	**$12,769.98**	**$111,149.33**	**$58,951.60**	**$16,314.86**	**$1,143.56**	**$24,900.90**	
Estimated FY 2013-14 Base Expenditures	**$258,108,306**	**$30,139,349**	**$5,284,574**	**$561,879**	**$3,556,779**	**$13,499,916**	**$1,060,466**	**$228,712**	**$1,668,360**	**$314,108,341**
Bottom Line Impacts										
Annualization of HB 09-1047 Alternative Therapies for Clients with Spinal Cord Injuries	$0	$0	$0	$0	$0	$0	$0	$0	($14,305)	($14,305)
Annualization of SB 12-159 "Evaluate Children With Autism Medicaid Waiver"	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Adjustment for 53 pay periods	$4,019,998	$468,562	$73,665	$9,036	$58,917	$218,530	$17,786	$3,627	$27,390	$4,897,511
Colorado Choice Transitions	$2,789,618	$382,140	$0	$0	$0	$0	$0	$0	$0	$3,171,758
Total Bottom Line Impacts	**$6,809,616**	**$850,702**	**$73,665**	**$9,036**	**$58,917**	**$218,530**	**$17,786**	**$3,627**	**$13,085**	**$8,054,964**
Estimated FY 2013-14 Total Expenditure	**$264,917,922**	**$30,990,051**	**$5,358,239**	**$570,915**	**$3,615,696**	**$13,718,446**	**$1,078,252**	**$232,339**	**$1,681,445**	**$322,163,305**
Estimated FY 2013-14 Per Enrollee	$12,171.74	$11,738.66	$4,831.60	$12,975.34	$112,990.50	$59,905.88	$16,588.49	$1,161.70	$25,096.19	$12,319.35
% Change over FY 2012-13 Per Enrollee	4.85%	4.79%	22.44%	1.15%	9.36%	3.45%	1.68%	7.45%	2.96%	5.00%

Out Year Projection

Per Capita Trends	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Alternative Therapies Waiver	TOTAL
Estimated FY 2013-14 Average HCBS Waiver Enrollment	21,765	2,640	1,109	44	32	229	65	200	67	26,151
Enrollment Trend Selected[1]	5.41%	5.49%	-0.34%	5.26%	-4.88%	1.84%	0.00%	0.00%	0.00%	
FY 2014-15 Estimated Enrollment	**22,942**	**2,785**	**1,105**	**46**	**30**	**233**	**65**	**200**	**67**	**27,473**
FY 2013-14 Cost per Enrollee	$12,171.74	$11,738.66	$4,831.60	$12,975.34	$112,990.50	$59,905.88	$16,588.49	$1,161.70	$25,096.19	$12,319.35
Percentage Selected to Modify Per Enrollee[2]	2.16%	1.92%	20.75%	-0.45%	7.58%	1.80%	0.00%	5.77%	2.16%	
FY 2014-15 Estimate Cost Per Enrollee	**$12,434.55**	**$11,963.54**	**$5,834.27**	**$12,917.33**	**$121,554.61**	**$60,984.37**	**$16,588.49**	**$1,228.76**	**$25,638.06**	
Estimated FY 2014-15 Base Expenditures	$285,273,446	$33,318,459	$6,446,868	$594,197	$3,646,638	$14,209,358	$1,078,252	$245,752	$1,717,750	$346,530,720
Bottom Line Impacts										
Colorado Choice Transitions	$4,486,049	$614,527	$0	$0	$0	$0	$0	$0	$0	$5,100,576
Annualization of 53 pay period adjustment	($4,019,998)	($468,562)	($73,665)	($9,036)	($58,917)	($218,530)	($17,786)	($3,627)	($27,390)	($4,897,511)
Total Bottom Line Impacts	**$466,051**	**$145,965**	**($73,665)**	**($9,036)**	**($58,917)**	**($218,530)**	**($17,786)**	**($3,627)**	**($27,390)**	**$203,065**
Estimated FY 2014-15 Total Expenditure	**$285,739,497**	**$33,464,424**	**$6,373,203**	**$585,161**	**$3,587,721**	**$13,990,828**	**$1,060,466**	**$242,125**	**$1,690,360**	**$346,733,785**
Estimated FY 2014-15 Per Enrollee	$12,454.86	$12,015.95	$5,767.60	$12,720.89	$119,590.70	$60,046.47	$16,314.86	$1,210.63	$25,229.25	$12,620.89
% Change over FY 2013-14 Per Enrollee	2.33%	2.36%	19.37%	-1.96%	5.84%	0.23%	-1.65%	4.21%	0.53%	2.45%

Footnotes:

Footnote	Waiver	Value	Waiver	Value	Waiver	Value
(1) Percentage selected to modify enrollment for FY 2012-13 through FY 2014-15	Elderly, Blind and Disabled Wavier	5.41%	Persons Living with AIDS Waiver	5.26%	Children with Autism Waiver	0.00%
	Community Mental Health Supports Waiver	Linear Trend	Consumer Directed Attendant Support-State Plan	-4.88%	Children with Life Limiting Illness Waiver	19.76%
	Disabled Children's Waiver	-0.67%	Brain Injury Waiver	1.84%	Alternative Therapies Waiver	NA
(2) Percentage selected to modify per enrollee costs for FY 2012-13 through FY 2014-15	Elderly, Blind and Disabled Wavier	2.16%	Persons Living with AIDS Waiver	-0.45%	Children with Autism Waiver	0.00%
	Community Mental Health Supports Waiver	1.92%	Consumer Directed Attendant Support-State Plan	7.58%	Children with Life Limiting Illness Waiver	5.77%
	Disabled Children's Waiver	41.5%, 20.75%	Brain Injury Waiver	1.80%	Alternative Therapies Waiver	2.16%

(3) Presented information regarding the enrolled clients in each waiver is derived from client tables that contain data beginning in FY 2007-08. The Department chose to use this information to present the number of clients enrolled in each waiver as it is a static monthly report showing the exact number of clients enrolled in each waiver. The Department believes this to be a more accurate representation of enrollment as compared to a claim based methodology.

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

FY 2010-11 July-December COFRS Total Actuals

Community Based Long Term Care	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	COFRS TOTAL
HCBS - Elderly, Blind, and Disabled	$53,732,719	$8,207,658	$42,158,348	$0	$15,839	$14,614	$0	$0	$0	$0	$28,651	$0	$0	$64,424	$104,222,253
HCBS - Mental Illness	$1,856,638	$1,297,696	$9,472,703	$0	$2,994	$2,848	$0	$0	$0	$0	$8,981	$0	$0	$5,532	$12,647,393
HCBS - Disabled Children	$0	$0	$932,746	$0	$0	$0	$0	$0	$0	$454	$577	$0	$0	$0	$933,778
HCBS - Persons Living with AIDS	$15,354	$1,909	$284,531	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$301,794
HCBS - Consumer Directed Attendant Support	$727,394	$110,838	$565,896	$0	$207	$0	$0	$0	$0	$0	$390	$0	$0	$898	$1,405,624
HCBS - Brain Injury	$8,987	$39,327	$581,300	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$61	$629,675
HCBS - Children with Autism	$0	$0	$800,181	$0	$0	$0	$0	$0	$0	$2,504	$0	$0	$0	$0	$802,685
HCBS - Pediatric Hospice	$0	$0	$66,819	$0	$0	$0	$0	$0	$0	$215	$519	$0	$0	$0	$67,553
Total	$56,341,092	$9,657,428	$54,862,525	$0	$19,040	$17,462	$0	$0	$0	$3,173	$39,119	$0	$0	$70,916	$121,010,755
Caseload	38,914	7,576	55,374	-	57,403	19,468	25,208	-	502	293,379	18,518	7,922	3,209	16,760	544,232
Half -Year Per Capita	$1,447.84	$1,274.80	$990.76	$0.00	$0.33	$0.90	$0.00	$0.00	$0.00	$0.01	$2.11	$0.00	$0.00	$4.23	$222.35

FY 2010-11 January - June COFRS Total Actuals

Community Based Long Term Care	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	COFRS TOTAL
HCBS - Elderly, Blind, and Disabled	$52,135,435	$8,303,517	$43,756,129	$0	($12,383)	$1,351	$11,962	$0	$0	$0	$42,521	$0	$0	$65,531	$104,304,063
HCBS - Mental Illness	$1,730,729	$1,354,314	$8,844,342	$0	($2,994)	$6,570	$0	$0	$0	$0	$4,617	$0	$0	$2,565	$11,940,143
HCBS - Disabled Children	$0	$0	$953,306	$0	$0	$0	$0	$0	$0	$117	$0	$0	$0	$0	$953,423
HCBS - Persons Living with AIDS	$13,692	$1,561	$231,668	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,682	$248,603
HCBS - Consumer Directed Attendant Support	$779,336	$123,767	$650,973	$0	($207)	$0	$167	$0	$0	$0	$621	$0	$0	$978	$1,555,635
HCBS - Brain Injury	$149,181	$770,000	$10,630,370	$0	$0	$3,254	$0	$0	$0	$0	$0	$0	$0	$436	$11,553,241
HCBS - Children with Autism	$0	$0	$525,851	$0	$0	$0	$0	$0	$0	$41	$0	$0	$0	$0	$525,892
HCBS - Pediatric Hospice	$0	$0	$51,848	$0	$0	$0	$0	$0	$0	($4)	($124)	$0	$0	$0	$51,720
Total	$54,808,373	$10,553,159	$65,644,487	$0	($15,584)	$11,175	$12,129	$0	$0	$154	$47,635	$0	$0	$71,192	$131,132,720
Caseload	38,929	7,957	57,195	-	64,516	20,839	29,126	-	561	311,441	18,268	7,814	3,218	17,420	577,284
Half -Year Per Capita	$1,407.91	$1,326.27	$1,147.73	$0.00	($0.24)	$0.54	$0.42	$0.00	$0.00	$0.00	$2.61	$0.00	$0.00	$4.09	$227.15

FY 2011-12 July-December COFRS Total Actuals

Community Based Long Term Care	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	COFRS TOTAL
HCBS - Elderly, Blind, and Disabled	$56,549,506	$9,493,911	$46,777,284	$0	$610	$0	$5,599	$0	$0	$0	$35,985	$0	$0	$111,087	$112,973,982
HCBS - Mental Illness	$1,814,065	$1,588,596	$9,521,924	$0	$0	$516	$1,639	$0	$0	$0	$7,763	$0	$0	$8,342	$12,942,845
HCBS - Disabled Children	$0	$0	$1,367,563	$0	$0	$0	$0	$0	$0	$273	$0	$0	$0	$0	$1,367,836
HCBS - Persons Living with AIDS	$14,616	$1,631	$245,614	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$8,233	$270,094
HCBS - Consumer Directed Attendant Support	$903,311	$151,654	$747,211	$0	$10	$0	$89	$0	$0	$0	$575	$0	$0	$1,774	$1,804,624
HCBS - Brain Injury	$80,699	$468,773	$5,949,560	$0	$0	$5,248	$0	$0	$0	$0	$0	$0	$0	$0	$6,504,280
HCBS - Children with Autism	$0	$0	$502,938	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$502,938
HCBS - Pediatric Hospice	$0	$0	$103,084	$0	$0	$0	$0	$0	$0	$0	$499	$0	$0	$0	$103,583
Total	$59,362,197	$11,704,565	$65,215,178	$0	$620	$5,764	$7,327	$0	$0	$273	$44,822	$0	$0	$129,436	$136,470,182
Caseload	39,635	8,277	58,964	-	67,889	22,937	33,529	-	594	327,398	18,112	7,581	2,771	18,304	605,991
Half -Year Per Capita	$1,497.72	$1,414.11	$1,106.02	$0.00	$0.01	$0.25	$0.22	$0.00	$0.00	$0.00	$2.47	$0.00	$0.00	$7.07	$225.20

FY 2011-12 January - June COFRS Total Actuals

Community Based Long Term Care	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	COFRS TOTAL
HCBS - Elderly, Blind, and Disabled	$54,953,795	$9,271,224	$46,670,966	$0	$2,103	$107	$11,342	$0	$0	$0	$33,518	$0	$0	$109,197	$111,052,252
HCBS - Mental Illness	$1,869,397	$1,677,427	$9,421,115	$0	$0	($9)	$1,581	$0	$0	$0	$2,999	$0	$0	$18,900	$12,991,410
HCBS - Disabled Children	$0	$0	$1,761,794	$0	$0	$0	$0	$0	$0	$443	$0	$0	$0	$0	$1,762,237
HCBS - Persons Living with AIDS	$12,527	($3,429)	$237,051	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($208)	$245,942
HCBS - Consumer Directed Attendant Support	$819,653	$138,307	$696,764	$0	$32	$2	$173	$0	$0	$0	$499	$0	$0	$1,630	$1,657,059
HCBS - Brain Injury	$84,516	$382,835	$5,586,256	$0	$0	($85)	$0	$0	$0	$0	$29,164	$0	$0	$165	$6,082,851
HCBS - Children with Autism	$0	$0	$512,761	$0	$0	$0	$0	$0	$0	$6,688	$0	$0	$0	$0	$519,449
HCBS - Pediatric Hospice	$0	$0	$67,334	$0	$0	$0	$0	$0	$0	$0	($7)	$0	$0	$0	$67,327
Total	$57,739,888	$11,466,364	$64,954,041	$0	$2,135	$15	$13,096	$0	$0	$7,131	$66,172	$0	$0	$129,685	$134,378,527
Caseload	39,740	8,383	59,434	52	68,689	24,535	35,461	1,134	597	334,633	18,034	7,630	2,770	18,871	619,964
Half -Year Per Capita	$1,452.94	$1,367.87	$1,092.88	$0.00	$0.03	$0.00	$0.37	$0.00	$0.00	$0.02	$3.67	$0.00	$0.00	$6.87	$216.75

Hospice Calculations for FY 2012-13, FY 2013-14, FY 2014-15

FY 2012-13 Calculation

Nursing Facility Room and Board		
Service Expenditures:	**Core Components**	**Reference**
Estimate of FY 2012-13 Per Diem Rate	$147.94	Footnote 1
Estimate of Patient Days	237,626	Footnote 2
Total Estimated Costs for FY 2012-13 Days of Service	$35,153,638	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	88.65%	Footnote 4
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$31,163,700	
Estimated Expenditures for FY 2011-12 Dates of Service	$3,802,068	Footnote 5
Estimated Nursing Facility Room and Board Expenditures in FY 2012-13 Prior to Adjustments	**$34,965,768**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2011-12 and paid in FY 2012-13 under SB 11-215	($57,900)	Footnote 6
HB 12-1340 1.5% rate reduction Effective July 1, 2012	($467,455)	Footnote 6
Total Bottom Line Adjustments:	**($525,355)**	
Total Estimated Nursing Facility Room and Board FY 2012-13 General Fund Expenditures	**$34,440,414**	
Percentage Change in Core Component Expenditure Over Prior Year	4.40%	
Hospice Services		
Service Expenditures:	**Core Components**	**Reference**
Hospice Routine Home Care	$8,594,508	Footnote 7
Hospice General Inpatient	$1,729,609	Footnote 7
Other Services	$89,810	Footnote 7
Estimated Hospice Services Expenditures in FY 2012-13 Prior to Adjustments	$10,413,928	
Bottom Line Adjustments:		
Total Bottom Line Adjustments:	**$0**	
Total Estimated Hospice Services FY 2012-13 General Fund Expenditures	**$10,413,928**	
Percentage Change in Expenditure Over Prior Year	11.62%	
Total Estimated FY 2012-13 Expenditures	**$44,854,342**	

Exhibit G - COMMUNITY BASED LONG TERM CARE - Hospice

FY 2013-14 Calculation		
Nursing Facility Room and Board		
Service Expenditures:	**Core Components**	**Reference**
Estimate of FY 2013-14 Per Diem Rate	$152.37	Footnote 1
Estimate of Patient Days	239,641	Footnote 2
Total Estimated Costs for FY 2013-14 Days of Service	$36,514,099	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	88.65%	Footnote 4
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$32,369,749	
Estimated Expenditures for FY 2012-13 Dates of Service	$3,989,938	Footnote 5
Estimated Nursing Facility Room and Board Expenditures in FY 2013-14 Prior to Adjustments	**$36,359,687**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2012-13 and paid in FY 2013-14 under HB 12-1340	($59,850)	Footnote 6
Estimated Expenditure from Additional Payment Cycle	$321,158	Footnote 8
Total Bottom Line Adjustments:	**$261,308**	
Total Estimated Nursing Facility Room and Board FY 2013-14 General Fund Expenditures	**$36,620,995**	
Percentage Change in Core Component Expenditure Over Prior Year	6.33%	
Hospice Services		
Service Expenditures:	**Core Components**	**Reference**
Hospice Routine Home Care	$9,561,971	Footnote 7
Hospice General Inpatient	$1,798,791	Footnote 7
Other Services	$102,770	Footnote 7
Estimated Hospice Services Expenditures in FY 2013-14 Prior to Adjustments	**$11,463,532**	
Bottom Line Adjustments		
Estimated Expenditure from Additional Payment Cycle	$127,695	
Total Bottom Line Adjustments:	**$127,695**	
Total Estimated Hospice Services FY 2013-14 General Fund Expenditures	**$11,591,227**	
Percentage Change in Expenditure Over Prior Year	11.31%	
Total Estimated FY 2013-14 Expenditures	**$48,212,222**	

Exhibit G - COMMUNITY BASED LONG TERM CARE - Hospice

FY 2014-15 Calculation		
Nursing Facility Room and Board		
Service Expenditures:	**Core Components**	**Reference**
Estimate of FY 2014-15 Per Diem Rate	$156.94	Footnote 1
Estimate of Patient Days	241,661	Footnote 2
Total Estimated Costs for FY 2014-15 Days of Service	$37,926,543	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	88.65%	Footnote 4
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$33,621,881	
Estimated Expenditures for FY 2013-14 Dates of Service	$4,144,350	Footnote 5
Estimated Nursing Facility Room and Board Expenditures in FY 2014-15 Prior to Adjustments	**$37,766,231**	
Bottom Line Adjustments:		
Total Bottom Line Adjustments:	**$0**	
Total Estimated Nursing Facility Room and Board FY 2014-15 General Fund Expenditures	**$37,766,231**	
Percentage Change in Core Component Expenditure Over Prior Year	3.13%	
Hospice Services		
Service Expenditures:	**Core Components**	**Reference**
Hospice Routine Home Care	$10,566,719	Footnote 7
Hospice General Inpatient	$1,867,972	Footnote 7
Other Services	$117,601	Footnote 7
Bottom Line Adjustments:		
Total Bottom Line Adjustments:	**$0**	
Total Estimated Hospice Services FY 2014-15 General Fund Expenditures	**$12,552,292**	
Percentage Change in Expenditure Over Prior Year	8.29%	
Total Estimated Expenditures	**$50,318,523**	

Hospice Nursing Facility Room and Board FY 2012-13 , FY 2013-14 and FY 2014-15 Footnotes:

(1) Fiscal year per diems are the quotient of annual IBNR-adjusted expenditure and patient days, by first-date-of-service. Estimates for FY 2012-13, FY 2013-14, and FY 2014-15 are computed by applying rate reductions where appropriate and projecting the maximum-allowable-growth (3%) in general fund expenditures. See footnote (4) for a detailed discussion of incurred-but-not-reported analysis. Rate reduction in FY 2012-13 due to HB 12-1340; see footnote (6) for further detail.

Year	Per Diem After Reductions	Maximum Allowable Growth in General Fund Portion	Rate Reduction	Paid Rate Before Reductions	Percentage Change in Core Rate Before Reductions
FY 2007-08	$132.36			$132.36	
FY 2008-09	$148.16			$148.16	11.94%
FY 2009-10	$138.23	3.00%	0.50%	$138.93	-6.23%
FY 2010-11	$137.15	1.90%	2.50%	$140.67	1.25%
FY 2011-12	$141.47	3.00%	1.50%	$143.63	2.10%
Estimated FY 2012-13	$145.72	3.00%	1.50%	$147.94	3.00%
Estimated FY 2013-14	$152.37	3.00%	-	$152.37	3.00%
Estimated FY 2014-15	$156.94	3.00%		$156.94	3.00%

(2) The patient days estimates for FY 2012-13, FY 2013-14 and FY 2014-15 are estimated using incurred-but-not-reported (IBNR) adjusted data from FY 2007-08 to FY 2011-12.

Fiscal Year	Patient Days	Percentage Change	Full Time Equivalent Clients	Percentage Change
FY 2007-08	206,269		565	
FY 2008-09	234,425	13.65%	642	13.63%
FY 2009-10	235,652	0.52%	646	0.62%
FY 2010-11	226,951	-3.69%	622	-3.72%
FY 2011-12	236,782	4.33%	649	4.34%
Estimated FY 2012-13	237,626	0.36%	651	0.31%
Estimated FY 2013-14	239,641	0.85%	657	0.92%
Estimated FY 2014-15	241,661	0.84%	662	0.76%

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

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

Estimate of Claims Incurred and Paid in the Same Fiscal Year

Month Incurred	Additional Months Until End of Fiscal Year	Estimated Percent Complete at End of Fiscal Year (IBNR Factor)
July	11	99.90%
August	10	99.86%
September	9	99.81%
October	8	99.68%
November	7	99.51%
December	6	99.17%
January	5	98.59%
February	4	97.38%
March	3	95.66%
April	2	92.35%
May	1	81.43%
June	0	0.44%
Average		88.65%

(5) As calculated in the table below, the estimated FY 2012-13 expenditure for core components with FY 2011-12 dates of service is the estimated FY 2011-12 core components per diem rate, less the estimated per diem patient payment rate, multiplied by the estimated number of patient days. This calculation is then multiplied by one minus the calculated IBNR rate.

Calculation of Expenditures From Claims in Previous Fiscal Year	FY 2011-12	Source
IBNR Factor	88.65%	Footnote (4)
Estimated Patient Days from previous fiscal year	236,782	Footnote (2)
Estimated Per Diem Rate for Core Components for previous fiscal year	$141.47	Footnote (1)
Estimated claims expenditures for core components from previous fiscal year to be paid in the current fiscal year	$3,802,068	As described in Footnote (5) narrative

(6) HB 10-1324 imposed a rate reduction of 1.5% effective March 1, 2010 and effective until June 30, 2011. HB 10-1379 imposed a rate reduction of 1% in addition to the rate reduction of HB 10-1324 for the period of July 1, 2010 to June 30, 2011. SB 11-215 imposed a rate reduction of 1.5% effective July 1, 2011 for FY 2011-12 that was extended for FY 2012-13 by HB 12-1340. The rate reductions apply to all days incurred under the effective periods of each bill. As not all days will be reported in the fiscal year in which they are incurred, the impact of the rate cuts extends over multiple fiscal years. The tables below show the incremental impact of the two bills. These figures may vary from previous submissions of the Department's requests due to revised forecasts for rates and patient days. No potential rate reductions for FY 2013-14 or FY 2014-15 are accounted for here.

SB 11-215	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
FY 2011-12 Rates	1.50%	$143.63	$141.47	($2.15)
FY 2011-12 Patient days				236,782
Estimated FY 2011-12 Days Paid in FY 2011-12				209,907
Total FY 2011-12 Impact				**($452,228)**
Estimated FY 2011-12 Days Paid in FY 2012-13				26,875
Total FY 2012-13 Impact				**($57,900)**

HB 12-1340	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
Estimated FY 2012-13 Rates	1.50%	$147.94	$145.72	($2.22)
Estimated FY 2012-13 Patient days				237,626
Estimated FY 2012-13 Days Paid in FY 2012-13				210,655
Total FY 2012-13 Impact				**($467,455)**
Estimated FY 2012-13 Days Paid in FY 2013-14				26,971
Total FY 2013-14 Impact				**($59,850)**

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

Cash Based Actuals

Hospice	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$17,064,571	$1,016,913	$4,530,283	$0	$163,150	$0	$0	$0	$0	$18,029	$2,715	$0	$0	$0	$22,795,661
FY 2004-05	$17,144,015	$1,326,788	$4,807,057	$0	$117,796	$0	$0	$0	$0	$156,717	$4,293	$2,364	$0	$0	$23,559,031
FY 2005-06	$21,266,594	$2,111,240	$4,880,020	$0	$111,898	$0	$0	$0	$0	$128,732	$0	$0	$0	$8,603	$28,507,087
FY 2006-07	$23,913,110	$1,986,641	$5,611,231	$0	$46,496	$0	$0	$0	$0	$141,295	$0	$0	$0	$88,575	$31,787,348
FY 2007-08	$25,148,153	$2,134,632	$5,123,646	$0	$70,365	$6,838	$0	$0	$0	$86,351	$0	$0	$0	$240,791	$32,810,776
FY 2008-09	$31,767,623	$2,005,681	$5,941,975	$0	$37,529	$7,535	$0	$0	$0	$77,422	$3,390	$2,017	$0	$59,700	$39,902,873
FY 2009-10 (DA)	$34,017,386	$3,025,452	$6,115,615	$0	$180,778	$23,084	$0	$0	$0	$231,678	$34,952	$0	$1,279	$6,603	$43,636,826
FY 2010-11 (DA)	$30,229,237	$2,102,622	$6,889,023	$0	$177,819	$50,718	$39,141	$0	$0	$60,107	$3,517	$0	$0	($4,548)	$39,547,635
FY 2011-12	$32,103,872	$2,846,601	$6,969,248	$15,185	$69,870	$44,236	$67,245	$4,370	$0	$116,333	$1,215	$1,787	$0	$86,846	$42,326,808
Estimated FY 2012-13	$33,319,091	$3,078,361	$7,324,018	$651,236	$76,360	$52,706	$82,392	$39,368	$0	$129,197	$1,238	$1,965	$0	$98,410	$44,854,342
Estimated FY 2013-14	$34,969,461	$3,332,331	$7,701,846	$1,673,912	$82,502	$57,818	$94,182	$40,420	$0	$146,370	$1,276	$2,162	$0	$109,942	$48,212,222
Estimated FY 2014-15	$35,794,670	$3,507,582	$7,884,433	$2,569,581	$84,467	$59,566	$98,139	$40,527	$0	$156,080	$1,290	$2,255	$0	$119,933	$50,318,523

Percent Change in Cash Based Actuals

Hospice	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	0.47%	30.47%	6.11%	0.00%	-27.80%	0.00%	0.00%	0.00%	0.00%	769.25%	58.12%	0.00%	0.00%	0.00%	3.35%
FY 2005-06	24.05%	59.12%	1.52%	0.00%	-5.01%	0.00%	0.00%	0.00%	0.00%	-17.86%	-100.00%	-100.00%	0.00%	0.00%	21.00%
FY 2006-07	12.44%	-5.90%	14.98%	0.00%	-58.45%	0.00%	0.00%	0.00%	0.00%	9.76%	0.00%	0.00%	0.00%	929.58%	11.51%
FY 2007-08	5.16%	7.45%	-8.69%	0.00%	51.34%	0.00%	0.00%	0.00%	0.00%	-38.89%	0.00%	0.00%	0.00%	171.85%	3.22%
FY 2008-09	26.32%	-6.04%	15.97%	0.00%	-46.67%	10.19%	0.00%	0.00%	0.00%	-10.34%	0.00%	0.00%	0.00%	-75.21%	21.62%
FY 2009-10 (DA)	7.08%	50.84%	2.92%	0.00%	381.70%	206.36%	0.00%	0.00%	0.00%	199.24%	931.03%	-100.00%	0.00%	-88.94%	9.36%
FY 2010-11 (DA)	-11.14%	-30.50%	12.65%	0.00%	-1.64%	119.71%	0.00%	0.00%	0.00%	-74.06%	-89.94%	0.00%	-100.00%	-168.88%	-9.37%
FY 2011-12	6.20%	35.38%	1.16%	0.00%	-60.71%	-12.78%	71.80%	0.00%	0.00%	93.54%	-65.45%	0.00%	0.00%	-2009.54%	7.03%
Estimated FY 2012-13	3.79%	8.14%	5.09%	4188.68%	9.29%	19.15%	22.53%	800.87%	0.00%	11.06%	1.89%	9.96%	0.00%	13.32%	5.97%
Estimated FY 2013-14	4.95%	8.25%	5.16%	157.04%	8.04%	9.70%	14.31%	2.67%	0.00%	13.29%	3.07%	10.03%	0.00%	11.72%	7.49%
Estimated FY 2014-15	2.36%	5.26%	2.37%	53.51%	2.38%	3.02%	4.20%	0.26%	0.00%	6.63%	1.10%	4.30%	0.00%	9.09%	4.37%

Per Capita Cost

Hospice	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$497.09	$183.29	$96.82	$0.00	$3.43	$0.00	$0.00	$0.00	$0.00	$0.09	$0.18	$0.00	$0.00	$0.00	$62.02
FY 2004-05	$479.15	$218.15	$100.30	$0.00	$2.06	$0.00	$0.00	$0.00	$0.00	$0.70	$0.27	$0.40	$0.00	$0.00	$58.02
FY 2005-06	$587.36	$349.43	$101.98	$0.00	$1.90	$0.00	$0.00	$0.00	$0.00	$0.60	$0.00	$0.00	$0.00	$0.78	$70.87
FY 2006-07	$666.33	$327.88	$114.99	$0.00	$0.92	$0.00	$0.00	$0.00	$0.00	$0.69	$0.00	$0.00	$0.00	$6.86	$81.04
FY 2007-08	$693.09	$347.32	$102.61	$0.00	$1.58	$0.77	$0.00	$0.00	$0.00	$0.42	$0.00	$0.00	$0.00	$16.94	$83.71
FY 2008-09	$844.46	$311.10	$115.70	$0.00	$0.76	$0.59	$0.00	$0.00	$0.00	$0.33	$0.19	$0.29	$0.00	$3.96	$91.35
FY 2009-10 (DA)	$883.87	$429.20	$114.82	$0.00	$3.14	$1.34	$0.00	$0.00	$0.00	$0.84	$1.90	$0.00	$0.35	$0.41	$87.48
FY 2010-11 (DA)	$776.68	$270.71	$122.40	$0.00	$2.92	$2.52	$1.44	$0.00	$0.00	$0.20	$0.19	$0.00	$0.00	($0.27)	$70.53
FY 2011-12	$807.85	$339.57	$117.26	$292.02	$1.02	$1.80	$1.90	$3.85	$0.00	$0.35	$0.07	$0.23	$0.00	$4.60	$68.27
Estimated FY 2012-13	$825.47	$346.90	$119.79	$298.32	$1.04	$1.84	$1.94	$3.94	$0.00	$0.36	$0.07	$0.24	$0.00	$4.70	$65.81
Estimated FY 2013-14	$848.88	$356.17	$122.99	$306.30	$1.07	$1.89	$1.99	$4.04	$0.00	$0.36	$0.07	$0.25	$0.00	$4.83	$65.29
Estimated FY 2014-15	$850.61	$357.11	$123.32	$307.11	$1.07	$1.90	$1.99	$4.05	$0.00	$0.37	$0.07	$0.25	$0.00	$4.84	$64.81

Percent Change in Per Capita Cost

Hospice	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-3.61%	19.02%	3.59%	0.00%	-39.90%	0.00%	0.00%	0.00%	0.00%	663.00%	49.30%	0.00%	0.00%	0.00%	-6.44%
FY 2005-06	22.58%	60.18%	1.67%	0.00%	-7.82%	0.00%	0.00%	0.00%	0.00%	-14.67%	-100.00%	-100.00%	0.00%	0.00%	22.15%
FY 2006-07	13.44%	-6.17%	12.76%	0.00%	-51.73%	0.00%	0.00%	0.00%	0.00%	14.44%	0.00%	0.00%	0.00%	784.73%	14.35%
FY 2007-08	4.02%	5.93%	-10.76%	0.00%	72.16%	0.00%	0.00%	0.00%	0.00%	-38.48%	0.00%	0.00%	0.00%	146.87%	3.29%
FY 2008-09	21.84%	-10.43%	12.76%	0.00%	-51.65%	-22.79%	0.00%	0.00%	0.00%	-22.20%	0.00%	0.00%	0.00%	-76.62%	9.13%
FY 2009-10 (DA)	4.67%	37.96%	-0.77%	0.00%	310.58%	126.98%	0.00%	0.00%	0.00%	155.23%	911.51%	-100.00%	0.00%	-89.53%	-4.23%
FY 2010-11 (DA)	-12.13%	-36.93%	6.60%	0.00%	-6.96%	87.27%	0.00%	0.00%	0.00%	-76.35%	-89.94%	0.00%	-100.00%	-164.16%	-19.39%
FY 2011-12	4.01%	25.44%	-4.20%	0.00%	-65.13%	-28.35%	31.62%	0.00%	0.00%	74.91%	-64.77%	0.00%	0.00%	-1829.32%	-3.19%
Estimated FY 2012-13	2.18%	2.16%	2.16%	2.16%	2.16%	2.16%	2.16%	2.16%	0.00%	2.16%	2.12%	2.18%	0.00%	2.16%	-3.60%
Estimated FY 2013-14	2.84%	2.67%	2.67%	2.67%	2.67%	2.67%	2.67%	2.67%	0.00%	2.67%	2.71%	2.65%	0.00%	2.67%	-0.79%
Estimated FY 2014-15	0.20%	0.27%	0.27%	0.27%	0.27%	0.27%	0.27%	0.26%	0.00%	0.27%	0.25%	0.25%	0.00%	0.27%	-0.74%

Exhibit G - COMMUNITY BASED LONG TERM CARE - Private Duty Nursing

Cash Based Actuals

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$75,532	$315,738	$9,645,058	$0	$0	$0	$0	$0	$0	$190,788	$2,949,031	$0	$0	$0	$13,176,147
FY 2004-05	$119,147	$360,893	$9,569,473	$0	$0	$0	$0	$0	$0	$505,864	$3,516,516	$0	$0	$0	$14,071,893
FY 2005-06	$157,164	$405,549	$10,536,627	$0	$0	$0	$0	$0	$0	$397,273	$4,120,147	$0	$0	$0	$15,616,760
FY 2006-07	$354,877	$155,949	$12,205,855	$0	$0	$0	$0	$0	$0	$562,535	$3,983,279	$0	$0	$37,261	$17,299,756
FY 2007-08	$313,936	$207,166	$13,885,052	$0	$0	$0	$0	$0	$0	$500,847	$4,832,273	$0	$0	$9,988	$19,749,262
FY 2008-09	$725,105	$186,844	$14,728,104	$0	$0	$0	$0	$0	$0	$250,793	$5,460,562	$0	$0	$0	$21,351,408
FY 2009-10 (DA)	$1,035,252	$240,541	$15,137,079	$0	$0	$0	$0	$0	$0	$604,720	$6,648,963	$0	$0	$0	$23,666,555
FY 2010-11 (DA)	$1,319,816	$0	$17,252,161	$0	$0	$0	$0	$0	$0	$502,792	$8,251,188	$0	$0	$0	$27,325,957
FY 2011-12	$1,832,636	$135,105	$20,720,340	$0	$0	$0	$0	$0	$0	$601,939	$7,854,133	$0	$0	$0	$31,144,153
Estimated FY 2012-13	$1,978,222	$146,628	$22,735,634	$0	$0	$0	$0	$0	$0	$661,136	$8,421,121	$0	$0	$0	$33,942,741
Estimated FY 2013-14	$2,483,446	$163,717	$25,563,609	$0	$0	$0	$0	$0	$0	$739,373	$8,954,473	$0	$0	$0	$37,904,618
Estimated FY 2014-15	$2,344,406	$175,909	$27,621,539	$0	$0	$0	$0	$0	$0	$795,459	$9,485,723	$0	$0	$0	$40,423,036

Percent Change in Cash Based Actuals

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	57.74%	14.30%	-0.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	165.14%	19.24%	0.00%	0.00%	0.00%	6.80%
FY 2005-06	31.91%	12.37%	10.11%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-21.47%	17.17%	0.00%	0.00%	0.00%	10.98%
FY 2006-07	125.80%	-61.55%	15.84%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	41.60%	-3.32%	0.00%	0.00%	100.00%	10.78%
FY 2007-08	-11.54%	32.84%	13.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.97%	21.31%	0.00%	0.00%	-73.19%	14.16%
FY 2008-09	130.97%	-9.81%	6.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-49.93%	13.00%	0.00%	0.00%	-100.00%	8.11%
FY 2009-10 (DA)	42.77%	28.74%	2.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	141.12%	21.76%	0.00%	0.00%	0.00%	10.84%
FY 2010-11 (DA)	27.49%	-100.00%	13.97%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-16.86%	24.10%	0.00%	0.00%	0.00%	15.46%
FY 2011-12	38.86%	100.00%	20.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	19.72%	-4.81%	0.00%	0.00%	0.00%	13.97%
Estimated FY 2012-13	7.94%	8.53%	9.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.83%	7.22%	0.00%	0.00%	0.00%	8.99%
Estimated FY 2013-14	25.54%	11.65%	12.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.83%	6.33%	0.00%	0.00%	0.00%	11.67%
Estimated FY 2014-15	-5.60%	7.45%	8.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.59%	5.93%	0.00%	0.00%	0.00%	6.64%

Per Capita Cost

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$2.20	$56.91	$206.14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.98	$197.74	$0.00	$0.00	$0.00	$35.85
FY 2004-05	$3.33	$59.34	$199.66	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.27	$222.63	$0.00	$0.00	$0.00	$34.66
FY 2005-06	$4.34	$67.12	$220.18	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.86	$250.31	$0.00	$0.00	$0.00	$38.83
FY 2006-07	$9.89	$25.74	$250.13	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.74	$238.18	$0.00	$0.00	$2.89	$44.11
FY 2007-08	$8.65	$33.71	$278.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.45	$281.91	$0.00	$0.00	$0.70	$50.39
FY 2008-09	$19.27	$28.98	$286.79	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.07	$302.81	$0.00	$0.00	$0.00	$48.88
FY 2009-10 (DA)	$26.90	$34.12	$284.19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.19	$361.73	$0.00	$0.00	$0.00	$47.45
FY 2010-11 (DA)	$33.91	$0.00	$306.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.66	$448.60	$0.00	$0.00	$0.00	$48.73
FY 2011-12	$46.12	$16.12	$348.63	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.80	$435.52	$0.00	$0.00	$0.00	$50.24
Estimated FY 2012-13	$49.01	$16.52	$371.86	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.82	$468.00	$0.00	$0.00	$0.00	$49.80
Estimated FY 2013-14	$60.29	$17.50	$408.23	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.84	$495.90	$0.00	$0.00	$0.00	$51.33
Estimated FY 2014-15	$55.71	$17.91	$432.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.86	$520.94	$0.00	$0.00	$0.00	$52.07

Percent Change in Per Capita Cost

COMMUNITY BASED LONG TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	51.36%	4.27%	-3.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	131.63%	12.59%	0.00%	0.00%	0.00%	-3.32%
FY 2005-06	30.33%	13.11%	10.28%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-18.06%	12.43%	0.00%	0.00%	0.00%	12.03%
FY 2006-07	127.88%	-61.65%	13.60%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	47.31%	-4.85%	0.00%	0.00%	100.00%	13.60%
FY 2007-08	-12.54%	30.96%	11.17%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.58%	18.36%	0.00%	0.00%	-75.78%	14.24%
FY 2008-09	122.77%	-14.03%	3.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-56.33%	7.41%	0.00%	0.00%	-100.00%	-3.00%
FY 2009-10 (DA)	39.60%	17.74%	-0.91%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	104.67%	19.46%	0.00%	0.00%	0.00%	-2.93%
FY 2010-11 (DA)	26.06%	-100.00%	7.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-24.20%	24.02%	0.00%	0.00%	0.00%	2.70%
FY 2011-12	36.01%	100.00%	13.74%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.43%	-2.92%	0.00%	0.00%	0.00%	3.10%
Estimated FY 2012-13	6.27%	2.48%	6.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.11%	7.46%	0.00%	0.00%	0.00%	-0.88%
Estimated FY 2013-14	23.02%	5.93%	9.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.10%	5.96%	0.00%	0.00%	0.00%	3.07%
Estimated FY 2014-15	-7.60%	2.34%	5.83%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.09%	5.05%	0.00%	0.00%	0.00%	1.44%

Exhibit G - COMMUNITY BASED LONG TERM CARE - Private Duty Nursing

	Current Year Projection														
COMMUNITY BASED LONG TERM CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-in**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Adults without Dependent Children**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Registered Nurse Services															
FY 2011-12 Hours	24,916	2,287	426,230	0	0	0	0	0	0	10,783	74,031	0	0	0	538,247
Estimated Growth Rate	10.86%	10.86%	10.86%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.86%	10.86%	0.00%	0.00%	0.00%	10.86%
Estimated FY 2012-13 Hours	27,623	2,535	472,536	0	0	0	0	0	0	11,954	82,074	0	0	0	596,722
FY 2011-12 Rate	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2012-13 Rate	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80
Estimated FY 2012-13 Expenditures	**$1,016,543**	**$93,290**	**$17,389,609**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$439,914**	**$3,020,373**	**$0**	**$0**	**$0**	**$21,959,729**
Registered Nurse Services Group , Licensed Practical Nurse Services, and Blended Services															
FY 2011-12 Hours	32,760	1,817	180,301	0	0	0	0	0	0	7,536	164,056	0	0	0	386,470
Estimated Growth Rate	6.01%	6.01%	6.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.01%	6.01%	0.00%	0.00%	0.00%	6.01%
Estimated FY 2012-13 Hours	34,730	1,926	191,141	0	0	0	0	0	0	7,989	173,919	0	0	0	409,705
FY 2011-12 Rate	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2012-13 Rate	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69
Estimated FY 2012-13 Expenditures	**$961,679**	**$53,339**	**$5,292,785**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$221,221**	**$4,815,909**	**$0**	**$0**	**$0**	**$11,344,932**
LPN-Group Services															
FY 2011-12 Hours	0	0	2,420	0	0	0	0	0	0	0	26,584	0	0	0	29,004
Estimated Growth Rate	3.44%	3.44%	3.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.44%	0.00%	0.00%	0.00%	3.44%
Estimated FY 2012-13 Hours	0	0	2,503	0	0	0	0	0	0	0	27,499	0	0	0	30,002
FY 2011-12 Rate	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2012-13 Rate	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27
Estimated FY 2012-13 Expenditures	**$0**	**$0**	**$53,239**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$584,840**	**$0**	**$0**	**$0**	**$638,079**
Totals															
Bottom Line Impacts															
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total FY 2012-13 Estimated Expenditure	**$1,978,222**	**$146,628**	**$22,735,634**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$661,136**	**$8,421,121**	**$0**	**$0**	**$0**	**$33,942,741**
% Change over Total FY 2011-12 Expenditure	7.94%	8.53%	9.73%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.83%	7.22%	0.00%	0.00%	0.00%	8.99%

Exhibit G - COMMUNITY BASED LONG TERM CARE - Private Duty Nursing

Request Year Projection															
COMMUNITY BASED LONG TERM CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-in**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Adults without Dependent Children**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Registered Nurse Services															
Estimated FY 2012-13 Hours	27,623	2,535	472,536	0	0	0	0	0	0	11,954	82,074	0	0	0	596,722
Estimated Growth Rate	12.15%	12.15%	12.15%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	12.15%	12.15%	0.00%	0.00%	0.00%	12.15%
Estimated FY 2013-14 Hours	30,980	2,843	529,962	0	0	0	0	0	0	13,407	92,048	0	0	0	669,240
Estimated FY 2012-13 Rate	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2013-14 Rate	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80
Estimated FY 2013-14 Expenditures	**$1,140,081**	**$104,627**	**$19,502,928**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$493,376**	**$3,387,432**	**$0**	**$0**	**$0**	**$24,628,444**
Registered Nurse Services Group , Licensed Practical Nurse Services, and Blended Services															
Estimated FY 2012-13 Hours	34,730	1,926	191,141	0	0	0	0	0	0	7,989	173,919	0	0	0	409,705
Estimated Growth Rate	6.01%	6.01%	6.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.01%	0.00%	0.00%	0.00%	0.00%	6.01%
Estimated FY 2013-14 Hours	36,818	2,042	202,632	0	0	0	0	0	0	8,469	173,919	0	0	0	434,336
FY 2011-12 Rate	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2012-13 Rate	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69
Estimated FY 2013-14 Expenditures	**$1,019,495**	**$56,545**	**$5,610,990**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$234,521**	**$4,815,909**	**$0**	**$0**	**$0**	**$12,026,995**
LPN-Group Services															
Estimated FY 2012-13 Hours	0	0	2,503	0	0	0	0	0	0	0	27,499	0	0	0	30,002
Estimated Growth Rate	0.00%	0.00%	3.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.44%	0.00%	0.00%	0.00%	3.44%
Estimated FY 2013-14 Hours	0	0	2,589	0	0	0	0	0	0	0	28,445	0	0	0	31,035
Estimated FY 2012-13 Rate	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2013-14 Rate	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27
Estimated FY 2013-14 Expenditures	**$0**	**$0**	**$55,072**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$604,968**	**$0**	**$0**	**$0**	**$660,040**
Totals															
Bottom Line Impacts															
53-week payment cycle in FY 2013-14	$34,336	$2,545	$394,620	$0	$0	$0	$0	$0	$0	$11,475	$146,164	$0	$0	$0	$589,140
Total Bottom Line Impacts	**$34,336**	**$2,545**	**$394,620**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$11,475**	**$146,164**	**$0**	**$0**	**$0**	**$589,140**
Total FY 2013-14 Estimated Expenditure	**$2,483,446**	**$163,717**	**$25,563,609**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$739,373**	**$8,954,473**	**$0**	**$0**	**$0**	**$37,904,618**
% Change over Total FY Estimated 2012-13 Expenditure	25.54%	11.65%	12.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.83%	6.33%	0.00%	0.00%	0.00%	11.67%

Exhibit G - COMMUNITY BASED LONG TERM CARE - Private Duty Nursing

Out Year Projection															
COMMUNITY BASED LONG TERM CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-in**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60%**	**Expansion Adults to 100%**	**Adults without Dependent Children**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Registered Nurse Services															
Estimated FY 2013-14 Hours	30,980	2,843	529,962	0	0	0	0	0	0	13,407	92,048	0	0	0	669,240
Estimated Growth Rate	10.84%	10.84%	10.84%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.84%	10.84%	0.00%	0.00%	0.00%	10.84%
Estimated FY 2014-15 Hours	34,337	3,151	587,388	0	0	0	0	0	0	14,859	102,023	0	0	0	741,758
Estimated FY 2013-14 Rate	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2014-15 Rate	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80	$36.80
Estimated FY 2014-15 Expenditures	**$1,263,619**	**$115,964**	**$21,616,247**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$546,838**	**$3,754,490**	**$0**	**$0**	**$0**	**$27,297,159**
Registered Nurse Services Group , Licensed Practical Nurse Services, and Blended Services															
Estimated FY 2013-14 Hours	36,818	2,042	202,632	0	0	0	0	0	0	8,469	173,919	0	0	0	434,336
Estimated Growth Rate	6.01%	6.01%	6.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.01%	6.01%	0.00%	0.00%	0.00%	6.01%
Estimated FY 2014-15 Hours	39,031	2,165	214,815	0	0	0	0	0	0	8,979	184,375	0	0	0	460,449
Estimated FY 2013-14 Rate	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2014-15 Rate	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69	$27.69
Estimated FY 2014-15 Expenditures	**$1,080,788**	**$59,945**	**$5,948,325**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$248,621**	**$5,105,443**	**$0**	**$0**	**$0**	**$12,750,063**
LPN-Group Services															
Estimated FY 2013-14 Hours	0	0	2,589	0	0	0	0	0	0	0	28,445	0	0	0	31,035
Estimated Growth Rate	0.00%	0.00%	3.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.44%	0.00%	0.00%	0.00%	3.44%
Estimated FY 2014-15 Hours	0	0	2,679	0	0	0	0	0	0	0	29,424	0	0	0	32,103
Estimated FY 2013-14 Rate	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2014-15 Rate	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27	$21.27
Estimated FY 2014-15 Expenditures	**$0**	**$0**	**$56,967**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$625,789**	**$0**	**$0**	**$0**	**$682,756**
Totals															
Bottom Line Impacts															
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total FY 2014-15 Estimated Expenditure	**$2,344,407**	**$175,909**	**$27,621,539**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$795,459**	**$9,485,723**	**$0**	**$0**	**$0**	**$40,423,036**
% Change over Total FY 2013-14 Estimated Expenditure	-5.60%	7.45%	8.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.59%	5.93%	0.00%	0.00%	0.00%	6.64%

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

Colorado Choice Transitions Budget Impact						
Fiscal Year	**Item**	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**Location of Budget Impact**
FY 2012-13	Demonstration Services (New Services)	$415,820	$103,955	$0	$311,865	Exhibit G
	Qualified Services (Existing Waiver Services)	$68,700	$17,175	$0	$51,525	Exhibit G
	Home Health	$24,406	$6,101	$0	$18,305	Exhibit F
	Total Estimated Cost of Services	$508,926	$127,231	$0	$381,695	
	Estimated Savings from Avoided Nursing Facility Expenditure	($517,114)	($258,557)	$0	($258,557)	Exhibit H
	Total Medical Services Premiums Impact	**($8,188)**	**($131,326)**	**$0**	**$123,138**	
	Rebalancing Fund [1]	$127,232	$0	$0	$127,232	Non-Appropriated Line Item
	Total Budget Impact	$119,044	($131,326)	$0	$250,370	
FY 2013-14	Demonstration Services (New Services)	$2,598,878	$649,719	$0	$1,949,159	Exhibit G
	Qualified Services (Existing Waiver Services)	$572,880	$143,220	$0	$429,660	Exhibit G
	Home Health	$152,536	$38,134	$0	$114,402	Exhibit F
	Total Estimated Cost of Services	$3,324,294	$831,073	$0	$2,493,221	
	Estimated Savings from Avoided Nursing Facility Expenditure	($3,927,327)	($1,963,663)	$0	($1,963,664)	Exhibit H
	Total Medical Services Premiums Impact	**($603,033)**	**($1,132,590)**	**$0**	**$529,557**	
	Rebalancing Fund [1]	$831,074	$0	$0	$831,074	Non-Appropriated Line Item
	Total Budget Impact	$228,041	($1,132,590)	$0	$1,360,631	
FY 2014-15	Demonstration Services (New Services)	$3,465,171	$866,293	$0	$2,598,878	Exhibit G
	Qualified Services (Existing Waiver Services)	$1,635,405	$408,851	$0	$1,226,554	Exhibit G
	Home Health	$203,381	$50,845	$0	$152,536	Exhibit F
	Total Estimated Cost of Services	$5,303,957	$1,325,989	$0	$3,977,968	
	Estimated Savings from Avoided Nursing Facility Expenditure	($8,639,028)	($4,319,514)	$0	($4,319,514)	Exhibit H
	Total Medical Services Premiums Impact	**($3,335,071)**	**($2,993,525)**	**$0**	**($341,546)**	
	Rebalancing Fund [1]	$1,325,989	$0	$0	$1,325,989	Non-Appropriated Line Item
	Total Budget Impact	($2,009,082)	($2,993,525)	$0	$984,443	

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

Exhibit H - Long Term Care and Insurance Summary

FY 2012-13 Long Term Care and Insurance Request															
FY 2012-13	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60% FPL**	**Expansion Adults to 100% FPL**	**Adults without Dependent Children (AwDC)**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Class I Nursing Facilities	$428,414,076	$34,964,656	$79,273,409	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$412,179	$543,064,320
Class II Nursing Facilities	$0	$940,754	$3,086,671	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,027,425
Program for All-Inclusive Care for the Elderly	$79,949,447	$7,888,312	$3,512,174	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$91,349,933
Subtotal Long Term Care	**$508,363,523**	**$43,793,722**	**$85,872,254**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$412,179**	**$638,441,678**
Supplemental Medicare Insurance Benefit	$62,781,854	$3,821,373	$33,409,561	$2,054,562	$216,812	$0	$0	$0	$0	$0	$0	$0	$0	$19,839,460	$122,123,622
Health Insurance Buy-In	$5,506	$16,944	$2,857,162	$0	$24,765	$0	$0	$0	$0	$33,088	$5,451	$8,549	$0	$0	$2,951,465
Subtotal Insurance	**$62,787,360**	**$3,838,317**	**$36,266,723**	**$2,054,562**	**$241,577**	**$0**	**$0**	**$0**	**$0**	**$33,088**	**$5,451**	**$8,549**	**$0**	**$19,839,460**	**$125,075,087**
Total Long Term Care and Insurance	**$571,150,883**	**$47,632,039**	**$122,138,977**	**$2,054,562**	**$241,577**	**$0**	**$0**	**$0**	**$0**	**$33,088**	**$5,451**	**$8,549**	**$0**	**$20,251,639**	**$763,516,765**
Class I Nursing Facility Supplemental Payments	$68,465,150	$5,587,726	$12,668,738	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$65,871	$86,787,485
Total Long Term Care and Insurance Including Financing	**$639,616,033**	**$53,219,765**	**$134,807,715**	**$2,054,562**	**$241,577**	**$0**	**$0**	**$0**	**$0**	**$33,088**	**$5,451**	**$8,549**	**$0**	**$20,317,510**	**$850,304,250**

FY 2013-14 Long Term Care and Insurance Request															
FY 2013-14	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60% FPL**	**Expansion Adults to 100% FPL**	**Adults without Dependent Children (AwDC)**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
Class I Nursing Facilities	$453,958,065	$37,049,407	$84,000,049	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$436,755	$575,444,276
Class II Nursing Facilities	$0	$1,102,987	$3,618,967	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,721,954
Program for All-Inclusive Care for the Elderly	$91,610,888	$9,586,806	$4,179,188	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$105,376,882
Subtotal Long Term Care	**$545,568,953**	**$47,739,200**	**$91,798,204**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$436,755**	**$685,543,112**
Supplemental Medicare Insurance Benefit	$68,130,573	$4,284,141	$36,353,982	$5,477,299	$242,963	$0	$0	$0	$0	$0	$0	$0	$0	$22,988,760	$137,477,718
Health Insurance Buy-In	$11,168	$34,374	$5,796,161	$0	$50,239	$0	$0	$0	$0	$67,124	$10,546	$17,344	$0	$0	$5,986,956
Subtotal Insurance	**$68,141,741**	**$4,318,515**	**$42,150,143**	**$5,477,299**	**$293,202**	**$0**	**$0**	**$0**	**$0**	**$67,124**	**$10,546**	**$17,344**	**$0**	**$22,988,760**	**$143,464,674**
Total Long Term Care and Insurance	**$613,710,694**	**$52,057,715**	**$133,948,347**	**$5,477,299**	**$293,202**	**$0**	**$0**	**$0**	**$0**	**$67,124**	**$10,546**	**$17,344**	**$0**	**$23,425,515**	**$829,007,786**
Class I Nursing Facility Supplemental Payments	$66,142,070	$5,398,130	$12,238,877	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$63,636	$83,842,713
Total Long Term Care and Insurance Including Financing	**$679,852,764**	**$57,455,845**	**$146,187,224**	**$5,477,299**	**$293,202**	**$0**	**$0**	**$0**	**$0**	**$67,124**	**$10,546**	**$17,344**	**$0**	**$23,489,151**	**$912,850,499**

Exhibit H - Long Term Care and Insurance Summary

FY 2014-15 Long Term Care and Insurance Request															
FY 2014-15	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Class I Nursing Facilities	$462,041,447	$37,709,126	$85,495,791	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$444,532	$585,690,896
Class II Nursing Facilities	$0	$1,198,092	$3,931,012	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,129,104
Program for All-Inclusive Care for the Elderly	$103,379,535	$11,133,265	$4,755,143	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$119,267,943
Subtotal Long Term Care	**$565,420,982**	**$50,040,483**	**$94,181,946**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$444,532**	**$710,087,943**
Supplemental Medicare Insurance Benefit	$74,113,494	$4,789,468	$39,527,069	$8,930,146	$264,196	$0	$0	$0	$0	$0	$0	$0	$0	$26,635,530	$154,259,903
Health Insurance Buy-In	$12,217	$37,602	$6,340,421	$0	$54,956	$0	$0	$0	$0	$73,427	$10,546	$18,973	$0	$0	$6,548,142
Subtotal Insurance	**$74,125,711**	**$4,827,070**	**$45,867,490**	**$8,930,146**	**$319,152**	**$0**	**$0**	**$0**	**$0**	**$73,427**	**$10,546**	**$18,973**	**$0**	**$26,635,530**	**$160,808,045**
Total Long Term Care and Insurance	**$639,546,693**	**$54,867,553**	**$140,049,436**	**$8,930,146**	**$319,152**	**$0**	**$0**	**$0**	**$0**	**$73,427**	**$10,546**	**$18,973**	**$0**	**$27,080,062**	**$870,895,988**
Class I Nursing Facility Supplemental Payments	$68,060,191	$5,554,675	$12,593,805	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$65,481	$86,274,152
Total Long Term Care and Insurance Including Financing	**$707,606,884**	**$60,422,228**	**$152,643,241**	**$8,930,146**	**$319,152**	**$0**	**$0**	**$0**	**$0**	**$73,427**	**$10,546**	**$18,973**	**$0**	**$27,145,543**	**$957,170,140**

Class I Nursing Home Calculations for FY 2012-13, FY 2013-14 and FY 2014-15

FY 2012-13 Calculation

Service Expenditures:	Core Components	Reference
Estimate of FY 2012-13 General Fund Portion of Per Diem Rate	$190.83	Footnote 1
Estimate of FY 2012-13 Patient Payment (per day)	($34.83)	Footnote 1
Estimated FY 2012-13 Medicaid Reimbursement (per day)	**$156.00**	
Estimate of Patient Days (without Hospital Back Up)	3,552,485	Footnote 2
Total Estimated Costs for FY 2012-13 Days of Service	$554,191,361	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.43%	Footnote 4
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$512,239,075	
Estimated Expenditures for FY 2011-12 Dates of Service	$39,041,708	Footnote 5
Estimated Expenditures in FY 2012-13 Prior to Adjustments	**$551,280,783**	
Bottom Line Adjustments:		
Hospital Back Up Program	$4,571,186	Footnote 6
Recoveries from Department Overpayment Review	($2,139,323)	Footnote 7
Savings from days incurred in FY 2011-12 and paid in FY 2012-13 under SB 11-215	($734,144)	Footnote 8
HB 12-1340 1.5% rate reduction Effective July 1, 2012	($9,397,068)	Footnote 8
Colorado Choice Transitions	($517,114)	Exhibit G
Total Bottom Line Adjustments:	**($8,216,463)**	
Total Estimated FY 2012-13 General Fund Expenditures	**$543,064,320**	
Percentage Change in Core Component Expenditure Over Prior Year	4.00%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$43,446,400	Page EH-10
Prior Year Rate Reconciliation	$5,277,654	Page EH-10
Rate Cut Backfill	$0	Page EH-10
Cognitive Performance Scale	$807,125	Page EH-10
PASRR - Resident	$2,773,147	Page EH-10
PASRR - Facility	$641,003	Page EH-10
Medicaid Supplemental Payment	$29,614,476	Page EH-10
Pay for Performance	$4,227,680	Page EH-10
Total Estimated Supplemental Payments	**$86,787,485**	
Total Estimated FY 2012-13 Expenditures	**$629,851,805**	

Class I Nursing Home Calculations for FY 2012-13, FY 2013-14 and FY 2014-15		
FY 2013-14 Calculation		
Service Expenditures:	**Core Components**	**Reference**
Estimate of FY 2013-14 General Fund Portion of Per Diem Rate	$195.25	Footnote 1
Estimate of FY 2013-14 Patient Payment (per day)	($35.12)	Footnote 1
Estimated FY 2013-14 Medicaid Reimbursement (per day)	**$160.13**	
Estimate of Patient Days (without Hospital Back Up)	3,575,470	Footnote 2
Total Estimated Costs for FY 2013-14 Days of Service	$572,546,998	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.43%	Footnote 4
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$529,205,190	
Estimated Expenditures for FY 2012-13 Dates of Service	$41,952,286	Footnote 5
Estimated Expenditures in FY 2013-14 Prior to Adjustments	**$571,157,476**	
Bottom Line Adjustments:		
Hospital Back Up Program	$4,571,186	Footnote 6
Recoveries from Department Overpayment Review	($2,218,264)	Footnote 7
Savings from days incurred in FY 2012-13 and paid in FY 2013-14 under HB 12-1340	($769,618)	Footnote 8
Colorado Choice Transitions	($3,927,327)	Exhibit G
Estimated Expenditures from Additional Payment Cycle	$6,630,823	Footnote 9
Total Bottom Line Adjustments:	**$4,286,800**	
Total Estimated FY 2013-14 Expenditures	**$575,444,276**	
Percentage Change in Core Component Expenditure Over Prior Year	5.96%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$34,456,677	Page EH-10
Prior Year Rate Reconciliation	$7,746,924	Page EH-10
Rate Cut Backfill	$0	Page EH-10
Cognitive Performance Scale	$886,643	Page EH-10
PASRR - Resident	$2,966,460	Page EH-10
PASRR - Facility	$440,770	Page EH-10
Medicaid Supplemental Payment	$30,669,660	Page EH-10
Pay for Performance	$6,675,579	Page EH-10
Total Estimated Supplemental Payments	**$83,842,713**	
Total Estimated FY 2013-14 Expenditures	**$659,286,989**	

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES

FY 2014-15 Calculation		
Service Expenditures:	**Core Components**	**Reference**
Estimate of FY 2014-15 General Fund Portion of Per Diem Rate	$200.57	Footnote 1
Estimate of FY 2014-15 Patient Payment (per day)	($35.63)	Footnote 1
Estimated FY 2014-15 Medicaid Reimbursement (per day)	**$164.94**	
Estimate of Patient Days (without Hospital Back Up)	3,599,261	Footnote 2
Total Estimated Costs for FY 2014-15 Days of Service	$593,656,873	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.43%	Footnote 4
Estimated Expenditures for Claims Paid in Current Year with Current Year Dates of Service	$548,717,048	
Estimated Expenditures for FY 2013-14 Dates of Service	$43,341,808	Footnote 5
Estimated Expenditures in FY 2014-15 Prior to Adjustments	**$592,058,856**	
Bottom Line Adjustments:		
Hospital Back Up Program	$4,571,186	Footnote 6
Recoveries from Department Overpayment Review	($2,300,118)	Footnote 7
Colorado Choice Transitions	($8,639,028)	Exhibit G
Total Bottom Line Adjustments:	**($6,367,960)**	
Total Estimated FY 2014-15 Expenditures	**$585,690,896**	
Percentage Change in Core Component Expenditure Over Prior Year	1.78%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$43,189,422	Page EH-10
Prior Year Rate Reconciliation	$5,246,438	Page EH-10
Rate Cut Backfill	$0	Page EH-10
Cognitive Performance Scale	$802,351	Page EH-10
PASRR - Resident	$2,756,744	Page EH-10
PASRR - Facility	$637,212	Page EH-10
Medicaid Supplemental Payment	$29,439,311	Page EH-10
Pay for Performance	$4,202,674	Page EH-10
Total Estimated Supplemental Payments	**$86,274,152**	
Total Estimated FY 2014-15 Expenditures	**$671,965,048**	

Class I Nursing Home Calculations for FY 2012-13 , FY 2013-14 and FY 2014-15 Footnotes:

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

Year	Per Diem	Patient Payment	Final Paid Rate	Rate Reduction	Per Diem Before Rate Reduction
FY 2002-03	$131.06	$24.75	$106.31	-	$131.06
FY 2003-04	$143.49	$24.93	$118.56	-	$143.49
FY 2004-05	$150.15	$25.89	$124.26	-	$150.15
FY 2005-06	$157.34	$27.52	$129.82	-	$157.34
FY 2006-07	$166.30	$30.25	$136.05	-	$166.30
FY 2007-08	$169.28	$31.20	$138.08	-	$169.28
FY 2008-09	$190.34	$33.10	$157.24	-	$190.34
FY 2009-10	$178.83	$33.58	$145.25	0.50%	$178.83
FY 2010-11	$173.27	$33.21	$140.06	2.50%	$177.71
FY 2011-12	$180.57	$34.09	$149.23	1.50%	$183.32
Estimated FY 2012-13	$187.97	$34.83	$153.14	1.50%	$190.83
Estimated FY 2013-14	$195.25	$35.12	$160.13	-	$195.25
Estimated FY 2014-15	$200.57	$35.63	$164.94		$200.57

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

Fiscal Year	Patient Days	Percentage Change	Full Time Equivalent Clients	Percentage Change
FY 2000-01	3,712,731	-	10,172	-
FY 2001-02	3,618,218	-2.55%	9,913	-2.55%
FY 2002-03	3,538,295	-2.21%	9,694	-2.21%
FY 2003-04	3,502,849	-1.00%	9,571	-1.27%
FY 2004-05	3,519,234	0.47%	9,642	0.74%
FY 2005-06	3,529,589	0.29%	9,670	0.29%
FY 2006-07	3,546,807	0.49%	9,717	0.49%
FY 2007-08	3,435,003	-3.15%	9,385	-3.42%
FY 2008-09	3,427,430	-0.22%	9,390	0.05%
FY 2009-10	3,452,331	0.73%	9,458	0.72%
FY 2010-11	3,526,588	2.15%	9,662	2.16%
FY 2011-12	3,520,854	-0.16%	9,620	-0.43%
Estimated FY 2012-13	3,552,485	0.90%	9,733	1.17%
Estimated FY 2013-14	3,575,470	0.65%	9,796	0.65%
Estimated FY 2014-15	3,599,261	0.67%	9,861	0.66%

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

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

Estimate of Claims Incurred and Paid in the Same Fiscal Year

Month Incurred	Additional Months Until End of Fiscal Year	Estimated Percent Complete at End of Fiscal Year
July	11	99.85%
August	10	99.78%
September	9	99.67%
October	8	99.50%
November	7	99.25%
December	6	98.70%
January	5	97.95%
February	4	97.13%
March	3	95.82%
April	2	93.61%
May	1	89.98%
June	0	37.93%
Average		92.43%

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

(5) As calculated in the table below, the estimated FY 2012-13 expenditure for core components with FY 2011-12 dates of service is the estimated FY 2011-12 core components per diem rate, less the estimated per diem patient payment rate, multiplied by the estimated number of patient days. This calculation is then multiplied by one minus the calculated IBNR rate.

Calculation of Expenditures From Claims in Previous Fiscal Year	FY 2011-12	Source
IBNR Factor	92.43%	Footnote (4)
Estimated Patient Days from previous fiscal year	3,520,854	Footnote (2)
Estimated Per Diem Rate for Core Components for previous fiscal year	$180.57	Footnote (1)
Less: Estimated Patient Payment Rate for previous fiscal year	$34.09	Footnote (1)
Estimated claims expenditures for core components from previous fiscal year to be paid in the current fiscal year	$39,041,708	As described in Footnote (5) narrative

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

Fiscal Year	Hospital Back Up	Percent Difference
FY 2003-04	$4,907,936	-
FY 2004-05	$5,731,131	16.77%
FY 2005-06	$5,033,659	-12.17%
FY 2006-07	$5,615,794	11.56%
FY 2007-08	$5,309,178	-5.46%
FY 2008-09	$6,920,964	30.36%
FY 2009-10	$4,376,832	-36.76%
FY 2010-11	$4,731,471	8.10%
FY 2011-12	$3,549,186	-24.99%
Estimated FY 2012-13	$4,571,186	0.00%
Estimated FY 2013-14	$4,571,186	0.00%
Estimated FY 2014-15	$4,571,186	0.00%

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

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES
Footnotes and Assumptions

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

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

Fiscal Year	Overpayment Recoveries	Percent Difference
FY 2010-11	$1,797,766	-
FY 2011-12	$2,063,191	14.76%
Estimated FY 2012-13	$2,139,323	3.69%
Estimated FY 2013-14	$2,218,264	3.69%
Estimated FY 2014-15	$2,300,118	3.69%

(8) HB 10-1324 imposed a rate reduction of 1.5% effective March 1, 2010 and effective until June 30, 2011. HB 10-1379 imposed a rate reduction of 1% in addition to the rate reduction of HB 10-1324 for the period of July 1, 2010 to June 30, 2011. SB 11-215 imposed a rate reduction of 1.5% effective July 1, 2011 for FY 2011-12 that was extended for FY 2012-13 by HB 12-1340. The rate reductions apply to all days incurred under the effective periods of each bill. As not all days will be reported in the fiscal year in which they are incurred, the impact of the rate cuts extends over multiple fiscal years. The tables below show the incremental impact of the three bills. These figures may vary from previous submissions of the Department's requests due to revised forecasts for rates and patient days.

SB 11-215	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
FY 2011-12 Rates	1.50%	$183.32	$180.57	($2.75)
FY 2011-12 Patient days				3,520,854
Estimated FY 2011-12 Days Paid in FY 2011-12				3,254,325
Total FY 2011-12 Impact				**($8,963,910)**
Estimated FY 2011-12 Days Paid in FY 2012-13				266,529
Total FY 2012-13 Impact				**($734,144)**

HB 12-1340	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
Estimated FY 2012-13 Rates	1.50%	$190.83	$187.97	($2.86)
Estimated FY 2012-13 Patient days				3,552,485
Estimated FY 2012-13 Days Paid in FY 2012-13				3,283,562
Total FY 2012-13 Impact				**($9,397,068)**
Estimated FY 2012-13 Days Paid in FY 2013-14				268,923
Total FY 2013-14 Impact				**($769,618)**

(9) There are 53 payment cycles in FY 2013-14 rather than the typical 52. Accordingly, an adjustment derived from the difference in expected expenditure between four-payment and five-payment months is added as a bottom line impact.

Expected FY 2013-14 Expenditure due to Additional Payment Cycle	
Average portion of monthly expenditure paid on fifth period	12.75%
Proportion of five-period month to truncated four-period month	1.146097845
Forecasted FY 2013-14 expenditure	$571,157,476
Expected payment in four-period month	$45,386,182
Expected payment in five-period month	$52,017,005
Final Adjustment	**$6,630,823**

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES
Supplemental Payments

Class I Nursing Facilities Supplemental Payments											
Year	Provider Fee Per Non Medicare Day Paid by Low Medicaid Volume Facilities	Provider Fee Per Non Medicare Day Paid by High Medicaid Volume Facilities	Growth Beyond General Fund Cap	Prior Year Rate Reconciliation	Rate Cut Backfill	Cognitive Performance Scale	PASRR - Resident[1]	PASRR - Facility[1]	Medicaid Supplemental Payment	Pay for Performance	Total Effective Add-on/ Supplemental
FY 2009-10	$5.90	$0.28	$31,277,211	$0	$2,995,689	$958,621	$2,713,717	$418,432	$12,830,094	$2,525,948	**$53,719,712**
FY 2010-11	$7.62	$1.17	$48,220,038	$6,575,460	$0	$81,245	$198,782	$49,344	$17,743,388	$1,174,416	**$74,042,673**
FY 2011-12	$12.35	$1.90	$43,446,400	$5,277,654	$0	$807,125	$2,773,147	$641,003	$29,614,476	$4,227,680	**$86,787,485**
Projected FY 2012-13	$12.67	$1.95	$34,456,677	$7,746,924	$0	$886,643	$2,966,460	$440,770	$30,669,660	$6,675,579	**$83,842,713**
Projected FY 2013-14	$13.04	$2.01	$43,189,422	$5,246,438	$0	$802,351	$2,756,744	$637,212	$29,439,311	$4,202,674	**$86,274,152**
Projected FY 2014-15	$13.42	$2.07	$44,441,915	$5,398,584	$0	$825,619	$2,836,690	$655,691	$30,293,051	$4,324,552	**$88,776,102**
Percent Change	Provider Fee Per Non Medicare Day Paid by Low Medicaid Volume Facilities	Provider Fee Per Non Medicare Day Paid by High Medicaid Volume Facilities	Growth Beyond General Fund Cap	Prior Year Rate Reconciliation	Rate Cut Backfill	Cognitive Performance Scale	PASRR - Resident[1]	PASRR - Facility[1]	Medicaid Supplemental Payment	Pay for Performance	Total Effective Add-on/ Supplemental
FY 2010-11	29.24%	317.86%	54.17%	-	-100.00%	-91.52%	-92.67%	-88.21%	38.30%	-53.51%	**37.83%**
Projected FY 2011-12	61.97%	62.4%	-9.90%	-19.74%	-	893.45%	1295.07%	1199.05%	66.90%	259.98%	**17.21%**
Projected FY 2012-13	2.59%	2.6%	-20.69%	46.79%	-	9.85%	6.97%	-31.24%	3.56%	57.90%	**-3.39%**
Projected FY 2013-14	2.92%	3.1%	25.34%	-32.28%	-	-9.51%	-7.07%	44.57%	-4.01%	-37.04%	**2.90%**

(1)PASRR: Preadmission Screening and Resident Review

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

Cash Based Actuals

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$336,650,323	$16,720,841	$62,600,540	$0	$12,286	$0	$0	$0	$0	$0	$0	$0	$0	$27,022	$416,011,012
FY 2004-05	$342,142,204	$19,699,056	$61,974,535	$0	$56,072	$0	$0	$0	$0	$0	$0	$0	$0	$6,466	$423,878,333
FY 2005-06	$370,539,529	$22,631,623	$63,039,217	$0	($10,541)	$0	$0	$0	$0	$1,810	$0	$0	$0	$318,690	$456,520,328
FY 2006-07	$384,275,629	$24,171,304	$68,903,820	$0	$1,596	$0	$0	$0	$0	$0	$0	$0	$0	$951,138	$478,303,487
FY 2007-08	$389,399,454	$25,395,243	$69,952,848	$0	$6,325	$0	$0	$0	$0	$0	$0	$0	$0	$1,814,628	$486,568,498
FY 2008-09	$423,682,370	$29,953,087	$77,004,135	$0	$22,194	$0	$0	$0	$0	$0	$0	$0	$0	$256,886	$530,918,672
FY 2009-10 (DA)	$393,028,828	$28,956,277	$73,847,716	$0	$5,285	$0	$0	$0	$0	$0	$0	$0	$0	$62,685	$495,900,792
FY 2010-11 (DA)	$390,609,241	$31,625,232	$76,509,001	$0	$7,615	$0	$0	$0	$0	$0	$0	$0	$0	$564,302	$499,315,391
FY 2011-12	$411,201,009	$33,559,826	$76,088,316	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$395,618	$521,244,769
Estimated FY 2012-13	$428,414,076	$34,964,656	$79,273,409	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$412,179	$543,064,320
Estimated FY 2013-14	$453,958,065	$37,049,407	$84,000,049	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$436,755	$575,444,276
Estimated FY 2014-15	$462,041,447	$37,709,126	$85,495,791	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$444,532	$585,690,896

Percent Change in Cash Based Actuals

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	1.63%	17.81%	-1.00%	0.00%	356.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-76.07%	1.89%
FY 2005-06	8.30%	14.89%	1.72%	0.00%	-118.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4828.72%	7.70%
FY 2006-07	3.71%	6.80%	9.30%	0.00%	-115.14%	0.00%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	198.45%	4.77%
FY 2007-08	1.33%	5.06%	1.52%	0.00%	296.31%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	90.78%	1.73%
FY 2008-09	8.80%	17.95%	10.08%	0.00%	250.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-85.84%	9.11%
FY 2009-10 (DA)	-7.24%	-3.33%	-4.10%	0.00%	-76.19%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-75.60%	-6.60%
FY 2010-11 (DA)	-0.62%	9.22%	3.60%	0.00%	44.08%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	800.21%	0.69%
FY 2011-12	5.27%	6.12%	-0.55%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-29.89%	4.39%
Estimated FY 2012-13	4.19%	4.19%	4.19%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.19%	4.19%
Estimated FY 2013-14	5.96%	5.96%	5.96%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.96%	5.96%
Estimated FY 2014-15	1.78%	1.78%	1.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.78%	1.78%

Per Capita Cost

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$9,806.59	$3,013.85	$1,337.93	$0.00	$0.26	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.75	$1,131.82
FY 2004-05	$9,562.39	$3,238.91	$1,293.05	$0.00	$0.98	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.67	$1,043.97
FY 2005-06	$10,233.92	$3,745.72	$1,317.30	$0.00	($0.18)	$0.00	$0.00	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$28.73	$1,135.01
FY 2006-07	$10,707.64	$3,989.32	$1,411.99	$0.00	$0.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$73.69	$1,219.45
FY 2007-08	$10,731.99	$4,132.00	$1,400.93	$0.00	$0.14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$127.66	$1,241.37
FY 2008-09	$11,262.46	$4,646.05	$1,499.45	$0.00	$0.45	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.04	$1,215.44
FY 2009-10 (DA)	$10,211.99	$4,107.86	$1,386.45	$0.00	$0.09	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.94	$994.19
FY 2010-11 (DA)	$10,035.95	$4,071.74	$1,359.31	$0.00	$0.12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$33.02	$890.43
FY 2011-12	$10,347.28	$4,003.32	$1,280.22	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$20.96	$840.77
Estimated FY 2012-13	$10,613.77	$3,940.12	$1,296.59	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$19.69	$796.82
Estimated FY 2013-14	$11,019.74	$3,959.96	$1,341.43	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$19.18	$779.30
Estimated FY 2014-15	$10,979.81	$3,839.25	$1,337.23	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.94	$754.39

Percent Change in Per Capita Cost

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-2.49%	7.47%	-3.35%	0.00%	276.92%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-75.64%	-7.76%
FY 2005-06	7.02%	15.65%	1.88%	0.00%	-118.37%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	4188.06%	8.72%
FY 2006-07	4.63%	6.50%	7.19%	0.00%	-116.67%	0.00%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	156.49%	7.44%
FY 2007-08	0.23%	3.58%	-0.78%	0.00%	366.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	73.24%	1.80%
FY 2008-09	4.94%	12.44%	7.03%	0.00%	221.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-86.65%	-2.09%
FY 2009-10 (DA)	-9.33%	-11.58%	-7.54%	0.00%	-80.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-76.88%	-18.20%
FY 2010-11 (DA)	-1.72%	-0.88%	-1.96%	0.00%	33.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	738.07%	-10.44%
FY 2011-12	3.10%	-1.68%	-5.82%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-36.52%	-5.58%
Estimated FY 2012-13	2.58%	-1.58%	1.28%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-6.06%	-5.23%
Estimated FY 2013-14	3.82%	0.50%	3.46%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.59%	-2.20%
Estimated FY 2014-15	-0.36%	-3.05%	-0.31%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-6.47%	-3.20%

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

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

Cash Based Actuals

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$0	$0	$1,104,554	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,104,554
FY 2004-05	$0	$0	$1,383,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,383,445
FY 2005-06	$69,154	$0	$1,367,696	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,436,850
FY 2006-07	$106,064	$27,660	$2,100,702	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,710	$2,270,136
FY 2007-08	$74,970	$191,024	$1,924,394	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$45,248	$2,235,636
FY 2008-09	$0	$335,754	$1,935,960	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,271,714
FY 2009-10 (DA)	($38,446)	$264,098	$989,694	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,215,347
FY 2010-11 (DA)	($84,407)	$729,155	$2,518,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,163,194
FY 2011-12	$0	$583,751	$1,915,323	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,499,074
Estimated FY 2012-13	$0	$940,754	$3,086,671	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,027,425
Estimated FY 2013-14	$0	$1,102,987	$3,618,967	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,721,954
Estimated FY 2014-15	$0	$1,198,092	$3,931,012	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,129,104

Percent Change in Cash Based Actuals

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-	-	25.25%	-	-	-	-	-	-	-	-	-	-	-	25.25%
FY 2005-06	-	-	-1.14%	-	-	-	-	-	-	-	-	-	-	-	3.86%
FY 2006-07	53.37%	-	53.59%	-	-	-	-	-	-	-	-	-	-	-	57.99%
FY 2007-08	-29.32%	590.61%	-8.39%	-	-	-	-	-	-	-	-	-	-	26.71%	-1.52%
FY 2008-09	-100.00%	75.77%	0.60%	-	-	-	-	-	-	-	-	-	-	-100.00%	1.61%
FY 2009-10 (DA)	-	-21.34%	-48.88%	-	-	-	-	-	-	-	-	-	-	-	-46.50%
FY 2010-11 (DA)	119.55%	176.09%	154.47%	-	-	-	-	-	-	-	-	-	-	-	160.27%
FY 2011-12	-100.00%	-19.94%	-23.95%	-	-	-	-	-	-	-	-	-	-	-	-21.00%
Estimated FY 2012-13	-	61.16%	61.16%	-	-	-	-	-	-	-	-	-	-	-	61.16%
Estimated FY 2013-14	-	17.24%	17.24%	-	-	-	-	-	-	-	-	-	-	-	17.24%
Estimated FY 2014-15	-	8.62%	8.62%	-	-	-	-	-	-	-	-	-	-	-	8.62%

Per Capita Cost

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$0.00	$0.00	$23.61	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.01
FY 2004-05	$0.00	$0.00	$28.86	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.41
FY 2005-06	$1.91	$0.00	$28.58	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.57
FY 2006-07	$2.96	$4.57	$43.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.77	$5.79
FY 2007-08	$2.07	$31.08	$38.54	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.18	$5.70
FY 2008-09	$0.00	$52.08	$37.70	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.20
FY 2009-10 (DA)	($1.00)	$37.47	$18.58	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.44
FY 2010-11 (DA)	($2.17)	$93.88	$44.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.64
FY 2011-12	$0.00	$69.64	$32.23	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.03
Estimated FY 2012-13	$0.00	$106.01	$50.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.91
Estimated FY 2013-14	$0.00	$117.89	$57.79	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.39
Estimated FY 2014-15	$0.00	$121.98	$61.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.61

Percent Change in Per Capita Cost

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-	-	22.24%	-	-	-	-	-	-	-	-	-	-	-	13.29%
FY 2005-06	-	-	-0.97%	-	-	-	-	-	-	-	-	-	-	-	4.69%
FY 2006-07	54.97%	-	50.63%	-	-	-	-	-	-	-	-	-	-	-	62.18%
FY 2007-08	-30.07%	580.09%	-10.48%	-	-	-	-	-	-	-	-	-	-	14.80%	-1.55%
FY 2008-09	-100.00%	67.57%	-2.18%	-	-	-	-	-	-	-	-	-	-	-100.00%	-8.77%
FY 2009-10 (DA)	-	-28.05%	-50.72%	-	-	-	-	-	-	-	-	-	-	-	-53.08%
FY 2010-11 (DA)	117.00%	150.55%	140.80%	-	-	-	-	-	-	-	-	-	-	-	131.15%
FY 2011-12	-100.00%	-25.82%	-27.96%	-	-	-	-	-	-	-	-	-	-	-	-28.55%
Estimated FY 2012-13	-	52.23%	56.66%	-	-	-	-	-	-	-	-	-	-	-	46.65%
Estimated FY 2013-14	-	11.21%	14.46%	-	-	-	-	-	-	-	-	-	-	-	8.12%
Estimated FY 2014-15	-	3.47%	6.39%	-	-	-	-	-	-	-	-	-	-	-	3.44%

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

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Current Year Projection															
FY 2011-12 Expenditure	$0	$583,751	$1,915,323	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,499,074
Percentage Selected to Modify Expenditure[1]	0.00%	34.49%	34.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	34.49%
Estimated FY 2012-13 Base Expenditures	$0	$785,087	$2,575,918	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,361,005
Bottom Line Impacts															
Census Increases in FY 2012-13	$0	$155,667	$510,753	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$666,420
Total Bottom Line Impacts	**$0**	**$155,667**	**$510,753**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$666,420**
Estimated FY 2012-13 Total Expenditures	**$0**	**$940,754**	**$3,086,671**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,027,425**
Estimated FY 2012-13 Per Capita	$0.00	$106.01	$50.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.91
% Change over FY 2011-12 Per Capita	0.00%	52.23%	56.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	46.65%
Request Year Projection															
FY 2012-13 Expenditure	$0	$940,754	$3,086,671	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,027,425
Percentage Selected to Modify Expenditure[1]	0.00%	17.25%	17.25%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	17.24%
Estimated FY 2013-14 Base Expenditures	$0	$1,102,987	$3,618,967	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,721,954
Bottom Line Impacts															
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2013-14 Total Expenditure	**$0**	**$1,102,987**	**$3,618,967**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,721,954**
Estimated FY 2012-13 Per Capita	$0.00	$112.30	$56.60	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.08
% Change over FY 2012-13 Per Capita	0.00%	5.93%	12.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.88%
Out Year Projection															
FY 2013-14 Expenditure	$0	$1,102,987	$3,618,967	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,721,954
Percentage Selected to Modify Expenditure[1]	0.00%	8.62%	8.62%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.62%
Estimated FY 2014-15 Base Expenditures	$0	$1,198,092	$3,931,012	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,129,104
Bottom Line Impacts															
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2014-15 Total Expenditure	**$0**	**$1,198,092**	**$3,931,012**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$5,129,104**
Estimated FY 2014-15 Per Capita	$0.00	$121.98	$61.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$6.61
% Change over FY 2013-14 Per Capita	0.00%	8.62%	8.62%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.72%

Footnotes

(1) The percentages selected to trend expenditure for FY 2012-13, FY 2013-14 and FY 2014-15 are 34.49%, and 17.25%, and 8.62% respectively. These trends are equal to the percentage change in per diem rates as determined by audited costs by the Department's rate contractor with reduced growth over time.

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

Cash Based Actuals

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$24,097,092	$1,864,579	$1,067,498	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$27,029,169
FY 2004-05	$31,140,652	$2,557,598	$1,461,755	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,160,005
FY 2005-06	$35,666,638	$2,962,484	$1,841,368	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$40,470,490
FY 2006-07	$37,878,793	$3,182,900	$1,810,588	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$42,872,281
FY 2007-08	$44,272,143	$3,549,809	$1,596,904	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$49,418,855
FY 2008-09	$54,470,714	$4,395,937	$2,183,184	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$61,049,836
FY 2009-10 (DA)	$61,924,560	$4,986,130	$2,345,339	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$69,256,028
FY 2010-11 (DA)	$73,232,307	$7,892,082	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$84,414,277
FY 2011-12	$73,671,387	$8,052,921	$3,756,277	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$85,480,585
Estimated FY 2012-13	$79,949,447	$7,888,312	$3,512,174	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$91,349,933
Estimated FY 2013-14	$91,610,888	$9,586,806	$4,179,188	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$105,376,882
Estimated FY 2014-15	$103,379,535	$11,133,265	$4,755,143	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$119,267,943

Percent Change in Cash Based Actuals

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	29.23%	37.17%	36.93%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	30.08%
FY 2005-06	14.53%	15.83%	25.97%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.10%
FY 2006-07	6.20%	7.44%	-1.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.93%
FY 2007-08	16.88%	11.53%	-11.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.27%
FY 2008-09	23.04%	23.84%	36.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	23.54%
FY 2009-10 (DA)	13.68%	13.43%	7.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.44%
FY 2010-11 (DA)	18.26%	58.28%	40.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	21.89%
FY 2011-12	0.60%	2.04%	14.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.26%
Estimated FY 2012-13	8.52%	-2.04%	-6.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.87%
Estimated FY 2013-14	14.59%	21.53%	18.99%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.36%
Estimated FY 2014-15	12.85%	16.13%	13.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.18%

Per Capita Cost

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$701.95	$336.08	$22.82	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$73.54
FY 2004-05	$870.34	$420.52	$30.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$86.60
FY 2005-06	$985.08	$490.32	$38.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$100.62
FY 2006-07	$1,055.47	$525.32	$37.10	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$109.30
FY 2007-08	$1,220.16	$577.58	$31.98	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$126.08
FY 2008-09	$1,447.96	$681.86	$42.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$139.76
FY 2009-10 (DA)	$1,608.97	$707.35	$44.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$138.85
FY 2010-11 (DA)	$1,881.56	$1,016.10	$58.45	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$150.54
FY 2010-11 (DA)	$1,853.83	$960.63	$63.20	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$137.88
Estimated FY 2012-13	$1,980.71	$888.92	$57.44	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$134.04
Estimated FY 2013-14	$2,223.84	$1,024.67	$66.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$142.71
Estimated FY 2014-15	$2,456.68	$1,133.50	$74.37	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$153.62

Percent Change in Per Capita Cost

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	23.99%	25.12%	33.65%	-	-	-	-	-	-	-	-	-	-	-	17.76%
FY 2005-06	13.18%	16.60%	26.16%	-	-	-	-	-	-	-	-	-	-	-	16.19%
FY 2006-07	7.15%	7.14%	-3.59%	-	-	-	-	-	-	-	-	-	-	-	8.63%
FY 2007-08	15.60%	9.95%	-13.80%	-	-	-	-	-	-	-	-	-	-	-	15.35%
FY 2008-09	18.67%	18.05%	32.93%	-	-	-	-	-	-	-	-	-	-	-	10.85%
FY 2009-10 (DA)	11.12%	3.74%	3.58%	-	-	-	-	-	-	-	-	-	-	-	-0.65%
FY 2010-11 (DA)	16.94%	43.65%	32.75%	-	-	-	-	-	-	-	-	-	-	-	8.42%
FY 2011-12	-1.47%	-5.46%	8.13%	-	-	-	-	-	-	-	-	-	-	-	-8.41%
Estimated FY 2012-13	6.84%	-7.46%	-9.11%	-	-	-	-	-	-	-	-	-	-	-	-2.79%
Estimated FY 2013-14	12.27%	15.27%	16.19%	-	-	-	-	-	-	-	-	-	-	-	6.47%
Estimated FY 2014-15	10.47%	10.62%	11.43%	-	-	-	-	-	-	-	-	-	-	-	7.64%

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

PACE Enrollment and Cost Per Enrollee															
PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**Categorically Eligible Low-Income Adults (AFDC-A)**	**Expansion Adults to 60% FPL**	**Expansion Adults to 100% FPL**	**Adults without Dependent Children (AwDC)**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**Baby Care Program-Adults**	**Non-Citizens**	**Partial Dual Eligibles**	**TOTAL**
PACE Average Monthly Paid Enrollment[1]															
FY 2004-05	845	57	31	-	-	-	-	-	-	-	-	-	-	-	933
FY 2005-06	943	64	40	-	-	-	-	-	-	-	-	-	-	-	1,047
FY 2006-07	1,020	69	40	-	-	-	-	-	-	-	-	-	-	-	1,129
FY 2007-08	1,121	82	37	-	-	-	-	-	-	-	-	-	-	-	1,240
FY 2008-09	1,273	100	48	-	-	-	-	-	-	-	-	-	-	-	1,421
FY 2009-10 (DA)	1,439	120	60	-	-	-	-	-	-	-	-	-	-	-	1,619
FY 2010-11 (DA)	1,600	171	75	-	-	-	-	-	-	-	-	-	-	-	1,847
FY 2011-12	1,754	204	96	-	-	-	-	-	-	-	-	-	-	-	2,055
Estimated FY 2012-13	1,933	219	97	-	-	-	-	-	-	-	-	-	-	-	2,249
Estimated FY 2013-14	2,137	256	112	-	-	-	-	-	-	-	-	-	-	-	2,505
Estimated FY 2014-15	2,326	287	123	-	-	-	-	-	-	-	-	-	-	-	2,736
Percent Changes in Enrollment															
FY 2005-06	11.63%	12.28%	29.57%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	12.26%
FY 2006-07	8.12%	8.07%	-1.45%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.75%
FY 2007-08	9.91%	18.31%	-7.16%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.83%
FY 2008-09	13.54%	21.69%	31.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	14.60%
FY 2009-10 (DA)	13.08%	20.25%	24.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.96%
FY 2010-11 (DA)	11.18%	42.94%	25.91%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	14.07%
FY 2011-12	9.63%	19.13%	27.99%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.26%
Estimated FY 2012-13	10.21%	7.19%	0.93%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.47%
Estimated FY 2013-14	10.53%	17.23%	14.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.36%
Estimated FY 2014-15	8.85%	12.02%	9.75%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.21%
Average Cost Per Enrollee[3]															
FY 2004-05	$36,852.84	$44,870.14	$47,153.39	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37,684.89
FY 2005-06	$37,812.50	$46,288.81	$45,843.19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$38,638.39
FY 2006-07	$37,142.14	$46,017.83	$45,741.17	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37,987.70
FY 2007-08	$39,496.37	$43,378.52	$43,453.17	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$39,869.99
FY 2008-09	$42,800.46	$44,143.30	$45,247.34	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,977.71
FY 2009-10 (DA)	$43,028.07	$41,637.83	$39,197.87	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,783.65
FY 2010-11 (DA)[2]	$42,506.96	$42,822.54	$40,559.63	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,456.77
FY 2011-12	$41,994.90	$39,490.25	$38,957.82	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$41,603.79
Estimated FY 2012-13	$41,353.85	$36,090.46	$36,090.46	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$40,614.63
Estimated FY 2013-14	$42,872.18	$37,415.54	$37,415.54	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,070.66
Estimated FY 2014-15	$44,446.25	$38,789.27	$38,789.27	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$43,599.20
Percent Changes in Cost Per Enrollee															
FY 2005-06	2.60%	3.16%	-2.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.53%
FY 2006-07	-1.77%	-0.59%	-0.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.68%
FY 2007-08	6.34%	-5.74%	-5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.95%
FY 2008-09	8.37%	1.76%	4.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.79%
FY 2009-10 (DA)	0.53%	-5.68%	-13.37%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.45%
FY 2010-11 (DA)[2]	-1.21%	2.85%	3.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.76%
FY 2011-12	-1.20%	-7.78%	-3.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.01%
Estimated FY 2012-13	-1.53%	-8.61%	-7.36%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.38%
Estimated FY 2013-14	3.67%	3.67%	3.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.58%
Estimated FY 2014-15	3.67%	3.67%	3.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.63%

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

Current Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2011-12 Average Monthly Paid Enrollment	1,754	204	96	-	-	-	-	-	-	-	-	-	-	-	2,055
Trend Factor[4]	10.21%	7.19%	0.00%	-	-	-	-	-	-	-	-	-	-	-	9.47%
FY 2012-13 Estimated Monthly Paid Enrollment	1,933	219	97	-	-	-	-	-	-	-	-	-	-	-	2,249
FY 2012-13 Estimated Cost Per Enrollee	$41,353.85	$36,090.46	$36,090.46	-	-	-	-	-	-	-	-	-	-	-	$40,614.63
Bottom Line Impacts															
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2012-13 Expenditure	**$79,949,447**	**$7,888,312**	**$3,512,174**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$91,349,933**
Estimated FY 2012-13 Per Capita	$2,011.81	$940.99	$59.09	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$134.04
% Change over FY 2011-12Per Capita	8.52%	-2.04%	-6.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.79%

Request Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2012-13 Estimated Monthly Paid Enrollment	1,933	219	97	-	-	-	-	-	-	-	-	-	-	-	2,249
Trend Factor	10.53%	17.23%	14.78%	-	-	-	-	-	-	-	-	-	-	-	11.36%
FY 2013-14 Estimated Monthly Paid Enrollment	2,137	256	112	-	-	-	-	-	-	-	-	-	-	-	2,505
FY 2013-14 Estimated Cost Per Enrollee	$42,872.18	$37,415.54	$37,415.54	-	-	-	-	-	-	-	-	-	-	-	$42,070.66
Bottom Line Impacts															
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2013-14 Expenditure	**$91,610,888**	**$9,586,806**	**$4,179,188**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$105,376,882**
Estimated FY 2013-14 Per Capita	$2,223.84	$1,024.67	$66.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$142.71
% Change over FY 2012-13 Per Capita	10.54%	8.89%	12.94%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.47%

Out Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2013-14 Estimated Monthly Paid Enrollment	2,137	256	112	-	-	-	-	-	-	-	-	-	-	-	2,505
Trend Factor	8.85%	12.02%	9.75%	-	-	-	-	-	-	-	-	-	-	-	9.21%
FY 2014-15 Estimated Monthly Paid Enrollment	2,326	287	123	-	-	-	-	-	-	-	-	-	-	-	2,736
FY 2014-15 Estimated Cost Per Enrollee	$44,446.25	$38,789.27	$38,789.27	-	-	-	-	-	-	-	-	-	-	-	$43,599.20
Bottom Line Impacts															
Total Bottom Line Impacts	$0	$0	$0		$0		$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2014-15 Expenditure	**$103,379,535**	**$11,133,265**	**$4,755,143**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$119,267,943**
Estimated FY 2014-15 Per Capita	$2,456.68	$1,133.50	$74.37	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$153.62
% Change over FY 2013-14 Per Capita	10.47%	10.62%	11.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.65%

Footnotes

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

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

(3) Per-enrollee costs for FY 2012-13 are a weighted average of FY 2012-13 rates by forecasted FY 2012-13 provider distribution and FY 2011-12 third-party-liability status. FY 2013-14 per-enrollee costs are estimated by application of the average growth in per-enrollee cost between FY 2007-08 and FY 2009-10 to FY 2012-13 estimates. FY 2014-15 per-enrollee costs are estimated by application of the same growth rate to estimated FY 2013-14 per-enrollee costs.

(4) Monthly Paid Enrollment figures for FY 2012-13, FY 2013-14, and FY 2014-15 are estimated via linear regression of historical enrollment by provider and eligibility type.

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

Cash Based Actuals

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$25,391,796	$1,480,703	$13,310,017	$0	$83,254	$0	$0	$0	$0	$0	$0	$0	$0	$7,347,457	$47,613,226
FY 2004-05	$31,170,839	$1,817,703	$16,339,309	$0	$102,202	$0	$0	$0	$0	$0	$0	$0	$0	$9,019,700	$58,449,753
FY 2005-06	$37,744,128	$2,201,019	$19,784,933	$0	$123,754	$0	$0	$0	$0	$0	$0	$0	$0	$10,921,770	$70,775,604
FY 2006-07	$44,106,993	$2,572,065	$23,120,257	$0	$144,616	$0	$0	$0	$0	$0	$0	$0	$0	$12,762,950	$82,706,881
FY 2007-08	$43,978,504	$2,564,572	$23,052,905	$0	$144,195	$0	$0	$0	$0	$0	$0	$0	$0	$12,725,770	$82,465,946
FY 2008-09	$49,992,538	$2,915,276	$26,205,375	$0	$163,913	$0	$0	$0	$0	$0	$0	$0	$0	$14,466,011	$93,743,114
FY 2009-10 (DA)	$54,965,748	$3,205,285	$28,812,261	$0	$180,219	$0	$0	$0	$0	$0	$0	$0	$0	$15,905,077	$103,068,590
FY 2010-11 (DA)	$63,751,826	$3,717,638	$33,417,798	$0	$209,027	$0	$0	$0	$0	$0	$0	$0	$0	$18,447,446	$119,543,734
FY 2011-12	$63,201,668	$3,688,256	$33,153,682	$46,299	$207,374	$0	$0	$0	$0	$0	$0	$0	$0	$18,301,648	$118,598,927
Estimated FY 2012-13	$62,781,854	$3,821,373	$33,409,561	$2,054,562	$216,812	$0	$0	$0	$0	$0	$0	$0	$0	$19,839,460	$122,123,622
Estimated FY 2013-14	$68,130,573	$4,284,141	$36,353,982	$5,477,299	$242,963	$0	$0	$0	$0	$0	$0	$0	$0	$22,988,760	$137,477,718
Estimated FY 2014-15	$74,113,494	$4,789,468	$39,527,069	$8,930,146	$264,196	$0	$0	$0	$0	$0	$0	$0	$0	$26,635,530	$154,259,903

Percent Change in Cash Based Actuals

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	22.76%	22.76%	22.76%	0.00%	22.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	22.76%	22.76%
FY 2005-06	21.09%	21.09%	21.09%	0.00%	21.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	21.09%	21.09%
FY 2006-07	16.86%	16.86%	16.86%	0.00%	16.86%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.86%	16.86%
FY 2007-08	-0.29%	-0.29%	-0.29%	0.00%	-0.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.29%	-0.29%
FY 2008-09	13.67%	13.67%	13.67%	0.00%	13.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.67%	13.67%
FY 2009-10 (DA)	9.95%	9.95%	9.95%	0.00%	9.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.95%	9.95%
FY 2010-11 (DA)	15.98%	15.98%	15.98%	0.00%	15.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.98%	15.98%
FY 2011-12	-0.86%	-0.79%	-0.79%	0.00%	-0.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.79%	-0.79%
Estimated FY 2012-13	-0.66%	3.61%	0.77%	4337.59%	4.55%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.40%	2.97%
Estimated FY 2013-14	8.52%	12.11%	8.81%	166.59%	12.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.87%	12.57%
Estimated FY 2013-14	8.78%	11.80%	8.73%	63.04%	8.74%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.86%	12.21%

Per Capita Cost

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$739.66	$266.89	$284.47	$0.00	$1.75	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$746.54	$129.54
FY 2004-05	$871.18	$298.87	$340.91	$0.00	$1.79	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$939.06	$143.96
FY 2005-06	$1,042.45	$364.29	$413.44	$0.00	$2.10	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$984.65	$175.96
FY 2006-07	$1,229.02	$424.50	$473.79	$0.00	$2.85	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$988.76	$210.86
FY 2007-08	$1,212.06	$417.27	$461.68	$0.00	$3.24	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$895.30	$210.39
FY 2008-09	$1,328.92	$452.19	$510.28	$0.00	$3.34	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$959.60	$214.61
FY 2009-10 (DA)	$1,428.16	$454.71	$540.93	$0.00	$3.13	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$999.13	$206.63
FY 2010-11 (DA)	$1,637.98	$478.65	$593.72	$0.00	$3.43	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,079.43	$213.18
FY 2011-12	$1,590.38	$439.97	$557.82	$890.37	$3.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$969.83	$191.30
Estimated FY 2012-13	$1,555.39	$430.63	$546.44	$941.16	$2.95	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$947.81	$179.19
Estimated FY 2013-14	$1,653.86	$457.90	$580.55	$1,002.25	$3.14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,009.34	$186.18
Estimated FY 2014-15	$1,761.21	$487.63	$618.24	$1,067.31	$3.35	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,074.88	$198.69

Percent Change in Per Capita Cost

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	17.78%	11.98%	19.84%	0.00%	2.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	25.79%	11.13%
FY 2005-06	19.66%	21.89%	21.28%	0.00%	17.32%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.85%	22.23%
FY 2006-07	17.90%	16.53%	14.60%	0.00%	35.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.42%	19.83%
FY 2007-08	-1.38%	-1.70%	-2.56%	0.00%	13.68%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-9.45%	-0.22%
FY 2008-09	9.64%	8.37%	10.53%	0.00%	3.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.18%	2.01%
FY 2009-10 (DA)	7.47%	0.56%	6.01%	0.00%	-6.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.12%	-3.72%
FY 2010-11 (DA)	14.69%	5.26%	9.76%	0.00%	9.58%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.04%	3.17%
FY 2011-12	-2.91%	-8.08%	-6.05%	0.00%	-11.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.15%	-10.26%
Estimated FY 2012-13	-2.20%	-2.12%	-2.04%	5.70%	-2.32%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.27%	-6.33%
Estimated FY 2013-14	6.33%	6.33%	6.24%	6.49%	6.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.49%	3.90%
Estimated FY 2013-14	6.49%	6.49%	6.49%	6.49%	6.69%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.49%	6.72%

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

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Current Year Projection															
FY 2011-12 Expenditure	**$63,201,668**	**$3,688,256**	**$33,153,682**	**$46,299**	**$207,374**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$18,301,648**	**$118,598,927**
FY 2011-12 First Half Expenditure	$33,313,385	$1,942,644	$17,462,401	$0	$109,227	$0	$0	$0	$0	$0	$0	$0	$0	$9,639,675	$62,467,332
FY 2011-12 Second Half Expenditure	$29,888,283	$1,745,612	$15,691,281	$46,299	$98,147	$0	$0	$0	$0	$0	$0	$0	$0	$8,661,973	$56,131,595
Estimated FY 2012-13 Caseload Trend	1.57%	5.86%	2.87%	2049.04%	6.98%	16.63%	19.94%	781.83%	4.02%	8.71%	-0.22%	7.62%	1.12%	10.92%	
Estimated FY 2012-13 First Half Expenditure	$30,357,529	$1,847,905	$16,141,621	$994,984	$104,998	$0	$0	$0	$0	$0	$0	$0	$0	$9,607,860	$59,054,897
Estimated Increase in Medicare Part B Premium (Effective January 1, 2013)[1]	6.49%	6.49%	6.49%	6.49%	6.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.49%	
Estimated FY 2012-13 Second Half Expenditure	$32,328,332	$1,967,870	$17,189,531	$1,059,578	$111,814	$0	$0	$0	$0	$0	$0	$0	$0	$10,231,600	$62,888,725
Bottom Line Impacts															
Contractor to Enroll More Clients in Medicare	$95,993	$5,598	$78,409	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$180,000
Total Bottom Line Impacts	**$95,993**	**$5,598**	**$78,409**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$180,000**
Estimated FY 2012-13 Total Expenditure[2]	**$62,781,854**	**$3,821,373**	**$33,409,561**	**$2,054,562**	**$216,812**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$19,839,460**	**$122,123,622**
Estimated FY 2011-12 Per Capita	$1,555.39	$430.63	$546.44	$941.16	$2.95	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$947.81	$179.19
% Change over FY 2010-11 Per Capita	-2.20%	-2.12%	-2.04%	5.70%	-2.32%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.27%	-6.33%
Request Year Projection															
Estimated FY 2012-13 Expenditure	$62,781,854	$3,821,373	$33,409,561	$2,054,562	$216,812	$0	$0	$0	$0	$0	$0	$0	$0	$19,839,460	$122,123,622
FY 2012-13 First Half Expenditure	$30,453,522	$1,853,503	$16,220,030	$994,984	$104,998	$0	$0	$0	$0	$0	$0	$0	$0	$9,607,860	$59,234,897
Estimated FY 2012-13 Second Half Expenditure	$32,328,332	$1,967,870	$17,189,531	$1,059,578	$111,814	$0	$0	$0	$0	$0	$0	$0	$0	$10,231,600	$62,888,725
Estimated FY 2013-14 Caseload Trend	2.06%	5.43%	2.42%	150.34%	5.23%	6.84%	11.33%	0.00%	5.48%	10.34%	0.35%	7.18%	0.93%	8.81%	8.35%
Estimated FY 2013-14 First Half Expenditure	$32,994,296	$2,074,725	$17,605,518	$2,652,548	$117,662	$0	$0	$0	$0	$0	$0	$0	$0	$11,133,004	$66,577,753
Estimated Increase in Medicare Part B Premium (Effective January 1, 2014)[1]	6.49%	6.49%	6.49%	6.49%	6.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.49%	
Estimated FY 2013-14 Second Half Expenditure	$35,136,277	$2,209,416	$18,748,464	$2,824,751	$125,301	$0	$0	$0	$0	$0	$0	$0	$0	$11,855,756	$70,899,965
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2012-13 Total Expenditure[2]	**$68,130,573**	**$4,284,141**	**$36,353,982**	**$5,477,299**	**$242,963**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$22,988,760**	**$137,477,718**
Estimated FY 2013-14 Per Capita	$1,653.86	$457.90	$580.55	$1,002.25	$3.14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,009.34	$186.18
% Change over FY 2012-13 Per Capita	6.33%	6.33%	6.24%	6.49%	6.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.49%	3.90%
Out Year Projection															
Estimated FY 2013-14 Expenditure	$68,130,573	$4,284,141	$36,353,982	$5,477,299	$242,963	$0	$0	$0	$0	$0	$0	$0	$0	$22,988,760	$137,477,718
Estimated FY 2013-14 First Half Expenditure	$32,994,296	$2,074,725	$17,605,518	$2,652,548	$117,662	$0	$0	$0	$0	$0	$0	$0	$0	$11,133,004	$66,577,753
Estimated FY 2013-14 Second Half Expenditure	$35,136,277	$2,209,416	$18,748,464	$2,824,751	$125,301	$0	$0	$0	$0	$0	$0	$0	$0	$11,855,756	$70,899,965
Estimated FY 2014-15 Caseload Trend	2.15%	4.98%	2.10%	53.10%	2.11%	2.75%	3.93%	0.00%	3.82%	6.35%	0.84%	4.04%	1.20%	8.80%	5.14%
Estimated FY 2014-15 First Half Expenditure	$35,891,707	$2,319,445	$19,142,182	$4,324,694	$127,945	$0	$0	$0	$0	$0	$0	$0	$0	$12,899,063	$74,705,036
Estimated Increase in Medicare Part B Premium (Effective January 1, 2015)[1]	6.49%	6.49%	6.49%	6.49%	6.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.49%	
Estimated FY 2014-15 Second Half Expenditure	$38,221,787	$2,470,023	$20,384,887	$4,605,452	$136,251	$0	$0	$0	$0	$0	$0	$0	$0	$13,736,467	$79,554,867
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2013-14 Total Expenditure[2]	**$74,113,494**	**$4,789,468**	**$39,527,069**	**$8,930,146**	**$264,196**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$26,635,530**	**$154,259,903**
Estimated FY 2014-15 Per Capita	$1,761.21	$487.63	$618.24	$1,067.31	$3.35	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,074.88	$198.69
% Change over Estimated FY 2013-14 Per Capita	6.49%	6.49%	6.49%	6.49%	6.69%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.49%	6.72%

Footnotes

[1]The Part B premium decreased to $99.90 from $115.40 effective January 1, 2012. The January 1, 2013 rate has not yet been issued by CMS. The average growth rate in premiums since CY 2003 is assumed for CY 2013.

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

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

Cash Based Actuals

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$280,042	$24,420	$206,845	$0	$49,728	$0	$0	$0	$0	$82,987	$13,912	$17,420	$10,796	$4,021	$690,172
FY 2004-05	$246,429	$21,489	$182,018	$0	$43,760	$0	$0	$0	$0	$73,026	$12,242	$15,329	$9,501	$3,538	$607,332
FY 2005-06	$212,695	$18,547	$157,102	$0	$37,769	$0	$0	$0	$0	$63,030	$10,566	$13,231	$8,200	$3,054	$524,194
FY 2006-07	$1,797	$20,389	$704,579	$0	$2,008	$0	$0	$0	$0	$9,795	$651	$3,133	$0	$0	$742,352
FY 2007-08	$3,274	$1,762	$877,995	$0	$1,605	$0	$0	$0	$0	$16,916	$1,188	$2,208	$0	$0	$904,947
FY 2008-09	($177)	$3,200	$917,027	$0	$5,034	$0	$0	$0	$0	$16,561	$0	$500	$0	$0	$942,145
FY 2009-10 (DA)	$3,552	$8,332	$993,385	$0	$3,197	$0	$0	$0	$0	$11,314	$210	$0	$0	$0	$1,019,989
FY 2010-11 (DA)	$1,979	$625	$1,025,861	$0	$5,099	$0	$0	$0	$0	$2,021	$1,059	$0	$0	$0	$1,036,644
FY 2011-12	$2,162	$6,655	$1,122,186	$0	$9,727	$0	$0	$0	$0	$12,996	$2,223	$3,358	$0	$0	$1,159,307
Estimated FY 2012-13	$5,506	$16,944	$2,857,162	$0	$24,765	$0	$0	$0	$0	$33,088	$5,451	$8,549	$0	$0	$2,951,465
Estimated FY 2013-14	$11,168	$34,374	$5,796,161	$0	$50,239	$0	$0	$0	$0	$67,124	$10,546	$17,344	$0	$0	$5,986,956
Estimated FY 2014-15	$12,217	$37,602	$6,340,421	$0	$54,956	$0	$0	$0	$0	$73,427	$10,546	$18,973	$0	$0	$6,548,142

Percent Change in Cash Based Actuals

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-12.00%	-12.00%	-12.00%	0.00%	-12.00%	0.00%	0.00%	0.00%	0.00%	-12.00%	-12.00%	-12.00%	-12.00%	-12.00%	-12.00%
FY 2005-06	-13.69%	-13.69%	-13.69%	0.00%	-13.69%	0.00%	0.00%	0.00%	0.00%	-13.69%	-13.69%	-13.69%	-13.69%	-13.68%	-13.69%
FY 2006-07	-99.16%	9.93%	348.49%	0.00%	-94.68%	0.00%	0.00%	0.00%	0.00%	-84.46%	-93.84%	-76.32%	-100.00%	-100.00%	41.62%
FY 2007-08	82.18%	-91.36%	24.61%	0.00%	-20.08%	0.00%	0.00%	0.00%	0.00%	72.70%	82.42%	-29.53%	0.00%	0.00%	21.90%
FY 2008-09	-105.40%	81.58%	4.45%	0.00%	213.73%	0.00%	0.00%	0.00%	0.00%	-2.10%	-100.00%	-77.35%	0.00%	0.00%	4.11%
FY 2009-10 (DA)	-2108.60%	160.41%	8.33%	0.00%	-36.50%	0.00%	0.00%	0.00%	0.00%	-31.69%	0.00%	-100.00%	0.00%	0.00%	8.26%
FY 2010-11 (DA)	-44.28%	-92.50%	3.27%	0.00%	59.49%	0.00%	0.00%	0.00%	0.00%	-82.14%	404.09%	0.00%	0.00%	0.00%	1.63%
FY 2011-12	9.25%	964.36%	9.39%	0.00%	90.78%	0.00%	0.00%	0.00%	0.00%	543.01%	109.89%	0.00%	0.00%	0.00%	11.83%
Estimated FY 2012-13	154.67%	154.61%	154.61%	0.00%	154.60%	0.00%	0.00%	0.00%	0.00%	154.60%	145.21%	154.59%	0.00%	0.00%	154.59%
Estimated FY 2013-14	102.83%	102.87%	102.86%	0.00%	102.86%	0.00%	0.00%	0.00%	0.00%	102.87%	93.47%	102.88%	0.00%	0.00%	102.85%
Estimated FY 2014-15	9.39%	9.39%	9.39%	0.00%	9.39%	0.00%	0.00%	0.00%	0.00%	9.39%	0.00%	9.39%	0.00%	0.00%	9.37%

Per Capita Cost

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$8.16	$4.40	$4.42	$0.00	$1.05	$0.00	$0.00	$0.00	$0.00	$0.42	$0.93	$2.07	$2.25	$0.41	$1.88
FY 2004-05	$6.89	$3.53	$3.80	$0.00	$0.77	$0.00	$0.00	$0.00	$0.00	$0.33	$0.78	$2.56	$1.84	$0.37	$1.50
FY 2005-06	$5.87	$3.07	$3.28	$0.00	$0.64	$0.00	$0.00	$0.00	$0.00	$0.29	$0.64	$2.58	$1.32	$0.28	$1.30
FY 2006-07	$0.05	$3.37	$14.44	$0.00	$0.04	$0.00	$0.00	$0.00	$0.00	$0.05	$0.04	$0.60	$0.00	$0.00	$1.89
FY 2007-08	$0.09	$0.29	$17.58	$0.00	$0.04	$0.00	$0.00	$0.00	$0.00	$0.08	$0.07	$0.35	$0.00	$0.00	$2.31
FY 2008-09	$0.00	$0.50	$17.86	$0.00	$0.10	$0.00	$0.00	$0.00	$0.00	$0.07	$0.00	$0.07	$0.00	$0.00	$2.16
FY 2009-10 (DA)	$0.09	$1.18	$18.65	$0.00	$0.06	$0.00	$0.00	$0.00	$0.00	$0.04	$0.01	$0.00	$0.00	$0.00	$2.04
FY 2010-11 (DA)	$0.05	$0.08	$18.23	$0.00	$0.08	$0.00	$0.00	$0.00	$0.00	$0.01	$0.06	$0.00	$0.00	$0.00	$1.85
FY 2011-12	$0.05	$0.79	$18.88	$0.00	$0.14	$0.00	$0.00	$0.00	$0.00	$0.04	$0.12	$0.44	$0.00	$0.00	$1.87
Estimated FY 2012-13	$0.14	$1.91	$46.73	$0.00	$0.34	$0.00	$0.00	$0.00	$0.00	$0.09	$0.30	$1.04	$0.00	$0.00	$4.33
Estimated FY 2013-14	$0.27	$3.67	$92.56	$0.00	$0.65	$0.00	$0.00	$0.00	$0.00	$0.17	$0.58	$1.97	$0.00	$0.00	$8.11
Estimated FY 2014-15	$0.29	$3.83	$99.17	$0.00	$0.70	$0.00	$0.00	$0.00	$0.00	$0.17	$0.58	$2.07	$0.00	$0.00	$8.43

Percent Change in Per Capita Cost

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	-15.56%	-19.77%	-14.03%	0.00%	-26.67%	0.00%	0.00%	0.00%	0.00%	-21.43%	-16.13%	23.67%	-18.22%	-9.76%	-20.21%
FY 2005-06	-14.80%	-13.03%	-13.68%	0.00%	-16.88%	0.00%	0.00%	0.00%	0.00%	-12.12%	-17.95%	0.78%	-28.26%	-24.32%	-13.33%
FY 2006-07	-99.15%	9.77%	340.24%	0.00%	-93.75%	0.00%	0.00%	0.00%	0.00%	-82.76%	-93.75%	-76.74%	-100.00%	-100.00%	45.38%
FY 2007-08	80.00%	-91.39%	21.75%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	60.00%	75.00%	-41.67%	0.00%	0.00%	22.22%
FY 2008-09	-100.00%	72.41%	1.59%	0.00%	150.00%	0.00%	0.00%	0.00%	0.00%	-12.50%	-100.00%	-80.00%	0.00%	0.00%	-6.49%
FY 2009-10 (DA)	0.00%	136.00%	4.42%	0.00%	-40.00%	0.00%	0.00%	0.00%	0.00%	-42.86%	0.00%	-100.00%	0.00%	0.00%	-5.56%
FY 2010-11 (DA)	-44.44%	-93.22%	-2.25%	0.00%	33.33%	0.00%	0.00%	0.00%	0.00%	-75.00%	500.00%	0.00%	0.00%	0.00%	-9.31%
FY 2011-12	0.00%	887.50%	3.57%	0.00%	75.00%	0.00%	0.00%	0.00%	0.00%	300.00%	100.00%	0.00%	0.00%	0.00%	1.08%
Estimated FY 2012-13	180.00%	141.77%	147.51%	0.00%	142.86%	0.00%	0.00%	0.00%	0.00%	125.00%	150.00%	136.36%	0.00%	0.00%	131.55%
Estimated FY 2013-14	92.86%	92.15%	98.07%	0.00%	91.18%	0.00%	0.00%	0.00%	0.00%	88.89%	93.33%	89.42%	0.00%	0.00%	87.30%
Estimated FY 2014-15	7.41%	4.36%	7.14%	0.00%	7.69%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.08%	0.00%	0.00%	3.95%

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

Expenditure Trends	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Expenditure Trends															
Actual FY 2011-12 Expenditure	$2,162	$6,655	$1,122,186	$0	$9,727	$0	$0	$0	$0	$12,996	$2,223	$3,358	$0	$0	$1,159,307
Average of FY 2004-05 through FY 2008-09	-448.93%	29.37%	74.44%	0.00%	9.76%	0.00%	0.00%	0.00%	0.00%	-11.85%	-25.02%	-59.38%	-22.74%	-22.74%	12.44%
Average of FY 2005-06 through FY 2008-09	-557.75%	40.14%	96.47%	0.00%	15.62%	0.00%	0.00%	0.00%	0.00%	-11.39%	-27.86%	-70.80%	-25.00%	-25.00%	18.97%
Average of FY 2006-07 through FY 2008-09	-710.61%	50.21%	12.46%	0.00%	52.38%	0.00%	0.00%	0.00%	0.00%	12.97%	-5.86%	-68.96%	0.00%	0.00%	11.42%
Average of FY 2007-08 through FY 2008-09	-1107.00%	121.00%	6.39%	0.00%	88.62%	0.00%	0.00%	0.00%	0.00%	-16.90%	-50.00%	-88.68%	0.00%	0.00%	6.19%
Average of FY 2005-06 through FY 2009-10	-455.05%	13.61%	77.83%	0.00%	24.39%	0.00%	0.00%	0.00%	0.00%	-25.54%	58.53%	-56.64%	-20.00%	-20.00%	15.50%
Average of FY 2006-07 through FY 2009-10	-544.03%	14.53%	10.17%	0.00%	54.16%	0.00%	0.00%	0.00%	0.00%	-10.81%	96.63%	-51.72%	0.00%	0.00%	8.98%
Average of FY 2007-08 through FY 2009-10	-752.76%	49.83%	5.35%	0.00%	78.91%	0.00%	0.00%	0.00%	0.00%	-38.64%	101.36%	-59.12%	0.00%	0.00%	4.67%
Average of FY 2008-09 through FY 2009-10	-1076.44%	33.96%	5.80%	0.00%	11.50%	0.00%	0.00%	0.00%	0.00%	-56.92%	202.05%	-50.00%	0.00%	0.00%	4.95%
Average of FY 2006-07 through FY 2010-11	-433.37%	204.50%	10.01%	0.00%	61.48%	0.00%	0.00%	0.00%	0.00%	99.96%	99.28%	-41.38%	0.00%	0.00%	9.55%
Average of FY 2007-08 through FY 2010-11	-562.26%	278.46%	6.36%	0.00%	81.88%	0.00%	0.00%	0.00%	0.00%	106.77%	103.50%	-44.34%	0.00%	0.00%	6.46%
Average of FY 2008-09 through FY 2010-11	-714.54%	344.09%	7.00%	0.00%	37.92%	0.00%	0.00%	0.00%	0.00%	143.06%	171.33%	-33.33%	0.00%	0.00%	7.24%
Average of FY 2009-10 through FY 2010-11	-17.52%	435.93%	6.33%	0.00%	75.14%	0.00%	0.00%	0.00%	0.00%	230.44%	256.99%	0.00%	0.00%	0.00%	6.73%
Current Year Projection															
FY 2011-12 Expenditure	$2,162	$6,655	$1,122,186	$0	$9,727	$0	$0	$0	$0	$12,996	$2,223	$3,358	$0	$0	$1,159,307
Percentage Selected to Modify Expenditure[1]	9.39%	9.39%	9.39%	0.00%	9.39%	0.00%	0.00%	0.00%	0.00%	9.39%	0.00%	9.39%	0.00%	0.00%	
Estimated FY 2012-13 Base Expenditure	$2,365	$7,280	$1,227,559	$0	$10,640	$0	$0	$0	$0	$14,216	$2,223	$3,673	$0	$0	$1,267,956
Bottom Line Impacts															
SB 10-167 "Medicaid Efficiency & False Claims" Provider Payment	$593	$1,825	$307,774	$0	$2,668	$0	$0	$0	$0	$3,564	$610	$921	$0	$0	$317,955
SB 10-167 "Medicaid Efficiency & False Claims" Premiums Payment	$2,548	$7,839	$1,321,829	$0	$11,457	$0	$0	$0	$0	$15,308	$2,618	$3,955	$0	$0	$1,365,554
Total Bottom Line Impacts	$3,141	$9,664	$1,629,603	$0	$14,125	$0	$0	$0	$0	$18,872	$3,228	$4,876	$0	$0	$1,683,509
Estimated FY 2012-13 Total Expenditure	**$5,506**	**$16,944**	**$2,857,162**	**$0**	**$24,765**	**$0**	**$0**	**$0**	**$0**	**$33,088**	**$5,451**	**$8,549**	**$0**	**$0**	**$2,951,465**
Estimated FY 2012-13 Per Capita	$0.14	$1.91	$46.73	$0.00	$0.87	$0.00	$0.00	$0.00	$0.00	$0.09	$0.30	$1.04	$0.00	$0.00	$4.33
% Change over FY 2011-12 Per Capita	180.00%	141.77%	147.51%	0.00%	521.43%	0.00%	0.00%	0.00%	0.00%	125.00%	150.00%	136.36%	0.00%	0.00%	131.55%
Request Year Projection															
Estimated FY 2012-13 Expenditure	$5,506	$16,944	$2,857,162	$0	$24,765	$0	$0	$0	$0	$33,088	$5,451	$8,549	$0	$0	$2,951,465
Percentage Selected to Modify Expenditure[2]	9.39%	9.39%	9.39%	9.39%	9.39%	9.39%	9.39%	9.39%	0.00%	9.39%	0.00%	9.39%	0.00%	0.00%	
Estimated FY 2013-14 Base Expenditures	$6,023	$18,535	$3,125,450	$0	$27,090	$0	$0	$0	$0	$36,195	$5,451	$9,352	$0	$0	$3,228,096
Bottom Line Impacts															
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$587	$1,809	$305,001	$0	$2,644	$0	$0	$0	$0	$3,532	$582	$913	$0	$0	$315,068
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$4,558	$14,030	$2,365,710	$0	$20,505	$0	$0	$0	$0	$27,397	$4,513	$7,079	$0	$0	$2,443,792
Total Bottom Line Impacts	$5,145	$15,839	$2,670,711	$0	$23,149	$0	$0	$0	$0	$30,929	$5,095	$7,992	$0	$0	$2,758,860
Estimated FY 2013-14 Total Expenditure	**$11,168**	**$34,374**	**$5,796,161**	**$0**	**$50,239**	**$0**	**$0**	**$0**	**$0**	**$67,124**	**$10,546**	**$17,344**	**$0**	**$0**	**$5,986,956**
Estimated FY 2013-14 Per Capita	$0.27	$3.67	$92.56	$0.00	$1.64	$0.00	$0.00	$0.00	$0.00	$0.17	$0.58	$1.97	$0.00	$0.00	$8.11
% Change over FY 2012-13 Per Capita	92.86%	92.15%	98.07%	0.00%	88.51%	0.00%	0.00%	0.00%	0.00%	88.89%	93.33%	89.42%	0.00%	0.00%	87.30%
Out Year Projection															
Estimated FY 2013-14 Expenditure	$11,168	$34,374	$5,796,161	$0	$50,239	$0	$0	$0	$0	$67,124	$10,546	$17,344	$0	$0	$5,986,956
Percentage Selected to Modify Expenditure[2]	9.39%	9.39%	9.39%	9.39%	9.39%	9.39%	9.39%	9.39%	0.00%	9.39%	0.00%	9.39%	0.00%	0.00%	
Estimated FY 2014-15 Base Expenditures	$12,217	$37,602	$6,340,421	$0	$54,956	$0	$0	$0	$0	$73,427	$10,546	$18,973	$0	$0	$6,548,142
Bottom Line Impacts															
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2014-15 Total Expenditure	**$12,217**	**$37,602**	**$6,340,421**	**$0**	**$54,956**	**$0**	**$0**	**$0**	**$0**	**$73,427**	**$10,546**	**$18,973**	**$0**	**$0**	**$6,548,142**
Estimated FY 2014-15 Per Capita	$0.29	$3.83	$99.17	$0.00	$1.75	$0.00	$0.00	$0.00	$0.00	$0.17	$0.58	$2.07	$0.00	$0.00	$8.43
% Change over FY 2013-14 Per Capita	7.41%	4.36%	7.14%	0.00%	6.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.08%	0.00%	0.00%	3.95%

Footnotes

Footnote	Group	Basis	Group	Basis	Group	Basis
(1) Percentage selected to modify expenditure for FY 2012-13	**OAP-A**	FY 2011-12 expenditure growth rate for AND/AB clients	**Exp. Adults**	0.00%	**BC Adults**	FY 2011-12 expenditure growth rate for AND/AB clients
	OAP-B	FY 2011-12 expenditure growth rate for AND/AB clients	**BCCP**	0.00%	**Non-Citizens**	0.00%
	AND/AB	FY 2011-12 expenditure growth rate for AND/AB clients	**Elig. Children**	FY 2011-12 expenditure growth rate for AND/AB clients	**Partial Dual**	0.00%
	AFDC-A	FY 2011-12 expenditure growth rate for AND/AB clients	**Foster Care**	0.00%		
(2) Percentage selected to modify expenditure for FY 2013-14 and FY 2014-15	**OAP-A**	FY 2011-12 expenditure growth rate for AND/AB clients	**Exp. Adults**	0.00%	**BC Adults**	FY 2011-12 expenditure growth rate for AND/AB clients
	OAP-B	FY 2011-12 expenditure growth rate for AND/AB clients	**BCCP**	0.00%	**Non-Citizens**	0.00%
	AND/AB	FY 2011-12 expenditure growth rate for AND/AB clients	**Elig. Children**	FY 2011-12 expenditure growth rate for AND/AB clients	**Partial Dual**	0.00%
	AFDC-A	FY 2011-12 expenditure growth rate for AND/AB clients	**Foster Care**	0.00%		

Exhibit I - Service Management - Summary

FY 2012-13 Service Management Request

Service Management	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Single Entry Points	$12,563,256	$2,679,600	$11,733,705	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$26,976,561
Disease Management	$93,384	$66,293	$549,838	$395	$234,603	$63,345	$82,131	$2,367	$10,162	$507,479	$58,690	$62,639	$41,489	$5,351	$1,778,166
Prepaid Inpatient Health Plan	$1,302,414	$743,768	$5,079,583	$571	$8,936,096	$3,561,303	$4,966,337	$2,438,788	$0	$17,113,172	$1,423,363	$649,895	$0	$0	$46,215,290
Total Service Management	**$13,959,054**	**$3,489,661**	**$17,363,126**	**$966**	**$9,170,699**	**$3,624,648**	**$5,048,468**	**$2,441,155**	**$10,162**	**$17,620,651**	**$1,482,053**	**$712,534**	**$41,489**	**$5,351**	**$74,970,017**

FY 2013-14 Service Management Request

Service Management	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Single Entry Points	$12,928,847	$2,977,036	$12,397,833	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$28,303,716
Disease Management	$62,272	$44,206	$366,649	$263	$156,440	$42,240	$54,768	$1,578	$6,777	$338,403	$39,136	$41,770	$27,666	$3,568	$1,185,736
Prepaid Inpatient Health Plan	$1,365,682	$780,182	$5,365,059	$794	$9,470,572	$3,774,150	$5,259,660	$2,362,857	$0	$18,157,468	$1,503,020	$688,648	$0	$0	$48,728,092
Total Service Management	**$14,356,801**	**$3,801,424**	**$18,129,541**	**$1,057**	**$9,627,012**	**$3,816,390**	**$5,314,428**	**$2,364,435**	**$6,777**	**$18,495,871**	**$1,542,156**	**$730,418**	**$27,666**	**$3,568**	**$78,217,544**

FY 2014-15 Service Management Request

Service Management	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Single Entry Points	$13,305,076	$3,307,487	$13,099,550	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$29,712,113
Disease Management	$66,847	$48,771	$394,141	$440	$167,789	$45,606	$60,052	$1,683	$7,404	$377,249	$41,568	$45,758	$29,466	$4,171	$1,290,945
Prepaid Inpatient Health Plan	$1,389,000	$787,057	$5,416,352	$794	$9,520,389	$3,794,082	$5,287,195	$2,362,857	$0	$18,407,501	$1,520,078	$694,572	$0	$0	$49,179,877
Total Service Management	**$14,760,923**	**$4,143,315**	**$18,910,043**	**$1,234**	**$9,688,178**	**$3,839,688**	**$5,347,247**	**$2,364,540**	**$7,404**	**$18,784,750**	**$1,561,646**	**$740,330**	**$29,466**	**$4,171**	**$80,182,935**

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

Cash Based Actuals

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$7,810,601	$1,041,413	$5,678,547	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$14,530,561
FY 2004-05	$9,077,168	$1,312,201	$6,867,466	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$17,256,835
FY 2005-06	$8,671,602	$1,294,860	$6,580,601	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,547,063
FY 2006-07	$9,171,616	$1,415,981	$7,414,939	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,002,536
FY 2007-08	$10,894,815	$1,743,587	$9,118,699	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$21,757,100
FY 2008-09	$11,356,087	$1,927,170	$9,783,919	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$23,067,175
FY 2009-10 (DA)	$11,622,897	$2,068,951	$10,015,703	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$23,707,551
FY 2010-11 (DA)	$11,482,516	$2,211,295	$10,327,849	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$24,021,660
FY 2011-12	$11,748,349	$2,505,790	$10,972,607	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,226,746
Estimated FY 2012-13	$12,563,256	$2,679,600	$11,733,705	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$26,976,561
Estimated FY 2013-14	$12,928,847	$2,977,036	$12,397,833	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$28,303,716
Estimated FY 2014-15	$13,305,076	$3,307,487	$13,099,550	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$29,712,113

Percent Change in Cash Based Actuals

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	16.22%	26.00%	20.94%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	18.76%
FY 2005-06	-4.47%	-1.32%	-4.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-4.11%
FY 2006-07	5.77%	9.35%	12.68%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.80%
FY 2007-08	18.79%	23.14%	22.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	20.86%
FY 2008-09	4.23%	10.53%	7.30%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.02%
FY 2009-10 (DA)	2.35%	7.36%	2.37%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.78%
FY 2010-11 (DA)	-1.21%	6.88%	3.12%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.32%
FY 2011-12	2.32%	13.32%	6.24%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.02%
Estimated FY 2012-13	6.94%	6.94%	6.94%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.94%
Estimated FY 2013-14	2.91%	11.10%	5.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.92%
Estimated FY 2014-15	2.91%	11.10%	5.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.98%

Per Capita Cost

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2003-04	$227.52	$187.71	$121.37	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$39.53
FY 2004-05	$253.69	$215.75	$143.28	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42.50
FY 2005-06	$239.50	$214.31	$137.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$41.14
FY 2006-07	$255.56	$233.70	$151.95	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45.90
FY 2007-08	$300.26	$283.69	$182.62	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$55.51
FY 2008-09	$301.87	$298.93	$190.52	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$52.81
FY 2009-10 (DA)	$302.00	$293.51	$188.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$47.53
FY 2010-11 (DA)	$295.02	$284.70	$183.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42.84
FY 2011-12	$295.63	$298.91	$184.62	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$40.69
Estimated FY 2012-13	$311.25	$301.96	$191.92	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$39.58
Estimated FY 2013-14	$313.85	$318.20	$197.99	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$38.33
Estimated FY 2014-15	$316.18	$336.74	$204.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$38.27

Percent Change in Per Capita Cost

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2004-05	11.50%	14.94%	18.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.51%
FY 2005-06	-5.59%	-0.67%	-4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-3.20%
FY 2006-07	6.71%	9.05%	10.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.57%
FY 2007-08	17.49%	21.39%	20.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	20.94%
FY 2008-09	0.54%	5.37%	4.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-4.86%
FY 2009-10 (DA)	0.04%	-1.81%	-1.30%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.00%
FY 2010-11 (DA)	-2.31%	-3.00%	-2.42%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-9.87%
FY 2011-12	0.21%	4.99%	0.62%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.02%
Estimated FY 2012-13	5.28%	1.02%	3.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.73%
Estimated FY 2013-14	0.84%	5.38%	3.16%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-3.16%
Estimated FY 2014-15	0.74%	5.83%	3.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.16%

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

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

HCBS Average Monthly Paid Enrollment[2]

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2008-09	9,491	1,465	8,153	-	-	-	-	-	-	-	-	-	-	-	19,109
FY 2009-10 (DA)	9,868	1,617	8,751	-	-	-	-	-	-	-	-	-	-	-	20,236
FY 2010-11 (DA)	10,276	1,791	9,244	-	-	-	-	-	-	-	-	-	-	-	21,311
FY 2011-12	10,575	2,009	9,769	-	-	-	-	-	-	-	-	-	-	-	22,353
Estimated FY 2012-13	10,883	2,232	10,322	-	-	-	-	-	-	-	-	-	-	-	23,437
Estimated FY 2013-14	11,200	2,480	10,906	-	-	-	-	-	-	-	-	-	-	-	24,586
Estimated FY 2014-15	11,526	2,755	11,523	-	-	-	-	-	-	-	-	-	-	-	25,804

Percent Changes in Utilization

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2008-09 to FY 2009-10	3.97%	10.38%	7.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.90%
FY 2009-10 to FY 2010-11	4.13%	10.76%	5.63%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.31%
FY 2010-11 to FY 2011-12	2.91%	12.17%	5.68%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.89%
Estimated FY 2012-13	2.91%	11.10%	5.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.85%
Estimated FY 2013-14	2.91%	11.11%	5.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.90%
Estimated FY 2014-15	2.91%	11.09%	5.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.95%

Cost per Enrollee

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2008-09	$1,196.51	$1,315.47	$1,200.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,207.14
FY 2009-10 (DA)	$1,177.84	$1,279.50	$1,144.52	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,171.55
FY 2010-11 (DA)	$1,117.41	$1,234.67	$1,117.25	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,127.20
FY 2011-12	$1,110.95	$1,247.28	$1,123.21	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,128.56
Estimated FY 2012-13	$1,154.39	$1,200.54	$1,136.77	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,151.02
Estimated FY 2013-14	$1,154.36	$1,200.42	$1,136.79	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,151.21
Estimated FY 2014-15	$1,154.35	$1,200.54	$1,136.82	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,151.45

Percentage Change in Cost per Enrollee

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2009-10 (DA)	-1.56%	-2.73%	-4.63%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.95%
FY 2010-11 (DA)	-5.13%	-3.50%	-2.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-3.79%
FY 2011-12	-0.58%	1.02%	0.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.12%
Estimated FY 2012-13	3.91%	-3.75%	1.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.99%
Estimated FY 2013-14	0.00%	-0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%
Estimated FY 2014-15	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.02%

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

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Current Year Projection															
FY 2012-13 Base Contracts	$12,563,256	$2,679,600	$11,733,705	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$26,976,561
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2012-13 Total Expenditure	**$12,563,256**	**$2,679,600**	**$11,733,705**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$26,976,561**
Estimated FY 2012-13 Per Capita	$311.25	$301.96	$191.92	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$39.58
% Change over FY 2011-12 Per Capita	5.28%	1.02%	3.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.73%
Request Year Projection															
Estimated FY 2013-14 Base Contracts	$12,563,256	$2,679,600	$11,733,705	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$26,976,561
Estimated Increase in HCBS Utilization[3]	2.91%	11.10%	5.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Estimated FY 2013-14 Base Expenditure	$12,928,847	$2,977,036	$12,397,833	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$28,303,716
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2013-14 Total Expenditure	**$12,928,847**	**$2,977,036**	**$12,397,833**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$28,303,716**
Estimated FY 2013-14 Per Capita	$313.85	$318.20	$197.99	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$38.33
% Change over FY 2012-13 Per Capita	0.84%	5.38%	3.16%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-3.16%
Out Year Projection															
FY 2014-15 Base Contracts	$12,928,847	$2,977,036	$12,397,833	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$28,303,716
Estimated Increase in HCBS Utilization[3]	2.91%	11.10%	5.66%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Estimated FY 2014-15 Base Expenditure	$13,305,076	$3,307,487	$13,099,550	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$29,712,113
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2014-15 Total Expenditure	**$13,305,076**	**$3,307,487**	**$13,099,550**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$29,712,113**
Estimated FY 2014-15 Per Capita	$316.18	$336.74	$204.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$38.27
% Change over FY 2013-14 Per Capita	0.74%	5.83%	3.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.16%

Footnotes

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

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

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

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

Cash Based Actuals

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2005-06	$38,074	$13,320	$114,902	$0	$52,228	$0	$0	$0	$637	$80,668	$12,989	$9,537	$0	$0	$322,355
FY 2006-07	$31,652	$16,971	$146,541	$0	$76,859	$0	$0	$0	$2,053	$120,548	$19,962	$14,413	$0	$0	$428,999
FY 2007-08	$165,996	$92,931	$833,085	$0	$378,473	$0	$0	$0	$12,812	$645,653	$113,811	$87,964	$0	$0	$2,330,726
FY 2008-09	$201,459	$112,661	$996,159	$0	$477,141	$0	$0	$0	$13,568	$835,312	$131,805	$114,165	$0	$0	$2,882,271
FY 2009-10 (DA)	$4,570	$2,655	$23,534	$0	$12,589	$0	$0	$0	$409	$21,785	$3,047	$3,027	$0	$0	$71,616
FY 2010-11 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2011-12	$51,573	$36,611	$303,654	$218	$129,562	$34,983	$45,358	$1,307	$5,612	$280,261	$32,412	$34,593	$22,913	$2,955	$982,012
Estimated FY 2012-13	$93,384	$66,293	$549,838	$395	$234,603	$63,345	$82,131	$2,367	$10,162	$507,479	$58,690	$62,639	$41,489	$5,351	$1,778,166
Estimated FY 2013-14	$62,272	$44,206	$366,649	$263	$156,440	$42,240	$54,768	$1,578	$6,777	$338,403	$39,136	$41,770	$27,666	$3,568	$1,185,736
Estimated FY 2014-15	$66,847	$48,771	$394,141	$440	$167,789	$45,606	$60,052	$1,683	$7,404	$377,249	$41,568	$45,758	$29,466	$4,171	$1,290,945

Percent Change in Cash Based Actuals

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2006-07	-16.87%	27.41%	27.54%	0.00%	47.16%	0.00%	0.00%	0.00%	222.29%	49.44%	53.68%	51.13%	0.00%	0.00%	33.08%
FY 2007-08	424.44%	447.59%	468.50%	0.00%	392.43%	0.00%	0.00%	0.00%	524.08%	435.60%	470.14%	510.31%	0.00%	0.00%	443.29%
FY 2008-09	21.36%	21.23%	19.57%	0.00%	26.07%	0.00%	0.00%	0.00%	5.90%	29.37%	15.81%	29.79%	0.00%	0.00%	23.66%
FY 2009-10 (DA)	-97.73%	-97.64%	-97.64%	0.00%	-97.36%	0.00%	0.00%	0.00%	-96.99%	-97.39%	-97.69%	-97.35%	0.00%	0.00%	-97.52%
FY 2010-11 (DA)	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%
FY 2011-12	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Estimated FY 2012-13	81.07%	81.07%	81.07%	81.19%	81.07%	81.07%	81.07%	81.10%	81.08%	81.07%	81.07%	81.07%	81.07%	81.08%	81.07%
Estimated FY 2013-14	-33.32%	-33.32%	-33.32%	-33.42%	-33.32%	-33.32%	-33.32%	-33.33%	-33.31%	-33.32%	-33.32%	-33.32%	-33.32%	-33.32%	-33.32%
Estimated FY 2014-15	7.35%	10.33%	7.50%	67.30%	7.25%	7.97%	9.65%	6.65%	9.25%	11.48%	6.21%	9.55%	6.51%	16.90%	8.87%

Per Capita Cost

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2005-06	$1.05	$2.20	$2.40	$0.00	$0.89	$0.00	$0.00	$0.00	$3.39	$0.38	$0.79	$1.86	$0.00	$0.00	$0.80
FY 2006-07	$0.88	$2.80	$3.00	$0.00	$1.52	$0.00	$0.00	$0.00	$9.00	$0.59	$1.19	$2.78	$0.00	$0.00	$1.09
FY 2007-08	$4.57	$15.12	$16.68	$0.00	$8.49	$0.00	$0.00	$0.00	$47.45	$3.16	$6.64	$13.99	$0.00	$0.00	$5.95
FY 2008-09	$5.36	$17.47	$19.40	$0.00	$9.71	$0.00	$0.00	$0.00	$42.80	$3.55	$7.31	$16.37	$0.00	$0.00	$6.60
FY 2009-10 (DA)	$0.12	$0.38	$0.44	$0.00	$0.22	$0.00	$0.00	$0.00	$0.96	$0.08	$0.17	$0.39	$0.00	$0.00	$0.14
FY 2010-11 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2011-12	$1.30	$4.37	$5.11	$4.19	$1.89	$1.43	$1.28	$0.04	$9.40	$0.84	$1.80	$4.53	$8.27	$0.16	$1.58
Estimated FY 2012-13	$1.28	$4.13	$4.97	$0.10	$1.76	$1.22	$1.07	$0.13	$9.04	$0.77	$1.80	$4.21	$8.18	$0.14	$1.44
Estimated FY 2013-14	$1.51	$4.72	$5.86	$0.05	$2.02	$1.38	$1.16	$2.41	$0.02	$18.74	$4.45	$14.78	$1.21	$0.00	$1,185,736.00
Estimated FY 2014-15	$1.59	$4.97	$6.16	$0.05	$2.13	$1.45	$1.22	$2.48	$0.02	$20.72	$4.54	$15.99	$1.19	$0.01	$1,290,945.00

Percent Change in Per Capita Cost

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2006-07	-16.19%	27.27%	25.00%	0.00%	70.79%	0.00%	0.00%	0.00%	165.49%	55.26%	50.63%	49.46%	0.00%	0.00%	36.25%
FY 2007-08	419.32%	440.00%	456.00%	0.00%	458.55%	0.00%	0.00%	0.00%	427.22%	435.59%	457.98%	403.24%	0.00%	0.00%	445.87%
FY 2008-09	17.29%	15.54%	16.31%	0.00%	14.37%	0.00%	0.00%	0.00%	-9.80%	12.34%	10.09%	17.01%	0.00%	0.00%	10.92%
FY 2009-10 (DA)	-97.76%	-97.82%	-97.73%	0.00%	-97.73%	0.00%	0.00%	0.00%	-97.76%	-97.75%	-97.67%	-97.62%	0.00%	0.00%	-97.88%
FY 2010-11 (DA)	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	-100.00%	-100.00%	-100.00%	-100.00%	0.00%	0.00%	-100.00%
FY 2011-12	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Estimated FY 2012-13	-1.72%	-5.59%	-2.81%	-97.62%	-6.71%	-14.51%	-16.68%	226.75%	-3.86%	-8.29%	0.07%	-7.00%	-1.08%	-11.77%	-8.80%
Estimated FY 2013-14	18.18%	14.41%	17.99%	-49.93%	14.57%	12.88%	8.77%	1743.92%	-99.78%	2332.50%	147.05%	250.83%	-85.21%	-100.00%	82292273.21%
Estimated FY 2014-15	5.30%	5.30%	5.12%	0.00%	5.45%	5.07%	5.17%	2.90%	0.00%	10.57%	2.02%	8.19%	-1.65%	100.00%	8.87%

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

Estimated FY 2014-15	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2012-13 Projection															
Estimated FY 2012-13 Base Per Capita	$1.28	$4.13	$4.97	$0.10	$1.76	$1.22	$1.07	$0.13	$9.04	$0.77	$1.80	$4.21	$8.18	$0.14	$1.44
Estimated FY 2012-13 Eligibles	40,364	8,874	61,140	2,183	73,483	28,615	42,531	10,000	621	363,786	17,994	8,211	2,801	20,932	681,535
Estimated FY 2012-13 Base Expenditures	**$51,573**	**$36,611**	**$303,654**	**$218**	**$129,562**	**$34,983**	**$45,358**	**$1,307**	**$5,612**	**$280,261**	**$32,412**	**$34,593**	**$22,913**	**$2,955**	**$982,012**
Bottom Line Impacts															
Smoking Quit line	$41,811	$29,682	$246,184	$177	$105,041	$28,362	$36,773	$1,060	$4,550	$227,218	$26,278	$28,046	$18,576	$2,396	$796,154
Total Bottom Line Impacts	**$41,811**	**$29,682**	**$246,184**	**$177**	**$105,041**	**$28,362**	**$36,773**	**$1,060**	**$4,550**	**$227,218**	**$26,278**	**$28,046**	**$18,576**	**$2,396**	**$796,154**
Estimated FY 2012-13 Total Expenditure	**$93,384**	**$66,293**	**$549,838**	**$395**	**$234,603**	**$63,345**	**$82,131**	**$2,367**	**$10,162**	**$507,479**	**$58,690**	**$62,639**	**$41,489**	**$5,351**	**$1,778,166**
Estimated FY 2012-13 Per Capita	$2.31	$7.47	$8.99	$0.18	$3.19	$2.21	$1.93	$0.24	$16.36	$1.39	$3.26	$7.63	$14.81	$0.26	$2.61
% Change over FY 2011-12 Per Capita	180.79%	181.06%	181.01%	180.25%	180.93%	180.77%	180.97%	183.63%	181.03%	180.43%	180.98%	181.11%	181.04%	184.17%	181.14%
FY 2013-14 Projection															
Percentage Selected to Modify Per Capita	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2013-14 Base Per Capita	$2.27	$7.09	$8.78	$0.07	$3.03	$2.07	$1.73	$0.24	$15.51	$1.26	$3.25	$7.12	$14.68	$0.23	$2.41
Estimated FY 2013-14 Eligibles	41,195	9,356	62,620	5,465	77,326	30,573	47,351	10,000	655	401,411	18,057	8,801	2,827	22,776	738,413
Estimated FY 2013-14 Base Expenditures	**$93,384**	**$66,293**	**$549,838**	**$395**	**$234,603**	**$63,345**	**$82,131**	**$2,367**	**$10,162**	**$507,479**	**$58,690**	**$62,639**	**$41,489**	**$5,351**	**$1,778,166**
Bottom Line Impacts															
Disease Management Pilot Sunset	($26,259)	($18,641)	($154,608)	($111)	($65,968)	($17,812)	($23,094)	($666)	($2,857)	($142,697)	($16,503)	($17,613)	($11,666)	($1,505)	($500,000)
Smoking Quit line	($4,853)	($3,446)	($28,581)	($21)	($12,195)	($3,293)	($4,269)	($123)	($528)	($26,379)	($3,051)	($3,256)	($2,157)	($278)	($92,430)
Total Bottom Line Impacts	**($31,112)**	**($22,087)**	**($183,189)**	**($132)**	**($78,163)**	**($21,105)**	**($27,363)**	**($789)**	**($3,385)**	**($169,076)**	**($19,554)**	**($20,869)**	**($13,823)**	**($1,783)**	**($592,430)**
Estimated FY 2013-14 Total Expenditure	**$62,272**	**$44,206**	**$366,649**	**$263**	**$156,440**	**$42,240**	**$54,768**	**$1,578**	**$6,777**	**$338,403**	**$39,136**	**$41,770**	**$27,666**	**$3,568**	**$1,185,736**
Estimated FY 2013-14 Per Capita	$1.51	$4.72	$5.86	$0.05	$2.02	$1.38	$1.16	$0.16	$10.35	$0.84	$2.17	$4.75	$9.79	$0.16	$1.61
% Change over FY 2012-13 Per Capita	-34.63%	-36.81%	-34.82%	-72.22%	-36.68%	-37.56%	-39.90%	-33.33%	-36.74%	-39.57%	-33.44%	-37.75%	-33.90%	-38.46%	-38.31%
FY 2014-15 Projection															
Percentage Selected to Modify Per Capita	5.20%	5.20%	5.20%	5.20%	5.20%	5.20%	5.20%	5.20%	5.20%	5.20%	5.20%	5.20%	5.20%	5.20%	
Estimated FY 2014-15 Base Per Capita	$1.59	$4.97	$6.16	$0.05	$2.13	$1.45	$1.22	$0.17	$10.89	$0.88	$2.28	$5.00	$10.30	$0.17	
Estimated FY 2014-15 Eligibles	42,081	9,822	63,935	8,367	78,958	31,414	49,210	10,000	680	426,907	18,209	9,157	2,861	24,780	776,381
Estimated FY 2014-15 Base Expenditures	**$66,847**	**$48,771**	**$394,141**	**$440**	**$167,789**	**$45,606**	**$60,052**	**$1,683**	**$7,404**	**$377,249**	**$41,568**	**$45,758**	**$29,466**	**$4,171**	
Bottom Line Impacts															
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2014-15 Total Expenditure	**$66,847**	**$48,771**	**$394,141**	**$440**	**$167,789**	**$45,606**	**$60,052**	**$1,683**	**$7,404**	**$377,249**	**$41,568**	**$45,758**	**$29,466**	**$4,171**	**$1,290,945**
Estimated FY 2014-15 Per Capita	$1.59	$4.97	$6.16	$0.05	$2.13	$1.45	$1.22	$0.17	$10.89	$0.88	$2.28	$5.00	$10.30	$0.17	$1.66
% Change over FY 2013-14 Per Capita	-459.11%	-1350.03%	-1769.28%	-6.92%	-580.74%	-386.08%	-305.79%	-51.00%	-2964.40%	-222.40%	-681.91%	-1324.65%	-3038.71%	-44.20%	-433.26%

Exhibit I - SERVICE MANAGEMENT - Prepaid Inpatient Health Plan Administration

Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2005-06	$518,021	$113,193	$895,454	$0	$617,504	$0	$0	$0	$0	$2,912,859	$202,140	$81,570	$0	$0	$5,340,741
FY 2006-07	$505,046	$102,136	$772,630	$0	$518,429	$1,000	$0	$0	$0	$2,412,273	$223,401	$85,502	$0	$0	$4,620,417
FY 2007-08	$366,151	$74,505	$536,817	$0	$430,680	$66,075	$0	$0	$0	$1,873,683	$176,254	$85,306	$0	$0	$3,609,472
FY 2008-09	$352,841	$75,159	$520,646	$0	$530,811	$95,675	$0	$0	$0	$2,101,664	$184,279	$74,059	$0	$0	$3,935,134
FY 2009-10 (DA)	$331,989	$116,999	$938,116	$0	$543,252	$170,250	$0	$0	$0	$2,715,378	$208,304	$87,465	$0	$0	$5,111,753
FY 2010-11 (DA)	$411,355	$211,517	$1,451,791	$0	$590,948	$202,779	$238,521	$0	$0	$3,063,511	$216,554	$88,268	$0	$0	$6,475,244
FY 2011-12	$859,426	$440,019	$3,171,186	$1,471	$5,009,974	$2,012,665	$2,795,661	$79,568	$0	$11,137,412	$901,952	$388,585	$107	$1,155	$26,799,181
Estimated FY 2012-13	$1,302,414	$743,768	$5,079,583	$571	$8,936,096	$3,561,303	$4,966,337	$2,438,788	$0	$17,113,172	$1,423,363	$649,895	$0	$0	$46,215,290
Estimated FY 2013-14	$1,365,682	$780,182	$5,365,059	$794	$9,470,572	$3,774,150	$5,259,660	$2,362,857	$0	$18,157,468	$1,503,020	$688,648	$0	$0	$48,728,092
Estimated FY 2014-15	$1,389,000	$787,057	$5,416,352	$794	$9,520,389	$3,794,082	$5,287,195	$2,362,857	$0	$18,407,501	$1,520,078	$694,572	$0	$0	$49,179,877

Percent Change in Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2006-07	-2.50%	-9.77%	-13.72%	0.00%	-16.04%	100.00%	0.00%	0.00%	0.00%	-17.19%	10.52%	4.82%	0.00%	0.00%	-13.49%
FY 2007-08	-27.50%	-27.05%	-30.52%	0.00%	-16.93%	6507.50%	0.00%	0.00%	0.00%	-22.33%	-21.10%	-0.23%	0.00%	0.00%	-21.88%
FY 2008-09	-3.64%	0.88%	-3.01%	0.00%	23.25%	44.80%	0.00%	0.00%	0.00%	12.17%	4.55%	-13.18%	0.00%	0.00%	9.02%
FY 2009-10 (DA)	-5.91%	55.67%	80.18%	0.00%	2.34%	77.95%	0.00%	0.00%	0.00%	29.20%	13.04%	18.10%	0.00%	0.00%	29.90%
FY 2010-11 (DA)	23.91%	80.78%	54.76%	0.00%	8.78%	19.11%	100.00%	0.00%	0.00%	12.82%	3.96%	0.92%	0.00%	0.00%	26.67%
FY 2011-12	108.93%	108.03%	118.43%	100.00%	747.79%	892.54%	1072.08%	100.00%	0.00%	263.55%	316.50%	340.23%	100.00%	100.00%	313.87%
Estimated FY 2012-13	51.54%	69.03%	60.18%	-61.18%	78.37%	76.94%	77.64%	2965.04%	0.00%	53.65%	57.81%	67.25%	-100.00%	-100.00%	72.45%
Estimated FY 2013-14	4.86%	4.90%	5.62%	39.05%	5.98%	5.98%	5.91%	-3.11%	0.00%	6.10%	5.60%	5.96%	0.00%	0.00%	5.44%
Estimated FY 2014-15	1.71%	0.88%	0.96%	0.00%	0.53%	0.53%	0.52%	0.00%	0.00%	1.38%	1.13%	0.86%	0.00%	0.00%	0.93%

Per Capita Cost

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2005-06	$14.31	$18.73	$18.71	$0.00	$10.49	$0.00	$0.00	$0.00	$0.00	$13.60	$12.28	$15.93	$0.00	$0.00	$13.28
FY 2006-07	$14.07	$16.86	$15.83	$0.00	$10.23	$0.19	$0.00	$0.00	$0.00	$11.74	$13.36	$16.50	$0.00	$0.00	$11.78
FY 2007-08	$10.09	$12.12	$10.75	$0.00	$9.67	$7.41	$0.00	$0.00	$0.00	$9.18	$10.28	$13.57	$0.00	$0.00	$9.21
FY 2008-09	$9.38	$11.66	$10.14	$0.00	$10.80	$7.52	$0.00	$0.00	$0.00	$8.94	$10.22	$10.62	$0.00	$0.00	$9.01
FY 2009-10 (DA)	$8.63	$16.60	$17.61	$0.00	$9.42	$9.91	$0.00	$0.00	$0.00	$9.85	$11.33	$11.17	$0.00	$0.00	$10.25
FY 2010-11 (DA)	$10.57	$27.23	$25.79	$0.00	$9.69	$10.06	$8.78	$0.00	$0.00	$10.13	$11.77	$11.22	$0.00	$0.00	$11.55
FY 2011-12	$21.63	$52.49	$53.36	$28.29	$72.94	$82.03	$78.84	$70.17	$0.00	$33.28	$50.01	$50.93	$0.04	$0.06	$43.23
Estimated FY 2012-13	$32.27	$83.81	$83.08	$0.26	$121.61	$124.46	$116.77	$243.88	$0.00	$47.04	$79.10	$79.15	$0.00	$0.00	$67.81
Estimated FY 2013-14	$33.15	$83.39	$85.68	$0.15	$122.48	$123.45	$111.08	$236.29	$0.00	$45.23	$83.24	$78.24	$0.00	$0.00	$65.99
Estimated FY 2014-15	$33.01	$80.13	$84.72	$0.09	$120.58	$120.78	$107.44	$236.29	$0.00	$43.12	$83.48	$75.85	$0.00	$0.00	$63.35

Percent Change in Per Capita Cost

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 2006-07	-1.68%	-9.98%	-15.39%	0.00%	-2.48%	100.00%	0.00%	0.00%	0.00%	-13.68%	8.79%	3.58%	0.00%	0.00%	-11.30%
FY 2007-08	-28.29%	-28.11%	-32.09%	0.00%	-5.47%	3800.00%	0.00%	0.00%	0.00%	-21.81%	-23.05%	-17.76%	0.00%	0.00%	-21.82%
FY 2008-09	-7.04%	-3.80%	-5.67%	0.00%	11.69%	1.48%	0.00%	0.00%	0.00%	-2.61%	-0.58%	-21.74%	0.00%	0.00%	-2.17%
FY 2009-10 (DA)	-8.00%	42.37%	73.67%	0.00%	-12.78%	31.78%	0.00%	0.00%	0.00%	10.18%	10.86%	5.18%	0.00%	0.00%	13.76%
FY 2010-11 (DA)	22.48%	64.04%	46.45%	0.00%	2.87%	1.51%	100.00%	0.00%	0.00%	2.84%	3.88%	0.45%	0.00%	0.00%	12.68%
FY 2011-12	104.64%	92.77%	106.90%	100.00%	652.73%	715.41%	797.95%	100.00%	0.00%	228.53%	324.89%	353.92%	100.00%	100.00%	274.29%
Estimated FY 2012-13	49.19%	59.67%	55.70%	-99.08%	66.73%	51.72%	48.11%	247.56%	0.00%	41.35%	58.17%	55.41%	-100.00%	-100.00%	56.86%
Estimated FY 2013-14	2.73%	-0.50%	3.13%	-42.31%	0.72%	-0.81%	-4.87%	-3.11%	0.00%	-3.85%	5.23%	-1.15%	0.00%	0.00%	-2.68%
Estimated FY 2014-15	-0.42%	-3.91%	-1.12%	-40.00%	-1.55%	-2.16%	-3.28%	0.00%	0.00%	-4.67%	0.29%	-3.05%	0.00%	0.00%	-4.00%

Exhibit I - SERVICE MANAGEMENT - Prepaid Inpatient Health Plan Administration

Current Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RMHP	$406,688	$119,902	$894,633	$0	$868,880	$347,638	$480,255	$0	$0	$4,360,935	$297,509	$103,324	$0	$0	$7,879,764
Estimated Expenditure for Colorado Access	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for Kaiser Foundation Health Plan	$409	$2,093	$13,498	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,000
Estimated Expenditure for CAHI	$209,210	$108,569	$87,221	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$405,000
Estimated Expenditure for RCCOs in the ACC	$467,462	$341,738	$2,771,054	$511	$5,565,791	$2,218,974	$3,140,027	$1,800,000	$0	$8,334,826	$830,100	$375,335	$0	$0	$25,845,818
Estimated Expenditure for PCMPs in the ACC	$163,410	$131,087	$985,754	$0	$1,843,781	$732,501	$975,035	480,000	$0	$3,432,582	$197,671	$126,887	$0	$0	$9,068,708
Estimated Expenditure for SDAC in the ACC	$55,235	$40,379	$327,423	$60	$657,644	$262,190	$371,020	158,788.00	$0	$984,829	$98,083	$44,349	$0	$0	$3,000,000
Estimated FY 2012-13 Total Expenditure	$1,302,414	$743,768	$5,079,583	$571	$8,936,096	$3,561,303	$4,966,337	$2,438,788	$0	$17,113,172	$1,423,363	$649,895	$0	$0	$46,215,290
Estimated FY 2012-13 Per Capita Cost	$32.27	$83.81	$83.08	$0.26	$121.61	$124.46	$116.77	$243.88	$0.00	$47.04	$79.10	$79.15	$0.00	$0.00	$67.81

Request Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RMHP	$428,599	$126,361	$942,832	$0	$915,692	$366,367	$506,129	$0	$0	$4,595,884	$313,537	$108,891	$0	$0	$8,304,292
Estimated Expenditure for Colorado Access	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for Kaiser Foundation Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for CAHI	$209,210	$108,569	$87,221	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$405,000
Estimated Expenditure for RCCOs in the ACC	$489,878	$358,124	$2,903,924	$535	$5,832,667	$2,325,372	$3,290,589	$1,740,000	$0	$8,734,476	$869,903	$393,332	$0	$0	$26,938,800
Estimated Expenditure for PCMPs in the ACC	$182,452	$146,522	$1,101,823	$198	$2,060,881	$818,751	$1,089,842	480,000	$0	$3,836,757	$220,947	$141,827	$0	$0	$10,080,000
Estimated Expenditure for SDAC in the ACC	$55,543	$40,606	$329,259	$61	$661,332	$263,660	$373,100	$142,857	$0	$990,351	$98,633	$44,598	$0	$0	$3,000,000
Estimated FY 2013-14 Total Expenditure	$1,365,682	$780,182	$5,365,059	$794	$9,470,572	$3,774,150	$5,259,660	$2,362,857	$0	$18,157,468	$1,503,020	$688,648	$0	$0	$48,728,092
Estimated FY 2013-14 Per Capita Cost	$33.15	$83.39	$85.68	$0.15	$122.48	$123.45	$111.08	$236.29	$0.00	$45.23	$83.24	$78.24	$0.00	$0.00	$65.99

Out Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Adults Without Dependent Children (AwDC)	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RMHP	$451,917	$133,236	$994,125	$0	$965,509	$386,299	$533,664	$0	$0	$4,845,917	$330,595	$114,815	$0	$0	$8,756,077
Estimated Expenditure for Colorado Access	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for Kaiser Foundation Health Plan	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for CAHI	$209,210	$108,569	$87,221	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$405,000
Estimated Expenditure for RCCOs in the ACC	$489,878	$358,124	$2,903,924	$535	$5,832,667	$2,325,372	$3,290,589	1,740,000	$0	$8,734,476	$869,903	$393,332	$0	$0	$26,938,800
Estimated Expenditure for PCMPs in the ACC	$182,452	$146,522	$1,101,823	$198	$2,060,881	$818,751	$1,089,842	480,000	$0	$3,836,757	$220,947	$141,827	$0	$0	$10,080,000
Estimated Expenditure for SDAC in the ACC	$55,543	$40,606	$329,259	$61	$661,332	$263,660	$373,100	$142,857	$0	$990,351	$98,633	$44,598	$0	$0	$3,000,000
Estimated FY 2014-15 Total Expenditure	$1,389,000	$787,057	$5,416,352	$794	$9,520,389	$3,794,082	$5,287,195	$2,362,857	$0	$18,407,501	$1,520,078	$694,572	$0	$0	$49,179,877
Estimated FY 2014-15 Per Capita Cost	$33.01	$80.13	$84.72	$0.09	$120.58	$120.78	$107.44	$236.29	$0.00	$43.12	$83.48	$75.85	$0.00	$0.00	$63.35

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

Exhibit I - SERVICE MANAGEMENT - Prepaid Inpatient Health Plan Administration

Cash Based Actuals by Provider

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2003-04	$3,308,119	$0	$0	$0	$0	$0	$0	$3,308,119
FY 2004-05	$4,285,446	$0	$0	$0	$0	$0	$0	$4,285,446
FY 2005-06	$5,340,741	$0	$0	$0	$0	$0	$0	$5,340,741
FY 2006-07	$4,620,417	$0	$0	$0	$0	$0	$0	$4,620,417
FY 2007-08	$3,609,472	$0	$0	$0	$0	$0	$0	$3,609,472
FY 2008-09	$3,935,134	$0	$0	$0	$0	$0	$0	$3,935,134
FY 2009-10	$4,744,734	$258,779	$65,940	$42,300	$0	$0	$0	$5,111,753
FY 2010-11	$5,437,512	$705,541	$130,440	$201,750	$182,819	$54,592	$650,000	$7,362,655
FY 2011-12	$8,387,798	$0	$240,000	$263,550	$12,303,473	$2,904,360	$2,700,000	$26,799,181
Estimated FY 2011-12	$7,879,764	$0	$16,000	$405,000	$25,845,818	$9,068,708	$3,000,000	$46,215,290
Estimated FY 2012-13	$8,304,292	$0	$0	$405,000	$26,938,800	$10,080,000	$3,000,000	$48,728,092
Estimated FY 2014-15	$8,756,077	$0	$0	$405,000	$26,938,800	$10,080,000	$3,000,000	$49,179,877

Percent Change in Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2004-05	29.54%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	29.54%
FY 2005-06	24.63%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	24.63%
FY 2006-07	-13.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-13.49%
FY 2007-08	-21.88%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-21.88%
FY 2008-09	9.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.02%
FY 2009-10	20.57%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	29.90%
FY 2010-11	14.60%	172.64%	97.82%	376.95%	100.00%	100.00%	100.00%	44.03%
FY 2011-12	54.26%	-100.00%	83.99%	30.63%	6629.87%	5220.12%	315.38%	263.99%
Estimated FY 2012-13	-6.06%	0.00%	-93.33%	53.67%	110.07%	212.24%	11.11%	72.45%
Estimated FY 2013-14	5.39%	0.00%	-100.00%	0.00%	4.23%	11.15%	0.00%	5.44%
Estimated FY 2014-15	5.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.93%

Prepaid Inpatient Health Plan Enrollment

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL[1]
Enrollment in Current Prepaid Inpatient Health Plans								
FY 2003-04	11,681	-	-	-	-	-	-	11,681
FY 2004-05	13,086	-	-	-	-	-	-	13,086
FY 2005-06	13,025	-	-	-	-	-	-	13,025
FY 2006-07	11,794	-	-	-	-	-	-	11,794
FY 2007-08	11,955	-	-	-	-	-	-	11,955
FY 2008-09	13,051	-	-	-	-	-	-	13,051
FY 2009-10	16,123	2,186	275	24	-	-	-	18,608
FY 2010-11	19,045	1,826	544	112	1,172	1,172	1,172	22,699
FY 2011-12	21,138	-	1,000	163	78,870	60,540	78,870	101,171
Estimated FY 2012-13	22,600	-	67	225	188,931	188,931	188,931	211,823
Estimated FY 2013-14	24,051	-	-	225	210,000	210,000	210,000	234,276
Estimated FY 2014-15	25,595	-	-	225	210,000	210,000	210,000	235,820
Annual Percent Change in Enrollment								
FY 2004-05	12.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	12.03%
FY 2005-06	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%
FY 2006-07	-9.45%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-9.45%
FY 2007-08	1.37%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.37%
FY 2008-09	9.17%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.17%
FY 2009-10	23.54%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	42.58%
FY 2010-11	18.12%	-16.47%	97.82%	366.67%	100.00%	100.00%	100.00%	21.99%
FY 2011-12	10.99%	-100.00%	83.82%	45.54%	6629.52%	5065.53%	6629.52%	345.71%
Estimated FY 2012-13[2]	10.12%	-100.00%	31.07%	35.71%	139.55%	212.08%	139.55%	833.18%
Estimated FY 2013-14[2]	1.07%	0.00%	-93.21%	96.05%	11.15%	11.15%	11.15%	10.60%
Estimated FY 2014-15[2]	0.00%	0.00%	-100.00%	0.67%	0.00%	0.00%	0.00%	0.66%

Exhibit I - SERVICE MANAGEMENT - Prepaid Inpatient Health Plan Administration

Cost Per Enrollee

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2003-04	$283.21	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$283.21
FY 2004-05	$327.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$327.48
FY 2005-06	$410.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$410.04
FY 2006-07	$391.76	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$391.76
FY 2007-08	$301.92	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$301.92
FY 2008-09	$301.52	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$301.52
FY 2009-10	$294.28	$118.38	$239.78	$1,762.50	$0.00	$0.00	$0.00	$274.71
FY 2010-11	$285.51	$386.39	$239.78	$1,801.34	$155.99	$46.58	$554.61	$324.36
FY 2011-12	$396.81	$0.00	$240.00	$1,616.87	$156.00	$47.97	$34.23	$264.89
Estimated FY 2012-13	$348.66	$0.00	$240.00	$1,800.00	$136.80	$48.00	$15.88	$218.18
Estimated FY 2013-14	$345.28	$0.00	$0.00	$1,800.00	$128.28	$48.00	$14.29	$207.99
Estimated FY 2014-15	$342.09	$0.00	$0.00	$1,800.00	$128.28	$48.00	$14.29	$208.55

Percent Change in Cost Per Enrollee

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2004-05	15.63%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.63%
FY 2005-06	25.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	25.21%
FY 2006-07	-4.46%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-4.46%
FY 2007-08	-22.93%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-22.93%
FY 2008-09	-0.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.13%
FY 2009-10	-2.40%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	-8.89%
FY 2010-11	-2.98%	226.40%	0.00%	2.20%	100.00%	100.00%	100.00%	18.07%
FY 2011-12	38.98%	-100.00%	0.09%	-10.24%	0.01%	2.98%	-93.83%	-18.33%
Estimated FY 2012-13	-12.13%	0.00%	0.00%	11.33%	-12.31%	0.06%	-53.61%	-17.63%
Estimated FY 2013-14	-0.97%	0.00%	-100.00%	0.00%	-6.23%	0.00%	-10.01%	-4.67%
Estimated FY 2014-15	-0.92%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.27%

Current Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
Estimated FY 2012-13 Enrollment	22,600	0	67	225	188,931	188,931	N/A	211,823
FY 2012-13 PMPM Administration Fee	$24.38	$0.00	$20.00	$150.00	$11.40	$4.00	N/A	
Number of Months Paid	12	-	12	12	12	12	N/A	
Estimated FY 2012-13 Base Expenditures	$6,611,900	$0	$16,000	$405,000	$25,845,818	$9,068,708	$3,000,000	$44,947,426
Estimated Contract Payment to PIHP for Cost Avoidanc	$1,267,864	$0	$0	$0	$0	$0	$0	$1,267,864
Estimated FY 2012-13 Total Expenditure	**$7,879,764**	**$0**	**$16,000**	**$405,000**	**$25,845,818**	**$9,068,708**	**$3,000,000**	**$46,215,290**
Estimated FY 2012-13 Cost Per Enrollee	$348.66	$0.00	$240.00	$1,800.00	$136.80	$48.00	$15.88	$218.18
% Change over FY 2011-12 Cost Per Enrollee	-12.13%	0.00%	0.00%	11.33%	-12.31%	0.06%	-53.61%	-17.63%

Request Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
Estimated 2013-14 Enrollment	24,051	0	-	225	210,000	210,000	N/A	234,276
FY 2013-14 PMPM Administration Fee	$24.38	$0.00	$0.00	$150.00	$10.69	$4.00	N/A	
Number of Months Paid	12	12	-	12	12	12	N/A	
Estimated FY 2013-14 Base Expenditures	$7,036,428	$0	$0	$405,000	$26,938,800	$10,080,000	$3,000,000	$47,460,228
Estimated Contract Payment to PIHP for Cost Avoidanc	$1,267,864	$0	$0	$0	$0	$0	$0	$1,267,864
Estimated FY 2013-14 Total Expenditure	**$8,304,292**	**$0**	**$0**	**$405,000**	**$26,938,800**	**$10,080,000**	**$3,000,000**	**$48,728,092**
Estimated FY 2013-14 Cost Per Enrollee	$345.28	-	$0.00	$1,800.00	$128.28	$48.00	$14.29	$207.99
% Change over FY 2012-13 Cost Per Enrollee	-0.97%	-	-100.00%	0.00%	-6.23%	0.00%	-10.01%	-4.67%

Out Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
Estimated 2014-15 Enrollment	25,595	0	0	225	210,000	210,000	N/A	235,820
FY 2014-15 PMPM Administration Fee	$24.38	$0.00	$0.00	$150.00	$10.69	$4.00	N/A	
Number of Months Paid	12	12	12	12	12	12	N/A	
Estimated FY 2014-15 Base Expenditures	$7,488,213	$0	$0	$405,000	$26,938,800	$10,080,000	$3,000,000	$47,912,013
Estimated Contract Payment to PIHP for Cost Avoidanc	$1,267,864	$0	$0	$0	$0	$0	$0	$1,267,864
Estimated FY 2014-15 Total Expenditure	**$8,756,077**	**$0**	**$0**	**$405,000**	**$26,938,800**	**$10,080,000**	**$3,000,000**	**$49,179,877**
Estimated FY 2014-15 Cost Per Enrollee	$342.09	$0.00	$0.00	$1,800.00	$128.28	$48.00	$14.29	$208.55
% Change over FY 2013-14 Cost Per Enrollee	-0.92%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.27%

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

(2) Percentages selected to modify enrollment:

- **RMHP:** FY 2011-12 through FY 2013-14. Base trend from June 2012 level.
- **Colorado Access:** Program ended June 30, 2011, at which time all clients were disenrolled from the program. Please see narrative for more information.
- **Kaiser Foundation Health Plan:** Program ended June 30, 2012; all clients were disenrolled from program.
- **Colorado Alliance Health & Independence:** Current projections for capped enrollment.
- **Accountable Care Collaborative:** Estimates for enrollment are based on Department's implementation plan. SDAC is paid on a fixed-price contract and is not a function of enrollmer

Exhibit J - Health Care Affordability Act of 2009 Estimates

Cash Funded Expansion Populations
Source of Funding

FY 2012-13 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Hospital Provider Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
HB 09-1293 Medicaid Expansion Clients							
Expansion Adults to 100%	42,531	$109,011,510	$0	$54,505,756	$0	$54,505,754	50.00%
Buy-In for Individuals with Disabilities	2,183	$23,069,309	$0	$10,778,485	$3,275,210	$9,015,613	50.00%
Adults Without Dependent Children	10,000	$90,339,815	$0	$45,169,907	$0	$45,169,908	50.00%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$222,420,634	$0	$110,454,148	$3,275,210	$108,691,275	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$168,366,501	$0	$84,183,250	$0	$84,183,251	50.00%
Outpatient Hospital Rates		$150,973,617	$0	$75,486,808	$0	$75,486,809	50.00%
Supplemental Hospital Payments (Upper Payment Limit)		$323,024,913	$0	$161,512,456	$0	$161,512,457	50.00%
Supplemental Hospital Payments (DSH)		$40,009,852	$0	$20,004,926	$0	$20,004,926	50.00%
Subtotal from HB 09-1293 Supplemental Payments		$682,374,883	$0	$341,187,440	$0	$341,187,443	
Cash Fund Financing		$0	($40,700,000)	$40,700,000	$0	$0	
HB 09-1293 Total		**$904,795,517**	**($40,700,000)**	**$492,341,588**	**$3,275,210**	**$449,878,718**	

FY 2013-14 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Hospital Provider Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
HB 09-1293 Medicaid Expansion Clients							
Expansion Adults to 100%	47,351	$124,414,821	$0	$31,103,705	$0	$93,311,116	75.00%
Buy-in for Individuals with Disabilities	5,465	$59,620,971	$0	$28,185,494	$7,992,980	$23,442,497	50.00%
Adults Without Dependent Children	10,000	$92,768,088	$0	$23,192,022	$0	$69,576,066	75.00%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$276,803,880	$0	$82,481,221	$7,992,980	$186,329,679	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$169,809,097	$0	$84,904,548	$0	$84,904,549	50.00%
Outpatient Hospital Rates		$150,133,499	$0	$75,066,750	$0	$75,066,749	50.00%
Supplemental Hospital Payments (Upper Payment Limit)		$334,489,350	$0	$167,244,675	$0	$167,244,675	50.00%
Supplemental Hospital Payments (DSH)		$41,000,000	$0	$20,500,000	$0	$20,500,000	50.00%
Subtotal from HB 09-1293 Supplemental Payments		$695,431,946	$0	$347,715,973	$0	$347,715,973	
Cash Fund Financing		$0	($15,700,000)	$15,700,000	$0	$0	
HB 09-1293 Total		**$972,235,826**	**($15,700,000)**	**$445,897,194**	**$7,992,980**	**$534,045,652**	

Exhibit J - Health Care Affordability Act of 2009 Estimates

FY 2014-15 Summary							
	Expenditure		Fund Calculations				
Eligibility Category	Caseload	Expenditure	General Fund	Hospital Provider Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
HB 09-1293 Medicaid Expansion Clients							
Expansion Adults to 100%	49,210	$130,193,207	$0	$0	$0	$130,193,207	100.00%
Buy-in for Individuals with Disabilities	8,367	$93,395,019	$0	$44,510,709	$12,142,700	$36,741,610	50.00%
Adults Without Dependent Children	10,000	$95,303,701	$0	$0	$0	$95,303,701	100.00%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$318,891,927	$0	$44,510,709	$12,142,700	$262,238,518	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$169,809,097	$0	$84,904,548	$0	$84,904,549	50.00%
Outpatient Hospital Rates		$150,133,499	$0	$75,066,750	$0	$75,066,749	50.00%
Supplemental Hospital Payments (Upper Payment Limit		$334,489,350	$0	$167,244,675	$0	$167,244,675	50.00%
Supplemental Hospital Payments (DSH)		$41,000,000	$0	$20,500,000	$0	$20,500,000	50.00%
Subtotal from HB 09-1293 Supplemental Payments		$695,431,946	$0	$347,715,973	$0	$347,715,973	
Cash Fund Financing		$0	($15,700,000)	$15,700,000	$0	$0	
HB 09-1293 Total		**$1,014,323,873**	**($15,700,000)**	**$407,926,682**	**$12,142,700**	**$609,954,491**	

Exhibit J - Health Care Affordability Act of 2009 Expansion Populations

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

Expansion Adults to 100%	Caseload	Per Capita	Total Funds [1]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$2,441.95	$103,858,631	$0	$51,929,316	$0	$51,929,315
Community Based Long Term Care		$2.45	$104,411	$0	$52,206	$0	$52,205
Long Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$118.70	$5,048,468	$0	$2,524,234	$0	$2,524,234
Total	**42,531**	**$2,563.11**	**$109,011,510**	**$0**	**$54,505,756**	**$0**	**$54,505,754**

Buy-In for Individuals with Disabilities	Caseload	Per Capita	Total Funds [1]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$9,327.78	$20,362,545	$0	$8,735,811	$2,890,924	$8,735,810
Community Based Long Term Care		$298.32	$651,236	$0	$279,389	$92,458	$279,389
Long Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$941.16	$2,054,562	$0	$1,762,870	$291,692	$0
Service Management		$0.44	$966	$0	$415	$137	$414
Total[1]	**2,183**	**$10,567.71**	**$23,069,309**	**$0**	**$10,778,485**	**$3,275,210**	**$9,015,613**

Adults Without Dependent Children	Caseload	Per Capita	Total Funds [1]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
Acute Care		$8,785.93	$87,859,292	$0	$43,929,646	$0	$43,929,646
Community Based Long Term Care		$3.94	$39,368	$0	$19,684	$0	$19,684
Long Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$244.12	$2,441,155	$0	$1,220,577	$0	$1,220,578
Total	**10,000**	**$9,033.98**	**$90,339,815**	**$0**	**$45,169,907**	**$0**	**$45,169,908**

FY 2012-13 Summary	Caseload	Per Capita	Total Funds [1]	General Fund	Hospital Provider Fee Fund	Medicaid Buy-in Fund	Federal Funds
	54,714	**$4,065.15**	**$222,420,634**	**$0**	**$110,454,148**	**$3,275,210**	**$108,691,275**

(1) Figures may not sum due to rounding.

Exhibit J - Health Care Affordability Act of 2009 Expansion Populations

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

Expansion Adults to 100%							
	Caseload	**Per Capita**	**Total Funds (1)**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,512.76	$118,981,918	$0	$29,745,479	$0	$89,236,439
Community Based Long Term Care		$2.50	$118,475	$0	$29,619	$0	$88,856
Long Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$112.23	$5,314,428	$0	$1,328,607	$0	$3,985,821
Total	**47,351**	**$2,627.50**	**$124,414,821**	**$0**	**$31,103,705**	**$0**	**$93,311,116**
Buy-In for Individuals with Disabilities							
	Caseload	**Per Capita**	**Total Funds (1)**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$9,600.86	$52,468,703	$0	$22,717,290	$7,034,124	$22,717,289
Community Based Long Term Care		$306.30	$1,673,912	$0	$724,751	$224,410	$724,751
Long Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$1,002.25	$5,477,299	$0	$4,742,995	$734,304	$0
Service Management		$0.19	$1,057	$0	$458	$142	$457
Total	**5,465**	**$10,909.60**	**$59,620,971**	**$0**	**$28,185,494**	**$7,992,980**	**$23,442,497**
Adults Without Dependent Children							
	Caseload	**Per Capita**	**Total Funds (1)**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds(2)**
Acute Care		$9,036.32	$90,363,233	$0	$22,590,808	$0	$67,772,425
Community Based Long Term Care		$4.04	$40,420	$0	$10,105	$0	$30,315
Long Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$236.44	$2,364,435	$0	$591,109	$0	$1,773,326
Total	**10,000**	**$9,276.81**	**$92,768,088**	**$0**	**$23,192,022**	**$0**	**$69,576,066**
FY 2013-14 Summary							
	Caseload	**Per Capita**	**Total Funds (1)**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**62,816**	**$4,406.58**	**$276,803,880**	**$0**	**$82,481,221**	**$7,992,980**	**$186,329,679**

(1) Figures may not sum due to rounding.

(2) The Department assumes that matching federal funds for this population will increase from 50% to 100% effective January 1, 2014 in accordance with the Affordable Care Act.

Exhibit J - Health Care Affordability Act of 2009 Expansion Populations

Hospital Provider Fee - Fund Splits and Service Category Impacts by Expansion Population
FY 2014-15

Expansion Adults to 100%							
	Caseload	**Per Capita**	**Total Funds (1)**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,534.48	$124,721,675	$0	$0	$0	$124,721,675
Community Based Long Term Care		$2.53	$124,285	$0	$0	$0	$124,285
Long Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$108.66	$5,347,247	$0	$0	$0	$5,347,247
Total	**49,210**	**$2,645.67**	**$130,193,207**	**$0**	**$0**	**$0**	**$130,193,207**
Buy-In for Individuals with Disabilities							
	Caseload	**Per Capita**	**Total Funds (1)**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund (2)**	**Federal Funds**
Acute Care		$9,787.74	$81,894,058	$0	$35,623,325	$10,647,409	$35,623,324
Community Based Long Term Care		$307.11	$2,569,581	$0	$1,117,749	$334,083	$1,117,749
Long Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$1,067.31	$8,930,146	$0	$7,769,098	$1,161,048	$0
Service Management		$0.15	$1,234	$0	$537	$160	$537
Total (2)	**8,367**	**$11,162.31**	**$93,395,019**	**$0**	**$44,510,709**	**$12,142,700**	**$36,741,610**
Adults Without Dependent Children							
	Caseload	**Per Capita**	**Total Funds (1)**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds (1)**
Acute Care		$9,289.86	$92,898,634	$0	$0	$0	$92,898,634
Community Based Long Term Care		$4.05	$40,527	$0	$0	$0	$40,527
Long Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$236.45	$2,364,540	$0	$0	$0	$2,364,540
Total	**10,000**	**$9,530.37**	**$95,303,701**	**$0**	**$0**	**$0**	**$95,303,701**
FY 2014-15 Summary							
	Caseload	**Per Capita**	**Total Funds (1)**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**67,577**	**$4,718.94**	**$318,891,927**	**$0**	**$44,510,709**	**$12,142,700**	**$262,238,518**

(1) Figure may not sum due to rounding.

(2) The Department assumes that matching federal funds for this population will increase from 50% to 100% effective January 1, 2014 in accordance with the Affordable Care Act.

Exhibit K - Upper Payment Limit Financing

Summary of Upper Payment Limit Financing

Nursing Facilities UPL	**FY 2012-13**	**FY 2013-14**	**FY 2014-15**
Total Funds	$2,771,704	$3,102,829	$3,201,709
General Fund	($3,242,300)	($3,102,829)	($3,201,709)
Cash Funds	$2,771,704	$3,102,829	$3,201,709
Federal Funds	$3,242,300	$3,102,829	$3,201,709
Home Health UPL			
Total Funds	$1,996,536	$2,060,162	$2,125,815
General Fund	($1,996,537)	($2,060,162)	($2,125,815)
Cash Funds	$1,996,536	$2,060,162	$2,125,815
Federal Funds	$1,996,537	$2,060,162	$2,125,815
Total Upper Payment Limit Financing			
Total Funds	$4,768,240	$5,162,991	$5,327,524
General Fund	($5,238,837)	($5,162,991)	($5,327,524)
Cash Funds	$4,768,240	$5,162,991	$5,327,524
Federal Funds	$5,238,837	$5,162,991	$5,327,524

Exhibit K - Upper Payment Limit Financing

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

State Nursing Facilities		
Provider Name	**Upper Payment Limit (Amount Remaining after Medicaid Payment)**	**Certified Uncompensated Cost[(1)]**
Colorado St. Veterans - Fitzsimmons	$1,815,960	$4,437,453
Colorado St. Veterans - Florence	$690,065	$2,114,319
Colorado St. Veterans - Homelake	($15,464)	($853,136)
Colorado St. Veterans - Rifle	$924,058	$2,991,252
Colorado St. Veterans - Walsenburg	$30,318	$9,827,642
Trinidad State Nursing Home	$587,852	$297,161
State Nursing Facilities Total	**$4,032,790**	**$18,814,691**
Government Nursing Facilities		
Arkansas Valley	$346,168	$407,426
Bent County Healthcare Center	$60,237	$1,544,804
Cheyenne Manor	$327,726	($1,083,811)
Cripple Creek Rehabilitation & Wellness Center	($19,662)	$512,109
E. Dene Moore Care Center	$723,378	$197,410
Gunnison Health Care	$219,418	$1,077,497
Lincoln Community Nursing Home	$196,985	$493,708
Prospect Park Living Center	$171,618	$950,394
Sedgwick County Memorial Nursing Home	($51,237)	($1,619,765)
Southeast Colorado Hospital-LTC	($58,899)	$1,217,079
Walbridge Memorial Convalescent	($95,583)	$1,055,929
Walsh Healthcare Center	$89,135	$381,520
Washington County Nursing	($23,146)	($18,589)
Weisbrod Memorial County Nursing Home	$95,077	$1,116,377
Government Nursing Facilities Total	**$1,981,214**	**$6,232,089**

(1) Certified uncompensated costs will be updated in the Department's February Medical Services Premiums request.

Exhibit K - Upper Payment Limit Financing

Supplemental Medicaid Nursing Facilities Payment	
Estimated CY 2011 Upper Payment Limit	$6,014,004
Estimated CY 2012 Upper Payment Limit	$6,205,657
Estimated CY 2013 Upper Payment Limit	$6,403,418

Supplemental Medicaid Nursing Facility Payment FY 2012-13	
Total Funds	$2,771,704
General Fund (offset by Federal Funds)	($3,242,300)
Cash Funds	$2,771,704
Federal Funds	$3,242,300

Supplemental Medicaid Nursing Facility Payment FY 2013-14	
Total Funds	$3,102,829
General Fund (offset by Federal Funds)	($3,102,829)
Cash Funds	$3,102,829
Federal Funds	$3,102,829

Supplemental Medicaid Nursing Facility Payment FY 2014-15	
Total Funds	$3,201,709
General Fund (offset by Federal Funds)	($3,201,709)
Cash Funds	$3,201,709
Federal Funds	$3,201,709

CY 2011 Inflation Factor [1]	**3.19%**
(1) Consumer Price Index for Urban Wage Earners and Clerical Workers, Medical Care, US City Average	

Exhibit K - Upper Payment Limit Financing

Home Health Upper Payment Limit Calculation
Estimate Based on Calendar Year 2012 Estimated Upper Payment Limit

Provider Name	Upper Payment Limit
Alamosa County Nursing Service	$85,184
Bent County Nursing Service	($11,192)
Delta Montrose Home Health Services	$130,431
Estes Park Home Health	$138,564
Fremont County Nursing Service	$79,549
Grand County Nursing Service	$66,527
Kiowa Home Health Services	$73,243
Kit Carson County Home Health	$87,620
Lincoln Community Home Health	$40,694
Mountain Home Health (Gunnison)	$0
Pioneers Hospital Home Health	$17,928
Prowers Home Health	$66,105
Rangely District Home Health	$0
Southeast Colorado Hospital HHA	$5,120
Southwest Memorial Hospital HHA	$120,377
St Vincent Home Health Care	$3,010,400
Yuma District Home Health Care	$82,522
Home Health Total	**$3,993,073**

Exhibit K - Upper Payment Limit Financing

Supplemental Medicaid Home Health Payment	
CY 2012 Upper Payment Limit	$3,993,073
CY 2013 Upper Payment Limit	$4,120,324
CY 2014 Upper Payment Limit	$4,251,630

Supplemental Medicaid Home Health Payment FY 2012-13	
Total Funds	$1,996,536
General Fund	($1,996,537)
Cash Funds	$1,996,536
Federal Funds	$1,996,537

Supplemental Medicaid Home Health Payment FY 2013-14	
Total Funds	$2,060,162
General Fund	($2,060,162)
Cash Funds	$2,060,162
Federal Funds	$2,060,162

Supplemental Medicaid Home Health Payment FY 2014-15	
Total Funds	$2,125,815
General Fund	($2,125,815)
Cash Funds	$2,125,815
Federal Funds	$2,125,815

CY 2011 Inflation Factor [1]	**3.19%**
(1) Consumer Price Index for Urban Wage Earners and Clerical Workers, Medical Care, US City Average.	

Exhibit K - Upper Payment Limit Financing

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

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

Exhibit K - Upper Payment Limit Financing

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

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

Note: Figures from CY 2009. Totals will be updated with CY 2010 data in the Department's Febraury 2013 Medical Services Premiums request.

Exhibit L - Recoveries

Department Recovery Revenue

Recovery Category	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	Estimated FY 2012-13	Estimated FY 2012-13	Estimated FY 2013-14
Estate Recoveries[(1)]	$3,168,376	$3,682,865	$3,006,302	$2,993,722	$3,453,178	$3,705,693	$3,976,674
Income Trust and Repayments[(1)]	$3,242,100	$3,217,373	$4,021,065	$4,202,267	$4,847,202	$5,201,656	$5,582,030
Third Party Health Insurance	$8,705,554	$14,857,476	$17,714,457	$19,834,962	$22,879,096	$24,552,141	$26,347,529
Third Party Casualty	$3,812,718	$3,917,944	$4,664,590	$6,983,907	$8,055,749	$8,644,830	$9,276,987
Total Recoveries Including Bottom Line Impacts[(2)]	**$18,928,748**	**$25,675,658**	**$29,406,414**	**$34,014,858**	**$39,235,225**	**$42,104,320**	**$45,183,220**

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

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

Contingency and Contractor Payments

Recovery Category	Contingency Amount[(4)]	FY 2008-09	FY 2009-10	FY 2010-11	Estimated FY 2011-12	Estimated FY 2012-13	Estimated FY 2013-14
Estate Recoveries	11.50%	$332,679	$386,701	$315,662	$397,115	$426,155	$457,317
Income Trust and Repayments[(3)]	0.00%	$0	$0	$0	$0	$0	$0
Third Party Health Insurance	6.90%	$513,628	$876,591	$1,045,153	$1,578,658	$1,694,098	$1,817,979
Third Party Casualty	9.40%	$320,268	$329,107	$391,826	$757,240	$812,614	$872,037
Total		**$1,166,575**	**$1,592,399**	**$1,752,641**	**$2,733,013**	**$2,932,867**	**$3,147,333**

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

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

Fund Splits

Total Medical Services Premiums Impact	Total Funds	General Fund	Cash Funds	Federal Funds	FFP
FY 2012-13	$0	($18,251,106)	$36,502,212	($18,251,106)	50.00%
FY 2013-14	$0	($19,585,726)	$39,171,453	($19,585,727)	50.00%
FY 2014-15	$0	($21,017,943)	$42,035,887	($21,017,944)	50.00%

Recovery Trend for FY 2011-12 to FY 2012-13	7.84%
Recovery Trend for FY 2012-13 to FY 2013-14	7.84%
Recovery Trend for FY 2013-14 to FY 2014-15	7.84%

Exhibit M

FY 2011-12	Cash-based Actuals														
	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-in	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	COFRS TOTAL
Acute Care															
Physician Services & EPSDT	$3,496,026	$7,111,322	$54,312,685	$65,386	$51,233,973	$12,827,290	$16,729,289	$254,561	$0	$108,220,089	$10,282,293	$16,641,874	$5,841,664	$3,787	$287,020,239
Emergency Transportation	$127,388	$284,073	$2,131,467	$133	$1,143,622	$273,060	$326,160	$26,001	$0	$1,599,438	$194,707	$167,590	$87,424	($5)	$6,361,058
Non-emergency Medical Transportation	$2,170,701	$1,007,841	$5,235,088	$443	$397,106	$112,746	$130,804	$1,752	$0	$1,217,489	$131,419	$55,775	$1,230	($228)	$10,462,166
Dental Services	$1,227,623	$328,572	$5,016,624	$1,339	$4,181,413	$1,234,241	$1,489,789	$36,007	$0	$85,091,328	$4,962,709	$336,789	$5,353	$0	$103,911,787
Family Planning	$0	$168	$16,872	$94	$181,591	$57,919	$88,899	$1,072	$0	$157,184	$52,601	$22,557	$0	$0	$578,957
Health Maintenance Organizations	$6,436,982	$6,682,350	$39,413,533	$6,100	$17,150,639	$5,403,532	$7,791,492	$0	$0	$35,919,341	$845,047	$1,066,895	$0	$0	$120,715,911
Inpatient Hospitals	$13,661,835	$15,340,090	$114,582,636	$177,773	$53,613,611	$9,420,522	$12,964,966	$891,142	$0	$76,041,187	$4,890,304	$26,947,586	$33,984,087	($13,122)	$362,502,617
Outpatient Hospitals	$2,955,034	$6,281,086	$52,781,917	$73,670	$48,496,585	$15,668,829	$19,539,773	$570,577	$0	$73,411,714	$5,760,929	$5,461,418	$1,478,314	$0	$232,479,846
Lab & X-Ray	$459,363	$872,743	$6,962,429	$4,882	$11,719,490	$3,160,822	$3,943,322	$72,092	$0	$7,263,261	$1,727,639	$3,649,035	$142,603	$322	$39,978,003
Durable Medical Equipment	$18,449,168	$5,367,881	$50,025,626	$5,509	$3,039,368	$1,149,743	$1,297,015	$19,968	$0	$9,835,195	$4,337,018	$159,994	$0	$19,967	$93,706,452
Prescription Drugs	$6,894,276	$18,586,340	$132,005,966	$66,035	$41,690,318	$14,638,225	$17,910,509	$486,584	$0	$63,118,535	$21,082,476	$2,262,197	$0	$0	$318,741,461
Drug Rebate	($3,239,849)	($8,734,338)	($62,033,986)	($31,032)	($19,591,664)	($6,878,988)	($8,416,743)	($228,662)	$0	($29,661,495)	($9,907,355)	($1,063,081)	$0	$0	($149,787,193)
Rural Health Centers	$59,913	$297,322	$1,232,984	$272	$1,604,626	$571,295	$650,762	$8,863	$0	$5,497,429	$310,962	$310,347	$23,141	$0	$10,567,916
Federally Qualified Health Centers	$945,395	$1,068,432	$8,305,722	$7,949	$13,803,136	$3,611,373	$4,922,023	$252,682	$0	$54,487,052	$1,927,134	$5,087,649	$371,769	$167	$94,790,483
Co-Insurance (Title XVIII-Medicare)	$16,681,939	$2,722,367	$11,215,656	$5,057	$158,901	$303,092	$629,323	$0	$0	$26,223	$17,454	$41,240	$1,973	$5,233,327	$37,036,552
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$0	$10,272,613	$0	$0	$0	$0	$0	$10,272,613
Prepaid Inpatient Health Plan Services	$1,808,943	$2,331,859	$18,074,087	$14,849	$7,896,730	$2,359,893	$2,867,598	$0	$0	$16,657,333	$2,332,229	$2,119,598	$0	$0	$56,463,119
Other Medical Services	$766	$590	$4,856	$3	$2,017	$556	$718	$21	$84	$4,256	$543	$504	$339	$42	$15,295
Home Health	$22,261,489	$7,461,699	$116,508,674	$0	$422,646	$116,744	$154,478	$490	$0	$4,089,841	$10,377,685	$50,035	$268	$163,684	$161,607,733
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$94,396,992**	**$67,010,397**	**$555,792,836**	**$398,462**	**$237,144,108**	**$64,030,894**	**$83,020,177**	**$2,393,150**	**$10,272,697**	**$512,975,400**	**$59,325,794**	**$63,318,002**	**$41,938,165**	**$5,407,941**	**$1,797,425,015**
Community Based Long Term Care															
HCBS - Elderly, Blind, and Disabled	$112,080,401	$18,862,257	$93,931,903	$0	$2,727	$107	$17,029	$0	$0	$0	$69,862	$0	$0	$221,425	$225,185,711
HCBS - Mental Illness	$3,683,462	$3,266,023	$18,943,039	$0	$0	$507	$3,220	$0	$0	$0	$10,762	$0	$0	$27,242	$25,934,255
HCBS - Disabled Children	$0	$0	$3,129,357	$0	$0	$0	$0	$0	$0	$716	$0	$0	$0	$0	$3,130,073
HCBS - Persons Living with AIDS	$27,143	($1,798)	$482,666	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$8,025	$516,036
HCBS - Consumer Directed Attendant Support	$1,722,964	$289,961	$1,443,974	$0	$42	$2	$262	$0	$0	$0	$1,074	$0	$0	$3,404	$3,461,683
HCBS - Brain Injury	$165,215	$851,608	$11,535,816	$0	$0	$5,163	$0	$0	$0	$0	$29,164	$0	$0	$165	$12,587,131
HCBS - Children with Autism	$0	$0	$1,015,699	$0	$0	$0	$0	$0	$0	$6,688	$0	$0	$0	$0	$1,022,387
HCBS - Pediatric Hospice	$0	$0	$170,418	$0	$0	$0	$0	$0	$0	$0	$492	$0	$0	$0	$170,910
Private Duty Nursing	$1,832,636	$135,105	$20,720,340	$0	$0	$0	$0	$0	$0	$601,939	$7,854,133	$0	$0	$0	$31,144,153
Hospice	$32,103,872	$2,846,601	$6,969,248	$15,185	$69,870	$44,236	$67,245	$4,370	$0	$116,333	$1,215	$1,787	$0	$86,846	$42,326,808
Subtotal Community Based Long Term Care	**$151,615,693**	**$26,249,757**	**$158,342,460**	**$15,185**	**$72,639**	**$50,015**	**$87,756**	**$4,370**	**$0**	**$725,676**	**$7,966,702**	**$1,787**	**$0**	**$347,107**	**$345,479,147**
Long Term Care															
Class I Nursing Facilities	$411,201,009	$33,559,826	$76,088,316	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$395,618	$521,244,769
Class II Nursing Facilities	$0	$583,751	$1,915,323	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,499,074
Program of All-Inclusive Care for the Elderly	$73,671,387	$8,052,921	$3,756,277	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$85,480,585
Subtotal Long Term Care	**$484,872,396**	**$42,196,498**	**$81,759,916**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$395,618**	**$609,224,428**
Insurance															
Supplemental Medicare Insurance Benefit	$63,201,668	$3,688,256	$33,153,682	$46,299	$207,374	$0	$0	$0	$0	$0	$0	$0	$0	$18,301,648	$118,598,927
Health Insurance Buy-In Program	$2,162	$6,655	$1,122,186	$0	$9,727	$0	$0	$0	$0	$12,996	$2,223	$3,358	$0	$0	$1,159,307
Subtotal Insurance	**$63,203,830**	**$3,694,911**	**$34,275,868**	**$46,299**	**$217,101**	**$0**	**$0**	**$0**	**$0**	**$12,996**	**$2,223**	**$3,358**	**$0**	**$18,301,648**	**$119,758,234**
Service Management															
Single Entry Points	$11,748,349	$2,505,790	$10,910,528	$0	$5,343	$0	$1,263	$0	$0	$1,749	$8,355	$0	$0	$45,369	$25,226,746
Disease Management	$51,573	$36,611	$303,654	$218	$129,562	$34,983	$45,358	$1,307	$5,612	$280,261	$32,412	$34,593	$22,913	$2,955	$982,012
Prepaid Inpatient Health Plan Administration	$514,348	$183,069	$1,118,391	$1,094	$951,739	$380,790	$526,053	$0	$0	$4,776,807	$325,880	$113,177	$0	$0	$8,891,348
Accountable Care Collaborative	$345,078	$256,950	$2,052,795	$377	$4,058,235	$1,631,875	$2,269,608	$79,568	$0	$6,360,605	$576,072	$275,408	$107	$1,155	$17,907,833
Subtotal Service Management	**$12,659,348**	**$2,982,420**	**$14,385,368**	**$1,689**	**$5,144,879**	**$2,047,648**	**$2,842,282**	**$80,875**	**$5,612**	**$11,419,422**	**$942,719**	**$423,178**	**$23,020**	**$49,479**	**$53,007,939**
Total Services	**$806,748,259**	**$142,133,983**	**$844,556,448**	**$461,635**	**$242,578,727**	**$66,128,557**	**$85,950,215**	**$2,478,395**	**$10,278,309**	**$525,133,494**	**$68,237,438**	**$63,746,325**	**$41,961,185**	**$24,501,793**	**$2,924,894,763**
Financing & Supplemental Payments															
Upper Payment Limit Financing	$3,006,644	$328,259	$1,725,903	$520	$345,582	$111,514	$139,126	$4,034	$0	$547,701	$114,617	$38,935	$10,444	$3,886	$6,377,165
Hospital Supplemental Payments	$17,049,970	$22,262,870	$172,465,286	$258,926	$105,744,967	$26,102,852	$33,793,401	$1,509,784	$0	$154,850,875	$11,052,910	$33,244,021	$36,231,786	($13,389)	$614,554,259
Nursing Facility Supplemental Payments	$68,465,150	$5,587,726	$12,668,738	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$65,871	$86,787,485
Physician Supplemental Payments	$60,715	$123,502	$943,247	$1,136	$889,781	$222,772	$290,538	$4,421	$0	$1,879,459	$178,573	$289,020	$101,452	$66	$4,984,682
Outstationing Payments	$18,395	$39,101	$328,574	$459	$301,897	$97,540	$121,637	$3,552	$0	$456,997	$35,862	$33,998	$9,203	$0	$1,447,215
Accounting Adjustments	$763,823	$147,724	$878,727	$451	$264,450	$73,358	$94,928	$2,831	$9,629	$556,699	$78,990	$65,448	$43,897	$6,238	$2,987,193
Subtotal Financing & Supplemental Payments	**$89,364,697**	**$28,489,182**	**$189,010,475**	**$261,492**	**$107,546,677**	**$26,608,036**	**$34,439,630**	**$1,524,622**	**$9,629**	**$158,291,731**	**$11,460,952**	**$33,671,422**	**$36,396,782**	**$62,672**	**$717,137,999**
Total	**$896,112,956**	**$170,623,165**	**$1,033,566,923**	**$723,127**	**$350,125,404**	**$92,736,593**	**$120,389,845**	**$4,003,017**	**$10,287,938**	**$683,425,225**	**$79,698,390**	**$97,417,747**	**$78,357,967**	**$24,564,465**	**$3,642,032,762**

Exhibit M

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

Exhibit M

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

Exhibit M

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

Exhibit M

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

Exhibit M

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

Exhibit M

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

Exhibit M

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

Exhibit M

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

Exhibit M

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

Exhibit N - Expenditure History by Service Category

ACUTE CARE	FY 2011-12	Percent Change from Prior Year	FY 2010-11	Percent Change from Prior Year	FY 2009-10	Percent Change From Prior Year	FY 2008-09	Percent Change From Prior Year
Physician Services & EPSDT	$287,020,239	1.57%	$282,592,042	16.33%	$242,929,414	4.30%	$232,912,692	22.16%
Emergency Transportation	$6,361,058	2.00%	$6,236,250	19.52%	$5,217,633	5.75%	$4,934,082	8.43%
Non-Emergency Medical Transportation	$10,462,166	-0.07%	$10,469,107	14.65%	$9,131,655	5.09%	$8,689,018	12.35%
Dental Services	$103,911,787	-4.29%	$108,570,692	22.25%	$88,806,857	16.15%	$76,456,424	41.86%
Family Planning	$578,957	31.16%	$441,414	37.10%	$321,975	0.80%	$319,424	58.07%
Health Maintenance Organizations	$120,715,911	2.75%	$117,488,456	-0.14%	$117,651,717	-8.85%	$129,074,827	26.28%
Inpatient Hospitals	$362,502,617	-2.52%	$371,861,948	10.23%	$337,358,448	-5.39%	$356,576,636	11.12%
Outpatient Hospitals	$232,479,846	6.89%	$217,492,911	50.04%	$144,956,141	-5.81%	$153,901,754	18.21%
Lab & X-Ray	$39,978,003	5.59%	$37,862,120	25.59%	$30,148,317	6.01%	$28,437,823	24.87%
Durable Medical Equipment	$93,706,452	3.40%	$90,627,945	15.78%	$78,272,962	1.64%	$77,011,816	1.58%
Prescription Drugs	$318,741,461	13.32%	$281,278,949	24.40%	$226,114,086	-3.23%	$233,666,309	7.75%
Drug Rebate	($149,787,193)	18.03%	($126,909,710)	27.09%	($99,855,328)	8.75%	($91,818,104)	65.54%
Rural Health Centers	$10,567,916	3.73%	$10,188,005	27.45%	$7,993,821	7.18%	$7,458,484	19.47%
Federally Qualified Health Centers	$94,790,483	4.97%	$90,306,523	18.44%	$76,244,360	4.32%	$73,089,013	16.72%
Co-Insurance (Title XVIII-Medicare)	$37,036,552	1.78%	$36,387,414	74.50%	$20,852,175	-25.79%	$28,098,389	24.84%
Breast and Cervical Cancer Treatment Program	$10,272,613	1.64%	$10,106,643	15.95%	$8,716,269	23.77%	$7,042,030	-0.65%
Prepaid Inpatient Health Plan Services	$56,463,119	11.04%	$50,849,494	13.75%	$44,703,819	24.21%	$35,989,196	6.85%
Other Medical Services	$15,295	8.03%	$14,158	-71.19%	$49,140	4.67%	$46,946	38.53%
Home Health	$161,607,733	-6.39%	$172,633,768	10.35%	$156,448,421	6.19%	$147,328,138	13.58%
Presumptive Eligibility	$0	0.00%	$0	0.00%	$0	0.00%	$0	-100.00%
Subtotal of Acute Care	**$1,797,425,015**	**1.64%**	**$1,768,498,130**	**18.21%**	**$1,496,061,883**	**-0.87%**	**$1,509,214,896**	**12.96%**
COMMUNITY BASED LONG TERM CARE								
HCBS - Elderly, Blind, and Disabled	$225,185,711	6.12%	$212,196,143	13.82%	$186,426,075	5.63%	$176,481,671	24.96%
HCBS - Mental Illness	$25,934,255	3.96%	$24,946,790	9.99%	$22,681,360	-1.21%	$22,958,866	12.49%
HCBS - Disabled Children	$3,130,073	59.29%	$1,965,004	11.44%	$1,763,210	0.89%	$1,747,683	29.09%
HCBS - Persons Living with AIDS	$516,036	-9.07%	$567,535	-2.39%	$581,405	-1.91%	$592,744	-0.45%
HCBS - Consumer Directed Attendant Support	$3,461,683	16.90%	$2,961,259	-15.80%	$3,516,917	-14.76%	$4,125,973	-70.76%
HCBS - Brain Injury	$12,587,131	2.36%	$12,297,265	7.10%	$11,482,073	-4.54%	$12,028,236	11.52%
HCBS - Children with Autism	$1,022,387	-24.69%	$1,357,612	-13.29%	$1,565,700	21.00%	$1,293,932	86.02%
HCBS - Pediatric Hospice	$170,910	34.89%	$126,702	33.68%	$94,781	223.36%	$29,312	0.00%
Private Duty Nursing	$31,144,153	12.18%	$27,761,694	19.50%	$23,230,817	8.80%	$21,351,408	8.11%
Hospice	$42,326,808	6.18%	$39,862,966	-7.98%	$43,321,496	8.57%	$39,902,873	21.62%
Subtotal of Community Based Long Term Care	**$345,479,147**	**6.62%**	**$324,042,970**	**9.97%**	**$294,663,833**	**5.04%**	**$280,512,697**	**16.04%**
LONG TERM CARE and INSURANCE								
Class I Nursing Facilities	$521,244,769	2.58%	$508,141,849	4.33%	$487,074,333	-8.26%	$530,918,672	9.11%
Class II Nursing Facilities	$2,499,074	5.77%	$2,362,706	17.21%	$2,015,835	-11.26%	$2,271,714	1.61%
Program of All-Inclusive Care for the Elderly	$85,480,585	1.24%	$84,429,683	21.94%	$69,240,623	13.42%	$61,049,836	23.54%
Supplemental Medicare Insurance Benefit	$118,598,927	-0.79%	$119,543,734	15.98%	$103,068,590	9.95%	$93,743,114	13.67%
Health Insurance Buy-In Program	$1,159,307	3.05%	$1,124,996	20.75%	$931,637	-1.12%	$942,145	4.11%
Subtotal of Long Term Care and Insurance	**$728,982,662**	**1.87%**	**$715,602,968**	**8.04%**	**$662,331,019**	**-3.86%**	**$688,925,481**	**10.83%**
SERVICE MANAGEMENT								
Single Entry Points	$25,226,746	5.02%	$24,021,660	1.32%	$23,707,551	2.78%	$23,067,175	6.02%
Disease Management	$982,012	0.00%	$0	-100.00%	$71,616	-97.52%	$2,882,271	23.66%
Prepaid Inpatient Health Plan Administration	$8,891,348	37.31%	$6,475,244	26.67%	$5,111,753	29.90%	$3,935,134	9.02%
Accountable Care Collaborative	$17,907,833	1917.99%	$887,411	0.00%	$0	0.00%	$0	0.00%
Subtotal Service Management	**$53,007,939**	**68.90%**	**$31,384,315**	**8.63%**	**$28,890,920**	**-3.32%**	**$29,884,581**	**7.90%**
Total Services	**$2,924,894,763**	**3.01%**	**$2,839,528,383**	**14.41%**	**$2,481,947,656**	**-1.06%**	**$2,508,537,655**	**12.64%**
Financing & Supplemental Payments								
Upper Payment Limit Financing	$6,377,165	-61.22%	$16,446,173	-8.31%	$17,936,927	-2.62%	$18,419,432	54.11%
Hospital Supplemental Payments	$614,554,259	34.96%	$455,348,284	45.73%	$312,468,739	0.00%	$0	0.00%
Nursing Facility Supplemental Payments	$86,787,485	13.72%	$76,315,634	60.83%	$47,451,412	0.00%	$0	0.00%
Physician Supplemental Payments	$4,984,682	83.54%	$2,715,842	-81.28%	$14,504,498	0.00%	$0	0.00%
Outstationing Payments	$1,447,215	-72.61%	$5,283,594	50.09%	$3,520,254	0.00%	$0	0.00%
Accounting Adjustments	$2,987,193	-29274.17%	($10,239)	-40.70%	($17,268)	-150.26%	$34,355	-67.84%
Subtotal Financing & Supplemental Payments	**$717,137,999**	**28.96%**	**$556,099,288**	**40.48%**	**$395,864,563**	**2045.17%**	**$18,453,787**	**53.03%**
Grand Total	**$3,642,032,762**	**7.26%**	**$3,395,627,671**	**17.99%**	**$2,877,812,218**	**13.88%**	**$2,526,991,443**	**12.86%**

Exhibit N - Expenditure History by Service Category

ACUTE CARE	FY 2007-08	Percent Change From Prior Year	FY 2006-07	Percent Change From Prior Year	FY 2005-06	Percent Change From Prior Year	FY 2004-05	Percent Change From Prior Year	FY 2003-04
Physician Services & EPSDT	$190,663,827	16.09%	$164,232,428	13.84%	$144,266,423	16.23%	$124,119,339	1.18%	$122,673,666
Emergency Transportatio	$4,550,505	6.21%	$4,284,622	18.64%	$3,611,441	3.96%	$3,473,741	-28.41%	$4,852,575
Non-Emergency Medical Transportatio	$7,733,949	-12832.88%	($60,740)	444.07%	($11,164)	-105.22%	$213,706	-91.83%	$2,616,352
Dental Services	$53,893,890	9.17%	$49,367,133	5.70%	$46,705,514	16.72%	$40,013,849	2.10%	$39,189,457
Family Planning	$202,073	996.27%	$18,433	-95.49%	$409,119	119.93%	$186,021	-9.06%	$204,545
Health Maintenance Organizations	$102,216,877	-5.73%	$108,429,033	-29.95%	$154,782,191	-4.51%	$162,090,246	-18.09%	$197,898,138
Inpatient Hospitals	$320,899,293	5.32%	$304,687,402	2.66%	$296,800,124	11.57%	$266,011,447	-2.65%	$273,247,361
Outpatient Hospitals	$130,192,196	12.46%	$115,767,273	10.03%	$105,213,743	12.39%	$93,618,116	5.13%	$89,047,191
Lab & X-Ray	$22,774,240	11.38%	$20,447,143	6.22%	$19,250,037	10.10%	$17,484,755	1.51%	$17,225,324
Durable Medical Equipment	$75,815,972	13.46%	$66,822,166	13.93%	$58,652,169	16.61%	$50,299,251	2.14%	$49,245,516
Prescription Drugs	$216,864,136	14.24%	$189,833,449	-19.88%	$236,947,825	-15.66%	$280,930,899	5.69%	$265,797,673
Drug Rebate	($55,465,088)	-5.42%	($58,644,804)	-25.83%	($79,068,617)	10.34%	($71,656,675)	33.98%	($53,484,910)
Rural Health Centers	$6,242,784	6.16%	$5,880,402	23.76%	$4,751,330	3.33%	$4,598,395	17.63%	$3,909,310
Federally Qualified Health Centers	$62,621,473	6.21%	$58,960,102	-4.84%	$61,957,718	8.99%	$56,845,564	10.60%	$51,398,899
Co-Insurance (Title XVIII-Medicare	$22,507,668	18.61%	$18,976,405	5.88%	$17,922,444	3.25%	$17,357,700	-9.62%	$19,205,728
Breast and Cervical Cancer Treatment Progran	$7,088,411	27.61%	$5,554,934	-18.41%	$6,808,264	173.41%	$2,490,090	-6.69%	$2,668,652
Prepaid Inpatient Health Plan Services	$33,682,305	7.66%	$31,285,316	-5.16%	$32,987,230	-51.83%	$68,474,304	297.28%	$17,235,604
Other Medical Services	$33,888	26.75%	$26,736	-10.59%	$29,903	1.48%	$29,468	-70.72%	$100,654
Home Health	$129,715,198	18.30%	$109,647,063	18.89%	$92,227,451	23.74%	$74,534,611	6.94%	$69,697,057
Presumptive Eligibility	$3,770,690	-51.96%	$7,849,344	196.81%	$2,644,540	0.00%	$0	0.00%	$0
Subtotal of Acute Care	**$1,336,004,286**	**11.02%**	**$1,203,363,838**	**-0.29%**	**$1,206,887,685**	**1.32%**	**$1,191,114,826**	**1.57%**	**$1,172,728,792**
COMMUNITY BASED LONG TERM CARE									
HCBS - Elderly, Blind, and Disablec	$141,231,844	14.20%	$123,673,036	15.28%	$107,276,565	13.86%	$94,216,182	-0.55%	$94,741,923
HCBS - Mental Illness	$20,409,887	18.34%	$17,246,320	15.10%	$14,984,173	15.09%	$13,019,463	-13.38%	$15,030,947
HCBS - Disabled Children	$1,353,847	49.62%	$904,883	36.73%	$661,823	37.33%	$481,927	34.28%	$358,891
HCBS - Persons Living with AIDS	$595,406	18.25%	$503,530	6.50%	$472,783	3.13%	$458,451	-18.46%	$562,218
HCBS - Consumer Directed Attendant Suppor	$14,109,819	12.16%	$12,580,285	73.81%	$7,237,889	22.42%	$5,912,371	92.92%	$3,064,733
HCBS - Brain Injury	$10,785,587	-2.94%	$11,112,528	26.08%	$8,813,686	-4.46%	$9,225,591	2.59%	$8,992,797
HCBS - Children with Autism	$695,586	3599.64%	$18,801	0.00%	$0	0.00%	$0	0.00%	$0
HCBS - Pediatric Hospice	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Private Duty Nursing	$19,749,262	14.16%	$17,299,756	10.78%	$15,616,760	10.98%	$14,071,893	6.80%	$13,176,147
Hospice	$32,810,776	3.22%	$31,787,348	11.51%	$28,507,087	21.00%	$23,559,031	3.35%	$22,795,661
Subtotal of Community Based Long Term Care	**$241,742,014**	**12.37%**	**$215,126,488**	**17.19%**	**$183,570,766**	**14.06%**	**$160,944,908**	**1.40%**	**$158,723,316**
LONG TERM CARE and INSURANCE									
Class I Nursing Facilities	$486,568,498	1.73%	$478,303,487	4.77%	$456,520,328	7.70%	$423,878,333	1.89%	$416,011,012
Class II Nursing Facilities	$2,235,636	-1.52%	$2,270,136	57.99%	$1,436,850	3.86%	$1,383,445	25.25%	$1,104,554
Program of All-Inclusive Care for the Elderl	$49,418,855	15.27%	$42,872,281	5.93%	$40,470,490	15.10%	$35,160,005	30.08%	$27,029,169
Supplemental Medicare Insurance Benefi	$82,465,946	-0.29%	$82,706,881	16.86%	$70,775,604	21.09%	$58,449,753	22.76%	$47,613,226
Health Insurance Buy-In Program	$904,947	21.90%	$742,352	41.62%	$524,194	-13.69%	$607,332	-12.00%	$690,172
Subtotal of Long Term Care and Insurance	**$621,593,882**	**2.42%**	**$606,895,137**	**6.52%**	**$569,727,466**	**9.67%**	**$519,478,869**	**5.49%**	**$492,448,133**
SERVICE MANAGEMENT									
Single Entry Points	$21,757,100	20.86%	$18,002,536	8.80%	$16,547,063	-4.11%	$17,256,835	18.76%	$14,530,561
Disease Management	$2,330,726	443.29%	$428,999	33.08%	$322,355	57.49%	$204,682	0.00%	$0
Prepaid Inpatient Health Plan Administratio	$3,609,472	-21.88%	$4,620,417	-13.49%	$5,340,741	24.63%	$4,285,446	29.54%	$3,308,119
Accountable Care Collaborative	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Subtotal Service Management	**$27,697,298**	**20.15%**	**$23,051,952**	**3.79%**	**$22,210,159**	**2.13%**	**$21,746,963**	**21.91%**	**$17,838,681**
Total Services	**$2,227,037,481**	**8.72%**	**$2,048,437,415**	**3.33%**	**$1,982,396,076**	**4.71%**	**$1,893,285,567**	**2.80%**	**$1,841,738,922**
Financing & Supplemental Payments									
Upper Payment Limit Financing	$11,952,096	-7.77%	$12,959,393	-6.55%	$13,868,231	-48.99%	$27,189,205	1.00%	$26,919,593
Hospital Supplemental Payments	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Nursing Facility Supplemental Payments	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Physician Supplemental Payments	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Outstationing Payments	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Accounting Adjustments	$106,828	0.00%	$0	-100.00%	$1	-100.00%	$66,754	-27.22%	$91,716
Subtotal Financing & Supplemental Payments	**$12,058,924**	**-6.95%**	**$12,959,393**	**-6.55%**	**$13,868,232**	**-49.12%**	**$27,255,959**	**0.91%**	**$27,011,308**
Grand Total	**$2,239,096,405**	**8.62%**	**$2,061,396,808**	**3.26%**	**$1,996,264,308**	**3.94%**	**$1,920,541,525**	**2.77%**	**$1,868,750,230**

Exhibit N - Expenditure History by Service Category - Delay Adjusted

ACUTE CARE	FY 2011-12	Percent Change from Prior Year	FY 2010-11 (DA)	Percent Change from Prior Year	FY 2009-10 (DA)	Percent Change From Prior Year	FY 2008-09	Percent Change From Prior Year
Physician Services & EPSDT	$287,020,239	4.99%	$273,385,005	8.43%	$252,136,452	8.25%	$232,912,692	22.16%
Emergency Transportation	$6,361,058	5.59%	$6,024,130	10.95%	$5,429,754	10.05%	$4,934,082	8.43%
Non-emergency Medical Transportation	$10,462,166	0.95%	$10,363,372	12.19%	$9,237,390	6.31%	$8,689,018	12.35%
Dental Services	$103,911,787	-0.87%	$104,818,977	13.25%	$92,558,572	21.06%	$76,456,424	41.86%
Family Planning	$578,957	35.12%	$428,473	27.93%	$334,916	4.85%	$319,424	58.07%
Health Maintenance Organizations	$120,715,911	2.75%	$117,488,424	-0.14%	$117,651,750	-8.85%	$129,074,827	26.28%
Inpatient Hospitals	$362,502,617	1.42%	$357,410,898	1.59%	$351,809,498	-1.34%	$356,576,636	11.12%
Outpatient Hospitals	$232,479,846	10.81%	$209,791,226	37.43%	$152,657,826	-0.81%	$153,901,754	18.21%
Lab & X-Ray	$39,978,003	9.29%	$36,581,144	16.39%	$31,429,294	10.52%	$28,437,823	24.87%
Durable Medical Equipment	$93,706,452	6.79%	$87,745,314	8.12%	$81,155,593	5.38%	$77,011,816	1.58%
Prescription Drugs	$318,741,461	16.98%	$272,469,874	15.98%	$234,923,161	0.54%	$233,666,309	7.75%
Drug Rebate	($149,787,193)	18.03%	($126,909,710)	27.09%	($99,855,328)	8.75%	($91,818,104)	65.54%
Rural Health Centers	$10,567,916	6.88%	$9,887,646	19.21%	$8,294,180	11.20%	$7,458,484	19.47%
Federally Qualified Health Centers	$94,790,483	8.29%	$87,530,065	10.77%	$79,020,818	8.12%	$73,089,013	16.72%
Co-Insurance (Title XVIII-Medicare)	$37,036,552	5.69%	$35,043,547	57.88%	$22,196,042	-21.01%	$28,098,389	24.84%
Breast and Cervical Cancer Treatment Program	$10,272,613	4.64%	$9,817,118	9.01%	$9,005,795	27.89%	$7,042,030	-0.65%
Prepaid Inpatient Health Plan Services	$56,463,119	11.04%	$50,849,494	13.75%	$44,703,819	24.21%	$35,989,196	6.85%
Other Medical Services	$15,295	8.03%	$14,158	-71.19%	$49,140	4.67%	$46,946	38.53%
Home Health	$161,607,733	-4.19%	$168,682,120	5.16%	$160,400,069	8.87%	$147,328,138	13.58%
Presumptive Eligibility	$0	0.00%	$0	0.00%	$0	0.00%	$0	-100.00%
Subtotal of Acute Care	**$1,797,425,015**	**5.03%**	**$1,711,421,275**	**10.19%**	**$1,553,138,739**	**2.91%**	**$1,509,214,896**	**12.96%**
COMMUNITY BASED LONG TERM CARE								
HCBS - Elderly, Blind, and Disabled	$225,185,711	7.99%	$208,526,316	9.70%	$190,095,902	7.71%	$176,481,671	24.96%
HCBS - Mental Illness	$25,934,255	5.48%	$24,587,535	6.71%	$23,040,614	0.36%	$22,958,866	12.49%
HCBS - Disabled Children	$3,130,073	65.86%	$1,887,201	2.51%	$1,841,013	5.34%	$1,747,683	29.09%
HCBS - Persons Living with AIDS	$516,036	-6.24%	$550,397	-8.04%	$598,542	0.98%	$592,744	-0.45%
HCBS - Consumer Directed Attendant Support	$3,461,683	16.90%	$2,961,259	-15.80%	$3,516,917	-14.76%	$4,125,973	-70.76%
HCBS - Brain Injury	$12,587,131	3.32%	$12,182,916	5.06%	$11,596,421	-3.59%	$12,028,236	11.52%
HCBS - Children with Autism	$1,022,387	-23.05%	$1,328,577	-16.69%	$1,594,735	23.25%	$1,293,932	86.02%
HCBS - Pediatric Hospice	$170,910	43.29%	$119,273	16.69%	$102,210	248.70%	$29,312	0.00%
Private Duty Nursing	$31,144,153	13.97%	$27,325,957	15.46%	$23,666,555	10.84%	$21,351,408	8.11%
Hospice	$42,326,808	7.03%	$39,547,635	-9.37%	$43,636,826	9.36%	$39,902,873	21.62%
Subtotal Community Based Long Term Care	**$345,479,147**	**8.29%**	**$319,017,067**	**6.45%**	**$299,689,736**	**6.84%**	**$280,512,697**	**16.04%**
LONG TERM CARE and INSURANCE								
Class I Nursing Facilities	$521,244,769	4.39%	$499,315,391	0.69%	$495,900,792	-6.60%	$530,918,672	9.11%
Class II Nursing Facilities	$2,499,074	-21.00%	$3,163,194	160.27%	$1,215,347	-46.50%	$2,271,714	1.61%
Program of All-Inclusive Care for the Elderly	$85,480,585	1.26%	$84,414,277	21.89%	$69,256,028	13.44%	$61,049,836	23.54%
Supplemental Medicare Insurance Benefit	$118,598,927	-0.79%	$119,543,734	15.98%	$103,068,590	9.95%	$93,743,114	13.67%
Health Insurance Buy-In Program	$1,159,307	11.83%	$1,036,644	1.63%	$1,019,989	8.26%	$942,145	4.11%
Subtotal Long Term Care and Insurance	**$728,982,662**	**3.04%**	**$707,473,240**	**5.52%**	**$670,460,746**	**-2.68%**	**$688,925,481**	**10.83%**
SERVICE MANAGEMENT								
Single Entry Points	$25,226,746	5.02%	$24,021,660	1.32%	$23,707,551	2.78%	$23,067,175	6.02%
Disease Management	$982,012	0.00%	$0	-100.00%	$71,616	-97.52%	$2,882,271	23.66%
Prepaid Inpatient Health Plan Administration	$8,891,348	37.31%	$6,475,244	26.67%	$5,111,753	29.90%	$3,935,134	9.02%
Subtotal Service Management	**$53,007,939**	**68.90%**	**$31,384,315**	**8.63%**	**$28,890,920**	**-3.32%**	**$29,884,581**	**7.90%**
Total Services	**$2,924,894,763**	**5.62%**	**$2,769,295,897**	**8.51%**	**$2,552,180,141**	**1.74%**	**$2,508,537,655**	**12.64%**
Financing & Supplemental Payments								
Upper Payment Limit Financing	$6,377,165	-61.22%	$16,446,173	-8.31%	$17,936,927	-2.62%	$18,419,432	54.11%
Hospital Supplemental Payments	$614,554,259	34.96%	$455,348,284	45.73%	$312,468,739	0.00%	$0	0.00%
Nursing Facility Supplemental Payments	$86,787,485	13.72%	$76,315,634	60.83%	$47,451,412	0.00%	$0	0.00%
Physician Supplemental Payments	$4,984,682	83.54%	$2,715,842	-81.28%	$14,504,498	0.00%	$0	0.00%
Outstationing Payments	$1,447,215	-72.61%	$5,283,594	50.09%	$3,520,254	0.00%	$0	0.00%
Accounting Adjustments	$2,987,193	-29274.17%	($10,239)	-40.70%	($17,268)	-150.26%	$34,355	-67.84%
Subtotal Financing & Supplemental Payments	**$717,137,999**	**28.96%**	**$556,099,288**	**40.48%**	**$395,864,563**	**2045.17%**	**$18,453,787**	**53.03%**
Grand Total	**$3,642,032,762**	**9.52%**	**$3,325,395,185**	**12.80%**	**$2,948,044,704**	**16.66%**	**$2,526,991,443**	**12.86%**

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

Exhibit N - Expenditure History by Service Category - Delay Adjusted

ACUTE CARE	FY 2007-08	Percent Change From Prior Year	FY 2006-07	Percent Change From Prior Year	FY 2005-06	Percent Change From Prior Year	FY 2004-05	Percent Change From Prior Year	FY 2003-04
Physician Services & EPSDT	$190,663,827	16.09%	$164,232,428	13.84%	$144,266,423	16.23%	$124,119,339	1.18%	$122,673,666
Emergency Transportation	$4,550,505	6.21%	$4,284,622	18.64%	$3,611,441	3.96%	$3,473,741	-28.41%	$4,852,575
Non-emergency Medical Transportation	$7,733,949	-12832.88%	($60,740)	444.07%	($11,164)	-105.22%	$213,706	-91.83%	$2,616,352
Dental Services	$53,893,890	9.17%	$49,367,133	5.70%	$46,705,514	16.72%	$40,013,849	2.10%	$39,189,457
Family Planning	$202,073	996.27%	$18,433	-95.49%	$409,119	119.93%	$186,021	-9.06%	$204,545
Health Maintenance Organizations	$102,216,877	-5.73%	$108,429,033	-29.95%	$154,782,191	-4.51%	$162,090,246	-18.09%	$197,898,138
Inpatient Hospitals	$320,899,293	5.32%	$304,687,402	2.66%	$296,800,124	11.57%	$266,011,447	-2.65%	$273,247,361
Outpatient Hospitals	$130,192,196	12.46%	$115,767,273	10.03%	$105,213,743	12.39%	$93,618,116	5.13%	$89,047,191
Lab & X-Ray	$22,774,240	11.38%	$20,447,143	6.22%	$19,250,037	10.10%	$17,484,755	1.51%	$17,225,324
Durable Medical Equipment	$75,815,972	13.46%	$66,822,166	13.93%	$58,652,169	16.61%	$50,299,251	2.14%	$49,245,516
Prescription Drugs	$216,864,136	14.24%	$189,833,449	-19.88%	$236,947,825	-15.66%	$280,930,899	5.69%	$265,797,673
Drug Rebate	($55,465,088)	-5.42%	($58,644,804)	-25.83%	($79,068,617)	10.34%	($71,656,675)	33.98%	($53,484,910)
Rural Health Centers	$6,242,784	6.16%	$5,880,402	23.76%	$4,751,330	3.33%	$4,598,395	17.63%	$3,909,310
Federally Qualified Health Centers	$62,621,473	6.21%	$58,960,102	-4.84%	$61,957,718	8.99%	$56,845,564	10.60%	$51,398,899
Co-Insurance (Title XVIII-Medicare)	$22,507,668	18.61%	$18,976,405	5.88%	$17,922,444	3.25%	$17,357,700	-9.62%	$19,205,728
Breast and Cervical Cancer Treatment Program	$7,088,411	27.61%	$5,554,934	-18.41%	$6,808,264	173.41%	$2,490,090	-6.69%	$2,668,652
Prepaid Inpatient Health Plan Services	$33,682,305	7.66%	$31,285,316	-5.16%	$32,987,230	-51.83%	$68,474,304	297.28%	$17,235,604
Other Medical Services	$33,888	26.75%	$26,736	-10.59%	$29,903	1.48%	$29,468	-70.72%	$100,654
Home Health	$129,715,198	18.30%	$109,647,063	18.89%	$92,227,451	23.74%	$74,534,611	6.94%	$69,697,057
Presumptive Eligibility	$3,770,690	-51.96%	$7,849,344	196.81%	$2,644,540	0.00%	$0	0.00%	$0
Subtotal of Acute Care	**$1,336,004,286**	**11.02%**	**$1,203,363,838**	**-0.29%**	**$1,206,887,685**	**1.32%**	**$1,191,114,826**	**1.57%**	**$1,172,728,792**
COMMUNITY BASED LONG TERM CARE									
HCBS - Elderly, Blind, and Disabled	$141,231,844	14.20%	$123,673,036	15.28%	$107,276,565	13.86%	$94,216,182	-0.55%	$94,741,923
HCBS - Mental Illness	$20,409,887	18.34%	$17,246,320	15.10%	$14,984,173	15.09%	$13,019,463	-13.38%	$15,030,947
HCBS - Disabled Children	$1,353,847	49.62%	$904,883	36.73%	$661,823	37.33%	$481,927	34.28%	$358,891
HCBS - Persons Living with AIDS	$595,406	18.25%	$503,530	6.50%	$472,783	3.13%	$458,451	-18.46%	$562,218
HCBS - Consumer Directed Attendant Support	$14,109,819	12.16%	$12,580,285	73.81%	$7,237,889	22.42%	$5,912,371	92.92%	$3,064,733
HCBS - Brain Injury	$10,785,587	-2.94%	$11,112,528	26.08%	$8,813,686	-4.46%	$9,225,591	2.59%	$8,992,797
HCBS - Children with Autism	$695,586	3599.64%	$18,801	0.00%	$0	0.00%	$0	0.00%	$0
HCBS - Pediatric Hospice	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Private Duty Nursing	$19,749,262	14.16%	$17,299,756	10.78%	$15,616,760	10.98%	$14,071,893	6.80%	$13,176,147
Hospice	$32,810,776	3.22%	$31,787,348	11.51%	$28,507,087	21.00%	$23,559,031	3.35%	$22,795,661
Subtotal Community Based Long Term Care	**$241,742,014**	**12.37%**	**$215,126,488**	**17.19%**	**$183,570,766**	**14.06%**	**$160,944,908**	**1.40%**	**$158,723,316**
LONG TERM CARE and INSURANCE									
Class I Nursing Facilities	$486,568,498	1.73%	$478,303,487	4.77%	$456,520,328	7.70%	$423,878,333	1.89%	$416,011,012
Class II Nursing Facilities	$2,235,636	-1.52%	$2,270,136	57.99%	$1,436,850	3.86%	$1,383,445	25.25%	$1,104,554
Program of All-Inclusive Care for the Elderly	$49,418,855	15.27%	$42,872,281	5.93%	$40,470,490	15.10%	$35,160,005	30.08%	$27,029,169
Supplemental Medicare Insurance Benefit	$82,465,946	-0.29%	$82,706,881	16.86%	$70,775,604	21.09%	$58,449,753	22.76%	$47,613,226
Health Insurance Buy-In Program	$904,947	21.90%	$742,352	41.62%	$524,194	-13.69%	$607,332	-12.00%	$690,172
Subtotal Long Term Care and Insurance	**$621,593,882**	**2.42%**	**$606,895,137**	**6.52%**	**$569,727,466**	**9.67%**	**$519,478,869**	**5.49%**	**$492,448,133**
SERVICE MANAGEMENT									
Single Entry Points	$21,757,100	20.86%	$18,002,536	8.80%	$16,547,063	-4.11%	$17,256,835	18.76%	$14,530,561
Disease Management	$2,330,726	443.29%	$428,999	33.08%	$322,355	57.49%	$204,682	0.00%	$0
Prepaid Inpatient Health Plan Administration	$3,609,472	-21.88%	$4,620,417	-13.49%	$5,340,741	24.63%	$4,285,446	29.54%	$3,308,119
Subtotal Service Management	**$27,697,298**	**20.15%**	**$23,051,952**	**3.79%**	**$22,210,159**	**2.13%**	**$21,746,963**	**21.91%**	**$17,838,681**
Total Services	**$2,227,037,481**	**8.72%**	**$2,048,437,415**	**3.33%**	**$1,982,396,076**	**4.71%**	**$1,893,285,567**	**2.80%**	**$1,841,738,922**
Financing & Supplemental Payments									
Upper Payment Limit Financing	$11,952,096	-7.77%	$12,959,393	-6.55%	$13,868,231	-48.99%	$27,189,205	1.00%	$26,919,593
Hospital Supplemental Payments	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Nursing Facility Supplemental Payments	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Physician Supplemental Payments	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Outstationing Payments	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Accounting Adjustments	$106,828	0.00%	$0	-100.00%	$1	-100.00%	$66,754	-27.22%	$91,716
Subtotal Financing & Supplemental Payments	**$12,058,924**	**-6.95%**	**$12,959,393**	**-6.55%**	**$13,868,232**	**-49.12%**	**$27,255,959**	**0.91%**	**$27,011,308**
Grand Total	**$2,239,096,405**	**8.62%**	**$2,061,396,808**	**3.26%**	**$1,996,264,308**	**3.94%**	**$1,920,541,525**	**2.77%**	**$1,868,750,230**

"(DA)": "Delay Adjusted" -- indicates actuals have bee

Exhibit O
Appropriations and Expenditures

Final FY 2011-12 Funding Splits						
	Total Funds	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
HB 12-1335 FY 2012-13 Long Bill Add-on	**$3,624,764,050**	**$938,721,581**	**$373,508,751**	**$518,815,398**	**$3,159,477**	**$1,790,558,843**
SB 11-125 "Nursing Home Fees & Order of Payments"	$30,994,411	$0	$0	$15,497,206	$0	$15,497,205
SB 11-177 "Repeal Sunset Teen Pregnancy & Dropout Program"	$144,165	($26,735)	$0	$19,763	$0	$151,137
SB 11-210 "Phase Out Supplemental OAP Health Fund"	$0	($2,230,500)	$0	$2,230,500	$0	$0
SB 11-211 "Tobacco Revenues Offset Medical Services"	$0	($33,000,000)	$0	$29,713,649	$3,286,351	$0
SB 11-212 "Use Provider Fee Offset GF Medicaid"	$0	($50,000,000)	$0	$50,000,000	$0	$0
SB 11-215 "2011 Nursing Facility Rate Reduction"	($8,865,830)	($4,432,915)	$0	$0	$0	($4,432,915)
SB 11-219 "2011 Transfers For Health Care Services"	$0	($15,775,670)	$0	$15,775,670	$0	$0
HB 12-1202 "Allow HCPF Approps For Quitline Matching Funds"	$577,316	$0	$0	$288,658	$0	$288,658
Appropriations Totals	$3,647,614,112	$833,255,761	$373,508,751	$632,340,844	$6,445,828	$1,802,062,928
Final Expenditures	$3,642,032,762	$833,239,176	$373,508,751	$629,762,743	$6,445,828	$1,799,076,264
Remaining Balance (Over Expenditure)	**$5,581,350**	**$16,585**	**$0**	**$2,578,101**	**$0**	**$2,986,664**
Totals reflect final COFRS close; they do not include post-closing entries.						

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

FY 2011-12 Final Actuals			
Aid Category	**Caseload**	**Per Capita**	**Total**
Adults 65 and Older (OAP-A)	39,740	$22,549.39	$896,112,956
Disabled Adults 60 to 64 (OAP-B)	8,383	$20,353.47	$170,623,165
Disabled Individuals to 59 (AND/AB)	59,434	$17,390.16	$1,033,566,923
Disabled Buy-in	52	$13,906.29	$723,127
Categorically Eligible Low-Income Adults (AFDC-A)	68,689	$5,097.26	$350,125,404
Expansion Adults to 60%	24,535	$3,779.77	$92,736,593
Expansion Adults to 100%	35,461	$3,394.99	$120,389,845
Adults without Dependent Children	1,134	$3,530.00	$4,003,017
Breast & Cervical Cancer Program	597	$17,232.73	$10,287,938
Eligible Children (AFDC-C/BC)	334,633	$2,042.31	$683,425,225
Foster Care	18,034	$4,419.34	$79,698,390
Baby Care Program-Adults	7,630	$12,767.73	$97,417,747
Non-Citizens	2,770	$28,288.07	$78,357,967
Partial Dual Eligibles	18,871	$1,301.70	$24,564,465
TOTAL	**619,963**	**TF**	**$3,642,032,762**
Total Funds include upper payment limit financing and supplemental payments and other Medicaid financing.		**GF**	$833,239,176
		GFE	$373,508,751
		CF	$629,762,743
		CFE	$6,445,828
		FF	$1,799,076,264

Exhibit O - Comparison of Budget Requests and Appropriations

FY 2008-09 Comparison of Requests and Appropriations

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

FY 2009-10 Comparison of Requests and Appropriations

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

FY 2010-11 Comparison of Requests and Appropriations

FY 2010-11	November 3, 2009	February 15, 2010	% Change	FY 2010-11 Long Bill and Special Bills Appropriation	November 1, 2010	February 15, 2011	% Change over Appropriation	FY 2010-11 Final Appropriation	FY 2010-11 Actuals	% Change over Final Appropriation
Acute Care	$1,817,833,344	$1,726,068,473	-5.05%	$1,676,041,654	$1,704,740,814	$1,988,376,289	16.64%	$1,731,337,041	$1,719,420,711	0.69%
Community Based Long Term Care	$316,627,466	$324,965,364	2.63%	$317,177,074	$324,524,665	$370,804,264	14.26%	$318,568,691	$319,017,067	-0.14%
Long Term Care	$647,638,356	$651,246,648	0.56%	$637,084,088	$631,054,441	$0	-100.00%	$658,241,538	$663,208,496	-0.75%
Insurance	$105,641,289	$119,159,548	12.80%	$114,705,505	$120,865,705	$0	-100.00%	$119,052,929	$120,580,378	-1.27%
Service Management	$47,855,679	$49,280,859	2.98%	$32,966,743	$33,560,570	$0	-100.00%	$33,411,741	$31,384,315	6.46%
Financing	$272,640,497	$323,073,599	18.50%	$328,883,062	$481,607,230	$795,588,346	65.19%	$483,683,032	$471,784,218	2.52%
Total	$3,208,236,631	$3,193,794,491	-0.45%	$3,106,858,126	$3,296,353,425	$3,154,768,899	-4.30%	$3,344,294,972	$3,325,395,185	0.57%
Class I Nursing Facilities	$558,617,741	$570,960,660	2.21%	$558,653,333	$551,778,173	$565,885,188	2.56%	$580,097,872	$575,631,025	0.78%

Exhibit O - Comparison of Budget Requests and Appropriations

FY 2011-12 Comparison of Requests and Appropriations

FY 2011-12	November 1, 2010	February 15, 2011	% Change	FY 2011-12 Long Bill and Special Bills Appropriation	November 1, 2011	February 15, 2012	% Change over Appropriation	FY 2011-12 Final Appropriation	FY 2011-12 Actuals	% Change over Feb.
Acute Care	$1,869,280,623	$1,841,198,096	-1.50%	$2,050,801,853	$1,804,376,597	$1,817,494,423	-11.38%	$1,820,645,131	$1,797,425,015	-1.10%
Community Based Long Term Care	$355,599,322	$344,929,391	-3.00%	$359,466,389	$339,735,624	$338,302,070	-5.89%	$338,302,070	$345,479,147	2.12%
Long Term Care	$643,090,480	$661,945,406	2.93%	$624,645,176	$602,704,785	$598,729,747	-4.15%	$598,729,747	$609,224,428	1.75%
Insurance	$135,182,109	$130,455,214	-3.50%	$124,533,974	$136,796,432	$114,861,433	-7.77%	$114,861,433	$119,758,234	4.26%
Service Management	$48,099,599	$47,337,900	-1.58%	$67,192,718	$55,222,856	$53,404,975	-20.52%	$53,982,291	$53,007,939	-0.74%
Financing	$498,614,128	$515,132,015	3.31%	$758,973,276	$637,431,859	$714,831,348	-5.82%	$721,093,440	$717,137,999	0.32%
Total	$3,549,866,261	$3,540,998,022	-0.25%	$3,985,613,386	$3,576,268,153	$3,637,623,996	-8.73%	$3,647,614,112	$3,642,032,762	0.12%
Class I Nursing Facilities	$551,945,698	$518,406,575	-6.08%	$529,778,682	$515,627,467	$512,062,190	-3.34%	$512,062,190	$521,244,769	1.79%

FY 2012-13 Comparison of Requests and Appropriations

FY 2012-13	November 1, 2011	February 15, 2012	% Change	FY 2012-13 Long Bill and Special Bills Appropriation	November 1, 2012	February 15, 2013	% Change over Appropriation	FY 2012-13 Final Appropriation	FY 2012-13 Actuals	% Change over Feb.
Acute Care	$1,869,280,623	$1,946,571,857	4.13%	$2,050,768,654	$1,989,065,304					
Community Based Long Term Care	$355,599,322	$358,768,860	0.89%	$359,473,847	$370,804,282					
Long Term Care	$643,090,480	$633,669,852	-1.46%	$711,408,187	$639,847,834					
Insurance	$135,182,109	$122,479,412	-9.40%	$124,556,953	$125,098,066					
Service Management	$48,099,599	$63,585,739	32.20%	$67,195,480	$72,408,107					
Financing	$498,614,128	$754,611,187	51.34%	$672,210,265	$795,588,346					
Total	$3,549,866,261	$3,879,686,907	9.29%	$3,985,613,386	$3,992,811,939					
Class I Nursing Facilities	$551,945,698	$538,803,358	-2.38%	$529,778,682	$544,532,608					

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

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60%	Expansion Adults to 100%	Adults without Dependent Children	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	Baby Care Program-Adults	Non-Citizens	Partial Dual Eligibles	TOTAL
FY 1997-98	$434,352,319	$38,025,425	$330,590,106		$82,516,222	$0	$0		$0	$142,956,889	$22,764,875	$28,964,028	$18,554,312	$6,246,815	$1,104,970,992
FY 1998-99	$463,746,968	$48,533,442	$361,070,568		$71,509,445	$0	$0		$0	$149,648,954	$23,328,439	$31,471,476	$20,738,242	$6,185,875	$1,176,233,410
FY 1999-00	$498,371,676	$54,962,843	$406,908,458		$80,904,393	$0	$0		$0	$169,614,835	$27,483,127	$33,530,293	$29,675,611	$6,968,865	$1,308,420,100
FY 2000-01	$515,213,506	$61,119,754	$450,888,114		$88,758,327	$0	$0		$0	$193,552,834	$30,746,407	$31,503,592	$36,930,022	$7,822,852	$1,416,535,408
FY 2001-02	$571,065,382	$61,284,519	$465,027,758		$104,227,966	$0	$0		$0	$220,555,126	$33,206,413	$33,946,549	$39,372,440	$8,118,537	$1,536,804,691
FY 2002-03	$564,628,021	$64,679,670	$516,439,288	$0	$139,745,425	$0	$0	$0	$1,428,780	$227,992,629	$37,567,968	$42,521,465	$48,734,092	$7,933,536	$1,651,670,874
FY 2003-04	$634,138,712	$76,646,130	$562,700,004	$0	$184,736,556	$0	$0	$0	$2,668,992	$233,391,821	$45,491,729	$64,293,820	$55,212,960	$9,469,507	$1,868,750,230
FY 2004-05	$652,991,016	$82,003,665	$540,574,590	$0	$193,239,971	$0	$0	$0	$2,490,659	$304,520,783	$46,710,822	$42,305,572	$44,773,436	$10,931,012	$1,920,541,525
FY 2005-06	$670,399,260	$87,347,546	$554,870,504	$0	$200,372,841	$0	$0	$0	$6,810,399	$317,181,796	$49,374,100	$41,186,119	$55,353,863	$13,367,880	$1,996,264,308
FY 2006-07	$680,873,516	$90,702,791	$573,755,682	$0	$197,852,527	$7,487,018	$0	$0	$5,557,749	$331,302,380	$53,781,937	$48,628,238	$54,484,004	$16,970,966	$2,061,396,808
FY 2007-08	$712,276,694	$101,257,270	$655,167,660	$0	$189,176,151	$18,502,735	$0	$0	$7,102,713	$364,161,301	$64,197,785	$54,600,185	$53,660,977	$18,992,933	$2,239,096,405
FY 2008-09	$789,584,078	$115,435,768	$735,082,424	$0	$208,663,632	$31,018,121	$0	$0	$7,056,952	$433,354,524	$67,739,569	$60,847,257	$59,283,547	$18,925,572	$2,526,991,443
FY 2009-10	$821,242,377	$128,660,905	$830,201,464	$0	$280,222,231	$52,512,326	$3,669,080	$0	$9,006,759	$561,985,044	$75,035,330	$91,641,692	$74,354,504	$19,512,991	$2,948,044,704
FY 2010-11	$859,971,334	$150,963,522	$943,370,577	$0	$298,860,409	$75,064,008	$82,213,922	$0	$9,817,158	$627,769,747	$81,811,588	$95,688,869	$75,541,134	$24,322,917	$3,325,395,185
FY 2011-12	$896,112,956	$170,623,165	$1,033,566,923	$723,127	$350,125,404	$92,736,593	$120,389,845	$4,003,017	$10,287,938	$683,425,225	$79,698,390	$97,417,747	$78,357,967	$24,564,465	$3,642,032,762

Fiscal Year	Expenditures	Percent Change	Dollar Increase/ Decrease	Average Yearly Percent Change From FY 97-98	Percent Change	Three-year Moving Average	Percent Change
FY 1997-98	$1,104,970,992						
FY 1998-99	$1,176,233,410	6.45%	$71,262,418				
FY 1999-00	$1,308,420,100	11.24%	$132,186,690	8.84%			
FY 2000-01	$1,416,535,408	8.26%	$108,115,307	8.65%	-2.19%	8.65%	
FY 2001-02	$1,536,804,691	8.49%	$120,269,284	8.61%	-0.46%	9.33%	7.87%
FY 2002-03	$1,651,670,874	7.47%	$114,866,182	8.38%	-2.64%	8.08%	-13.45%
FY 2003-04	$1,868,750,230	13.14%	$217,079,357	9.18%	9.46%	9.70%	20.14%
FY 2004-05	$1,920,541,525	2.77%	$51,791,295	8.26%	-9.97%	7.80%	-19.65%
FY 2005-06	$1,996,264,308	3.94%	$75,722,783	7.72%	-6.53%	6.62%	-15.10%
FY 2006-07	$2,061,396,808	3.26%	$65,132,500	7.23%	-6.42%	3.33%	-49.76%
FY 2007-08	$2,239,096,405	8.62%	$177,699,597	7.37%	1.93%	5.28%	58.62%
FY 2008-09	$2,526,991,443	12.86%	$287,895,038	7.86%	6.78%	8.25%	56.33%
FY 2009-10	$2,948,044,704	16.66%	$421,053,261	8.60%	9.32%	12.71%	54.16%
FY 2010-11	$3,325,395,185	12.80%	$377,350,481	8.92%	3.76%	14.11%	10.96%
FY 2011-12	$3,642,032,762	9.52%	$316,637,577	8.96%	0.48%	12.99%	-7.88%
	Official Projection	**Percent Change**	**Dollar Increase/ Decrease**	**Projection Using Most Recent Average Change**	**Percent Change over Official Projection**	**Projection Using Most Recent Three-year Average**	**Percent Change over Premium Workbook Projection**
FY 2012-13 Projection	$3,993,255,681	9.64%	$351,222,919	$3,968,507,655	-0.62%	$4,115,303,557	3.06%
FY 2013-14 Projection	$4,281,788,931	7.23%	$288,533,250	$4,336,593,654	1.28%	$4,512,166,798	5.38%
FY 2014-15 Projection	$4,447,257,384	3.86%	$165,468,453	$4,663,775,159	4.87%	$4,838,194,044	8.79%
FY 2012-13 Appropriation	$4,142,818,122						
Difference Between FY 2012-13 Projections and FY 2012-13 Appropriation	($149,562,441)	-3.61%		($174,310,467)	-4.21%	($27,514,565)	-0.66%
Difference Between FY 2013-14 Projections and FY 2012-13 Appropriation	$138,970,809	3.35%		$193,775,532	4.68%	$369,348,676	8.92%
Difference Between FY 2014-15 Projections and FY 2012-13 Appropriation	$304,439,262	7.35%		$520,957,037	12.57%	$695,375,922	16.79%

Actuals, Projection, and Appropriation exclude Upper Payment Limit Financing.

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

Fiscal Year	Total Expenditures*	Annual % Change	Total Caseload**	Annual % Change
FY 1997-98	$1,104,970,992		250,098	
FY 1998-99	$1,176,233,410	6.45%	238,594	-4.60%
FY 1999-00	$1,308,420,100	11.24%	237,598	-0.42%
FY 2000-01	$1,416,535,408	8.26%	253,254	6.59%
FY 2001-02	$1,536,804,691	8.49%	275,399	8.74%
FY 2002-03	$1,651,670,874	7.47%	331,800	20.48%
FY 2003-04	$1,868,750,230	13.14%	367,559	10.78%
FY 2004-05	$1,920,541,525	2.77%	406,024	10.46%
FY 2005-06	$1,996,264,308	3.94%	402,218	-0.94%
FY 2006-07	$2,061,396,808	3.26%	392,228	-2.48%
FY 2007-08	$2,239,096,405	8.62%	391,962	-0.07%
FY 2008-09	$2,526,991,443	12.86%	436,812	11.44%
FY 2009-10	$2,948,044,704	16.66%	498,797	14.19%
FY 2010-11	$3,325,395,185	12.80%	560,759	12.42%
FY 2011-12	$3,642,032,762	9.52%	619,963	10.56%
FY 2012-13 Projection	$3,993,255,681	9.64%	681,535	9.93%
FY 2013-14 Projection	$4,281,788,931	7.23%	738,413	8.35%
FY 2014-15 Projection	$4,447,257,384	3.86%	776,381	5.14%

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

**Caseload does not include retroactivity.

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

Service Category	FY 2012-13 COFRS Actuals (July-September)	FY 2011-12 Cash Flow % (July-September)	FY 2012-13 Year End ROUGH Projection	FY 2012-13 Appropriation	Long Bill Appropriation Minus Cash Flow
ACUTE CARE					
Physician Services & EPSDT	$72,440,105	25.24%	$287,020,239	N/A	N/A
Emergency Transportation	$1,769,078	27.81%	$6,361,058	N/A	N/A
Non-emergency Medical Transportation	$1,680,499	16.06%	$10,462,166	N/A	N/A
Dental Services	$26,519,878	25.52%	$103,911,787	N/A	N/A
Family Planning	$160,401	27.71%	$578,957	N/A	N/A
Health Maintenance Organizations	$32,924,188	27.27%	$120,715,911	N/A	N/A
Inpatient Hospitals	$99,703,393	27.50%	$362,502,617	N/A	N/A
Outpatient Hospitals	$66,090,520	28.43%	$232,479,846	N/A	N/A
Lab & X-Ray	$10,763,273	26.92%	$39,978,003	N/A	N/A
Durable Medical Equipment	$24,281,214	25.91%	$93,706,452	N/A	N/A
Prescription Drugs	$79,346,803	24.89%	$318,741,461	N/A	N/A
Drug Rebate	($42,072,071)	28.09%	($149,787,193)	N/A	N/A
Rural Health Centers	$2,979,955	28.20%	$10,567,916	N/A	N/A
Federally Qualified Health Centers	$23,383,797	24.67%	$94,790,483	N/A	N/A
Co-Insurance (Title XVIII-Medicare)	$7,737,419	20.89%	$37,036,552	N/A	N/A
Breast and Cervical Cancer Treatment Program	$2,371,457	23.09%	$10,272,613	N/A	N/A
Prepaid Inpatient Health Plan Services	$16,569,466	29.35%	$56,463,119	N/A	N/A
Other Medical Services	$1,331	8.71%	$15,295	N/A	N/A
Home Health	$42,722,307	26.44%	$161,607,733	N/A	N/A
Presumptive Eligibility	$0	0.00%	$0	N/A	N/A
Subtotal of Acute Care	**$469,373,014**	**26.11%**	**$1,797,425,015**	**$2,050,801,853**	**($253,376,838)**
COMMUNITY BASED LONG TERM CARE					
HCBS - Elderly, Blind, and Disabled	$56,551,384	25.11%	$225,185,711	N/A	N/A
HCBS - Mental Illness	$6,762,188	26.07%	$25,934,255	N/A	N/A
HCBS - Disabled Children	$1,058,721	33.82%	$3,130,073	N/A	N/A
HCBS - Persons Living with AIDS	$128,621	24.92%	$516,036	N/A	N/A
HCBS - Consumer Directed Attendant Support	$432,014	12.48%	$3,461,683	N/A	N/A
HCBS - Brain Injury	$3,201,949	25.44%	$12,587,131	N/A	N/A
HCBS - Children with Autism	$270,600	26.47%	$1,022,387	N/A	N/A
HCBS - Pediatric Hospice	$36,825	21.55%	$170,910	N/A	N/A
Private Duty Nursing	$8,431,014	27.07%	$31,144,153	N/A	N/A
Hospice	$10,002,479	23.63%	$42,326,808	N/A	N/A
Subtotal of Community Based Long Term Care	**$86,875,795**	**25.15%**	**$345,479,147**	**$359,466,389**	**($13,987,242)**
LONG TERM CARE and INSURANCE					
Class I Nursing Facilities	$131,073,307	25.15%	$521,244,769	$529,778,682	($8,533,913)
Class II Nursing Facilities	$498,161	19.93%	$2,499,074	$5,216,775	($2,717,701)
Program for All-Inclusive Care for the Elderly	$24,806,182	29.02%	$85,480,585	$89,649,719	($4,169,134)
Subtotal Long Term Care	**$156,377,650**	**25.67%**	**$609,224,428**	**$624,645,176**	**($15,420,748)**
Supplemental Medicare Insurance Benefit	$29,092,708	24.53%	$118,598,927	$120,810,425	($2,211,498)
Health Insurance Buy-In Program	$296,480	25.57%	$1,159,307	$3,723,549	($2,564,242)
Subtotal Insurance	**$29,389,188**	**24.54%**	**$119,758,234**	**$124,533,974**	**($4,775,740)**
Subtotal of Long Term Care and Insurance	**$185,766,838**	**25.48%**	**$728,982,662**	**$749,179,150**	**($20,196,488)**
SERVICE MANAGEMENT	$0	0.00%			
Single Entry Points	$6,445,421	25.55%	$25,226,746	$26,976,561	($1,749,815)
Disease Management	$0	0.00%	$0	$1,873,470	($1,873,470)
Prepaid Inpatient Health Plan Administration	$7,592,227	85.39%	$8,891,348	$38,342,687	($29,451,339)
Subtotal Service Management	**$14,037,648**	**39.99%**	**$35,100,106**	**$67,192,718**	**($32,092,612)**
Total	**$756,053,294**	**26.01%**	**$2,906,986,930**	**$3,226,640,110**	**($319,653,180)**

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

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

Exhibit AA - Calculation of Current Total Long Bill Group Impact						
FY 2012-13 Mental Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2012-13 Mental Health Capitation Appropriation						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$312,580,712	$142,712,972	$0	$13,648,932	$0	$156,218,808
FY 2012-13 Total Mental Heath Capitation Spending Authority	**$312,580,712**	**$142,712,972**	**$0**	**$13,648,932**	**$0**	**$156,218,808**
Projected Total FY 2012-13 Mental Health Capitation Expenditure	**$311,570,590**	**$140,957,349**	**$0**	**$14,825,346**	**$0**	**$155,787,895**
FY 2012-13 Mental Health Capitation Estimated Change from Appropriation	**($1,010,122)**	**($1,755,623)**	**$0**	**$1,176,414**	**$0**	**($430,913)**
Percent Change from Spending Authority	-0.32%	-1.23%	-	8.62%	-	-0.28%
FY 2012-13 Mental Health Fee-for-Service						
FY 2012-13 Mental Health Fee-For-Service Appropriation						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$4,147,628	$2,073,815	$0	$0	$0	$2,073,813
FY 2012-13 Total Mental Heath Fee-For-Service Spending Authority	**$4,147,628**	**$2,073,815**	**$0**	**$0**	**$0**	**$2,073,813**
Projected Total FY 2012-13 Mental Health Fee-for-Service Expenditure	**$4,249,210**	**$2,124,605**	**$0**	**$0**	**$0**	**$2,124,605**
Total FY 2012-13 Mental Health Fee-For-Service Change from Appropriation	**$101,582**	**$50,790**	**$0**	**$0**	**$0**	**$50,792**
Percent Change from Spending Authority	2.45%	2.45%	-	-	-	2.45%
FY 2012-13 Medicaid Mental Health Programs						
FY 2012-13 Total Spending Authority	**$316,728,340**	**$144,786,787**	**$0**	**$13,648,932**	**$0**	**$158,292,621**
Total Projected FY 2012-13 Expenditures	$315,819,800	$143,081,954	$0	$14,825,346	$0	$157,912,500
FY 2012-13 Estimated Change from Appropriation	**($908,540)**	**($1,704,833)**	**$0**	**$1,176,414**	**$0**	**($380,121)**
Percent Change from Spending Authority	-0.29%	-1.18%	-	8.62%	-	-0.24%

Exhibit AA - Calculation of Current Total Long Bill Group Impact						
FY 2013-14 Mental Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2012-13 Mental Health Capitation Appropriation Plus Special Bills	**$312,580,712**	**$142,712,972**	**$0**	**$13,648,932**	**$0**	**$156,218,808**
Bill Annualizations						
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility'	$3,218,931	$1,126,626	$0	$0	$0	$2,092,305
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility'	$215,864	$75,552	$0	$0	$0	$140,312
Total Annualizations	$3,434,795	$1,202,178	$0	$0	$0	$2,232,617
FY 2013-14 Mental Health Capitation Base Amount	**$316,015,507**	**$143,915,150**	**$0**	**$13,648,932**	**$0**	**$158,451,425**
Projected Total FY 2013-14 Mental Health Capitation Expenditure	**$347,855,029**	**$153,927,267**	**$0**	**$12,335,664**	**$0**	**$181,592,098**
Total FY 2013-14 Mental Health Capitation Request	**$31,839,522**	**$10,012,117**	**$0**	**($1,313,268)**	**$0**	**$23,140,673**
Percent Change from FY 2013-14 Mental Health Capitation Base	10.08%	6.96%	-	-9.62%	-	14.60%
Percent Change from FY 2012-13 Estimated Mental Health Capitation Expenditure	11.65%	9.20%	-	-16.79%	-	16.56%
FY 2013-14 Mental Health Fee-for-Service						
FY 2012-13 Mental Health Fee-For-Service Appropriation Plus Special Bills	**$4,147,628**	**$2,073,815**	**$0**	**$0**	**$0**	**$2,073,813**
FY 2013-14 Mental Health Fee-For-Service Base Amount	**$4,147,628**	**$2,073,815**	**$0**	**$0**	**$0**	**$2,073,813**
Projected Total FY 2012-13 Mental Health Fee-for-Service Expenditure	**$4,693,094**	**$2,346,547**	**$0**	**$0**	**$0**	**$2,346,547**
Total FY 2013-14 Mental Health Fee-For-Service Request	**$545,466**	**$272,732**	**$0**	**$0**	**$0**	**$272,734**
Percent Change from FY 2013-14 Mental Health Fee-For-Service Base	13.15%	13.15%	-	-	-	13.15%
Percent Change from FY 2012-13 Estimated Mental Health Fee-For-Service Expenditure	10.45%	10.45%	-	-	-	10.45%
FY 2013-14 Medicaid Mental Health Programs						
FY 2013-14 Base Amount	**$320,163,135**	**$145,988,965**	**$0**	**$13,648,932**	**$0**	**$160,525,238**
Total Projected FY 2013-14 Expenditure	$352,548,123	$156,273,814	$0	$12,335,664	$0	$183,938,645
Total FY 2013-14 Request	**$32,384,988**	**$10,284,849**	**$0**	**($1,313,268)**	**$0**	**$23,413,407**
Percent Change from Spending Authority	10.12%	7.04%	-	-9.62%	-	14.59%

Exhibit AA - Calculation of Current Total Long Bill Group Impact						
FY 2014-15 Mental Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2013-14 Mental Health Capitation Appropriation Plus Special Bills	**$316,015,507**	**$143,915,150**	**$0**	**$13,648,932**	**$0**	**$158,451,425**
Bill Annualizations						
FY 2014-15 Mental Health Capitation Base Amount	**$316,015,507**	**$143,915,150**	**$0**	**$13,648,932**	**$0**	**$158,451,425**
Projected Total FY 2014-15 Mental Health Capitation Expenditure	**$381,272,451**	**$166,395,265**	**$0**	**$8,539,327**	**$0**	**$206,337,859**
Total FY 2014-15 Mental Health Capitation Continuation Amount	**$65,256,944**	**$22,480,115**	**$0**	**($5,109,605)**	**$0**	**$47,886,434**
Percent Change from FY 2014-15 Mental Health Capitation Base	20.65%	15.62%	-	-37.44%	-	30.22%
Percent Change from FY 2013-14 Estimated Mental Health Capitation Expenditure	9.61%	8.10%	-	-30.78%	-	13.63%
FY 2014-15 Mental Health Fee-for-Service						
FY 2013-14 Mental Health Fee-For-Service Appropriation Plus Special Bills	**$4,147,628**	**$2,073,815**	**$0**	**$0**	**$0**	**$2,073,813**
FY 2014-15 Mental Health Fee-For-Service Base Amount	**$4,147,628**	**$2,073,815**	**$0**	**$0**	**$0**	**$2,073,813**
Projected Total FY 2013-14 Mental Health Fee-for-Service Expenditure	**$4,836,640**	**$2,418,320**	**$0**	**$0**	**$0**	**$2,418,320**
Total FY 2014-15 Mental Health Fee-For-Service Continuation Amount	**$689,012**	**$344,505**	**$0**	**$0**	**$0**	**$344,507**
Percent Change from FY 2014-15 Mental Health Fee-For-Service Base	16.61%	16.61%	-	-	-	16.61%
Percent Change from FY 2013-14 Estimated Mental Health Fee-For-Service Expenditure	3.06%	3.06%	-	-	-	3.06%
FY 2014-15 Medicaid Mental Health Programs						
FY 2014-15 Base Amount	**$320,163,135**	**$145,988,965**	**$0**	**$13,648,932**	**$0**	**$160,525,238**
Total Projected FY 2014-15 Expenditure	$386,109,091	$168,813,585	$0	$8,539,327	$0	$208,756,179
Total FY 2014-15 Continuation Amount	**$65,945,956**	**$22,824,620**	**$0**	**($5,109,605)**	**$0**	**$48,230,941**
Percent Change from Spending Authority	20.60%	15.63%	-	-37.44%	-	30.05%

Exhibit BB - Calculation of Fund Splits

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

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Source of Funding
Mental Health Capitation Base Traditional Clients	$282,947,934	$141,473,967	$0	$0	$141,473,967	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients [(1)]	$178,530	$31,242	$31,243	$0	$116,045	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
HB 09-1293 Hospital Provider Fee Expansion Adults to 100% and Adults without Dependent Children	$25,644,198	$0	$12,822,099	$0	$12,822,099	50.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293 Hospital Provider Fee Buy-In for Disabled Individuals	$3,994,257	$0	$1,997,128	$0	$1,997,129	50.00%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$535,278	$187,347	$0	$0	$347,931	65.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$106,566	$37,298	$0	$0	$69,268	65.00%	General Fund
Estimated FY 2012-13 Capitation Expenditure	**$313,406,763**	**$141,729,854**	**$14,850,470**	**$0**	**$156,826,439**		
Date of Death Retractions	($595,623)	($297,811)	$0	$0	($297,812)	50.00%	
Estimated Recoupments	($1,240,550)	($474,694)	($25,124)	$0	($740,732)	59.71%	General Fund and CF: Hospital Provider Fee Cash Fund
Adults without Dependent Children Reconciliations	$0	$0	$0	$0	$0	50.00%	CF: Hospital Provider Fee Cash Fund
Final Estimated FY 2012-13 Capitation Expenditure	**$311,570,590**	**$140,957,349**	**$14,825,346**	**$0**	**$155,787,895**		
Medicaid Mental Health Fee-for-Service Payments	**$4,249,210**	**$2,124,605**	**$0**	**$0**	**$2,124,605**	50.00%	
Final Estimated FY 2012-13 Medicaid Mental Health Community Programs Expenditure	**$315,819,800**	**$143,081,954**	**$14,825,346**	**$0**	**$157,912,500**		

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

Exhibit BB - Calculation of Fund Splits

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

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Source of Funding
Mental Health Capitation Base Traditional Clients	$306,842,270	$153,421,135	$0	$0	$153,421,135	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients (1)	$194,920	$34,111	$34,111	$0	$126,698	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
HB 09-1293 Hospital Provider Fee Expansion Adults to 100% and Adults without Dependent Children	$28,157,812	$0	$7,039,453	$0	$21,118,359	75.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293 Hospital Provider Fee Buy-In for Disabled Individuals	$10,605,598	$0	$5,302,799	$0	$5,302,799	50.00%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$3,750,173	$1,312,561	$0	$0	$2,437,612	65.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$222,452	$77,858	$0	$0	$144,594	65.00%	General Fund
Estimated FY 2013-14 Capitation Expenditure	**$349,773,225**	**$154,845,665**	**$12,376,363**	**$0**	**$182,551,197**		
Date of Death Retractions	($544,783)	($272,391)	$0	$0	($272,392)	50.00%	General Fund
Estimated Recoupments	($1,373,413)	($646,007)	($40,699)	$0	($686,707)	50.00%	General Fund and CF: Hospital Provider Fee Cash Fund
Adults without Dependent Children Reconciliations	$0	$0	$0	$0	$0	75.00%	CF: Hospital Provider Fee Cash Fund
Final Estimated FY 2013-14 Capitation Expenditure	**$347,855,029**	**$153,927,267**	**$12,335,664**	**$0**	**$181,592,098**		
Medicaid Mental Health Fee-for-Service Payments	**$4,693,094**	**$2,346,547**	**$0**	**$0**	**$2,346,547**	50.00%	General Fund
Final Estimated FY 2012-13 Medicaid Mental Health Community Programs Expenditure	**$352,548,123**	**$156,273,814**	**$12,335,664**	**$0**	**$183,938,645**		

Exhibit BB - Calculation of Fund Splits

Calculation of Fund Split - FY 2014-15 Mental Health Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Source of Funding
Mental Health Capitation Base Traditional Clients	$331,189,281	$165,594,640	$0	$0	$165,594,641	50.00%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$209,462	$73,312	$0	$0	$136,150	65.00%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
HB 09-1293 Hospital Provider Fee Expansion Adults to 100% and Adults without Dependent Children	$29,901,614	$0	$0	$0	$29,901,614	100.00%	CF: Hospital Provider Fee Cash Fund
HB 09-1293 Hospital Provider Fee Buy-In for Disabled Individuals	$17,176,280	$0	$8,588,140	$0	$8,588,140	50.00%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$4,565,177	$1,597,812	$0	$0	$2,967,365	65.00%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$230,873	$80,806	$0	$0	$150,067	65.00%	General Fund
Estimated FY 2014-15 Capitation Expenditure	**$383,272,687**	**$167,346,570**	**$8,588,140**	**$0**	**$207,337,977**		
Date of Death Retractions	($490,306)	($245,153)	$0	$0	($245,153)	50.00%	
Estimated Recoupments	($1,509,930)	($706,152)	($48,813)	$0	($754,965)	50.00%	CF: Hospital Provider Fee Cash Fund
Adults without Dependent Children Reconciliations	$0	$0	$0	$0	$0	100.00%	CF: Hospital Provider Fee Cash Fund
Final Estimated FY 2014-15 Capitation Expenditure	**$381,272,451**	**$166,395,265**	**$8,539,327**	**$0**	**$206,337,859**		
Medicaid Mental Health Fee-for-Service Payments	**$4,836,640**	**$2,418,320**	**$0**	**$0**	**$2,418,320**	50.00%	
Final Estimated FY 2014-15 Medicaid Mental Health Community Programs Expenditure	**$386,109,091**	**$168,813,585**	**$8,539,327**	**$0**	**$208,756,179**		

Cash Funds Report

Cash Fund	FY 2012-13			FY 2013-14			FY 2014-15		
	Spending Authority	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**
Cash Funds									
Hospital Provider Fee Cash Fund	$13,614,743	$14,794,103	$1,179,360	$13,614,743	$12,301,553	($1,313,190)	$13,614,743	$8,539,327	($5,075,416)
Breast and Cervical Cancer Prevention and Treatment Fund	$34,189	$31,243	($2,946)	$34,189	$34,111	($78)	$34,189	$0	($34,189)
Total Cash Funds	**$13,648,932**	**$14,825,346**	**$1,176,414**	**$13,648,932**	**$12,335,664**	**($1,313,268)**	**$13,648,932**	**$8,539,327**	**($5,109,605)**
Reappropriated Funds - Transfers from the Department of Public Health and Environment									
(9) Prevention Services Division; (A) Prevention Programs, (3) Chronic Disease and Cancer Prevention Grants Program	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Reappropriated Funds	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Exhibit CC - Medicaid Mental Health Community Programs Expenditure Summary
Actuals, Appropriations and Estimates Prior to Recoupments

ITEM	FY 2011-12 Actual		FY 2012-13 Appropriated		FY 2012-13 Estimate		FY 2012-13 Change from Appropriation		FY 2013-14 Estimate		FY 2013-14 Change from FY 2012-13 Estimate		FY 2013-14 Change from FY 2012-13 Appropriation		FY 2014-15 Estimate		FY 2014-15 Change from FY 2013-14 Estimate	
	Caseload	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**
Mental Health Capitation Payments																		
Adults 65 and Older (OAP-A)	39,740	$6,501,731	40,820	$6,633,710	40,364	$6,647,593	(456)	$13,883	41,195	$6,986,349	831	$338,756	375	$352,639	42,081	$7,350,968	886	$364,619
Disabled Individuals Through 64 (AND/AB, OAP-B)	67,869	$120,858,807	73,254	$135,234,500	72,197	$132,555,546	(1,057)	($2,678,954)	77,441	$150,695,765	5,244	$18,140,219	4,187	$15,461,265	82,124	$168,958,718	4,683	$18,262,953
Low Income Adults	136,315	$37,302,066	153,880	$44,159,170	152,840	$43,754,714	(1,040)	($404,456)	164,051	$48,715,906	11,211	$4,961,192	10,171	$4,556,736	168,739	$51,951,096	4,688	$3,235,190
Adults without Dependent Children	1,134	$91,244	10,000	$9,443,024	10,000	$13,481,055		$4,038,031	10,000	$14,108,016		$626,961		$4,664,992	10,000	$14,761,116	0	$653,100
Eligible Children (AFDC-C/BC)	334,633	$67,777,256	367,649	$79,275,859	363,786	$79,518,692	(3,863)	$242,833	401,411	$92,247,200	37,625	$12,728,508	33,762	$12,971,341	426,907	$103,190,682	25,496	$10,943,482
Foster Care	18,034	$38,817,457	18,159	$37,723,995	17,994	$37,270,633	(165)	($453,362)	18,057	$36,825,069	63	($445,564)	(102)	($898,926)	18,209	$36,850,645	152	$25,576
Breast and Cervical Cancer Program	597	$158,074	679	$194,703	621	$178,530	(58)	($16,173)	655	$194,920	34	$16,390	(24)	$217	680	$209,462	25	$14,542
Sub-total Mental Health Capitation Payments	**598,322**	**$271,506,635**	**664,441**	**$312,664,961**	**657,802**	**$313,406,763**	**(6,639)**	**$741,802**	**712,810**	**$349,773,225**	**55,008**	**$36,366,462**	**48,369**	**$37,108,264**	**748,740**	**$383,272,687**	**35,930**	**$33,499,462**
Recoupments for Prior Years' Payments for Ineligibles		($1,789,439)		($1,672,249)		($1,240,550)		$431,699		($1,373,413)		($132,863)		$298,836		($1,509,930)		($136,517)
Date of Death Retractions [(1)]		($661,803)		($562,802)		($595,623)		($32,821)		($544,783)		$50,840		$18,019		($490,306)		$54,477
Adults without Dependent Children Reconciliations		$0		$1,588,000		$0		($1,588,000)		$0		$0		($1,588,000)		$0		$0
Total Mental Health Capitation Payments	**598,322**	**$269,717,196**	**664,441**	**$312,017,910**	**657,802**	**$311,570,590**	**(6,639)**	**($447,320)**	**712,810**	**$347,855,029**	**55,008**	**$36,284,439**	**48,369**	**$35,837,119**	**748,740**	**$381,272,451**	**35,930**	**$33,417,422**
Incremental Percent Change							**-1.00%**	**-0.14%**			8.36%	11.65%	7.28%	11.49%			5.04%	9.61%
Mental Health Fee-for Service-Payments																		
Inpatient Services		$632,150		$678,379		$694,994		$16,615		$767,595		$72,601		$89,216		$791,073		$23,478
Outpatient Services		$3,064,324		$3,288,417		$3,368,955		$80,538		$3,720,885		$351,930		$432,468		$3,834,695		$113,810
Physician Services		$168,509		$180,832		$185,261		$4,429		$204,614		$19,353		$23,782		$210,872		$6,258
Total Mental Health Fee-for-Service Payments		**$3,864,984**		**$4,147,628**		**$4,249,210**		**$101,582**		**$4,693,094**		**$443,884**		**$545,466**		**$4,836,640**		**$143,546**
Total Mental Health Community Programs		**$273,582,180**		**$316,165,538**		**$315,819,800**		**($345,738)**		**$352,548,123**		**$36,728,323**		**$36,382,585**		**$386,109,091**		**$33,560,968**
Incremental Percent Change								-0.11%				11.63%		11.51%				9.52%

[1] Date of death retractions are already included in FY 2011-12 actual expenditure figures; the total amount of retractions is presented here for informational purposes.

Exhibit DD - Medicaid Mental Health Community Programs, Caseload

Medicaid Mental Health Community Programs Average Monthly Caseload

Item	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/ BC)	Foster Care	Breast and Cervical Cancer Program	TOTAL MENTAL HEALTH
FY 2006-07 Actuals	35,888	54,858	61,031	-	205,390	16,724	228	374,119
FY 2007-08 Actuals	36,284	56,079	59,761	-	204,022	17,141	270	373,557
% Change from FY 2006-07	1.10%	2.23%	-2.08%	-	-0.67%	2.49%	18.42%	-0.15%
FY 2008-09 Actuals	37,619	57,802	68,850	-	235,129	18,033	317	417,750
% Change from FY 2007-08	3.68%	3.07%	15.21%	-	15.25%	5.20%	17.41%	11.83%
FY 2009-10 Actuals	38,487	60,313	85,907	-	275,672	18,381	425	479,185
% Change from FY 2008-09	2.31%	4.34%	24.77%	-	17.24%	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,921	64,052	116,149	-	302,410	18,393	531	540,456
% Change from FY 2009-10	1.13%	6.20%	35.20%	-	9.70%	0.07%	24.94%	12.79%
FY 2011-12 Actuals	39,740	67,869	136,315	1,134	334,633	18,034	597	598,322
% Change from FY 2010-11	2.10%	5.96%	17.36%	-	10.66%	-1.95%	12.43%	10.71%
FY 2012-13 Projection	40,364	72,197	152,840	10,000	363,786	17,994	621	657,802
% Change from FY 2011-12	1.57%	6.38%	12.12%	782.00%	8.71%	-0.22%	4.02%	9.94%
FY 2013-14 Projection	41,195	77,441	164,051	10,000	401,411	18,057	655	712,810
% Change from FY 2012-13	2.06%	7.26%	7.34%	0.00%	10.34%	0.35%	5.48%	8.36%
FY 2014-15 Projection	42,081	82,124	168,739	10,000	426,907	18,209	680	748,740
% Change from FY 2013-14	2.15%	6.05%	2.86%	0.00%	6.35%	0.84%	3.82%	5.04%
FY 2012-13 Appropriation	40,820	73,254	153,880	10,000	367,649	18,159	679	664,441
Difference between the FY 2012-13 Appropriation and the FY 2012-13 Projection	(456)	(1,057)	(1,040)	0	(3,863)	(165)	(58)	(6,639)

Expanded Medicaid Average Monthly Caseload for Mental Health Community Programs

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB) [1]	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Baby Care Program-Adults	Adults without Dependent Children	Eligible Children (AFDC-C/ BC)	Foster Care	Breast and Cervical Cancer Program	TOTAL MENTAL HEALTH
FY 2006-07 Actuals	35,888	6,059	48,799	50,687	5,162	-	5,182	-	205,390	16,724	228	374,119
FY 2007-08 Actuals	36,284	6,146	49,933	44,555	8,918	-	6,288	-	204,022	17,141	270	373,557
% Change from FY 2006-07	1.10%	1.44%	2.32%	-12.10%	100.00%	0.00%	21.34%	-	-0.67%	2.49%	18.42%	-0.15%
FY 2008-09 Actuals	37,619	6,447	51,355	49,147	12,727	-	6,976	-	235,129	18,033	317	417,750
% Change from FY 2007-08	3.68%	4.90%	2.85%	10.31%	42.71%	0.00%	10.94%	-	15.25%	5.20%	17.41%	11.83%
FY 2009-10 Actuals	38,487	7,049	53,264	57,661	17,178	3,238	7,830	-	275,672	18,381	425	479,185
% Change from FY 2008-09	2.31%	9.34%	3.72%	17.32%	34.97%	0.00%	12.24%	-	17.24%	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,921	7,767	56,285	60,960	20,154	27,167	7,868	-	302,410	18,393	531	540,456
% Change from FY 2009-10	1.13%	10.19%	5.67%	5.72%	17.32%	100.00%	0.49%	-	9.70%	0.07%	24.94%	12.79%
FY 2011-12 Actuals	39,740	8,383	59,486	68,689	24,535	35,461	7,630	1,134	334,633	18,034	597	598,322
% Change from FY 2010-11	2.10%	7.93%	5.69%	12.68%	21.74%	30.53%	-3.02%	-	10.66%	-1.95%	12.43%	10.71%
FY 2012-13 Projection	40,364	8,874	63,323	73,483	28,615	42,531	8,211	10,000	363,786	17,994	621	657,802
% Change from FY 2011-12	1.57%	5.86%	6.45%	6.98%	16.63%	19.94%	7.62%	781.83%	8.71%	-0.22%	4.02%	9.94%
FY 2013-14 Projection	41,195	9,356	68,085	77,326	30,573	47,351	8,801	10,000	401,411	18,057	655	712,810
% Change from FY 2012-13	2.06%	5.43%	7.52%	5.23%	6.84%	11.33%	7.18%	0.00%	10.34%	0.35%	5.48%	8.36%
FY 2014-15 Projection	42,081	9,822	72,302	78,958	31,414	49,210	9,157	10,000	426,907	18,209	680	748,740
% Change from FY 2013-14	2.15%	4.98%	6.19%	2.11%	2.75%	3.93%	4.04%	0.00%	6.35%	0.84%	3.82%	5.04%
FY 2012-13 Appropriation	40,820	8,948	64,306	77,455	26,498	42,381	7,546	10,000	367,649	18,159	679	664,441
Difference between the FY 2012-13 Appropriation and the FY 2012-13 Projection	(456)	(74)	(983)	(3,972)	2,117	150	665	0	(3,863)	(165)	(58)	(6,639)

[1] The caseload for disabled individuals to 59 includes the disabled buy-in population funded by the Hospital Provider Fee Cash Fund. This expansion took effect in FY 2011-12 Q3 & Q4.

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

Mental Health Capitation Payments Per Capita History

Item	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/ BC)	Foster Care	Breast and Cervical Cancer Program	TOTAL PER CAPITA
FY 2007-08 Actuals	$159.45	$1,473.28	$243.04	-	$184.13	$3,235.25	$222.88	$494.28
FY 2008-09 Actuals	$163.48	$1,593.93	$247.30	-	$185.92	$3,147.83	$230.52	$469.21
% Change from FY 2007-08	2.53%	8.19%	1.75%	-	0.97%	-2.70%	3.43%	-5.07%
FY 2009-10 Actuals	$148.47	$1,632.73	$247.36	-	$180.47	$2,792.78	$230.48	$450.48
% Change from FY 2008-09	-9.18%	2.43%	0.02%	-	-2.93%	-11.28%	-0.02%	-3.99%
FY 2010-11 Actuals	$160.97	$1,757.63	$268.13	-	$191.64	$2,341.69	$253.28	$464.69
% Change from FY 2009-10	8.42%	7.65%	8.40%	-	6.19%	-16.15%	9.89%	3.15%
FY 2011-12 Actuals	$163.61	$1,780.77	$273.65	$80.46	$202.54	$2,152.46	$264.78	$453.78
% Change from FY 2010-11	1.64%	1.32%	2.06%	-	5.69%	-8.08%	4.54%	-2.35%
FY 2012-13 Projection	$161.95	$1,829.71	$286.21	$1,347.14	$218.57	$2,070.55	$286.40	$475.52
% Change from FY 2011-12	-1.01%	2.75%	4.59%	100.00%	7.91%	-3.81%	8.17%	4.79%
FY 2013-14 Projection	$167.18	$1,940.64	$296.90	$1,409.93	$229.79	$2,038.73	$296.66	$489.93
% Change from FY 2012-13	3.23%	6.06%	3.74%	4.66%	5.13%	-1.54%	3.58%	3.03%
FY 2014-15 Projection	$172.56	$2,052.86	$307.83	$1,475.33	$241.71	$2,023.18	$307.23	$511.24
% Change from FY 2013-14	1.11%	4.41%	4.17%	52.33%	6.52%	-2.68%	5.88%	3.91%

Expanded Medicaid Per Capita Summary for Mental Health Capitation Payments

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Baby Care Program-Adults	Adults without Dependent Children	Eligible Children (AFDC-C/ BC)	Foster Care	Breast and Cervical Cancer Program	TOTAL PER CAPITA
FY 2007-08 Actuals	$159.45	$1,400.04	$1,482.29	$245.09	$238.32	-	$235.19	-	$184.13	$3,235.25	$222.88	$494.28
FY 2008-09 Actuals	$163.48	$1,511.57	$1,604.27	$252.17	$244.48	-	$218.14	-	$185.92	$3,147.83	$230.52	$469.21
% Change from FY 2007-08	2.53%	7.97%	8.23%	2.89%	2.58%	-	-7.25%	-	0.97%	-2.70%	3.43%	-5.07%
FY 2009-10 Actuals	$148.47	$1,537.50	$1,645.34	$253.36	$257.25	-	$201.68	-	$180.47	$2,792.78	$230.48	$450.48
% Change from FY 2008-09	-9.18%	1.72%	2.56%	0.47%	5.22%	-	-7.55%	-	-2.93%	-11.28%	-0.02%	-3.99%
FY 2010-11 Actuals	$160.97	$1,659.68	$1,771.15	$284.94	$218.34	$281.77	$218.28	-	$191.64	$2,341.69	$253.28	$464.69
% Change from FY 2009-10	8.42%	7.95%	7.65%	12.46%	-15.13%	-	8.23%	-	6.19%	-16.15%	9.89%	3.15%
FY 2011-12 Actuals	$163.61	$1,695.05	$1,792.85	$271.33	$276.12	$285.90	$229.60	$80.46	$202.54	$2,152.46	$264.78	$453.78
% Change from FY 2010-11	1.64%	2.13%	1.23%	-4.78%	26.46%	1.47%	5.19%	-	5.69%	-8.08%	4.54%	-2.35%
FY 2012-13 Projection	$161.95	$1,829.71	$1,829.71	$286.21	$286.21	$286.21	$286.21	$1,347.14	$218.57	$2,070.55	$286.40	$475.52
% Change from FY 2011-12	-1.01%	7.94%	2.06%	5.48%	3.65%	0.11%	24.66%	1574.30%	7.91%	-3.81%	8.17%	4.79%
FY 2013-14 Projection	$167.18	$1,940.64	$1,940.64	$296.90	$296.90	$296.90	$296.90	$1,409.93	$229.79	$2,038.73	$296.66	$489.93
% Change from FY 2012-13	3.23%	6.06%	6.06%	3.74%	3.74%	3.74%	3.74%	4.66%	5.13%	-1.54%	3.58%	3.03%
FY 2014-15 Projection	$172.56	$2,052.86	$2,052.86	$307.83	$307.83	$307.83	$307.83	$1,475.33	$241.71	$2,023.18	$307.23	$511.24
% Change from FY 2013-14	3.22%	5.78%	5.78%	3.68%	3.68%	3.68%	3.68%	4.64%	5.19%	-0.76%	3.56%	4.35%

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

Annual Total Expenditures

	Item	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Breast & Cervical Cancer Program	MENTAL HEALTH TOTAL
FY 2007-08	Capitations	$5,785,556	$82,620,046	$14,524,307	$0	$37,565,608	$55,455,338	$60,178	$196,011,033
	Fee-For-Service								
	Inpatient Services	$7,069	$221,467	$45,469	$0	$93,439	$46,660	$0	$414,104
	Outpatient Services	$12,721	$267,020	$231,300	$0	$282,037	$74,411	$0	$867,489
	Physician Services	$479	$32,552	$9,170	$0	$8,970	$2,972	$0	$54,143
	Sub-Total Fee-For-Service	$20,269	$521,039	$285,939	$0	$384,446	$124,043	$0	$1,335,736
	Total FY 2007-08 Expenditures	**$5,805,825**	**$83,141,085**	**$14,810,246**	**$0**	**$37,950,054**	**$55,579,381**	**$60,178**	**$197,346,769**
FY 2008-09	Capitations	$6,149,782	$92,132,599	$17,026,544	$0	$43,714,042	$56,764,896	$73,074	$215,860,937
	Fee-For-Service								
	Inpatient Services	$22,235	$331,864	$107,478	$0	$171,764	$8,913	$0	$642,254
	Outpatient Services	$9,657	$284,108	$300,557	$0	$364,710	$103,091	$0	$1,062,123
	Physician Services	$285	$37,367	$12,386	$0	$13,685	$8,153	$0	$71,876
	Sub-Total Fee-For-Service	$32,177	$653,339	$420,421	$0	$550,159	$120,157	$0	$1,776,253
	Total FY 2008-09 Expenditures	**$6,181,959**	**$92,785,938**	**$17,446,965**	**$0**	**$44,264,201**	**$56,885,053**	**$73,074**	**$217,637,190**
	% Change from FY 2007-08	**6.48%**	**11.60%**	**17.80%**	**0.00%**	**16.64%**	**2.35%**	**21.43%**	**10.28%**
FY 2009-10 [1]	Capitations	$5,714,066	$98,475,008	$21,250,051	$0	$49,749,580	$51,334,158	$97,955	$226,620,818
	Fee-For-Service								
	Inpatient Services	$36,707	$327,355	$24,703	$0	$184,094	$23,702	$0	$596,561
	Outpatient Services	$18,805	$528,618	$623,741	$0	$601,664	$139,423	$0	$1,912,251
	Physician Services	$61	$45,659	$6,543	$0	$22,296	$4,291	$0	$78,850
	Sub-Total Fee-For-Service	$55,573	$901,632	$654,987	$0	$808,054	$167,416	$0	$2,587,662
	Total FY 2009-10 Expenditures	**$5,769,639**	**$99,376,640**	**$21,905,038**	**$0**	**$50,557,634**	**$51,501,574**	**$97,955**	**$229,208,480**
	% Change from FY 2007-08	**-6.67%**	**7.10%**	**25.55%**	**0.00%**	**14.22%**	**-9.46%**	**34.05%**	**5.32%**
FY 2010-11 [1]	Capitations	$6,265,262	$112,579,810	$31,142,656	$0	$57,953,130	$43,070,676	$134,493	$251,146,027
	Fee-For-Service								
	Inpatient Services	$26,281	$462,018	$73,357	$0	$209,493	$31,297	$0	$802,447
	Outpatient Services	$19,668	$838,729	$1,066,059	$0	$843,338	$204,022	$0	$2,971,816
	Physician Services	$44	$53,652	$13,542	$0	$19,019	$10,074	$0	$96,331
	Sub-Total Fee-For-Service	$45,993	$1,354,399	$1,152,958	$0	$1,071,850	$245,393	$0	$3,870,594
	Total FY 2010-11 Expenditures	**$6,311,255**	**$113,934,209**	**$32,295,614**	**$0**	**$59,024,980**	**$43,316,069**	**$134,493**	**$255,016,621**
	% Change from FY 2009-10	**9.39%**	**14.65%**	**47.43%**	**0.00%**	**16.75%**	**-15.89%**	**37.30%**	**11.26%**
FY 2011-12	Capitations	$6,501,731	$120,858,807	$37,302,066	$91,244	$67,777,256	$38,817,457	$158,074	$271,506,635
	Fee-For-Service								
	Inpatient Services	$21,297	$355,817	$66,514	$0	$176,653	$11,869	$0	$632,150
	Outpatient Services	$19,808	$762,439	$1,230,908	$423	$894,312	$156,434	$0	$3,064,324
	Physician Services	$0	$49,001	$18,279	$0	$95,442	$5,786	$0	$168,509
	Sub-Total Fee-For-Service	$41,105	$1,167,257	$1,315,701	$423	$1,166,408	$174,089	$0	$3,864,984
	Total FY 2011-12 Expenditures	**$6,542,836**	**$122,026,064**	**$38,617,767**	**$91,667**	**$68,943,664**	**$38,991,546**	**$158,074**	**$275,371,619**
	% Change from FY 2010-11	**3.67%**	**7.10%**	**19.58%**	**0.00%**	**16.80%**	**-9.98%**	**17.53%**	**7.98%**

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

Exhibit DD - Medicaid Mental Health Community Programs Expenditures Historical Summary

Expanded Annual Total Expenditures

	Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Categorically Eligible Low-Income Adults (AFDC-A)	Expansion Adults to 60% FPL	Expansion Adults to 100% FPL	Baby Care Program-Adults	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Breast & Cervical Cancer Program	MENTAL HEALTH TOTAL
FY 2007-08	Capitations	$5,785,556	$8,604,645	$74,015,401	$10,920,110	$2,125,310	$0	$1,478,887	$0	$37,565,608	$55,455,338	$60,178	$184,640,568
	Fee-For-Service												
	Inpatient Services	$7,069	$13,110	$208,357	$36,603	$8,866	$0	$0	$0	$93,439	$46,660	$0	$414,104
	Outpatient Services	$12,721	$14,262	$252,758	$181,408	$43,943	$0	$5,949	$0	$282,037	$74,411	$0	$867,489
	Physician Services	$479	$2,275	$30,277	$6,235	$1,510	$0	$1,425	$0	$8,970	$2,972	$0	$54,143
	Sub-Total Fee-For-Service	$20,269	$29,647	$491,392	$224,245	$54,320	$0	$7,374	$0	$384,446	$124,043	$0	$1,335,736
	Total FY 2007-08 Expenditures	**$5,805,825**	**$8,634,292**	**$74,506,793**	**$11,144,355**	**$2,179,630**	**$0**	**$1,486,261**	**$0**	**$37,950,054**	**$55,579,381**	**$60,178**	**$197,346,769**
FY 2008-09	Capitations	$6,149,782	$9,745,116	$82,387,483	$12,393,351	$3,111,446	$0	$1,521,747	$0	$43,714,042	$56,764,896	$73,074	$196,011,033
	Fee-For-Service												
	Inpatient Services	$22,235	$9,653	$322,211	$85,371	$22,107	$0	$0	$0	$171,764	$8,913	$0	$642,254
	Outpatient Services	$9,657	$19,613	$264,495	$231,456	$59,937	$0	$9,164	$0	$364,710	$103,091	$0	$1,062,123
	Physician Services	$285	$1,580	$35,787	$8,969	$1,904	$0	$1,513	$0	$13,685	$8,153	$0	$71,876
	Sub-Total Fee-For-Service	$32,177	$30,846	$622,493	$325,796	$83,948	$0	$10,677	$0	$550,159	$120,157	$0	$1,776,253
	Total FY 2008-09 Expenditures	**$6,181,959**	**$9,775,962**	**$83,009,976**	**$12,719,147**	**$3,195,394**	**$0**	**$1,532,424**	**$0**	**$44,264,201**	**$56,885,053**	**$73,074**	**$217,637,190**
	% Change from FY 2007-08	**6.48%**	**13.22%**	**11.41%**	**14.13%**	**100.00%**	**0.00%**	**3.11%**	**0.00%**	**16.64%**	**2.35%**	**21.43%**	**10.28%**
FY 2009-10 [1]	Capitations	$5,714,066	$10,837,828	$87,637,180	$14,608,762	$4,419,081	$643,078	$1,579,130	$0	$49,749,580	$51,334,158	$97,955	$215,860,937
	Fee-For-Service												
	Inpatient Services	$36,707	$0	$327,355	$18,244	$5,435	$1,024	$0	$0	$184,094	$23,702	$0	$596,561
	Outpatient Services	$18,805	$35,433	$493,185	$443,259	$132,053	$24,891	$23,538	$0	$601,664	$139,423	$0	$1,912,251
	Physician Services	$61	$631	$45,028	$3,657	$1,090	$205	$1,591	$0	$22,296	$4,291	$0	$78,850
	Sub-Total Fee-For-Service	$55,573	$36,064	$865,568	$465,160	$138,578	$26,120	$25,129	$0	$808,054	$167,416	$0	$2,587,662
	Total FY 2009-10 Expenditures	**$5,769,639**	**$10,873,892**	**$88,502,748**	**$15,073,922**	**$4,557,659**	**$669,198**	**$1,604,259**	**$0**	**$50,557,634**	**$51,501,574**	**$97,955**	**$229,208,480**
	% Change from FY 2008-09	**-6.67%**	**11.23%**	**6.62%**	**18.51%**	**42.63%**	**0.00%**	**4.69%**	**0.00%**	**14.22%**	**-9.46%**	**34.05%**	**5.32%**
FY 2010-11 [1]	Capitations	$6,265,262	$12,890,748	$99,689,062	$17,369,817	$4,400,500	$7,654,920	$1,717,419	$0	$57,953,130	$43,070,676	$134,493	$251,146,027
	Fee-For-Service												
	Inpatient Services	$26,281	$0	$462,018	$41,298	$13,654	$18,405	$0	$0	$209,493	$31,297	$0	$802,447
	Outpatient Services	$19,668	$54,047	$784,682	$584,992	$193,410	$260,702	$26,955	$0	$843,338	$204,022	$0	$2,971,816
	Physician Services	$44	$559	$53,093	$6,489	$2,145	$2,892	$2,017	$0	$19,019	$10,074	$0	$96,331
	Sub-Total Fee-For-Service	$45,993	$54,606	$1,299,792	$632,779	$209,209	$281,999	$28,972	$0	$1,071,850	$245,393	$0	$3,870,594
	Total FY 2010-11 Expenditures	**$6,311,255**	**$12,945,354**	**$100,988,854**	**$18,002,596**	**$4,609,709**	**$7,936,919**	**$1,746,391**	**$0**	**$59,024,980**	**$43,316,069**	**$134,493**	**$255,016,621**
	% Change from FY 2009-10	**9.39%**	**19.05%**	**14.11%**	**19.43%**	**1.14%**	**100.00%**	**8.86%**	**0.00%**	**16.75%**	**-15.89%**	**37.30%**	**11.26%**
FY 2011-12	Capitations	$6,501,731	$14,209,564	$106,649,243	$18,637,481	$6,774,573	$10,138,129	$1,751,883	$91,244	$67,777,256	$38,817,457	$158,074	$271,506,635
	Fee-For-Service												
	Inpatient Services	$21,297	$12,590	$343,228	$35,504	$12,681	$18,329	$0	$0	$176,653	$11,869	$0	$632,150
	Outpatient Services	$19,808	$66,220	$696,219	$643,536	$229,865	$332,229	$25,278	$423	$894,312	$156,434	$0	$3,064,324
	Physician Services	$0	$580	$48,421	$9,138	$3,264	$4,718	$1,159	$0	$95,442	$5,786	$0	$168,509
	Sub-Total Fee-For-Service	$41,105	$79,389	$1,087,868	$688,177	$245,810	$355,276	$26,438	$423	$1,166,408	$174,089	$0	$3,864,984
	Total FY 2011-12 Expenditures	**$6,542,836**	**$14,288,953**	**$107,737,111**	**$19,325,658**	**$7,020,383**	**$10,493,405**	**$1,778,321**	**$91,667**	**$68,943,664**	**$38,991,546**	**$158,074**	**$275,371,619**
	% Change from FY 2010-11	**3.67%**	**10.38%**	**6.68%**	**7.35%**	**52.30%**	**32.21%**	**1.83%**	**0.00%**	**16.80%**	**-9.98%**	**17.53%**	**7.98%**

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

Exhibit EE - Expenditure Calculations by Eligibility Category

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

FY 2012-13 Q1 and Q2 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children (3)	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Weighted Capitation Rate	$13.53	$149.99	$23.53	$109.87	$17.80	$174.33	$23.53	
Estimated Monthly Caseload (1)	40,160	70,844	149,045	10,000	356,122	17,997	614	644,782
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Costs for FY 2012-13 Q1 and Q2 Capitated Payments	$3,260,189	$63,755,349	$21,042,173	$6,592,200	$38,033,830	$18,824,502	$86,685	$151,594,928
Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	97.99%	93.83%	95.21%	98.00%	96.77%	99.03%	98.92%	
Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,194,659	$59,821,644	$20,034,253	$6,460,356	$36,805,337	$18,641,904	$85,749	$145,043,902
Expenditures for Prior Period Dates of Service	$65,173	$3,275,841	$918,593	$129,207	$1,142,714	$187,702	$868	$5,720,098
Total Expenditures in FY 2012-13 Q1 and Q2	**$3,259,832**	**$63,097,485**	**$20,952,846**	**$6,589,563**	**$37,948,051**	**$18,829,606**	**$86,617**	**$150,764,000**

FY 2012-13 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$13.93	$158.51	$24.37	$114.96	$18.71	$170.80	$24.37	
Estimated Monthly Caseload (1)	40,566	73,550	156,634	10,000	371,450	17,991	629	670,820
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2012-13 Q3 and Q4 Capitated Payments	$3,390,506	$69,950,463	$22,903,023	$6,897,600	$41,698,977	$18,437,177	$91,972	$163,369,718
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	97.99%	93.83%	95.21%	98.00%	96.77%	99.03%	98.92%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,322,357	$65,634,519	$21,805,968	$6,759,648	$40,352,100	$18,258,336	$90,979	$156,223,907
Estimated Expenditures for Prior Period Dates of Service	$65,404	$3,823,542	$995,900	$131,844	$1,218,541	$182,691	$934	$6,418,856
Total Estimated Expenditures in FY 2012-13 Q3 and Q4	**$3,387,761**	**$69,458,061**	**$22,801,868**	**$6,891,492**	**$41,570,641**	**$18,441,027**	**$91,913**	**$162,642,763**
Total Estimated FY 2012-13 Expenditures	**$6,647,593**	**$132,555,546**	**$43,754,714**	**$13,481,055**	**$79,518,692**	**$37,270,633**	**$178,530**	**$313,406,763**
Estimated Date of Death Retractions	($110,487)	($456,104)	($9,692)	($9,692)	($5,560)	($13,107)	($673)	($605,315)
Total Estimated FY 2012-13 Expenditures Including Date of Death Retractions	**$6,537,106**	**$132,099,442**	**$43,745,022**	**$13,471,363**	**$79,513,132**	**$37,257,526**	**$177,857**	**$312,801,448**
Estimated FY 2012-13 Monthly Caseload	40,364	72,197	152,840	10,000	363,786	17,994	621	657,802
Estimated FY 2012-13 Per Capita Expenditure	**$161.95**	**$1,829.71**	**$286.21**	**$1,347.14**	**$218.57**	**$2,070.55**	**$286.40**	**$475.52**

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

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

[3] The estimate of percentage of claims paid in current period with current period date of service for adults without dependent children cannot be calculated with the incurred but not reported methodology which is used in all other eligibility categories because of insufficient periods of observation. Instead the Department chose 98% for FY 2012-13 Q1 and Q2 and onward because the population is capped below its natural level due to financial constraints and the turnaround between disenrollment and enrollment is rapid which suggests that the IBNR factor should be high. Some amount of run out was allowed for conservativeness sake. These assumptions will be revisited once IBNR data becomes available.

Exhibit EE - Expenditure Calculations by Eligibility Category

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

FY 2013-14 Q1 and Q2 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children (3)	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$13.93	$158.51	$24.37	$114.96	$18.71	$170.80	$24.37	
Estimated Monthly Caseload (1)	40,982	76,130	162,141	10,000	390,844	18,028	646	698,771
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2013-14 Q1 and Q2 Capitated Payments	$3,425,276	$72,404,198	$23,708,257	$6,897,600	$43,876,147	$18,475,094	$94,458	$168,881,030
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	97.99%	93.83%	95.21%	98.00%	96.77%	99.03%	98.92%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,356,428	$67,936,859	$22,572,631	$6,759,648	$42,458,947	$18,295,886	$93,438	$161,473,837
Estimated Expenditures for Prior Period Dates of Service	$67,641	$4,135,193	$1,084,029	$137,952	$1,330,018	$180,196	$992	$6,936,021
Total Estimated Expenditures in FY 2013-14 Q1 and Q2	**$3,424,069**	**$72,072,052**	**$23,656,660**	**$6,897,600**	**$43,788,965**	**$18,476,082**	**$94,430**	**$168,409,858**

FY 2013-14 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children (3)	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$14.35	$167.52	$25.24	$120.28	$19.67	$169.08	$25.24	
Estimated Monthly Caseload (1)	41,408	78,752	165,961	10,000	411,977	18,086	664	726,848
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2013-14 Q3 and Q4 Capitated Payments	$3,565,229	$79,155,210	$25,133,134	$7,216,800	$48,621,526	$18,347,885	$100,556	$182,140,340
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	97.99%	93.83%	95.21%	98.00%	96.77%	99.03%	98.92%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,493,568	$74,271,334	$23,929,257	$7,072,464	$47,051,051	$18,169,911	$99,470	$174,087,055
Estimated Expenditures for Prior Period Dates of Service	$68,712	$4,352,379	$1,129,989	$137,952	$1,407,184	$179,076	$1,020	$7,276,312
Total Estimated Expenditures in FY 2013-14 Q3 and Q4	**$3,562,280**	**$78,623,713**	**$25,059,246**	**$7,210,416**	**$48,458,235**	**$18,348,987**	**$100,490**	**$181,363,367**
Total Estimated FY 2013-14 Expenditures	**$6,986,349**	**$150,695,765**	**$48,715,906**	**$14,108,016**	**$92,247,200**	**$36,825,069**	**$194,920**	**$349,773,225**
Estimated Date of Death Retractions	($99,438)	($410,494)	($8,723)	($8,723)	($5,004)	($11,796)	($605)	($544,783)
Total Estimated FY 2013-14 Expenditures Including Date of Death Retractions	**$6,886,911**	**$150,285,271**	**$48,707,183**	**$14,099,293**	**$92,242,196**	**$36,813,273**	**$194,315**	**$349,228,442**
Estimated FY 2013-14 Monthly Caseload	41,195	77,441	164,051	10,000	401,411	18,057	655	712,810
Estimated FY 2013-14 Per Capita Expenditure	**$167.18**	**$1,940.64**	**$296.90**	**$1,409.93**	**$229.79**	**$2,038.73**	**$296.66**	**$489.93**

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

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

[3] The estimate of percentage of claims paid in current period with current period date of service for adults without dependent children cannot be calculated with the incurred but not reported methodology which is used in all other eligibility categories because of insufficient periods of observation. Instead the Department chose 98% for FY 2012-13 Q1 and Q2 and onward because the population is capped below its natural level due to financial constraints and the turnaround between disenrollment and enrollment is rapid which suggests that the IBNR factor should be high. Some amount of run out was allowed for conservativeness sake. These assumptions will be revisited once IBNR data becomes available.

Mental Health Capitation Calculations by Eligibility Category for FY 2014-15

FY 2014-15 Q1 and Q2 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children (3)	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$14.35	$167.52	$25.24	$120.28	$19.67	$169.08	$25.24	
Estimated Monthly Caseload (1)	41,855	80,984	168,201	10,000	424,199	18,163	676	744,078
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2014-15 Q1 and Q2 Capitated Payments	$3,603,716	$81,398,638	$25,472,359	$7,216,800	$50,063,966	$18,426,000	$102,373	$186,283,852
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	97.99%	93.83%	95.21%	98.00%	96.77%	99.03%	98.92%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,531,281	$76,376,342	$24,252,233	$7,072,464	$48,446,900	$18,247,268	$101,267	$178,027,755
Estimated Expenditures for Prior Period Dates of Service	$71,116	$4,685,775	$1,193,903	$144,336	$1,548,646	$178,420	$1,084	$7,823,280
Total Estimated Expenditures in FY 2014-15 Q1 and Q2	**$3,602,397**	**$81,062,117**	**$25,446,136**	**$7,216,800**	**$49,995,546**	**$18,425,688**	**$102,351**	**$185,851,035**

FY 2014-15 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults	Adults without Dependent Children (3)	Eligible Children (AFDC-C/BC)	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$14.78	$177.04	$26.15	$125.85	$20.68	$168.23	$26.15	
Estimated Monthly Caseload (1)	42,306	83,263	169,276	10,000	429,614	18,254	683	753,396
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2014-15 Q3 and Q4 Capitated Payments	$3,751,696	$88,445,289	$26,559,404	$7,551,000	$53,306,505	$18,425,223	$107,163	$198,146,280
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service (2)	97.99%	93.83%	95.21%	98.00%	96.77%	99.03%	98.92%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,676,287	$82,988,215	$25,287,209	$7,399,980	$51,584,705	$18,246,498	$106,006	$189,288,900
Estimated Expenditures for Prior Period Dates of Service	$72,284	$4,908,386	$1,217,751	$144,336	$1,610,431	$178,459	$1,105	$8,132,752
Total Estimated Expenditures in FY 2014-15 Q3 and Q4	**$3,748,571**	**$87,896,601**	**$26,504,960**	**$7,544,316**	**$53,195,136**	**$18,424,957**	**$107,111**	**$197,421,652**
Total Estimated FY 2014-15 Expenditures	**$7,350,968**	**$168,958,718**	**$51,951,096**	**$14,761,116**	**$103,190,682**	**$36,850,645**	**$209,462**	**$383,272,687**
Estimated Date of Death Retractions	($89,494)	($369,445)	($7,851)	($7,851)	($4,504)	($10,616)	($545)	($490,306)
Total Estimated FY 2014-15 Expenditures Including Date of Death Retractions	**$7,261,474**	**$168,589,273**	**$51,943,245**	**$14,753,265**	**$103,186,178**	**$36,840,029**	**$208,917**	**$382,782,381**
Estimated FY 2014-15 Monthly Caseload	42,081	82,124	168,739	10,000	426,907	18,209	680	748,740
Estimated FY 2014-15 Per Capita Expenditure	**$172.56**	**$2,052.86**	**$307.83**	**$1,475.33**	**$241.71**	**$2,023.18**	**$307.23**	**$511.24**

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

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

[3] The estimate of percentage of claims paid in current period with current period date of service for adults without dependent children cannot be calculated with the incurred but not reported methodology which is used in all other eligibility categories because of insufficient periods of observation. Instead the Department chose 98% for FY 2012-13 Q1 and Q2 and onward because the population is capped below its natural level due to financial constraints and the turnaround between disenrollment and enrollment is rapid which suggests that the IBNR factor should be high. Some amount of run out was allowed for conservativeness sake. These assumptions will be revisited once IBNR data becomes available.

Exhibit EE - Incurred But Not Reported Runout by Fiscal Period

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	*0.39%*	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	*1.62%*	0.39%	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	*97.99%*	1.62%	0.39%	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	97.99%	1.62%	0.39%	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	97.99%	1.62%	0.39%	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	97.99%	1.62%	0.39%
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	97.99%	1.62%
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	97.99%

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	*1.83%*	0.81%	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	*3.53%*	1.83%	0.81%	-	-	-
Incurred in FY 2012-13 Q1 and Q2	*93.83%*	3.53%	1.83%	0.81%	-	-
Incurred in FY 2012-13 Q3 and Q4	-	93.83%	3.53%	1.83%	0.81%	-
Incurred in FY 2013-14 Q1 and Q2	-	-	93.83%	3.53%	1.83%	0.81%
Incurred in FY 2013-14 Q3 and Q4	-	-	-	93.83%	3.53%	1.83%
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	93.83%	3.53%
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	93.83%

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	*0.70%*	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	*4.09%*	0.70%	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	*95.21%*	4.09%	0.70%	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	95.21%	4.09%	0.70%	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	95.21%	4.09%	0.70%	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	95.21%	4.09%	0.70%
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	95.21%	4.09%
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	95.21%

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	*0.00%*	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	*2.00%*	0.00%	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	*98.00%*	2.00%	0.00%	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	98.00%	2.00%	0.00%	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	98.00%	2.00%	0.00%	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	98.00%	2.00%	0.00%
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	98.00%	2.00%
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	98.00%

Exhibit EE - Incurred But Not Reported Runout by Fiscal Period

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	*0.46%*	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	*2.77%*	0.46%	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	*96.77%*	2.77%	0.46%	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	96.77%	2.77%	0.46%	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	96.77%	2.77%	0.46%	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	96.77%	2.77%	0.46%
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	96.77%	2.77%
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	96.77%

Incurred But Not Reported (IBNR) Estimate for Foster Care

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	*0.35%*	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	*0.62%*	0.35%	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	*99.03%*	0.62%	0.35%	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	99.03%	0.62%	0.35%	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	99.03%	0.62%	0.35%	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	99.03%	0.62%	0.35%
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	99.03%	0.62%
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	99.03%

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	*0.03%*	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	*1.05%*	0.03%	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	*98.92%*	1.05%	0.03%	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	98.92%	1.05%	0.03%	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	98.92%	1.05%	0.03%	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	98.92%	1.05%	0.03%
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	98.92%	1.05%
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	98.92%

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	$12,881	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	$52,292	$12,589	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	$3,194,659	$52,815	$12,715	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	$3,322,357	$54,926	$13,223	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	$3,356,428	$55,489	$13,359	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	$3,493,568	$57,757	$13,904
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	$3,531,281	$58,380
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	$3,676,287
Total Paid in Current Period	$3,194,659	$3,322,357	$3,356,428	$3,493,568	$3,531,281	$3,676,287
Total IBNR Amount	$65,173	$65,404	$67,641	$68,712	$71,116	$72,284
Total Paid for All Incurred Dates	$3,259,832	$3,387,761	$3,424,069	$3,562,280	$3,602,397	$3,748,571

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	$1,100,232	$445,113	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	$2,175,609	$1,127,865	$499,219	-	-	-
Incurred in FY 2012-13 Q1 and Q2	$59,821,644	$2,250,564	$1,166,723	$516,418	-	-
Incurred in FY 2012-13 Q3 and Q4	-	$65,634,519	$2,469,251	$1,280,093	$566,599	-
Incurred in FY 2013-14 Q1 and Q2	-	-	$67,936,859	$2,555,868	$1,324,997	$586,474
Incurred in FY 2013-14 Q3 and Q4	-	-	-	$74,271,334	$2,794,179	$1,448,540
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	$76,376,342	$2,873,372
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	$82,988,215
Total Paid in Current Period	$59,821,644	$65,634,519	$67,936,859	$74,271,334	$76,376,342	$82,988,215
Total IBNR Amount	$3,275,841	$3,823,542	$4,135,193	$4,352,379	$4,685,775	$4,908,386
Total Paid for All Incurred Dates	$63,097,485	$69,458,061	$72,072,052	$78,623,713	$81,062,117	$87,896,601

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	$128,201	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	$790,392	$135,275	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	$20,034,253	$860,625	$147,295	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	$21,805,968	$936,734	$160,321	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	$22,572,631	$969,668	$165,958	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	$23,929,257	$1,027,945	$175,932
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	$24,252,233	$1,041,819
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	$25,287,209
Total Paid in Current Period	$20,034,253	$21,805,968	$22,572,631	$23,929,257	$24,252,233	$25,287,209
Total IBNR Amount	$918,593	$995,900	$1,084,029	$1,129,989	$1,193,903	$1,217,751
Total Paid for All Incurred Dates	$20,952,846	$22,801,868	$23,656,660	$25,059,246	$25,446,136	$26,504,960

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	$0	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	$129,207	$0	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	$6,460,356	$131,844	$0	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	$6,759,648	$137,952	$0	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	$6,759,648	$137,952	$0	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	$7,072,464	$144,336	$0
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	$7,072,464	$144,336
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	$7,399,980
Total Paid in Current Period	$6,460,356	$6,759,648	$6,759,648	$7,072,464	$7,072,464	$7,399,980
Total IBNR Amount	$129,207	$131,844	$137,952	$137,952	$144,336	$144,336
Total Paid for All Incurred Dates	$6,589,563	$6,891,492	$6,897,600	$7,210,416	$7,216,800	$7,544,316

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	$149,104	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	$993,610	$165,004	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	$36,805,337	$1,053,537	$174,956	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	$40,352,100	$1,155,062	$191,815	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	$42,458,947	$1,215,369	$201,830	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	$47,051,051	$1,346,816	$223,659
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	$48,446,900	$1,386,772
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	$51,584,705
Total Paid in Current Period	$36,805,337	$40,352,100	$42,458,947	$47,051,051	$48,446,900	$51,584,705
Total IBNR Amount	$1,142,714	$1,218,541	$1,330,018	$1,407,184	$1,548,646	$1,610,431
Total Paid for All Incurred Dates	$37,948,051	$41,570,641	$43,788,965	$48,458,235	$49,995,546	$53,195,136

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Foster Care

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	$70,824	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	$116,878	$65,979	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	$18,641,904	$116,712	$65,886	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	$18,258,336	$114,310	$64,530	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	$18,295,886	$114,546	$64,663	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	$18,169,911	$113,757	$64,218
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	$18,247,268	$114,241
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	$18,246,498
Total Paid in Current Period	$18,641,904	$18,258,336	$18,295,886	$18,169,911	$18,247,268	$18,246,498
Total IBNR Amount	$187,702	$182,691	$180,196	$179,076	$178,420	$178,459
Total Paid for All Incurred Dates	$18,829,606	$18,441,027	$18,476,082	$18,348,987	$18,425,688	$18,424,957

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

	Paid in FY 2012-13 Q1 and Q2	Paid in FY 2012-13 Q3 and Q4	Paid in FY 2013-14 Q1 and Q2	Paid in FY 2013-14 Q3 and Q4	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4
Incurred in all other previous periods	$24	-	-	-	-	-
Incurred in FY 2011-12 Q3 and Q4	$844	$24	-	-	-	-
Incurred in FY 2012-13 Q1 and Q2	$85,749	$910	$26	-	-	-
Incurred in FY 2012-13 Q3 and Q4	-	$90,979	$966	$28	-	-
Incurred in FY 2013-14 Q1 and Q2	-	-	$93,438	$992	$28	-
Incurred in FY 2013-14 Q3 and Q4	-	-	-	$99,470	$1,056	$30
Incurred in FY 2014-15 Q1 and Q2	-	-	-	-	$101,267	$1,075
Incurred in FY 2014-15 Q3 and Q4	-	-	-	-	-	$106,006
Total Paid in Current Period	$85,749	$90,979	$93,438	$99,470	$101,267	$106,006
Total IBNR Amount	$868	$934	$992	$1,020	$1,084	$1,105
Total Paid for All Incurred Dates	$86,617	$91,913	$94,430	$100,490	$102,351	$107,111

Exhibit FF - Medicaid Mental Health Retroactivity Adjustment

Fiscal Year		Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [1]	Adults without Dependent Children [3]	Eligible Children (AFDC-C/BC)	Foster Care
FY 2007-08	Average Monthly Claims	36,907	61,336	69,407	-	225,162	17,810
	Average Caseload	36,284	56,079	59,761	-	204,022	17,141
	Claims as a Percentage of Caseload	101.72%	109.37%	116.14%	-	110.36%	103.90%
FY 2008-09	Average Monthly Claims	37,865	62,496	77,211	-	251,445	18,597
	Average Caseload	37,619	57,802	68,850	-	235,129	18,033
	Claims as a Percentage of Caseload	100.65%	108.12%	112.14%	-	106.94%	103.13%
FY 2009-10	Average Monthly Claims	38,645	65,337	94,478	-	290,971	18,842
	Average Caseload	38,487	60,313	85,907	-	275,672	18,381
	Claims as a Percentage of Caseload	100.41%	108.33%	109.98%	-	105.55%	102.51%
FY 2010-11	Average Monthly Claims	38,950	68,948	127,050	-	323,344	18,794
	Average Caseload	38,921	64,052	116,149	-	302,410	18,393
	Claims as a Percentage of Caseload	100.07%	107.64%	109.39%	-	106.92%	102.18%
FY 2011-12	Estimated Average Monthly Claims	39,227	69,682	142,090	5,928	346,020	18,303
	Average Caseload	39,740	67,869	136,315	6,810	334,633	18,034
	Claims as a Percentage of Caseload	98.71%	102.67%	104.24%	87.05%	103.40%	101.49%
Weighted Average Claims as a Percentage of Caseload [2]		100.07%	107.64%	109.39%	-	106.92%	102.18%
Retroactivity Adjustment Factor		0.07%	7.64%	9.39%	9.39%	6.92%	2.18%

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

[2] The retroactivity adjustment captures the difference in total claims paid versus caseload due to retroactive eligibility. After analyzing the data and historical trends, the Department determined that the most recent year with adequate runout, which in this request is FY 2010-11, most accurately represents the relationship between average monthly claims and average caseload for all eligibility categories.

[3] The retroactivity adjustment factor for Adults without Dependent Children cannot be calculated in the same manner as the other categories because it does not have adequate runout. Therefore the Department has selected the Low Income Adults retroactivity adjustment factor for the Adults without Dependent Children factor because both eligibilities are determined strictly on level of income.

Exhibit FF - Medicaid Mental Health Partial Month Adjustment Multiplier

Fiscal Year		Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [(1)]	Adults without Dependent Children [(4)]	Eligible Children (AFDC-C/BC)	Foster Care
FY 2007-08	Weighted Claims-Based Rate	$13.07	$113.61	$17.48	-	$13.87	$260.01
	Weighted Capitation Rate	$13.15	$114.07	$17.51	-	$13.94	$262.46
	Claims as a Percentage of Capitation	99.36%	99.60%	99.84%	-	99.49%	99.07%
FY 2008-09	Weighted Claims-Based Rate	$13.49	$122.69	$18.40	-	$14.47	$253.56
	Weighted Capitation Rate (2)	$13.57	$123.19	$18.47	-	$14.57	$255.41
	Claims as a Percentage of Capitation	99.42%	99.59%	99.62%	-	99.34%	99.27%
FY 2009-10	Weighted Claims-Based Rate	$13.21	$127.20	$18.74	-	$14.21	$225.86
	Weighted Capitation Rate [(2)]	$13.29	$127.70	$18.82	-	$14.29	$227.45
	Claims as a Percentage of Capitation	99.40%	99.61%	99.56%	-	99.44%	99.30%
FY 2010-11	Weighted Claims-Based Rate	$13.51	$136.45	$20.56	-	$15.11	$191.24
	Weighted Capitation Rate [(2)]	$13.59	$136.98	$20.64	-	$15.19	$192.53
	Claims as a Percentage of Capitation	99.39%	99.61%	99.63%	-	99.45%	99.33%
FY 2011-12	Weighted Claims-Based Rate	$13.71	$139.16	$21.46	$100.81	$16.13	$176.70
	Weighted Capitation Rate	$13.77	$139.57	$21.51	$100.81	$16.20	$177.69
	Claims as a Percentage of Capitation	99.55%	99.71%	99.75%	100.00%	99.57%	99.44%
Average Claims as a Percentage of Capitation [(3)]		99.39%	99.61%	99.63%	-	99.45%	99.33%
Partial Month Adjustment Multiplier		-0.61%	-0.39%	-0.37%	-0.37%	-0.55%	-0.67%

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

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

[3] The partial month adjustment captures the difference in the amount paid per claim versus the capitation rate due to paying an adjusted rate for clients enrolled for only part of a month. After analyzing the data and historical trends, the Department determined that the most recent year with adequate runout, which in this request is FY 2010-11, most accurately represents the relationship between the claims-based rate and the capitation rate for all eligibility categories.

[4] The partial month adjustment factor for Adults without Dependent Children cannot be calculated in the same manner as the other categories because it does not have adequate runout. Therefore the Department has selected the Low Income Adults retroactivity adjustment factor for the Adults without Dependent Children factor because both eligibilities are determined strictly on level of income.

Exhibit GG - Medicaid Mental Health Capitation Rate Trends and Forecasts							
Capitation Rate Trends							
Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [1]	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care	Weighted Mental Health Total [2]
FY 2007-08 Actuals	**$13.15**	**$114.07**	**$17.51**	**-**	**$13.94**	**$262.46**	**$40.88**
FY 2008-09 Actuals [3]	**$13.37**	**$121.31**	**$18.18**	**-**	**$14.34**	**$251.88**	**$39.96**
% Change from FY 2007-08	1.67%	6.35%	3.83%	-	2.87%	-4.03%	-2.25%
FY 2009-10 Actuals [3]	**$13.40**	**$131.64**	**$19.33**	**-**	**$14.71**	**$220.67**	**$38.08**
% Change from FY 2008-09	0.22%	8.52%	6.33%	-	2.58%	-12.39%	-4.72%
FY 2010-11 Actuals [3]	**$13.80**	**$139.12**	**$20.94**	**-**	**$15.41**	**$195.38**	**$37.29**
% Change from FY 2009-10	2.99%	5.68%	8.33%	-	4.76%	-11.46%	-2.06%
FY 2011-12 Actuals	**$13.89**	**$140.77**	**$21.69**	**$100.81**	**$16.33**	**$179.29**	**$36.60**
% Change from FY 2010-11	0.65%	1.19%	3.58%	-	5.97%	-8.24%	-1.87%
FY 2012-13 Q1 and Q2 Known Rate	$13.60	$139.89	$21.59	$100.81	$16.74	$171.75	$36.84
% Change from FY 2011-12	-2.09%	-0.63%	-0.46%	0.00%	2.51%	-4.21%	0.66%
FY 2012-13 Q3 and Q4 Estimated Rate	$14.01	$147.84	$22.36	$105.48	$17.60	$168.28	$38.13
% Change from FY 2012-13 Q1 and Q2	3.01%	5.68%	3.57%	4.63%	5.14%	-2.02%	3.49%
% Change from FY 2011-12	0.86%	5.02%	3.09%	4.63%	7.78%	-6.14%	4.18%
FY 2012-13 Known Weighted Average Rate [4]	**$13.81**	**$143.94**	**$21.98**	**$103.15**	**$17.18**	**$170.02**	**$37.49**
% Change from FY 2011-12	-0.58%	2.25%	1.34%	2.32%	5.21%	-5.17%	2.44%
FY 2013-14 Q1 and Q2 Known Rate	$14.01	$147.84	$22.36	$105.48	$17.60	$168.28	$37.83
% Change from FY 2012-13 Q3 and Q4 Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.77%
% Change from FY 2012-13 Average Rate	1.45%	2.71%	1.73%	2.26%	2.44%	-1.02%	0.92%
FY 2013-14 Q3 and Q4 Estimated Rate	$14.43	$156.24	$23.16	$110.36	$18.50	$166.58	$39.22
% Change from FY 2013-14 Q1 and Q2 Rate	3.00%	5.68%	3.58%	4.63%	5.11%	-1.01%	3.66%
% Change from FY 2013-14 Average Rate	4.49%	8.55%	5.37%	6.99%	7.68%	-2.02%	4.61%
FY 2013-14 Estimated Weighted Average Rate [4]	**$14.22**	**$152.11**	**$22.76**	**$107.92**	**$18.06**	**$167.43**	**$38.54**
% Change from FY 2012-13 Average Rate	2.97%	5.68%	3.55%	4.62%	5.12%	-1.52%	2.80%
FY 2014-15 Q1 and Q2 Estimated Rate	$14.43	$156.24	$23.16	$110.36	$18.50	$166.58	$39.18
% Change from FY 2013-14 Q3 and Q4 Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.10%
% Change from FY 2013-14 Average Rate	1.48%	2.72%	1.76%	2.26%	2.44%	-0.51%	1.66%
FY 2014-15 Q3 and Q4 Estimated Rate	$14.86	$165.12	$23.99	$115.47	$19.45	$165.74	$41.16
% Change from FY 2014-15 Q1 and Q2 Rate	2.98%	5.68%	3.58%	4.63%	5.14%	-0.50%	5.05%
% Change from FY 2014-15 Average Rate	4.50%	8.55%	5.40%	7.00%	7.70%	-1.01%	6.79%
FY 2014-15 Estimated Weighted Average Rate [4]	**$14.65**	**$160.74**	**$23.58**	**$112.92**	**$18.98**	**$166.16**	**$40.18**
% Change from FY 2013-14 Average Rate	3.02%	5.67%	3.60%	4.63%	5.09%	-0.76%	4.25%

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

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

[3] The Department has adjusted the rates paid to the BHOs in FY 2008-09 through FY 2010-11 due to budget actions. The numbers provided, here, reflects the actuarial point estimates prior to budget actions and therefore do not match the numbers in Exhibit FF, which demonstrate the actual paid rates to the BHOs.

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

Exhibit HH - Forecast Model Comparisons - Final Forecasts
Adjustment Factors for Forecasted Rates

Model	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [1]	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care
FY 2012-13 Estimated Q1/Q2 Rate						
Weighted Capitation Point Estimate	***$13.60***	***$139.89***	***$21.59***	***$100.81***	***$16.74***	***$171.75***
Retroactivity Adjustment Multiplier (Exhibit FF)	0.07%	7.64%	9.39%	9.39%	6.92%	2.18%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.61%	-0.39%	-0.37%	-0.37%	-0.55%	-0.67%
Final Adjustment Factor [3]	**-0.54%**	**7.22%**	**8.99%**	**8.99%**	**6.33%**	**1.50%**
FY 2012-13 Final Paid Q1/Q2 Rate [2]	**$13.53**	**$149.99**	**$23.53**	**$109.87**	**$17.80**	**$174.33**
FY 2012-13 Estimated Q3/Q4 Rate						
Weighted Capitation Point Estimate	**$14.01**	**$147.84**	**$22.36**	**$105.48**	**$17.60**	**$168.28**
Retroactivity Adjustment Multiplier (Exhibit FF)	0.07%	7.64%	9.39%	9.39%	6.92%	2.18%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.61%	-0.39%	-0.37%	-0.37%	-0.55%	-0.67%
Final Adjustment Factor [3]	**-0.54%**	**7.22%**	**8.99%**	**8.99%**	**6.33%**	**1.50%**
FY 2012-13 Final Estimated Q3/Q4 Rate	**$13.93**	**$158.51**	**$24.37**	**$114.96**	**$18.71**	**$170.80**
FY 2013-14 Estimated Q1/Q2 Rate [4]						
Weighted Capitation Point Estimate	**$14.01**	**$147.84**	**$22.36**	**$105.48**	**$17.60**	**$168.28**
Retroactivity Adjustment Multiplier (Exhibit FF)	0.07%	7.64%	9.39%	9.39%	6.92%	2.18%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.61%	-0.39%	-0.37%	-0.37%	-0.55%	-0.67%
Final Adjustment Factor [3]	**-0.54%**	**7.22%**	**8.99%**	**8.99%**	**6.33%**	**1.50%**
FY 2013-14 Final Estimated Q1/Q2 Rate	**$13.93**	**$158.51**	**$24.37**	**$114.96**	**$18.71**	**$170.80**
FY 2013-14 Estimated Q3/Q4 Rate						
Weighted Capitation Point Estimate	**$14.43**	**$156.24**	**$23.16**	**$110.36**	**$18.50**	**$166.58**
Retroactivity Adjustment Multiplier (Exhibit FF)	0.07%	7.64%	9.39%	9.39%	6.92%	2.18%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.61%	-0.39%	-0.37%	-0.37%	-0.55%	-0.67%
Final Adjustment Factor [3]	**-0.54%**	**7.22%**	**8.99%**	**8.99%**	**6.33%**	**1.50%**
FY 2013-14 Final Estimated Q3/Q4 Rate	**$14.35**	**$167.52**	**$25.24**	**$120.28**	**$19.67**	**$169.08**

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

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

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

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

Exhibit HH - Forecast Model Comparisons - Final Forecasts

Adjustment Factors for Forecasted Rates

Model	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [1]	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care
FY 2014-15 Estimated Q1/Q2 Rate [3]						
Weighted Capitation Point Estimate	**$14.43**	**$156.24**	**$23.16**	**$110.36**	**$18.50**	**$166.58**
Retroactivity Adjustment Multiplier (Exhibit FF)	0.07%	7.64%	9.39%	9.39%	6.92%	2.18%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.61%	-0.39%	-0.37%	-0.37%	-0.55%	-0.67%
Final Adjustment Factor [2]	**-0.54%**	**7.22%**	**8.99%**	**8.99%**	**6.33%**	**1.50%**
FY 2014-15 Final Estimated Q1/Q2 Rate	**$14.35**	**$167.52**	**$25.24**	**$120.28**	**$19.67**	**$169.08**
FY 2014-15 Estimated Q3/Q4 Rate						
Weighted Capitation Point Estimate	**$14.86**	**$165.12**	**$23.99**	**$115.47**	**$19.45**	**$165.74**
Retroactivity Adjustment Multiplier (Exhibit FF)	0.07%	7.64%	9.39%	9.39%	6.92%	2.18%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.61%	-0.39%	-0.37%	-0.37%	-0.55%	-0.67%
Final Adjustment Factor [2]	**-0.54%**	**7.22%**	**8.99%**	**8.99%**	**6.33%**	**1.50%**
FY 2014-15 Final Estimated Q3/Q4 Rate	**$14.78**	**$177.04**	**$26.15**	**$125.85**	**$20.68**	**$168.23**

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

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

[3] The rate set for Q3 and Q4 of FY 2013-14 will be the same rate in effect for Q1 and Q2 of FY 2014-15.

Exhibit HH - Forecast Model Comparisons - Capitation Trend Models

Capitation Rate Forecast Model for FY 2012-13 Q3 and Q4

Model	Adults 65 and Older (OAP-A)	Disabled Individuals Through 64 (AND/AB, OAP-B)	Low Income Adults [1]	Adults without Dependent Children	Eligible Children (AFDC-C/BC)	Foster Care
FY 2010-11 Actual Rate	$13.80	$139.12	$20.94	-	$15.41	$195.38
FY 2011-12 Q1 and Q2 Weighted Average Rate	$14.18	$141.67	$21.77	-	$15.89	$186.87
FY 2011-12 Q3 and Q4 Weighted Average Rate	$13.61	$139.89	$21.61	$100.81	$16.75	$171.66
FY 2011-12 Full Year Average Rate	$13.89	$140.77	$21.69	$100.81	$16.33	$179.29
FY 2012-13 Q1 and Q2 Weighted Average Rate	$13.60	$139.89	$21.59	$100.81	$16.74	$171.75
Recent Growth Rates						
% Growth from FY 2010-11 to FY 2011-12 Rate	0.65%	1.19%	**3.58%**	-	**5.97%**	-8.24%
% Growth from CY 2011 to CY 2012 Rate	-4.09%	-1.26%	-0.83%	-	5.35%	**-8.09%**
Selected Trend Models						
Average Growth Model	$14.58	$157.81	$26.16	-	$17.60	$159.07
% Difference from FY 2012-13 Q1 and Q2 Rate	7.21%	12.81%	21.17%	-	**5.14%**	-7.38%
% Difference from FY 2011-12 Full Year Average Rate	4.97%	12.10%	20.61%	-	7.78%	-11.28%
Two Period Moving Average Model	$14.09	$140.00	$21.05	-	$17.15	$202.93
% Difference from FY 2012-13 Q1 and Q2 Rate	3.60%	0.08%	-2.50%	-	2.45%	18.15%
% Difference from FY 2011-12 Full Year Average Rate	1.44%	-0.55%	-2.95%	-	5.02%	13.19%
Exponential Growth Model	$16.82	$167.39	$29.89	-	$20.01	$216.81
% Difference from FY 2012-13 Q1 and Q2 Rate	23.68%	19.66%	38.44%	-	19.53%	26.24%
% Difference from FY 2011-12 Full Year Average Rate	21.09%	18.91%	37.81%	-	22.54%	20.93%
Linear Growth Model	$16.26	$162.50	$25.75	-	$19.15	$217.76
% Difference from FY 2012-13 Q1 and Q2 Rate	19.56%	16.16%	19.27%	-	14.40%	26.79%
% Difference from FY 2011-12 Full Year Average Rate	17.06%	15.44%	18.72%	-	17.27%	21.46%
CY 2013 Forecast Minimum	$14.09	$140.00	$21.05	-	$17.15	$159.07
CY 2013 Forecast Maximum	$16.82	$167.39	$29.89	-	$20.01	$217.76
% change from CY 2012 Rate to Selected CY 2013 Capitation Rate [2]	2.99%	5.68%	3.58%	4.63%	5.14%	-2.02%
CY 2013 Forecast Point Estimate	**$14.01**	**$147.84**	**$22.36**	**$105.48**	**$17.60**	**$168.28**
% change from CY 2013 Rate to Selected CY 2014 Capitation Rate [3]	2.99%	5.68%	3.58%	4.63%	5.14%	-1.01%
CY 2014 Forecast Point Estimate	**$14.43**	**$156.24**	**$23.16**	**$110.36**	**$18.50**	**$166.58**
% change from CY 2014 Rate to Selected CY 2015 Capitation Rate [4]	2.99%	5.68%	3.58%	4.63%	5.14%	-0.51%
CY 2015 Forecast Point Estimate	**$14.86**	**$165.12**	**$23.99**	**$115.47**	**$19.45**	**$165.74**

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

Footnote	Population	Selection	Population	Selection
[2] Percentage selected to modify capitation rates for CY 2013: Where applicable, percentage selections have been bolded for clarification.	Adults 65 and Older (OAP-A)	Rate change from FY 2009-10 to FY 2010-11	Adults without Dependent Children	Average of trends selected for Disabled Individuals Through 64 (AND/AB, OAP-B) and Low Income Adults
	Disabled Individuals Through 64 (AND/AB, OAP-B)	Rate change from FY 2009-10 to FY 2010-11	Eligible Children (AFDC-C/BC)	Average growth model
	Low Income Adults	Rate change from FY 2010-11 to FY 2011-12	Foster Care	One-fourth of rate change from CY 2011 to CY 2012
[3] Percentage selected to modify capitation rates for CY 2014: Where applicable, percentage selections have been bolded for clarification.	Adults 65 and Older (OAP-A)	Rate change from FY 2009-10 to FY 2010-11	Adults without Dependent Children	Average of trends selected for Disabled Individuals Through 64 (AND/AB, OAP-B) and Low Income Adults
	Disabled Individuals Through 64 (AND/AB, OAP-B)	Rate change from FY 2009-10 to FY 2010-11	Eligible Children (AFDC-C/BC)	Average growth model
	Low Income Adults	Rate change from FY 2010-11 to FY 2011-12	Foster Care	One-eighth of rate change from CY 2011 to CY 2012
[4] Percentage selected to modify capitation rates for CY 2015: Where applicable, percentage selections have been bolded for clarification.	Adults 65 and Older (OAP-A)	Rate change from FY 2009-10 to FY 2010-11	Adults without Dependent Children	Average of trends selected for Disabled Individuals Through 64 (AND/AB, OAP-B) and Low Income Adults
	Disabled Individuals Through 64 (AND/AB, OAP-B)	Rate change from FY 2009-10 to FY 2010-11	Eligible Children (AFDC-C/BC)	Average growth model
	Low Income Adults	Rate change from FY 2010-11 to FY 2011-12	Foster Care	One-sixteenth of rate change from CY 2011 to CY 2012

Exhibit II - Recoupments and Reconciliations

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

	FY 2010-11 Actuals	FY 2011-12 Actuals	FY 2012-13 Estimate	FY 2013-14 Estimate	FY 2014-15 Estimate
Recoupment for FY 2004-05 Ineligibles	($1,793,362)	$0	$0	$0	$0
Recoupment for FY 2008-09 Ineligibles	$0	($689,563)	$0	$0	$0
Estimated Recoupment for FY 2009-10 Ineligibles	$0	($1,099,876)	$0	$0	$0
Estimated Recoupment for FY 2010-11 Ineligibles (1)	$0	$0	*($1,240,550)*	$0	$0
Estimated Recoupment for FY 2011-12 Ineligibles (1)	$0	$0	$0	*($1,373,413)*	$0
Estimated Recoupment for FY 2012-13 Ineligibles (1)	$0	$0	$0	$0	*($1,509,930)*
Net Impact of Estimated Recoupments	($1,793,362)	($1,789,439)	($1,240,550)	($1,373,413)	($1,509,930)

[1] Estimated recoupments for FY 2010-11, FY 2011-12, and FY 2012-13 ineligibles are based on the recoupment made for FY 2009-10 ineligibles, which is the most recently reconciled year. The Department trended future recoupments for each fiscal year's ineligibles by that fiscal year's caseload growth as it is anticipated that more will be recouped as the magnitude of the base expenditure increases over time.

Recoupment Fund Splits

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Recoupments in FY 2010-11	($1,793,362)	($896,681)	$0	$0	($896,681)
Recoupments in FY 2011-12 (2)	($1,789,439)	($714,137)	($2,855)	$0	($1,072,447)
Estimated Recoupments in FY 2012-13 (3)	($1,240,550)	($474,694)	($25,124)	$0	($740,732)
Estimated Recoupments in FY 2013-14	($1,373,413)	($646,007)	($40,699)	$0	($686,707)
Estimated Recoupments in FY 2014-15	($1,509,930)	($706,152)	($48,813)	$0	($754,965)

[2] Fund splits for recoupments for FY 2008-09 ineligibles account for differing levels of federal match over the course of that fiscal year due to the American Reinvestment and Recovery Act; in FY 2008-09, three months of expenses were matched at the standard 50%, six months were matched at 58.78%, and three months were matched at 61.59%. Fund splits for recoupments for FY 2009-10 ineligibles account for a federal match of 61.59% over the course of that fiscal year due to the American Reinvestment and Recovery Act.

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

Exhibit JJ - Expansion Populations (1)								
FY 2012-13 Calculation								
DESCRIPTION OF ESTIMATE				**CALCULATION OF MATCH**				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
Expansion Adults to 100%	42,531	$286.21	$12,172,798	$0	$6,086,399	$0	$6,086,399	50.00%
Adults without Dependent Children	10,000	$1,347.14	$13,471,400	$0	$6,735,700	$0	$6,735,700	50.00%
Buy-In for Disabled Individuals	2,183	$1,829.71	$3,994,257	$0	$1,997,128	$0	$1,997,129	50.00%
Total from Hospital Provider Fee Fund (2)	**-**	**-**	**$29,638,455**	**$0**	**$14,819,227**	**$0**	**$14,819,228**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Eligible Children: Family Medical Program	2,449	$218.57	$535,278	$187,347	$0	$0	$347,931	65.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Baby Care Program-Adults	372	$286.21	$106,566	$37,298	$0	$0	$69,268	65.00%
FY 2013-14 Calculation								
DESCRIPTION OF ESTIMATE				**CALCULATION OF MATCH**				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
Expansion Adults to 100% (3)	47,351	$296.90	$14,058,512	$0	$3,514,628	$0	$10,543,884	75.00%
Adults without Dependent Children	10,000	$1,409.93	$14,099,300	$0	$3,524,825	$0	$10,574,475	75.00%
Buy-In for Disabled Individuals	5,465	$1,940.64	$10,605,598	$0	$5,302,799	$0	$5,302,799	50.00%
Total from Hospital Provider Fee Fund (2)	**-**	**-**	**$38,763,410**	**$0**	**$12,342,252**	**$0**	**$26,421,158**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Eligible Children: Family Medical Program	16,320	$229.79	$3,750,173	$1,312,561	$0	$0	$2,437,612	65.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Baby Care Program-Adults	749	$296.90	$222,452	$77,858	$0	$0	$144,594	65.00%

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

[2] This amount does not include payments from the Hospital Provider Fee for reconciliations; the total amount estimated to be paid out of the Hospital Provider Fee in FY 2013-14 is $12,585,859.

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

Exhibit JJ - Expansion Populations [1]

FY 2014-15 Calculation

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate [3]**
Hospital Provider Fee Cash Fund:								
Expansion Adults to 100% [3]	49,210	$307.83	$15,148,314	$0	$0	$0	$15,148,314	100.00%
Adults without Dependent Children [3]	10,000	$1,475.33	$14,753,300	$0	$0	$0	$14,753,300	100.00%
Buy-In for Disabled Individuals	8,367	$2,052.86	$17,176,280	$0	$8,588,140	$0	$8,588,140	50.00%
Total from Hospital Provider Fee Fund [2]	**-**	**-**	**$47,077,894**	**$0**	**$8,588,140**	**$0**	**$38,489,754**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Eligible Children: Family Medical Program	18,887	$241.71	$4,565,177	$1,597,812	$0	$0	$2,967,365	65.00%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Baby Care Program-Adults	750	$307.83	$230,873	$80,806	$0	$0	$150,067	65.00%

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

[2] This amount does not include payments from the Hospital Provider Fee for reconciliations; the total amount estimated to be paid out of the Hospital Provider Fee in FY 2014-15 is $9,345,527

[3] The Department will receive 100% FFP for the Expansion Adults to 100% and Adults without Dependent Children populations beginning in January 2014 due to the passage of the Affordable Care Act. The average FFP over FY 2014-15 is 100%.

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

FY 2012-13 Calculation

Components	FY 2011-12 Actual	FY 2012-13 Appropriation	Estimated Change in Total Mental Health Caseload			FY 2012-13 Estimate	FY 2012-13 Change from Appropriation
			FY 2011-12 Average Monthly Caseload	FY 2012-13 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$632,150	$678,379	598,322	657,802	9.94%	$694,994	$16,615
Outpatient Services	$3,064,324	$3,288,417	598,322	657,802	9.94%	$3,368,955	$80,538
Physician Services	$168,509	$180,832	598,322	657,802	9.94%	$185,261	$4,429
Total After Prior Year Adjustments	**$3,864,984**	$4,147,628				**$4,249,210**	**$101,582**

FY 2013-14 Calculation

Components	FY 2012-13 Estimate	Estimated Change in Total Mental Health Caseload			FY 2013-14 Estimate [1]	FY 2013-14 Change from FY 2012-13 Estimate
		FY 2012-13 Forecasted Average Monthly Caseload	FY 2013-14 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$694,994	657,802	712,810	8.36%	$767,595	$72,601
Outpatient Services	$3,368,955	657,802	712,810	8.36%	$3,720,885	$351,930
Physician Services	$185,261	657,802	712,810	8.36%	$204,614	$19,353
Total After Prior Year Adjustments	**$4,249,210**				**$4,693,094**	**$443,884**

[1] FY 2013-14 estimates are adjusted for the 53 weeks in the fiscal year

FY 2014-15 Calculation

Components	FY 2013-14 Estimate [2]	Estimated Change in Total Mental Health Caseload			FY 2014-15 Estimate	FY 2014-15 Change from FY 2012-13 Estimate
		FY 2013-14 Forecasted Average Monthly Caseload	FY 2014-15 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$753,112	712,810	748,740	5.04%	$791,073	$37,961
Outpatient Services	$3,650,680	712,810	748,740	5.04%	$3,834,695	$184,015
Physician Services	$200,753	712,810	748,740	5.04%	$210,872	$10,119
Total After Prior Year Adjustments	**$4,604,545**				**$4,836,640**	**$232,095**

[2] The FY 2013-14 estimates are the base for the FY 2014-15 estimates and are therefore readjusted for the 52 week fiscal year

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

Medicaid Mental Health Fee-for-Service Fund Splits

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Total Estimated FY 2012-13 Fee-for-Service Expenditure	$4,249,210	$2,124,605	$0	$0	$2,124,605
Total Estimated FY 2012-13 Fee-for-Service Expenditure	$4,693,094	$2,346,547	$0	$0	$2,346,547
Total Estimated FY 2013-14 Fee-for-Service Expenditure	$4,836,640	$2,418,320	$0	$0	$2,418,320

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

	Actual/Estimated Expenditures	Percent Change	Dollar Increase/ Decrease	Two-year Rolling Average	Percent Change Two-year Average	Three-year Rolling Average	Percent Change Three-year Average
FY 2007-08 Actual	$196,011,033	N/A	N/A	N/A	N/A	N/A	N/A
FY 2008-09 Actual	$215,860,937	10.13%	$19,849,904	$205,935,985	N/A	N/A	N/A
FY 2009-10 Actual	$226,620,818	4.98%	$10,759,881	$221,240,878	7.43%	$212,830,929	N/A
FY 2010-11 Actual	$251,146,027	10.82%	$24,525,209	$238,883,423	7.97%	$231,209,261	8.64%
FY 2011-12 Actual	$271,506,635	8.11%	$20,360,608	$261,326,331	9.39%	$249,757,827	8.02%
FY 2012-13 Appropriation vs. FY 2011-12 Actual	$312,017,910	14.92%	$40,511,275	$291,762,273	11.65%	$278,223,524	11.40%
FY 2012-13 Estimate vs. FY 2011-12 Actual	$311,570,590	14.76%	$40,063,955	$291,538,613	11.56%	$278,074,417	11.34%
FY 2012-13 Estimate vs. Appropriation	$311,570,590	-0.14%	($447,320)	$291,538,613	-0.08%	$278,074,417	-0.05%
FY 2013-14 Estimate vs. FY 2012-13 Appropriation	$347,855,029	11.49%	$35,837,119	$329,936,470	13.08%	$310,459,858	11.59%
FY 2013-14 Estimate vs. FY 2012-13 Estimate	$347,855,029	11.65%	$36,284,439	$329,712,810	13.09%	$310,310,751	11.59%
FY 2014-15 Estimate vs. FY 2012-13 Appropriation	$381,272,451	22.20%	$69,254,541	$346,645,181	18.81%	$347,048,463	24.74%
FY 2014-15 Estimate vs. FY 2013-14 Estimate	$381,272,451	9.61%	$33,417,422	$364,563,740	10.57%	$346,899,357	11.79%

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

Department of Health Care Policy and Financing
Medicaid Caseload
FY 2013-14 Budget Request

November 1, 2012

TABLE OF CONTENTS

INTRODUCTION....................3
RECENT CASELOAD HISTORY....................5
METHODOLOGY....................16
TREND MODELS....................16
REGRESSION MODELS....................16
TREND VS. REGRESSION MODELS....................17
CATEGORICAL PROJECTIONS....................17
ADULTS 65 AND OLDER....................18
DISABLED ADULTS 60 TO 64....................23
DISABLED INDIVIDUALS TO 59....................27
DISABLED BUY-IN....................32
CATEGORICALLY ELIGIBLE LOW-INCOME ADULTS....................33
EXPANSION ADULTS TO 60% FPL....................38
EXPANSION ADULTS TO 100% FPL....................41
BREAST AND CERVICAL CANCER PROGRAM....................44
ELIGIBLE CHILDREN....................48
FOSTER CARE....................55
BABY CARE-ADULTS....................59
NON-CITIZENS....................64
PARTIAL DUAL ELIGIBLES....................68
SUMMARY....................72

MEDICAID CASELOAD

INTRODUCTION

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

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

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

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

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

retroactivity. By rebuilding the caseload without retroactivity, the Department was able to put the FY 2003-04 projection in perspective and test the historical data for accuracy. Medicaid eligibility, retroactive back to the date of application, is still in effect; however, it is no longer reported in caseload. For a complete explanation of how the historical data was rebuilt and tested, refer to the November 3, 2003 Budget Request, pages K-98 and K-99.

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

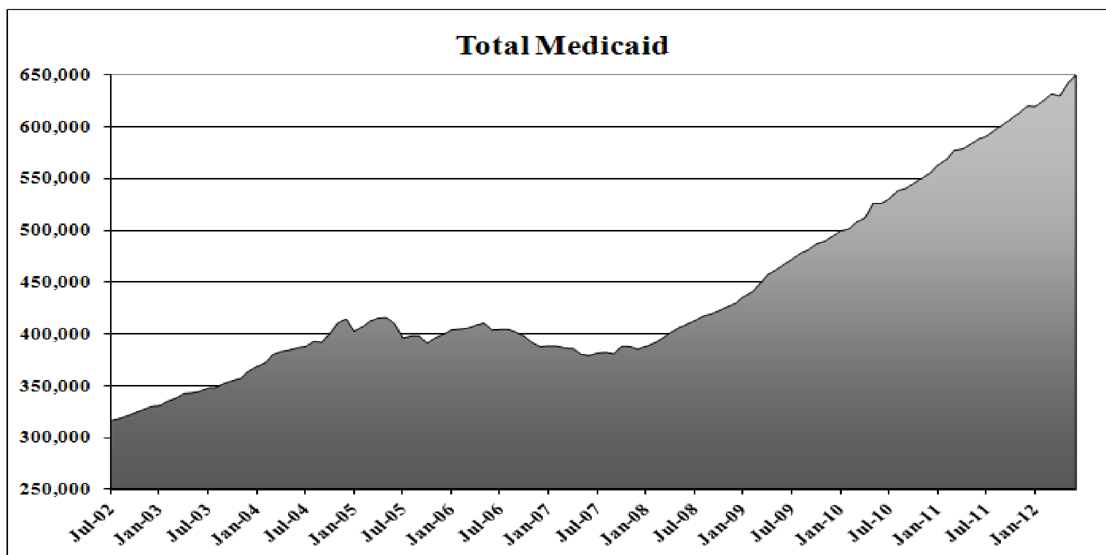
The Department has developed a new caseload report that it believes measures caseload more accurately: the REX01/COLD (MARS) R-474701. This report captures eligibility movements for the entire month in question and also stores the data table that underlies the report. As a result, the Department is able to analyze caseload by many other demographic and geographic characteristics while still balancing to the official Medicaid caseload. The Department began to use this new caseload report with the July 2008 caseload report to the Joint Budget Committee. Because of the differences between the methodologies used in the original and new caseload reports, the Department restated historical Medicaid caseload through FY 2002-03. All caseload history and forecasts included in the following narrative, as well as the Medical Services Premiums and Medicaid Mental Health projections, are the official restated caseload.

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

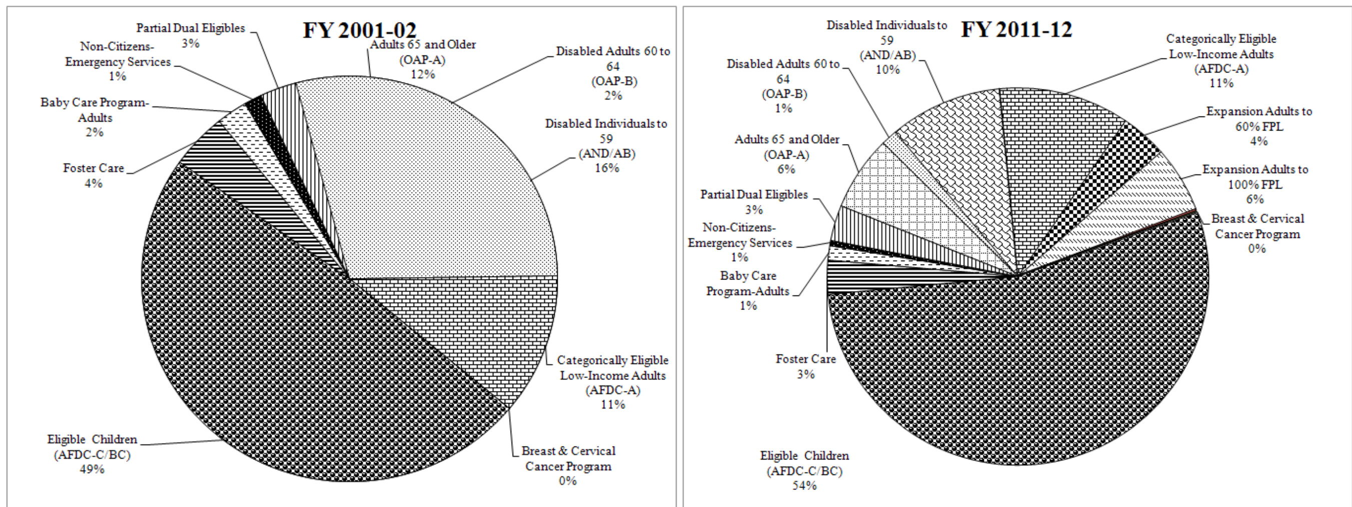
Fiscal Year	Medical Services Premiums Caseload	Less: Mental Health Ineligible Categories	Mental Health Caseload
FY 2002-03	331,800	(13,072)	318,728
FY 2003-04	367,559	(14,635)	352,924
FY 2004-05	406,024	(14,755)	391,269
FY 2005-06	402,218	(17,304)	384,914
FY 2006-07	392,228	(18,109)	374,119
FY 2007-08	391,962	(18,405)	373,557
FY 2008-09	436,812	(19,062)	417,750
FY 2009-10	498,797	(19,612)	479,185
FY 2010-11	560,759	(20,303)	540,456
FY 2011-12	619,963	(21,641)	598,322

Recent Caseload History

Exhibit B tabulates actual caseload figures and growth rates by eligibility category from FY 1995-96 to FY 2010-11. Projections for FY 2011-12 to FY 2013-14 are also presented in the table and will be discussed in the Categorical Projections section of this document. A graphical representation of aggregate Medicaid caseload history from FY 2002-03 is shown below. Medicaid in Colorado had double-digit growth rates in FY 2003-04 and FY 2004-05 of 10.78% and 10.48%, respectively. These high rates of growth ceased in FY 2005-06, and caseload declined by 0.95% in FY 2005-06 and by a further 2.48% in FY 2006-07. Monthly declines continued in the first half of FY 2007-08 but reversed in the second half, resulting in a nearly flat decline of 0.07% for the fiscal year. With the weak economy, caseload has continued to grow at double digit rates, with in annual growth of 11.44% in FY 2008-09, 14.19% in FY 2009-10, 12.41% in FY 2010-11, and 10.56% in FY 2011-12. Reasons for these recent growth rates will be discussed below.

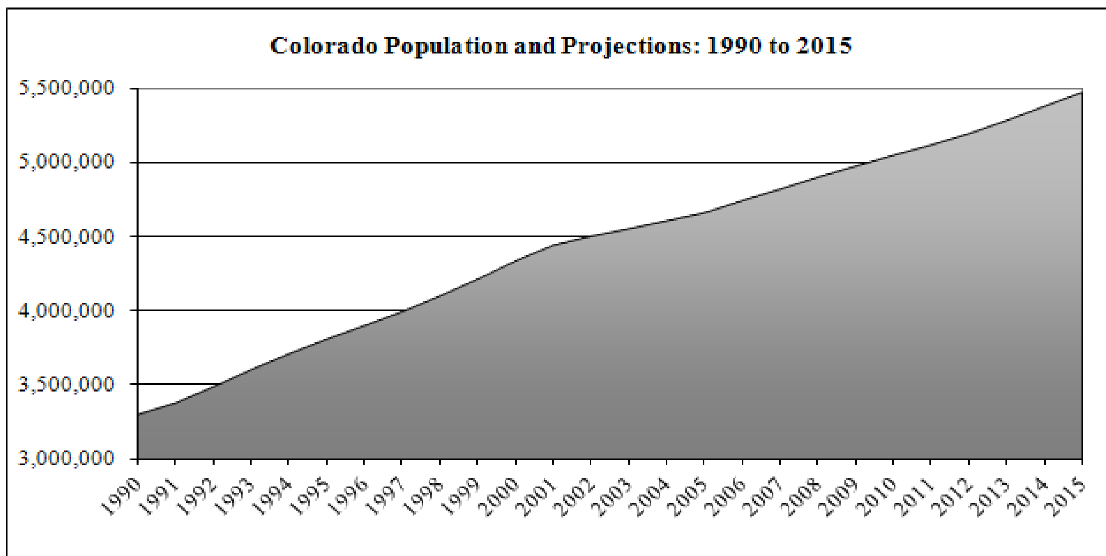


The following charts show a side-by-side comparison of the Medicaid caseload by category as a percentage of the overall caseload for FY 2001-02 and FY 2011-12. As a percentage of the entire Medicaid caseload, Eligible Children has increased by five percentage points, the largest gain when compared with all other categories. Despite strong growth in recent years, the percentage of overall caseload in the Disabled Individuals to 59 (AND/AB) category has declined by approximately six percentage points, and Adults 65 and Older (OAP-A) has decreased by five percentage points. This change in case mix implies that increases in a less expensive category (Eligible Children) has been coupled with decreases in more expensive categories (Disabled Individuals to 59 (AND/AB) Adults 65 and Older (OAP-A)) over the last 10 years.



Medicaid caseload trends are influenced by a number of factors including: population trends, in-State migration, age of the population, length of stay, economic conditions, and State and federal policy changes. Projecting annual caseload is complicated by the fact that each of these factors can contribute to categorical changes, some of which may be contradictory. For example, the State may enact legislation that removes clients from a Medicaid category who are aged 65 and older, while the population of adults aged 65 and older is increasing. Therefore, projections represent the *net effect* of what the Department expects will happen. Each factor and its expected impact on the Medicaid caseload are discussed below.

Population - Colorado's total population has increased by approximately 15.35% from July of 2002 to July of 2012, an average rate of 1.44% per year. The Department of Local Affairs forecasts that Colorado's population will increase a further 5.37% from July of 2012 to July of 2015, with annual growth rates in line with historical trends. As the overall population has grown, so too has Medicaid caseload. This positive correlation implies that if population is projected to grow in the future, Medicaid caseload may also increase.



When using population data to project caseload, the Department marries population subgroups to their appropriate Medicaid category. For example, when projecting caseload for Eligible Children, the

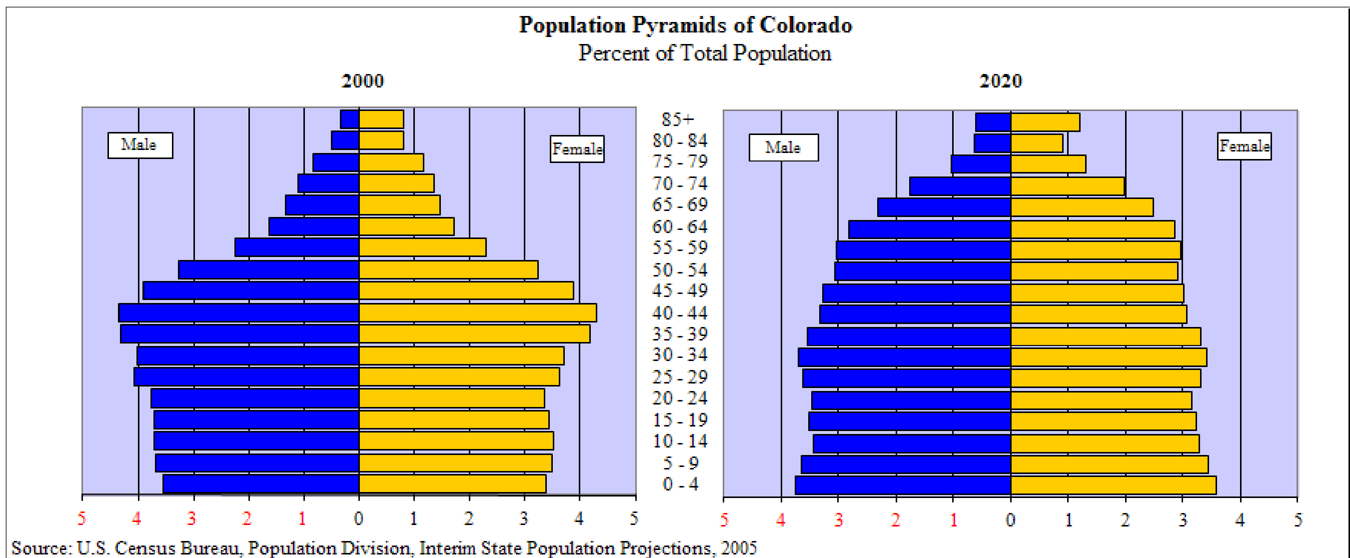
Department uses population statistics for Colorado residents aged 0 to 18. By using subgroups instead of total population figures, the Department is able to capture subgroup specific trends.

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

Age - The age of the population can provide some insight as to why Medicaid caseloads have been increasing. As the population ages, so too does the demand for medical care. Generally, as individuals age, their health becomes more fragile and the more likely they are to seek health care. From 2002 to 2012, Colorado's median age increased by 1.9 years, a 5.4% increase[3]. This may be the result of retirees moving to the State, increased longevity, or fewer births. Regardless of the reason, an aging population has a direct effect on the demand for medical services, though not necessarily Medicaid. According to data from the United States Census Bureau, Colorado had the 10th lowest median age in 2010 and the 4th lowest old-age dependency ratio in 2009 (defined as the population 65 and older as a percent of population 18 to 64) in the nation.[4] The population over 60 in Colorado is projected to increase by 52.4% between 2002 and 2012, which is expected to cause an increase in the State's median age. Additionally, Colorado's old-age dependency ratio is projected to increase from 15.6 in 2000 to 24.6 in 2020, a 57.2% increase.[5] This growth is significantly higher than the nation average, which is projected to increase by 34.8% over the same timeframe. This suggests that Colorado will be aging faster than the average state over the forecast period. Since 2009, Colorado has experienced increases in the eligibility categories that include older individuals, though the growth was not as high as population growth in the general population aged 60 and over. This may be the result of a healthier aging population and demographic factors, such as the elderly population working longer and some of the baby-boom generation not yet reaching retirement age.

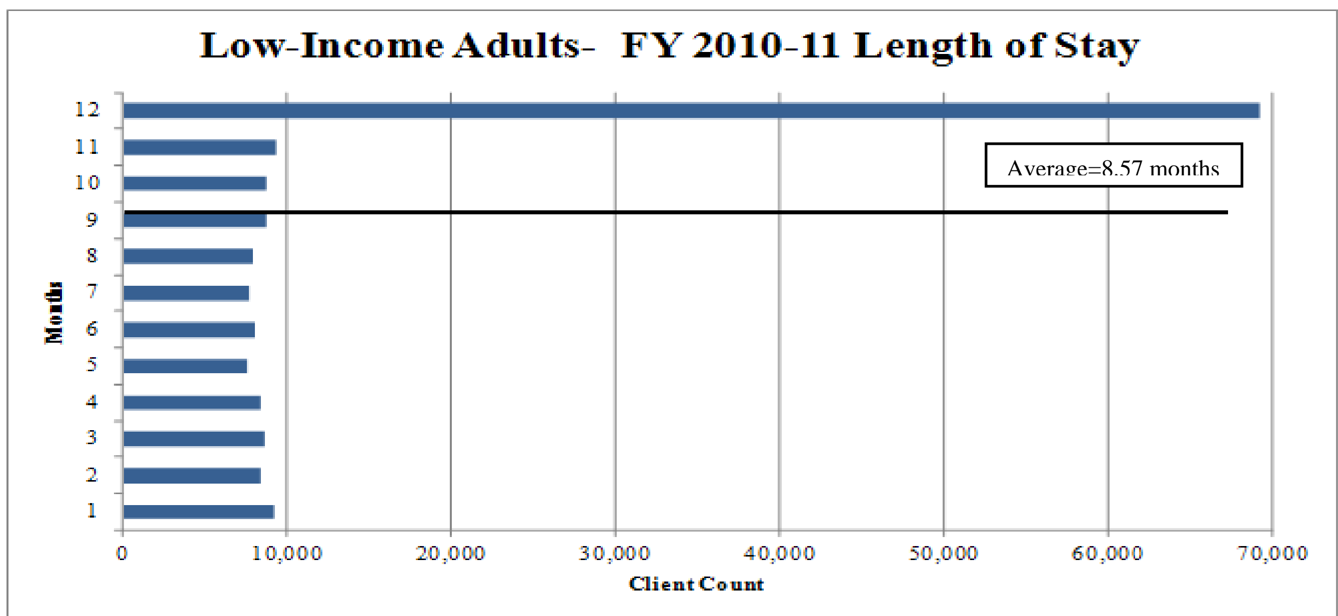
---

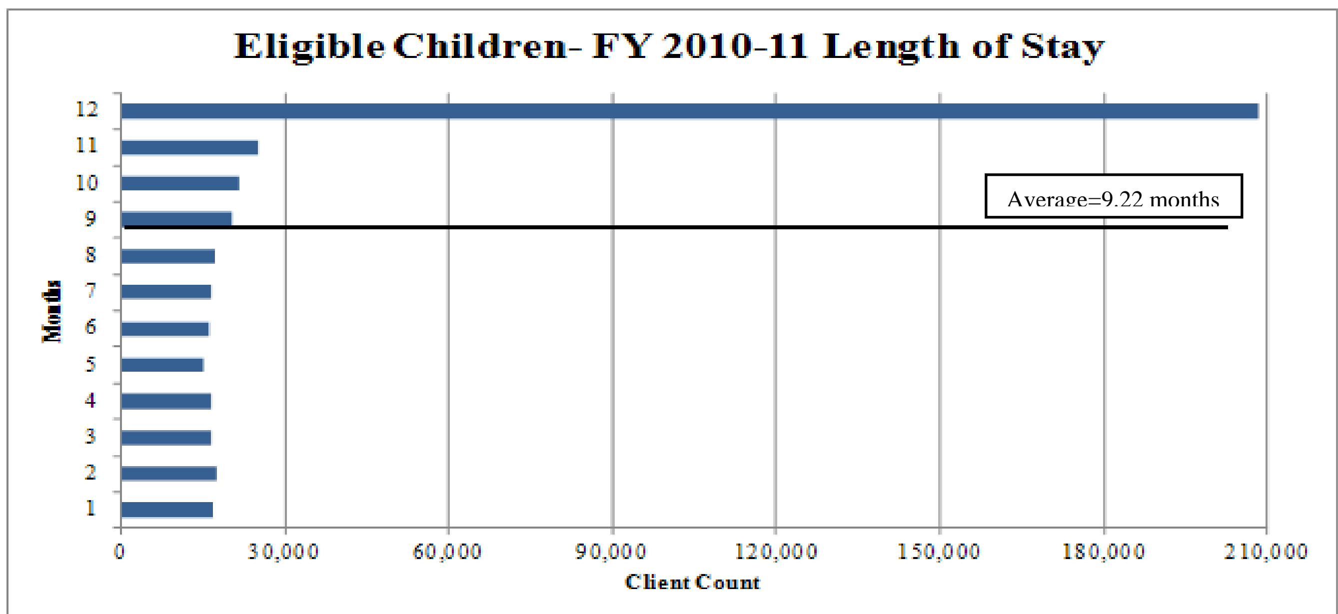
[1] Source: Department of Local Affairs, Demography Division
[2] Source: 2010 American Community Survey http://www.census.gov/acs/www/
[3] Source: Department of Local Affairs, Demography Division
[4] Source: 2010 American Community Survey http://www.census.gov/acs/www/
[5] Source: U.S. Census Bureau, Population Division, Interim State Population Projections, 2005 http://www.census.gov/population/www/projections/index.html



Length of Stay- Medicaid caseload is not only affected by the number of individuals served but also the length of time they remain in the program. The severity and length of the recent economic downturn has prolonged the average amount of time clients remain on the Medicaid caseload. The table below shows that the average number of months on Medicaid dropped by 10.6% for adults and 8.5% for children between FY 2003-04 FY 2004-05 and in FY 2005-06 increased to levels near those for FY 2003-04. As caseload declined in FY 2006-07 and FY 2007-08, the average length of stay also declined. While the average length of stay for low-income adults declined in FY 2009-10, this was solely due to the implementation of the expansion to 100% of the federal poverty level in May 2009, which artificially reduced the average number of months of enrollment as these clients were eligible for only two months. Excluding these clients, the Department estimates that the average length of stay for low-income adults was approximately 7.91 months. In FY 2010-11, the average length of stay increased for both low-income adults and children, which is expected during periods of economic weakness. As can be seen in the table and charts that follow, enrollment in Medicaid averaged 8.57 months for low-income adults and 9.22 months for Eligible Children in FY 2010-11. The distribution of length of enrollment, however, is heavily weighted toward enrollment for the full year. This calculation, however, only considers enrollment in a given year in isolation, and does not account for clients that have eligibility that overlaps multiple fiscal years due to the timing of their eligibility determination. The Department will continue to refine this analysis to account for these factors and to provide a more accurate picture of the amount of time that individuals are enrolled in Medicaid over multiple years rather than considering fiscal years in isolation and independently of each other. At this time, the Department does not have sufficient data regarding the average length of stay for FY 2011-12, and will report this as data become available.

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





Economic Conditions - Economic indicators help partially explain why some Medicaid caseload trends occur. Since Medicaid is a needs-based program where clients must meet income limits, it follows that caseload for families and children should be countercyclical to economic conditions. For example, as the state experiences recessionary conditions, the Medicaid caseload will increase. After the recession that ended in the early 1990s, Colorado enjoyed almost ten years of economic expansion. The terror attacks on the United States in 2001 combined with the bursting of the stock market bubble in late 2000 brought that expansion to a halt. For the first time in more than a decade, Colorado experienced significant job losses coupled with falling wages. In mid-2003, the Colorado economy hit bottom after the decline that started in early 2001. Due to seasonal fluctuations and wide confidence intervals for over the month changes, employment data is best analyzed by comparing the same month for different years. The first post-recession over-the-year gain in non-agricultural employment occurred in March of 2004. The State officially entered an expansionary period in early 2006, as employment surpassed the late 2000 peak. The recovery period lasted 30 months, one of the longest on record. Employment began to soften in October 2008, when 4,600 jobs were shed over the year. The State experienced over-the-year job losses for two years and the annual contractions appear to have peaked in September 2009, when job losses numbered 128,400 (5.5%) over the year. The State has seen very moderate over-the-year employment increases as of September 2010. As of August 2012, the over-the-year jobs gain was estimated to be 33,300, or 1.47%[6]. Current economic forecasts project very moderate increases in employment throughout the forecast period.

The table that follows shows historical and projected unemployment rates, non-agricultural employment, and job growth statistics.[7]

Year	Wage and Salary Income (billions)	Non-Agricultural Employment	Employment Growth	Unemployment Rate
2004	$92.1	2,179,600	1.2%	5.6%
2005	$98.9	2,226,000	2.1%	5.1%
2006	$105.8	2,279,100	2.4%	4.4%
2007	$113.0	2,331,300	2.3%	3.7%
2008	$117.2	2,350,400	0.8%	4.8%
2009	$112.8	2,245,200	-4.5%	8.1%
2010	$114.3	2,220,400	-1.1%	8.9%
2011	$119.7	2,258,200	1.7%	8.3%
2012	$124.3	2,296,700	1.7%	8.0%
2013	$128.7	2,320,300	1.0%	7.8%
2014	$134.9	2,358,000	1.6%	7.0%

The timing of an economic cycle is important in estimating the impact on the Medicaid caseload. As the economy recovers from a downturn, workers need to find jobs in order to withdraw from the Medicaid rolls. Jobs that primarily affect family and children Medicaid populations[8] are hourly and concentrated in the service industry. These employment types are often the last to benefit from improving economic conditions. Therefore, any economic impact on the Medicaid caseload will have a lagged effect. Second, as workers find jobs they do not instantaneously lose their Medicaid eligibility. Since 1990, states have been federally required to provide Transitional Medical Assistance (known as Transitional Medicaid) benefits for up to one year to families who lost eligibility because of increased income due to

[6] Source: United States Department of Labor, Bureau of Labor Statistics, Current Employment Statistics http://www.bls.gov/data/
[7] Source: Office of State Planning and Budgeting, September 2012 Economic Forecast
[8] Projecting elderly and disabled client populations does not prioritize economic variables

employment. This policy was directed at clients who potentially might turn down employment for fear of losing their Medicaid benefits. To be eligible for Transitional Medicaid, a client must have been eligible in at least three of the preceding six months, though states may elect to reduce this requirement to fewer than three months. Clients may receive Transitional Medicaid as long as their income is below 185% of the federal poverty level, provided that the proper income reporting requirements are followed. Another small group of clients are eligible for Transitional Medicaid services that would otherwise lose their Medicaid benefits due to child or spousal support payments. Families in this group receive a four-month extension. Although this program has been set to expire many times, it has been renewed regularly, most recently through December 31, 2012. While the future of Transitional Medicaid is unknown once the federal Affordable Care Act is implemented, the Department assumed that the federal Transitional Medicaid program would continue throughout FY 2014-15 for the purposes of projecting caseload. As illustrated in the following table, the average number of adults and children on Transitional Medicaid increased dramatically in FY 2004-05. The Department suspects that the high growth in FY 2004-05 and FY 2005-06 may be partially related to large monthly increases that occurred around the implementation of the Colorado Benefits Management System. Monthly caseload declined between December 2005 and June 2008, but caseload increased throughout FY 2008-09 and FY 2009-10.

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

Fiscal Year	Average Number of Eligible Children on Transitional Medicaid	Average Number of Adults on Transitional Medicaid
FY 2002-03	7,645	4,689
FY 2003-04	7,349	4,709
FY 2004-05	10,776	6,586
FY 2005-06	16,749	10,745
FY 2006-07	16,065	9,968
FY 2007-08	13,000	7,778
FY 2008-09	13,489	7,905
FY 2009-10	13,582	8,099
FY 2010-11	11,042	6,173
FY 2011-12	21,311	11,171

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

- Breast and Cervical Cancer Prevention and Treatment Act of 2000, Public Law 106-354: Established a new group of eligibility for women under 65 who have been screened under the Centers for Disease Control and Prevention Board and need treatment for either diagnosis. Colorado implemented this optional eligibility group in July 2002 pursuant to SB 01S2-012.
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003: This act causes more potential beneficiaries to be screened for Medicaid when they apply for this Medicare benefit.
- Presumptive eligibility for Medicaid pregnant women was discontinued on September 1, 2004. It was re-established by HB 05-1262 on July 1, 2005.
- HB 05-1262, the Tobacco Tax bill: This bill provided funding for the removal of the Medicaid asset test, the expansion of the income guideline used to establish eligibility for parents of children eligible for either Medicaid or the Children's Basic Health Plan to 60% of the federal poverty level (known as Expansion Adults to 60% FPL), and to expand the number of children enrolled in the Home- and Community-Based Services and the Children’s Extensive Support Waiver.
- Deficit Reduction Act of 2005: This Act contained provisions related to premiums and cost sharing, benefits, and asset transfers that will have implications for Medicaid beneficiaries. In addition, the Deficit Reduction Act contained a provision requiring States to obtain satisfactory documentary evidence of citizenship and identity for all Medicaid applicants who have declared that they are citizens or nationals of the United States, with exemptions for individuals that are eligible for Medicaid and entitled to or enrolled in Medicare and those eligible for Medicaid by virtue of receiving Supplemental Security Income benefits.
- SB 07-211: Established presumptive eligibility for Medicaid children.
- HB 09-1353: Expanded Medicaid eligibility to pregnant women who are legal permanent residents that have been in the country for less than 5 years.
- HB 09-1293: Expanded Medicaid eligibility to parents of children eligible for either Medicaid or the Children's Basic Health Plan to 60% of the federal poverty level, established the Buy-In Program for Individuals with Disabilities, and established the Adults without Dependent Children program.

Oftentimes, a forecast cannot instantaneously incorporate policy changes even with the use of dummy or indicator variables. When this occurs, adjustments are made to the forecast off-line. Detailed accountings of off-line adjustments are in Exhibit B, page EB-2.

Off-line adjustments are made due to SB 11-008, which increases eligibility for children age 6 to 19 in Medicaid from 100% to 133% FPL, and SB 11-250, which increases eligibility for pregnant women in Medicaid from 133% to 185% FPL. The implementation date for both of these expansions is anticipated to be January 1, 2013. Pregnant women with income between 135% and 185% FPL that are currently eligible for CHP+ will be moved immediately to Medicaid upon implementation, while children age 6 to 19 in CHP+ with income between 101% and 133% FPL will transition at their annual eligibility redetermination.

Under current Medicaid regulations, the rules for counting income vary from state to state and also differ based on the category through which an individual is eligible for the program. For example, Medicaid allows applicants to disregard some child support payments and the first $90 of earned income, and to deduct certain childcare expenses from income when determining eligibility for benefits. States also have the flexibility to disregard additional income and deduct other expenses, and a number of states have used this authority to expand Medicaid eligibility. States' use of deductions and income disregards has the effect of increasing income eligibility standards for many families, but they also have resulted in a somewhat more complex application and renewal process. This process is exacerbated by different income and household counting rules for federal CHIP programs, which often do not align with Medicaid rules. Pursuant to the federal Affordable Care Act, eligibility for Family Medicaid, CHIP and premium subsidies to purchase coverage in health insurance exchanges (the Colorado Health Benefit Exchange, or COHBE, in Colorado) will be determined using the Modified Adjusted Gross Income (MAGI) beginning January 1, 2014. MAGI is Adjusted Gross Income as determined under the federal income tax, plus various income amounts and adjustments, and is calculated for the household, defined as the tax filing unit. The family's assets will not be considered in determining eligibility, and a standard 5% of the federal poverty level disregard will be applied. The new rules also change how family size is calculated and how household income is defined. Currently under Medicaid and CHIP programs, states take different approaches to determining family size and which family members' income to count depending on who in the family is applying for benefits. Under the new rules, however, family size and household income will be based on the tax filing unit. All individuals claimed as a dependent on a taxpayer's return will be included in determining that taxpayer's family size. These new income eligibility rules generally will apply to all children (except foster children) who qualify for Medicaid and to all adults under age 65. The health reform law does not change Medicaid eligibility rules for beneficiaries who are 65 or older or those in eligibility categories based on disability, though those who qualify for Medicaid as a disabled individual may be determined with the new income eligibility rules temporarily until their disability determination has been completed.

The transition to MAGI will result in standardization of the definition and measurement of income, both across states and programs. This will result in streamlined eligibility determinations that are based solely on national tax filing standards rather than disparate methodologies. For example, in Colorado, Medicaid applies a mandatory minimum disregard to earnings, whereas CHP+ does not, and CHP+ disregards any income earned by a child in the household, whereas Medicaid may count the child's income depending on the family circumstance.

In addition, Medicaid and CHP+ define the family unit differently. For Medicaid, the "family" is determined more like the "nuclear" approach. This would include a spouse, parents, and any dependent children in the home. For CHP+, the "family" is defined as all related family members in the household that receive at least 50% of their financial support from the household.

For example, take a family applying for coverage for a child in a household with a married couple, the dependent child, and a grandmother, and annual household income is $25,000. Under Medicaid rules, the grandmother is not counted in the household; therefore, the household size is three and the FPL of

the child is approximately 135%, making the family over-income for Medicaid eligibility. Under CHP+ rules, the grandmother is counted in the household; therefore, the household size is four and the FPL of the child is approximately 112% and is eligible for CHP+.

As can be seen in the example above, these factors lead to individuals enrolled in CHP+ that appear to meet Medicaid income eligibility. In FY 2011-12, approximately 43% of children enrolled in CHP+ had income below 133% FPL and 67% of pregnant women had income below 185% FPL. Under the streamlined income and household counting rules of MAGI, there will no longer be any clients in CHP+ with income below 133% FPL for children and 185% FPL for pregnant women, and clients will be transitioned from CHP+ to Medicaid. The Department is including a bottom-line adjustment to reflect this change.

Please note that these estimates are initial and will change over the next year. The Centers for Medicare and Medicaid Services is still in the process of release guidance on how MAGI will be applied and implemented, and there is little information regarding how MAGI plus the 5% standard disregard compares to the variety of income disregards that Colorado currently has for Medicaid and CHP+.

The transition to MAGI will not only cause movement of clients from CHP+ to Medicaid, but will likely also result in significant movement within the low-income adults eligibility groups in Medicaid. Because all Family Medicaid clients will have their eligibility redetermined using the new MAGI standards, existing low-income adults will likely move between the Categorically Eligible Low-Income, Expansion Adults to 60% FPL, and Expansion Adults to 100% FPL categories. This is important as these categories have differing sources of state funding as well as federal medical assistance percentages (FMAP); the Categorically Eligible Low-Income and Expansion Adults to 60% FPL categories are funded with General Fund and Tobacco Tax at the standard 50% FMAP, whereas the Expansion Adults to 100% FPL category is funded with the Hospital Provider Fee and may be eligible for the enhanced FMAP under the federal Affordable Care Act. The Department anticipates a similar impact within the Baby Care Program-Adults category between clients up to 133% FPL and between 134% and 185% FPL, which have differing FMAPs (clients up to 133% FPL receive the standard 50% FMAP whereas those between 134% and 185% FPL will receive the CHP+ FMAP of 65% pursuant to a Section 1115 waiver). Because there is little information regarding how MAGI plus the 5% standard disregard compares to the variety of income disregards that Colorado currently has for Medicaid, the magnitude and direction of these impacts is unknown at this time. The Department will closely monitor movement within Medicaid when data becomes available in early 2014.

The combination of the aforementioned factors led to significant growth in the Medicaid caseload between FY 2002-03 and FY 2004-05. During this time, Medicaid caseload increased by 74,224 clients, growth of 22.37%. Caseload decreased in the subsequent years, resulting in a decline of 14,062, or 3.46%, between FY 2004-05 and FY 2007-08. The Department believes that the improving economic conditions were the driving factor in this decrease, as consistent monthly declines occurred in Categorically Eligible Low-Income Adults and Eligible Children, which are expected to be most affected by the economy. This trend reversed as of the second half of FY 2007-08, when the Eligible Children caseload started to show significant monthly increases. Strong increases continued in Medicaid in FY 2008-09, FY 2009-10 and FY 2010-11, with average monthly growth increasing at an increasing rate throughout the year, resulting in annual growth of 11.44%, 14.19%, and 12.42%, respectively. Strong monthly growth continued in FY 2011-12, with annual caseload increasing by 10.56% to a new historical high of 619,963. Given the recent trends and projected economic conditions, base caseload is anticipated to continue growing at a decreasing rate through the forecast period, and large caseload increases are anticipated due to expansions from SB 11-008 SB 11-250 and the transition to MAGI calculations under the federal Affordability Care Act. The Department is forecasting

Medicaid caseload to increase by 9.93% in FY 2012-13 to 681,535. In FY 2013-14, the trend is projected to be 8.35%, and caseload is forecasted to reach 738,413. Expansions from SB 11-008 and SB 11-250 and the transition to MAGI calculations account for 22,695 of the projected 56,878 total Medicaid caseload increase in FY 2013-14. The following table shows actual and projected aggregate Medicaid caseload from FY 2004-05 through FY 2014-15.

Fiscal Year	Medicaid Caseload	Growth Rate	Level Growth
FY 2004-05	406,024	10.46%	38,465
FY 2005-06	402,218	-0.94%	(3,806)
FY 2006-07	392,228	-2.48%	(9,990)
FY 2007-08	391,962	-0.07%	(266)
FY 2008-09	436,812	11.44%	44,850
FY 2009-10	498,797	14.19%	61,985
FY 2010-11	560,759	12.42%	61,962
FY 2011-12	619,963	10.56%	59,204
FY 2012-13 Projection	681,535	9.93%	61,572
FY 2013-14 Projection	738,413	8.35%	56,878
FY 2014-15 Projection	776,381	5.14%	37,968

METHODOLOGY

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

Trend Models

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

Exponential Smoothing

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

Box Jenkins

As compared to Exponential Smoothing models, Box-Jenkins models are more complex, but often produce results that are more accurate with a time-series that is longer and stable. Box-Jenkins models identify Autoregressive Integrated Moving Average processes that provide a good fit to a stationary time-series. The optimal model can contain numerous autoregressive terms, moving average terms, or combinations thereof, causing the Box-Jenkins models to be much more complex than their Exponential Smoothing counterparts. A minimum of 50 observations is recommended to perform a Box-Jenkins forecast.

Regression Models

Regression analysis, unlike trend analysis, incorporates independent variables when making projections. For example, a regression equation may include the unemployment rate if the forecaster expects that it has an effect on the caseload for Categorically Eligible Low-Income Adults. Statistically, the forecaster can test whether or not there is a relationship between independent variables and the caseload by

constructing a correlation matrix. Variables that are highly correlated with the caseload are more likely to be predictive. Regression equations are useful in that they provide some insight into why the trend projection is increasing, decreasing, or static. Although regression equations help explain why trends occur, their value depends on the quality of the independent variables used. In order to project caseload, historical and forecasted values of the independent variables must be used. Therefore, the accuracy of the caseload forecast depends on the accuracy of the forecasted independent variables.

In June 2012, the Office of State Planning and Budgeting and the Colorado Department of Local Affairs' Demography Division supplied actual and forecasted values of the following independent variables, which were used in the regression models:

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

The Department uses the June forecasts for variables because caseload estimates must be completed before September in order to calculate the November 1st request.

Trend vs. Regression Models

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

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

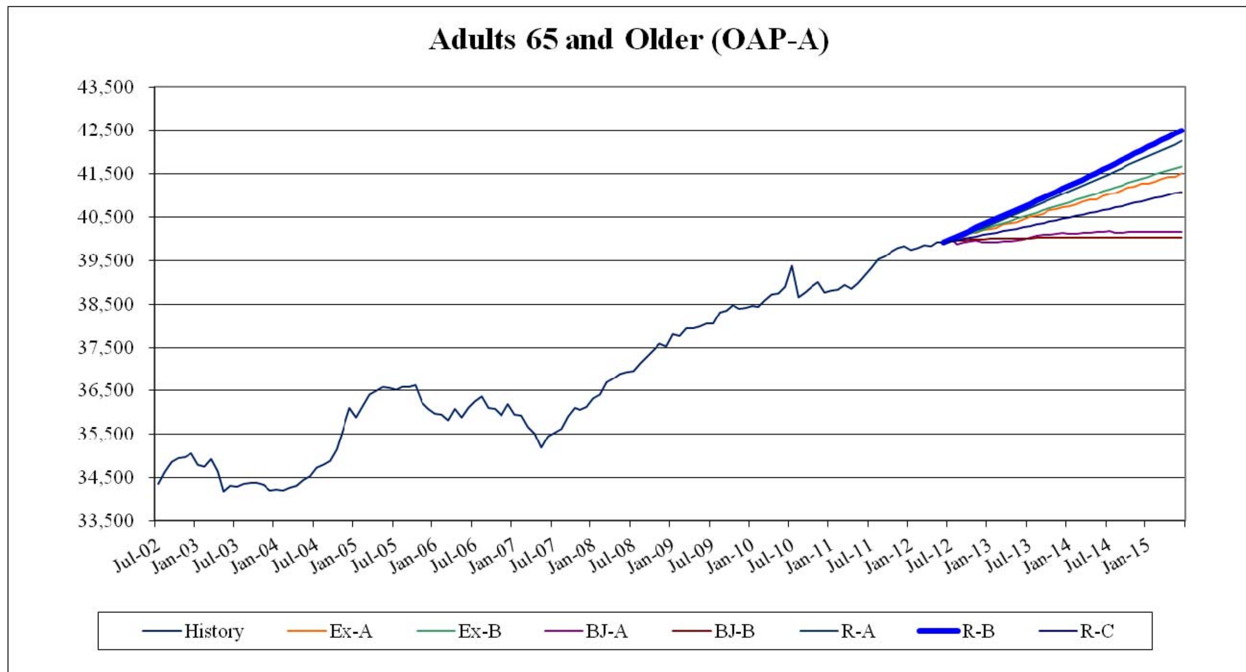
CATEGORICAL PROJECTIONS

This section details the caseload projections by eligibility category. For each category, the following are presented: a discussion of the category, model results, rationale for the forecast, statutory authority, and historical caseload and forecasts. FY 2014-15 projections are included for informational purposes. Graphical representations of caseload history to FY 2002-03 are included in each categorical section.

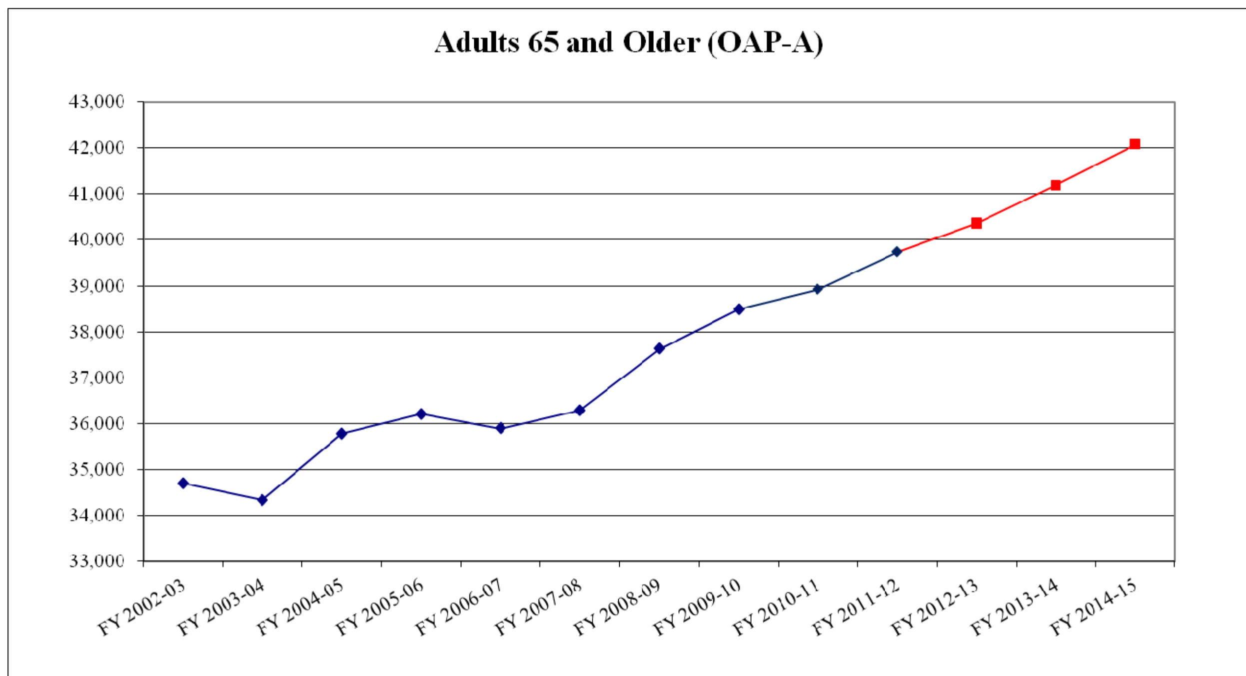
Adults 65 and Older

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

Adults 65 and Older: Model Results



	Adjusted R2	Notes
Exponential Smoothing A*	0.9973	
Exponential Smoothing B*	0.9974	
Box-Jenkins A	0.9898	
Box-Jenkins B	0.9705	
Regression A	0.9972	OAP-A [-1], OAP-A [-7], CBMS Dummy [-2], Systems Dummy
Regression B	0.9972	OAP-A [-1], Population 65+, CBMS Dummy, CBMS Dummy [-2], Auto [-5]
Regression C	0.9973	OAP-A [-1], Total Population, CBMS Dummy, Trend



Adults 65 and Older: Model Results

FY 2012-13	FY 2010-11	FY 2011-12	Projected Growth Rate	Projected FY 2012-13 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	38,921	39,740	1.19%	40,213	473	44
Exponential Smoothing B*	38,921	39,740	1.26%	40,241	501	49
Box Jenkins A	38,921	39,740	0.53%	39,951	211	6
Box Jenkins B	38,921	39,740	0.64%	39,994	254	8
Regression A	38,921	39,740	1.39%	40,292	552	60
Regression B	**38,921**	**39,740**	**1.57%**	**40,364**	**624**	**68**
Regression C	38,921	39,740	0.93%	40,110	370	29

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2013-14	FY 2011-12	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	39,740	40,364	1.32%	40,897	533	44
Exponential Smoothing B*	39,740	40,364	1.46%	40,953	589	49
Box Jenkins A	39,740	40,364	0.42%	40,534	170	13
Box Jenkins B	39,740	40,364	0.09%	40,400	36	1
Regression A	39,740	40,364	1.92%	41,139	775	66
Regression B	**39,740**	**40,364**	**2.06%**	**41,195**	**831**	**71**
Regression C	39,740	40,364	0.92%	40,735	371	32

FY 2014-15	Projected FY 2012-13 Caseload	Projected FY 2013-14 Caseload	Projected Growth Rate	Projected FY 2014-15 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	40,364	41,195	1.30%	41,731	536	44
Exponential Smoothing B*	40,364	41,195	1.43%	41,784	589	49
Box Jenkins A	40,364	41,195	0.11%	41,240	45	1
Box Jenkins B	40,364	41,195	0.01%	41,199	4	0
Regression A	40,364	41,195	1.97%	42,007	812	68
Regression B	**40,364**	**41,195**	**2.15%**	**42,081**	**886**	**76**
Regression C	40,364	41,195	1.01%	41,611	416	35

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

Adults 65 and Older: Trend Selections

FY 2012-13: 1.57%
FY 2013-14: 2.06%
FY 2014-15: 2.15%

Adults 65 and Older: Justifications

- This population will be effected by the "baby boomers", defined by the U.S. Census Bureau as the generation born between 1946 and 1964, beginning in approximately calendar year 2011.
- Regression analysis indicates that the caseload for this population is not significantly correlated with the size of the over-65 population or economic conditions. Data for FY 2011-12 indicate that approximately 29.8% of this eligibility type were automatically eligible for Medicaid due to their receipt of Supplemental Security Income (SSI). Additionally, 89.0% of this population were dual eligibles in FY 2010-11 and 32.7% were enrolled in Home- and Community-Based Services waivers (HCBS). Enrollment in waivers has increased by an average of 5.1% per year for the last three years. (Source: MARS 474701 report)
- This population may be effected by provisions in the Deficit Reduction Act of 2005, notably sections 6011 (lengthening of look-back period), 6012 (treatment of annuities), 6014 (disqualification of individuals with substantial home equity), 6015 (reform of asset test rules). These provisions may decrease the long-term growth rates as fewer people may now be eligible due to these provisions.
- The graph above shows that historically, this population has had relatively flat growth, though monthly growth has been strong since FY 2007-08. Between FY 2002-03 and FY 2006-07, the caseload increased by an average of 19 clients per month, compared with 77 between FY 2007-08 and FY 2010-11. Historical growth rates are stable and tend to fluctuate between 1% and 2%. The Department suspects that the high growth rate in FY 2004-05 is due to the court order regarding the Colorado Benefits Management System. The Department speculates that the decline in FY 2006-07 may be indicative that the effects of the asset and annuities provisions in the Deficit Reduction Act may be stronger than expected. The Department has seen strong growth in the Home- and Community-Based Services for the Elderly, Blind, and Disabled waiver over the last four years. There has also been a large increase in the number of clients in this eligibility type who are not eligible for SSI or on a waiver. The Department believes this is related to caseload declines in the State-only Old Age Pension Health and Medical Care program, which were caused by the implementation of new requirements around Systematic Alien Verification for Entitlements (SAVE) to comply with HB 06S-1023 and Department regulations.
- Growth in FY 2011-12 was lower than the Department's February 2012 forecast, in which the annual caseload was projected to be 39,867 and average monthly growth was projected to be 94. The selected trend for FY 2012-13 is lower than that from the Department's February 2012 forecast, and would result in average growth of 68 per month for FY 2012-13.
- Out-year trends are moderately positive to reflect the aging population, and are slightly moderated to reflect the Deficit Reduction provisions, which may negatively affect caseload. Population growth in this age group is projected to overtake that of the 60-64 group in 2012 to become the fastest growing age group, with projected increases of an average of 5.8% per year over the forecast period.

25.5-5-101 (1), C.R.S.
(f) Individuals receiving supplemental security income;
(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions;
(h) Institutionalized individuals who were eligible for medical assistance in December 1973;

(i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under P.L. 92-336;
(j) Individuals who become ineligible for cash assistance as a result of old-age, survivors, and disability insurance cost-of-living increases after April 1977;

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

Adults 65 and Older: Historical Caseload and Forecasts

Adults 65 and Older: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	38,900	-	-
Jul-10	39,382	482	1.24%
Aug-10	38,648	(734)	-1.86%
Sep-10	38,774	126	0.33%
Oct-10	38,901	127	0.33%
Nov-10	39,009	108	0.28%
Dec-10	38,769	(240)	-0.62%
Jan-11	38,813	44	0.11%
Feb-11	38,823	10	0.03%
Mar-11	38,939	116	0.30%
Apr-11	38,861	(78)	-0.20%
May-11	38,981	120	0.31%
Jun-11	39,154	173	0.44%
Jul-11	39,341	187	0.48%
Aug-11	39,537	196	0.50%
Sep-11	39,600	63	0.16%
Oct-11	39,697	97	0.24%
Nov-11	39,789	92	0.23%
Dec-11	39,843	54	0.14%
Jan-12	39,742	(101)	-0.25%
Feb-12	39,800	58	0.15%
Mar-12	39,849	49	0.12%
Apr-12	39,837	(12)	-0.03%
May-12	39,924	87	0.22%
Jun-12	39,923	(1)	0.00%

	Caseload*	% Change	Level Change
FY 1995-96	31,321	-	-
FY 1996-97	32,080	2.42%	759
FY 1997-98	32,664	1.82%	584
FY 1998-99	33,007	1.05%	343
FY 1999-00	33,135	0.39%	128
FY 2000-01	33,649	1.55%	514
FY 2001-02	33,916	0.79%	267
FY 2002-03	34,704	2.32%	788
FY 2003-04	34,329	-1.08%	(375)
FY 2004-05	35,780	4.23%	1,451
FY 2005-06	36,207	1.19%	427
FY 2006-07	35,888	-0.88%	(319)
FY 2007-08	36,284	1.10%	396
FY 2008-09	37,619	3.68%	1,335
FY 2009-10	38,487	2.31%	868
FY 2010-11	38,921	1.13%	434
FY 2011-12	39,740	2.10%	819
FY 2012-13	40,364	1.57%	624
FY 2013-14	41,195	2.06%	831
FY 2014-15	42,081	2.15%	886

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

February 2012 Forecast	
Forecasted June 2012 Level	40,278

February 2012 Trends			
FY 2011-12	39,867	2.43%	946
FY 2012-13	40,820	2.39%	953
FY 2013-14	41,914	2.68%	1,094

Actuals	Monthly Change	% Change
6-month average	13	0.03%
12-month average	64	0.16%
18-month average	64	0.16%
24-month average	43	0.11%

Monthly Average Growth Comparisons		
February 2012 Forecast	94	0.24%
FY 2011-12 Actuals	64	0.16%
FY 2011-12 1st Half	115	0.29%
FY 2011-12 2nd Half	13	0.03%
FY 2012-13 Forecast	68	0.17%
February 2012 Forecast	85	0.21%
FY 2013-14 Forecast	71	0.18%

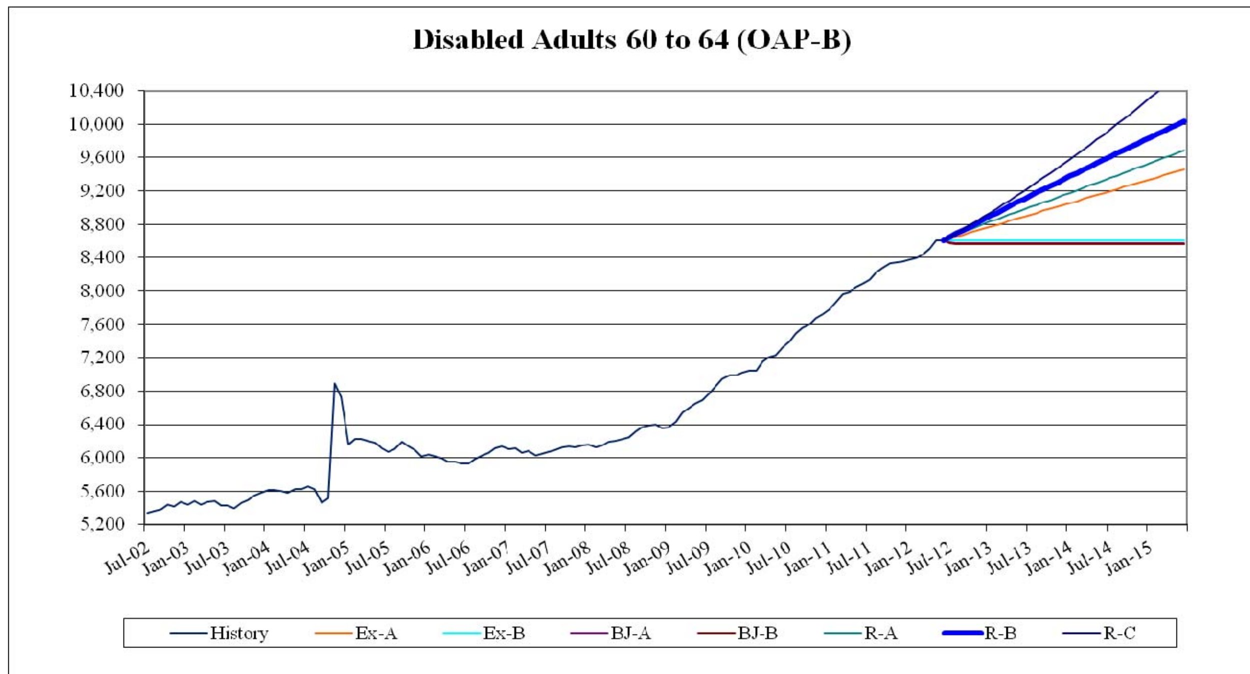
Base trend from June 2012 level			
FY 2012-13	39,923	0.46%	183

Disabled Adults 60 to 64

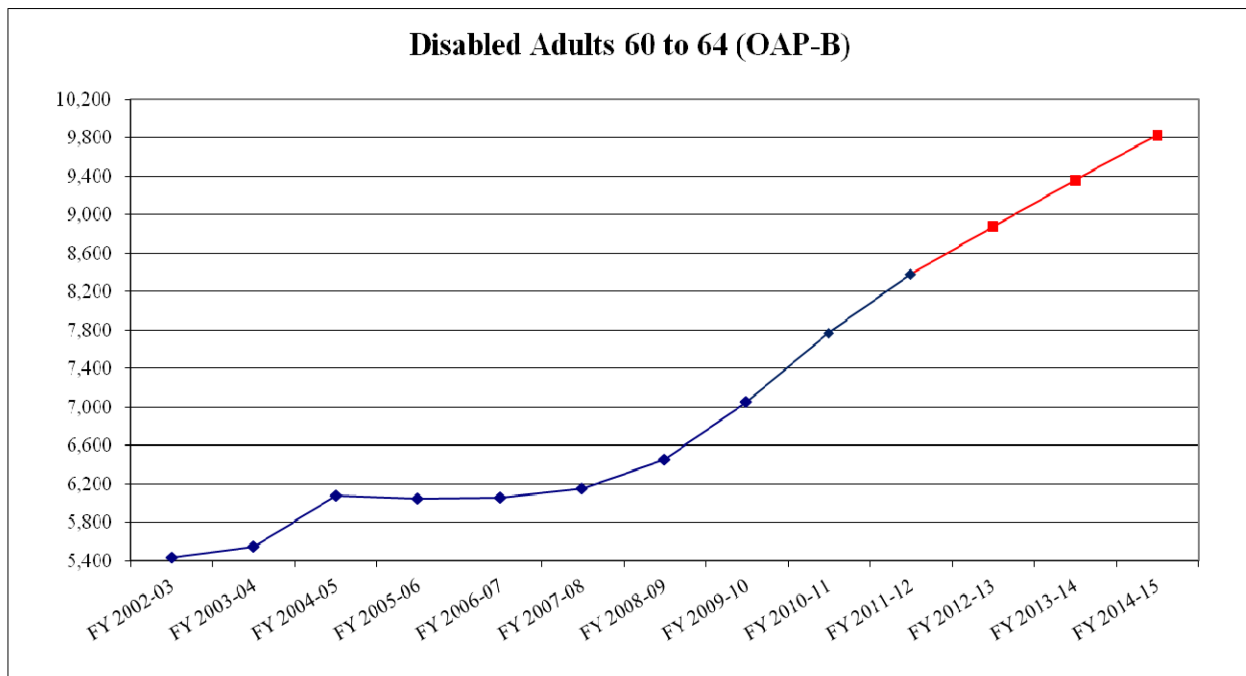
Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental Security Income, authorized under Title XVI of the Social Security Act of 1965, is a federal cash assistance program for persons aged 65 and older, blind, or disabled. An individual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

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

Disabled Adults 60 to 64: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A*	0.9919	
Exponential Smoothing B*	0.9709	
Box-Jenkins A	0.9928	
Box-Jenkins B	0.9694	
Regression A	0.9982	OAP-B [-1], OAP-B [-3], CBMS Dummy, Auto [-4]
Regression B	0.9991	OAP-B [-1], OAP-B [-2], Population 60-64, CBMS Dummy, CBMS Dummy [-2], Trend, Constant, Auto [-1]
Regression C	0.9990	OAP-B [-1], OAP-B [-2], Total Population, CBMS Dummy, CBMS Dummy [-2], Auto [-1]



Disabled Adults 60 to 64: Model Results

FY 2012-13	FY 2010-11	FY 2011-12	Projected Growth Rate	Projected FY 2012-13 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	7,767	8,383	4.49%	8,759	376	24
Exponential Smoothing B*	7,767	8,383	2.65%	8,605	222	0
Box Jenkins A	7,767	8,383	2.33%	8,578	195	(2)
Box Jenkins B	7,767	8,383	2.12%	8,561	178	(4)
Regression A	7,767	8,383	5.13%	8,813	430	31
Regression B	**7,767**	**8,383**	**5.86%**	**8,874**	**491**	**41**
Regression C	7,767	8,383	6.36%	8,916	533	49

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2013-14	FY 2011-12	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	8,383	8,874	3.24%	9,162	288	24
Exponential Smoothing B*	8,383	8,874	0.00%	8,874	0	0
Box Jenkins A	8,383	8,874	0.00%	8,874	0	0
Box Jenkins B	8,383	8,874	0.00%	8,874	0	0
Regression A	8,383	8,874	3.98%	9,227	353	29
Regression B	**8,383**	**8,874**	**5.43%**	**9,356**	**482**	**39**
Regression C	8,383	8,874	7.19%	9,512	638	57

FY 2014-15	Projected FY 2012-13 Caseload	Projected FY 2013-14 Caseload	Projected Growth Rate	Projected FY 2014-15 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	8,874	9,356	3.14%	9,650	294	24
Exponential Smoothing B*	8,874	9,356	0.00%	9,356	0	0
Box Jenkins A	8,874	9,356	0.00%	9,356	0	0
Box Jenkins B	8,874	9,356	0.00%	9,356	0	0
Regression A	8,874	9,356	3.88%	9,719	363	30
Regression B	**8,874**	**9,356**	**4.98%**	**9,822**	**466**	**38**
Regression C	8,874	9,356	7.64%	10,071	715	65

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

Disabled Adults 60 to 64: Trend Selections

FY 2012-13: 5.86%
FY 2013-14: 5.43%
FY 2014-15: 4.98%

Disabled Adults 60 to 64: Justifications

- The 1,615 client caseload spike in November 2004 is directly related to the court order regarding the Colorado Benefits Management System. Of this group, 1,166 clients came from the Disabled Adults to 59 (AND/AB) population, while the remaining 449 clients came from the Adults 65 and Older (OAP-A) population. This has been corrected for in regressions.
- Historically, this category has displayed consistently slow growth, with caseload increasing by an average of 12 clients per month between FY 2002-03 and FY 2007-08, excluding the level shift that occurred from the court order regarding the Colorado Benefits Management System. Growth from FY 2008-09 through FY 2010-11 averaged 52 per month. This population, like the Adults 65 and Older category, may be effected by the asset and annuities provisions in the Deficit Reduction Act of 2005, which would promote low growth. This category began to be effected by the baby-boom generation, defined by the U.S. Census Bureau as the generation born between 1946 and 1964, in calendar year 2006, which may have resulted in higher growth. Population growth in this age group was 10.4% in 2009 and 7.0% in 2010. The Department has seen strong growth in the Home- and Community-Based Services (HCBS) for the Elderly, Blind, and Disabled waiver over the last four years. There has also been a large increase in the number of clients in this eligibility type who are not eligible for Supplemental Security Income (SSI) or on a waiver. The Department believes this is related to caseload declines in the State-only Old Age Pension Health and Medical Care program, which were caused by the implementation of new requirements around Systematic Alien Verification for Entitlements (SAVE) to comply with HB 06S-1023 and Department regulations.
- However, because this population is disabled, the effects of both the baby boom generation and the Deficit Reduction Act are likely to be mitigated. Data for FY 2011-12 indicate that approximately 53.8% of this eligibility type were automatically eligible for Medicaid due to their receipt of SSI. Additionally, 45.3% of this population were dual eligibles in FY 2011-12 and 33.4% were enrolled in HCBS waivers. Enrollment in waivers has increased by an average of 11.8% per year for the last three years. (Source: MARS 474701 report)
- Growth in FY 2011-12 was in line with the Department's February 2012 forecast, in which the annual caseload was projected to be 8,399 and average monthly growth was projected to be 46. The selected trend for FY 2012-13 is slightly lower than that from the February 2012 forecast, and would yield average growth of 41 per month in FY 2012-13.
- Out-year trends are moderate, as this population may become affected by a larger portion of the baby-boom generation over the next 5 years. Population growth in this age group is forecasted to slow, with projected increases of an average of approximately 2.8% per year over the forecast period.

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

(f) Individuals receiving supplemental security income;

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

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

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

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

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

Disabled Adults 60 to 64: Historical Caseload and Forecasts

Disabled Adults 60 to 64: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	7,326	-	-
Jul-10	7,395	69	0.94%
Aug-10	7,492	97	1.31%
Sep-10	7,562	70	0.93%
Oct-10	7,602	40	0.53%
Nov-10	7,682	80	1.05%
Dec-10	7,721	39	0.51%
Jan-11	7,781	60	0.78%
Feb-11	7,870	89	1.14%
Mar-11	7,966	96	1.22%
Apr-11	7,987	21	0.26%
May-11	8,051	64	0.80%
Jun-11	8,089	38	0.47%
Jul-11	8,133	44	0.54%
Aug-11	8,222	89	1.09%
Sep-11	8,280	58	0.71%
Oct-11	8,328	48	0.58%
Nov-11	8,343	15	0.18%
Dec-11	8,355	12	0.14%
Jan-12	8,373	18	0.22%
Feb-12	8,401	28	0.33%
Mar-12	8,445	44	0.52%
Apr-12	8,507	62	0.73%
May-12	8,600	93	1.09%
Jun-12	8,605	5	0.06%

	Caseload*	% Change	Level Change
FY 1995-96	4,261	-	-
FY 1996-97	4,429	3.94%	168
FY 1997-98	4,496	1.51%	67
FY 1998-99	4,909	9.19%	413
FY 1999-00	5,092	3.73%	183
FY 2000-01	5,157	1.28%	65
FY 2001-02	5,184	0.52%	27
FY 2002-03	5,431	4.76%	247
FY 2003-04	5,548	2.15%	117
FY 2004-05	6,082	9.63%	534
FY 2005-06	6,042	-0.66%	(40)
FY 2006-07	6,059	0.28%	17
FY 2007-08	6,146	1.44%	87
FY 2008-09	6,447	4.90%	301
FY 2009-10	7,049	9.34%	602
FY 2010-11	7,767	10.19%	718
FY 2011-12	8,383	7.93%	616
FY 2012-13	8,874	5.86%	491
FY 2013-14	9,356	5.43%	482
FY 2014-15	9,822	4.98%	466

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

February 2012 Forecast	
Forecasted June 2012 Level	8,643

Actuals	Monthly Change	% Change
6-month average	42	0.49%
12-month average	43	0.52%
18-month average	49	0.60%
24-month average	53	0.67%

Base trend from June 2012 level			
FY 2012-13	8,605	2.65%	222

February 2012 Trends			
FY 2011-12	8,399	8.14%	632
FY 2012-13	8,948	6.54%	549
FY 2013-14	9,491	6.07%	543

Monthly Average Growth Comparisons		
February 2012 Forecast	46	0.57%
FY 2011-12 Actuals	43	0.52%
FY 2011-12 1st Half	44	0.54%
FY 2011-12 2nd Half	42	0.49%
FY 2012-13 Forecast	41	0.51%
February 2012 Forecast	46	0.53%
FY 2013-14 Forecast	39	0.45%

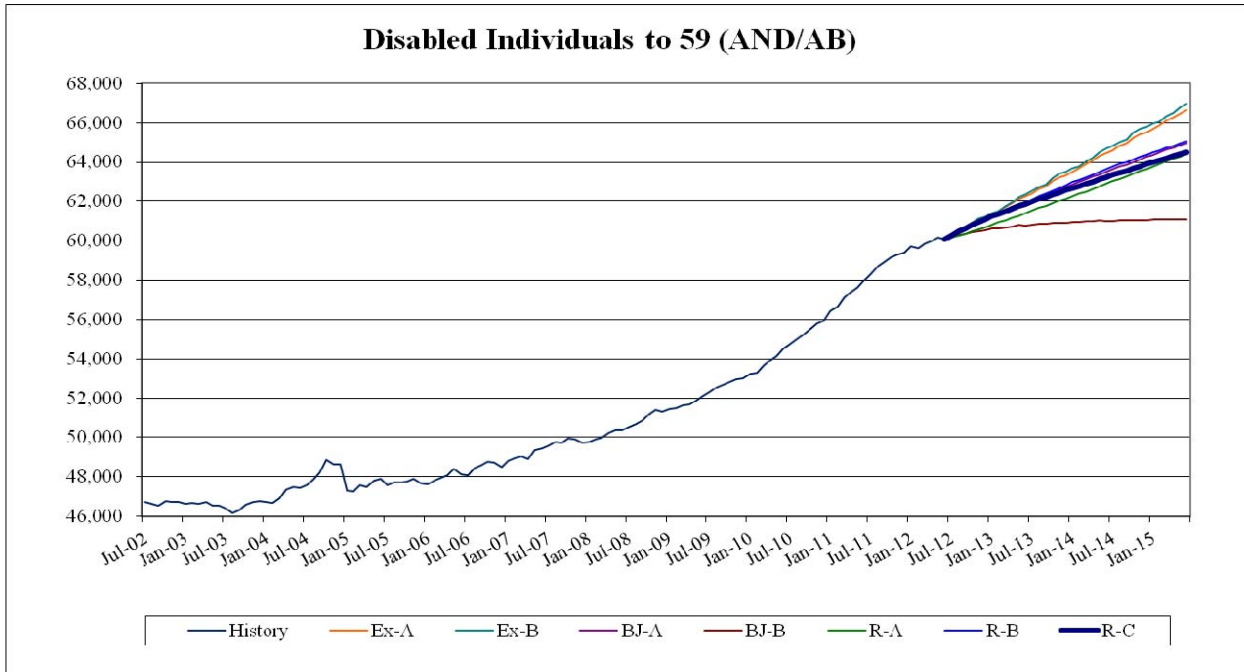
Disabled Individuals to 59

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

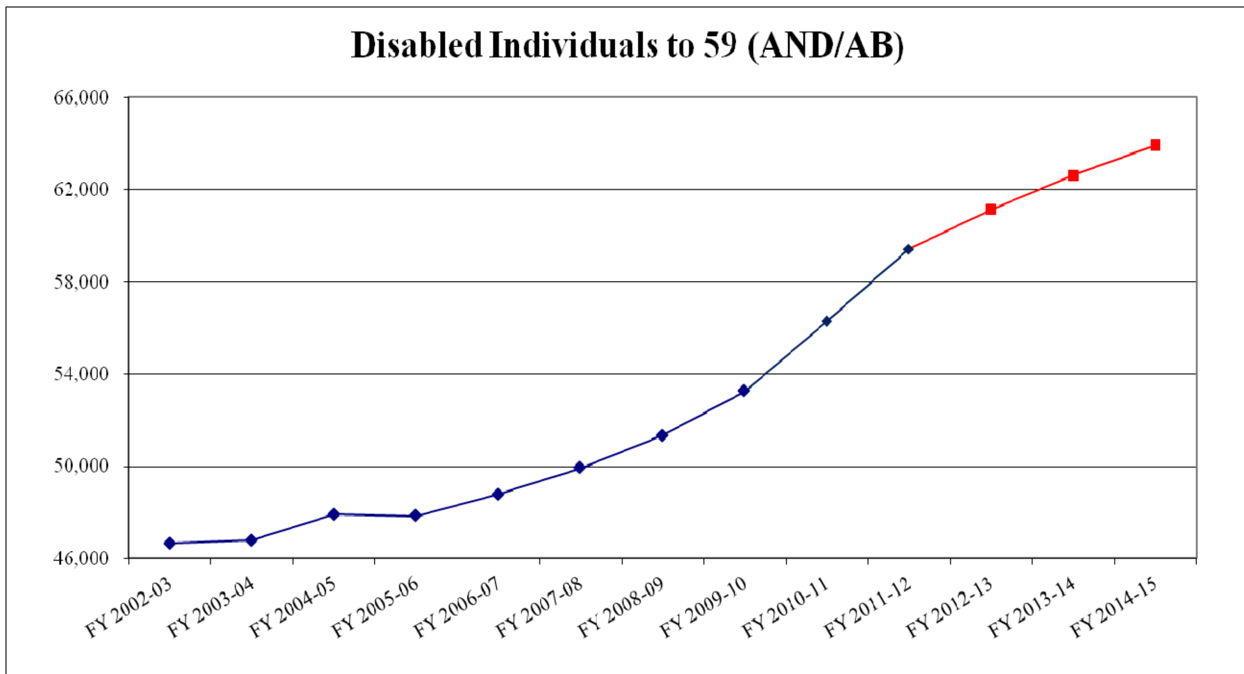
The 1990 outcome of the *Zebley v. Sullivan* lawsuit found that children could not be held to higher standard of disability than adults. Zebley required that children's disability be measured using child-appropriate activities. As a result, the number of children determined to be disabled significantly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

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

Disabled Individuals to 59: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A*	0.9982	
Exponential Smoothing B*	0.9973	
Box-Jenkins A	0.9983	
Box-Jenkins B	0.9965	
Regression A	0.9978	AND/AB [-1], AND/AB [-3], Auto [-5]
Regression B	0.9978	AND/AB [-1], Unemployment Rate, CBMS Dummy, Auto [-12]
Regression C	0.9978	AND/AB [-1], AND/AB [-24], Auto [-12]



Disabled Individuals to 59: Model Results						
FY 2012-13	**FY 2010-11**	**FY 2011-12**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	56,285	59,434	3.10%	61,276	1,842	182
Exponential Smoothing B*	56,285	59,434	3.15%	61,306	1,872	191
Box Jenkins A	56,285	59,434	2.89%	61,152	1,718	150
Box Jenkins B	56,285	59,434	1.87%	60,545	1,111	57
Regression A	56,285	59,434	2.24%	60,765	1,331	110
Regression B	56,285	59,434	2.95%	61,187	1,753	154
Regression C	**56,285**	**59,434**	**2.87%**	**61,140**	**1,706**	**147**

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2013-14	FY 2011-12	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	59,434	61,140	3.55%	63,310	2,170	181
Exponential Smoothing B*	59,434	61,140	3.73%	63,421	2,281	191
Box Jenkins A	59,434	61,140	2.68%	62,779	1,639	134
Box Jenkins B	59,434	61,140	0.63%	61,525	385	19
Regression A	59,434	61,140	2.37%	62,589	1,449	124
Regression B	59,434	61,140	2.79%	62,846	1,706	141
Regression C	**59,434**	**61,140**	**2.42%**	**62,620**	**1,480**	**114**

FY 2014-15	Projected FY 2012-13 Caseload	Projected FY 2013-14 Caseload	Projected Growth Rate	Projected FY 2014-15 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	61,140	62,620	3.43%	64,768	2,148	181
Exponential Smoothing B*	61,140	62,620	3.60%	64,874	2,254	191
Box Jenkins A	61,140	62,620	2.43%	64,142	1,522	123
Box Jenkins B	61,140	62,620	0.22%	62,758	138	7
Regression A	61,140	62,620	2.43%	64,142	1,522	127
Regression B	61,140	62,620	2.44%	64,148	1,528	117
Regression C	**61,140**	**62,620**	**2.10%**	**63,935**	**1,315**	**107**

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

Disabled Individuals to 59: Trend Selections

FY 2012-13: 2.87%
FY 2013-14: 2.42%
FY 2014-15: 2.10%

Disabled Individuals to 59: Justifications

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

population have increased significantly in the last four fiscal years, with caseload in HCBS waivers showing strong growth. In addition, over the last four years, the number of individuals eligible for Medicaid due to receipt of SSI has represented most of the growth in this eligibility group. The Department believes that this may be related to economic condition in that individuals with work-limiting disabilities who were employed prior to the recession and have exhausted their federally-extended unemployment benefits may now be applying for Supplemental Security Income (SSI) if they cannot find work. Data for FY 2011-12 indicate that approximately 68.8% of this eligibility type were automatically eligible for Medicaid due to their receipt of Supplemental Security Income (SSI). Additionally, 32.7% of this population were dual eligibles in FY 2011-12 and 28.5% were enrolled in Home- and Community-Based (HCBS) waivers. Enrollment in waivers has increased by an average of 4.3% per year for the last three years. (Source: MARS 474701 report)

- Growth in FY 2011-12 was lower than the Department's February 2012 forecast, in which the annual caseload was projected to be 59,589 and average monthly growth was projected to be 233. The selected trend FY 2012-13 is lower than the February 2012 forecast, and would yield average growth of 147 per month for FY 2012-13.
- Out-year growth is projected to moderate and maintain a long-term trend.

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

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

Disabled Individuals to 59: Historical Caseload and Forecasts

Disabled Individuals to 59: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	54,493	-	-
Jul-10	54,740	247	0.45%
Aug-10	55,032	292	0.53%
Sep-10	55,223	191	0.35%
Oct-10	55,508	285	0.52%
Nov-10	55,804	296	0.53%
Dec-10	55,937	133	0.24%
Jan-11	56,417	480	0.86%
Feb-11	56,671	254	0.45%
Mar-11	57,103	432	0.76%
Apr-11	57,385	282	0.49%
May-11	57,608	223	0.39%
Jun-11	57,986	378	0.66%
Jul-11	58,294	308	0.53%
Aug-11	58,712	418	0.72%
Sep-11	58,937	225	0.38%
Oct-11	59,159	222	0.38%
Nov-11	59,298	139	0.23%
Dec-11	59,384	86	0.15%
Jan-12	59,709	325	0.55%
Feb-12	59,635	(74)	-0.12%
Mar-12	59,847	212	0.36%
Apr-12	59,970	123	0.21%
May-12	60,167	197	0.33%
Jun-12	60,091	(76)	-0.13%

	Caseload*	% Change	Level Change
FY 1995-96	44,736	-	-
FY 1996-97	46,090	3.03%	1,354
FY 1997-98	46,003	-0.19%	(87)
FY 1998-99	46,310	0.67%	307
FY 1999-00	46,386	0.16%	76
FY 2000-01	46,046	-0.73%	(340)
FY 2001-02	46,349	0.66%	303
FY 2002-03	46,647	0.64%	298
FY 2003-04	46,789	0.30%	142
FY 2004-05	47,929	2.44%	1,140
FY 2005-06	47,855	-0.15%	(74)
FY 2006-07	48,799	1.97%	944
FY 2007-08	49,933	2.32%	1,134
FY 2008-09	51,355	2.85%	1,422
FY 2009-10	53,264	3.72%	1,909
FY 2010-11	56,285	5.67%	3,021
FY 2011-12	59,434	5.59%	3,149
FY 2012-13	61,140	2.87%	1,706
FY 2013-14	62,620	2.42%	1,480
FY 2014-15	63,935	2.10%	1,315

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

February 2012 Trends			
FY 2011-12	59,589	5.87%	3,304
FY 2012-13	62,098	4.21%	2,509
FY 2013-14	64,184	3.36%	2,086

February 2012 Forecast	
Forecasted June 2012 Level	60,782

Actuals		
	Monthly Change	% Change
6-month average	118	0.20%
12-month average	175	0.30%
18-month average	231	0.40%
24-month average	233	0.41%

Base trend from June 2012 level			
FY 2012-13	60,091	1.11%	657

Monthly Average Growth Comparisons		
February 2012 Forecast	233	0.40%
FY 2011-12 Actuals	175	0.30%
FY 2011-12 1st Half	233	0.40%
FY 2011-12 2nd Half	118	0.20%
FY 2012-13 Forecast	147	0.25%
February 2012 Forecast	195	0.32%
FY 2013-14 Forecast	114	0.19%

Disabled Buy-In

HB 09-1293 (Colorado Health Care Affordability Act) establishes the Buy-In Program for Individuals with Disabilities, which will allow individuals to pay a premium to purchase Medicaid coverage if they are over income or are otherwise ineligible for Medicaid. The Buy-In Program for Working Adults with Disabilities was implemented on March 1, 2012 and allows eligible clients age 16 to 65 with income up to 450% of the federal poverty level that have a qualifying disability and are working to receive Medicaid by paying a monthly premium based on their income. The Buy-In Program for Disabled Children was implemented on July 1, 2012. This program allows children under age 19 with a qualifying disability and family income up to 300% of the federal poverty level to receive Medicaid by paying a monthly premium based on their family income.

Disabled Buy-In: Trend Selections

FY 2012-13: 4,146.15%
FY 2013-14: 156.84%
FY 2014-15: 50.01%

Disabled Buy-In: Justifications

- HB 09-1293 establishes the Buy-In Program for Working Adults with Disabilities beginning March 1, 2012 and for Disabled Children July 1, 2012. This program allows individuals to pay a premium to purchase Medicaid coverage if they are over income or are otherwise ineligible for Medicaid.
- The Department's forecast for this eligibility group is based on analysis of data on uninsurance from the 2010 American Community Survey, trended forward to account for population growth and the impact of economic conditions. The Department has utilized data on the number of uninsured working adults ages 19 to 65 with a disability and children age 0 to 19 with a disability, stratified by income, to estimate caseload. The forecast assumes that the number of uninsured that opt to buy into Medicaid will increase marginally with income, and that enrollment will be phased-in on a monthly basis over two years based on experience with previous expansion populations in Medicaid.
- FY 2011-12 caseload for this eligibility category was in line with the Department's February 2012 forecast, in which the annual caseload was projected to be 58. At this time, the Department does not see any reason to deviate from the February 2012 forecast for this population. This forecast would yield average growth of 281 per month for FY 2012-13 and 267 per month in FY 2013-14. This strong monthly growth represents the gradual phasing-on of both disabled working adults and children into the program.

Disabled Buy-In: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jul-11	0	-	-
Aug-11	0	0	0.00%
Sep-11	0	0	0.00%
Oct-11	0	0	0.00%
Nov-11	0	0	0.00%
Dec-11	0	0	0.00%
Jan-12	0	0	0.00%
Feb-12	0	0	0.00%
Mar-12	51	51	0.00%
Apr-12	133	82	160.78%
May-12	202	69	51.88%
Jun-12	240	38	18.81%

	Caseload	% Change	Level Change
FY 2011-12	52	-	-
FY 2012-13	2,183	4,098.08%	2,131
FY 2013-14	5,465	150.34%	3,282
FY 2014-15	8,367	53.10%	2,902

February 2012 Trends			
FY 2011-12	58	-	-
FY 2012-13	2,208	3,706.90%	2,150
FY 2013-14	5,671	156.84%	3,463

Monthly Growth Estimates		
FY 2012-13	281	30.38%
FY 2013-14	267	5.44%
FY 2014-15	226	2.84%

February 2012 Forecast	
Forecasted June 2012 Level	386

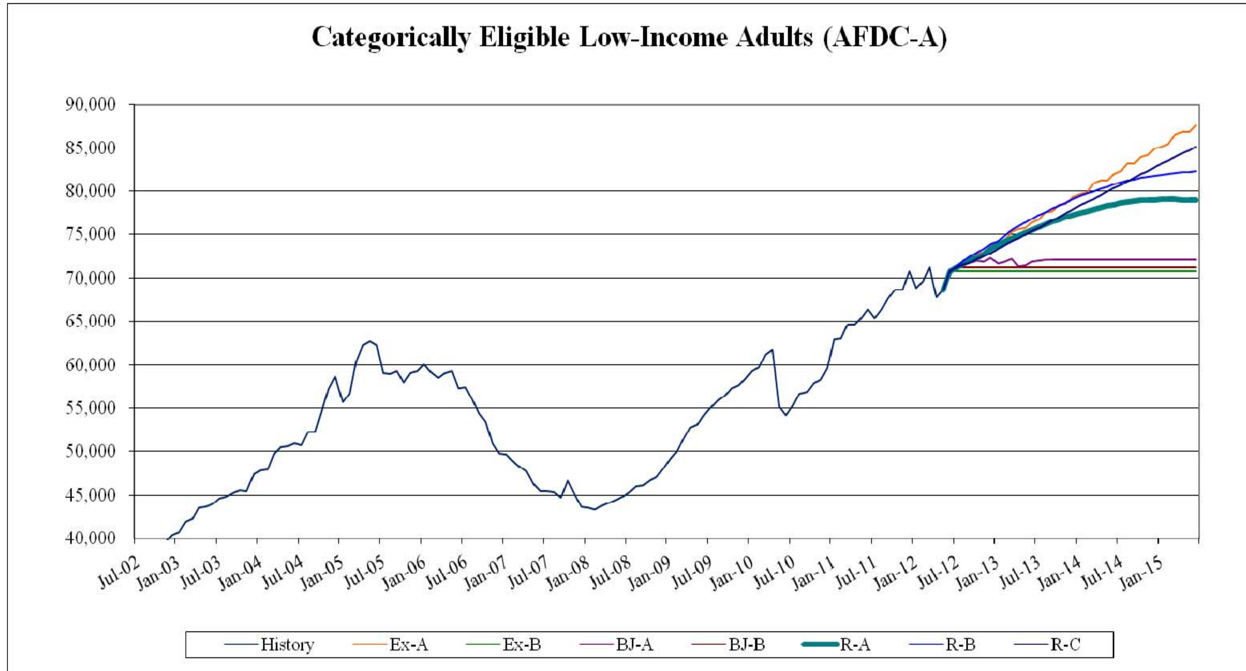
Categorically Eligible Low-Income Adults

One of the primary ways that adults qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to Families with Dependent Children program was discontinued. Aid to Families with Dependent Children was replaced by the Temporary Assistance for Needy Families program (referred to as Colorado Works) on July 16, 1996. Clients enrolled in the Temporary Assistance for Needy Families program are no longer automatically eligible for Medicaid. Therefore, the Categorically Eligible Low-Income Adults category includes adults who receive Medicaid under Section 1931 and those families who receive Temporary Aid to Needy Families financial assistance coupled with Medicaid. Also included in this category are adults receiving Transitional Medicaid. Transitional Medicaid is available to adults in families who have received 1931 Medicaid in three of the past six months and become ineligible due to an increase in earned income. Adults may receive Transitional Medicaid benefits for one year. In FY 2011-12, there were an average of 11,171 adults in this program. Although this program has been set to expire many times, it has been renewed regularly, most recently through December 31, 2012. While the future of Transitional Medicaid is unknown once the federal Affordable Care Act is implemented, the Department assumed that the federal Transitional Medicaid program would continue throughout FY 2014-15 for the purposes of projecting caseload.

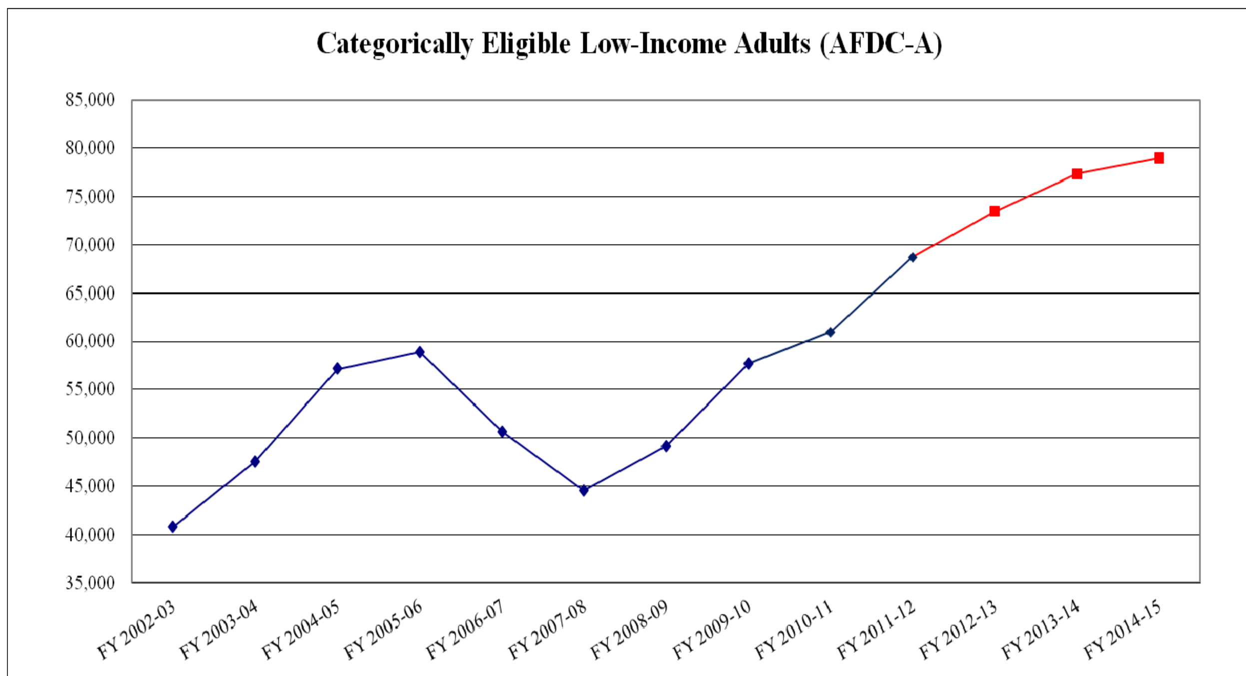
Before 1999, caseload in this category was falling. Decreases in caseload can be attributed to economic expansion and effects of the Personal Responsibility Work and Opportunity Reconciliation Act, known as welfare reform. When welfare reform was instituted in Colorado in 1997, the link between cash assistance for welfare and Medicaid was broken. When the Department implemented this change into the Client Oriented Information Network eligibility data system, it was estimated that 46,006[9] clients had their cases closed in error. In reaction, the Tatum lawsuit was brought against the State. Starting in May 2001, the Department began to reinstate clients who inadvertently lost their Medicaid eligibility. This may help to explain why from 1997 to 1999 caseload fell, and may have contributed to a spike in caseload in FY 2001-02. For a complete explanation of the Tatum lawsuit, see the November 1, 2001 Budget Request, pages A-37 to A-38.

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

Categorically Eligible Low-Income Adults: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A*	0.9943	
Exponential Smoothing B*	0.9666	
Box-Jenkins A	0.9960	
Box-Jenkins B	0.9679	
Regression A	0.9960	AFDC-A [-1], AFDC-A [-9], Unemployment Rate, CBMS Dummy, Systems Dummy, Auto [-6]
Regression B	0.9962	AFDC-A [-1], AFDC-A [-9], Unemployment Rate, Total Wages, CBMS Dummy, CBMS Dummy [-2], Systems Dummy, Auto [-9]
Regression C	0.9957	AFDC-A [-1], AFDC-A [-9], Total Wages, CBMS Dummy, Systems Dummy



Categorically Eligible Low-Income Adults: Model Results

FY 2012-13	FY 2010-11	FY 2011-12	Projected Growth Rate	Projected FY 2012-13 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	60,960	68,689	7.50%	73,841	5,152	466
Exponential Smoothing B*	60,960	68,689	3.13%	70,839	2,150	0
Box Jenkins A	60,960	68,689	4.43%	71,732	3,043	87
Box Jenkins B	60,960	68,689	3.71%	71,237	2,548	33
Regression A	**60,960**	**68,689**	**6.98%**	**73,483**	**4,794**	**395**
Regression B	60,960	68,689	7.97%	74,164	5,475	499
Regression C	60,960	68,689	6.58%	73,209	4,520	381

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2013-14	FY 2011-12	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	68,689	73,483	7.57%	79,046	5,563	466
Exponential Smoothing B*	68,689	73,483	0.00%	73,483	0	0
Box Jenkins A	68,689	73,483	0.43%	73,799	316	14
Box Jenkins B	68,689	73,483	0.00%	73,483	0	0
Regression A	**68,689**	**73,483**	**5.23%**	**77,326**	**3,843**	**243**
Regression B	68,689	73,483	6.71%	78,414	4,931	330
Regression C	68,689	73,483	6.67%	78,384	4,901	412

FY 2014-15	Projected FY 2012-13 Caseload	Projected FY 2013-14 Caseload	Projected Growth Rate	Projected FY 2014-15 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	73,483	77,326	7.04%	82,770	5,444	466
Exponential Smoothing B*	73,483	77,326	0.00%	77,326	0	0
Box Jenkins A	73,483	77,326	0.01%	77,334	8	0
Box Jenkins B	73,483	77,326	0.00%	77,326	0	0
Regression A	**73,483**	**77,326**	**2.11%**	**78,958**	**1,632**	**37**
Regression B	73,483	77,326	3.36%	79,924	2,598	125
Regression C	73,483	77,326	6.23%	82,143	4,817	399

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

Categorically Eligible Low-Income Adults: Trend Selections

FY 2012-13: 6.98%
FY 2013-14: 5.23%
FY 2014-15: 2.11%

Categorically Eligible Low-Income Adults: Justifications

- Caseload trends in this category are highly affected by economic conditions, and tend to be positively correlated with the population of adults aged 19 to 59. Growth in the 19 to 59 population dropped from approximately 2.7% per year from FY 1995-96 to FY 2001-02 to 1.0% per year from FY 2002-03 to FY 2011-12. The growth in this population is projected to remain at an average of 1.0% over the forecast period[10]. The economy is projected remain relatively weak over the forecast period, with the unemployment rate to average 7.6% between 2012 and 2014. Wage and salary income is projected to increase by an average of 4.1% between 2012 and 2014.[11]
- There were large and consistent declines between July 2006 and December 2007, which seems to indicate that the improved economy was having the expected effect on caseload. There is evidence that a number of clients that left this eligibility category went to the Expansion Adults to 60% FPL, from both 1931 and Transitional Medicaid, due to increased income. Similarly, large and consistent increases since July 2008 indicate that the weakening economic conditions are impacting caseload in this eligibility type.
- The Department believes that economic conditions are largely responsible for the growth over the last four years, as the seasonally adjusted unemployment rate increased from a low of 3.5% in March 2007 to a high of 9.0% in November 2011 (source: Bureau of Labor Statistics). The unemployment rate is at the highest level in recent history, and has also remained at a high level for an unprecedented period of time. The unemployment rate has largely exceeded 8.0% since April 2009. During the 2001-2002 recession, the AFDC adults caseload was increasing by approximately 1.7% per month for 36 months. Caseload has increased by an average of 1.3% since January 2008, excluding outliers.
- Growth in FY 2011-12 was lower than the Department's February 2012 forecast, in which the annual caseload was projected to be 70,299 and average monthly growth was projected to be 650. The selected trend for FY 2012-13 is lower than that from the Department's February 2012 forecast, and would yield average increases of 395 per month for FY 2012-13. This forecast is reflective of the consistent increases since the second half of FY 2007-08, which moderated in FY 2009-10 but increased in FY 2010-11. Because the economy is believed to be largely responsible this change, projected economic conditions give no indication that the trend will not continue to be positive throughout FY 2012-13. This eligibility category has had experienced volatile monthly growth since late 2011, which the Department believes may be related to the implementation of an automated income verification interface. The Department will continue to monitor caseload trends in this category, though overall positive caseload trends are expected to continue.
- Current forecasts indicate that the economic conditions should begin to improve at the end of 2012. The selected out-year trend reflects this, and the monthly increases are forecasted to moderate over the forecast period.

25.5-5-101 (1), C.R.S.
(a) Individuals who meet the eligibility criteria for the aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;
(b) Families who meet the eligibility criteria for the aid to families with dependent children program established in rules that were in effect on July 16, 1996, and who subsequently would have become

[10] Source: Department of Local Affairs, Demography Division
[11] Source: Office of State Planning and Budgeting, September 2012 Economic Forecast

ineligible under such eligibility criteria because of increased earnings or increased hours of employment whose eligibility is specified for a period of time by the federal government;
(c) Qualified pregnant women . . . who meet the income resource requirements of the state's aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;

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

Categorically Eligible Low-Income Adults: Historical Caseload and Forecasts

Categorically Eligible Low-Income Adults: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	54,173	-	-
Jul-10	55,213	1,040	1.92%
Aug-10	56,687	1,474	2.67%
Sep-10	56,852	165	0.29%
Oct-10	57,801	949	1.67%
Nov-10	58,276	475	0.82%
Dec-10	59,591	1,315	2.26%
Jan-11	62,929	3,338	5.60%
Feb-11	63,025	96	0.15%
Mar-11	64,697	1,672	2.65%
Apr-11	64,673	(24)	-0.04%
May-11	65,402	729	1.13%
Jun-11	66,369	967	1.48%
Jul-11	65,372	(997)	-1.50%
Aug-11	66,406	1,034	1.58%
Sep-11	67,613	1,207	1.82%
Oct-11	68,677	1,064	1.57%
Nov-11	68,638	(39)	-0.06%
Dec-11	70,766	2,128	3.10%
Jan-12	68,831	(1,935)	-2.73%
Feb-12	69,644	813	1.18%
Mar-12	71,278	1,634	2.35%
Apr-12	67,739	(3,539)	-4.97%
May-12	68,601	862	1.27%
Jun-12	70,837	2,236	3.26%

	Caseload*	% Change	Level Change
FY 1995-96	36,690	-	-
FY 1996-97	33,250	-9.38%	(3,440)
FY 1997-98	27,179	-18.26%	(6,071)
FY 1998-99	22,852	-15.92%	(4,327)
FY 1999-00	23,515	2.90%	663
FY 2000-01	27,081	15.16%	3,566
FY 2001-02	33,347	23.14%	6,266
FY 2002-03	40,798	22.34%	7,451
FY 2003-04	47,562	16.58%	6,764
FY 2004-05	57,140	20.14%	9,578
FY 2005-06	58,885	3.05%	1,745
FY 2006-07	50,687	-13.92%	(8,198)
FY 2007-08	44,555	-12.10%	(6,132)
FY 2008-09	49,147	10.31%	4,592
FY 2009-10	57,661	17.32%	8,514
FY 2010-11	60,960	5.72%	3,299
FY 2011-12	68,689	12.68%	7,729
FY 2012-13	73,483	6.98%	4,794
FY 2013-14	77,326	5.23%	3,843
FY 2014-15	78,958	2.11%	1,632

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

February 2012 Forecast	
Forecasted June 2012 Level	74,173

February 2012 Trends			
FY 2011-12	70,299	15.32%	9,339
FY 2012-13	77,455	10.18%	7,156
FY 2013-14	81,351	5.03%	3,896

Actuals	Monthly Change	% Change
6-month average	12	0.06%
12-month average	372	0.57%
18-month average	625	0.99%
24-month average	694	1.14%

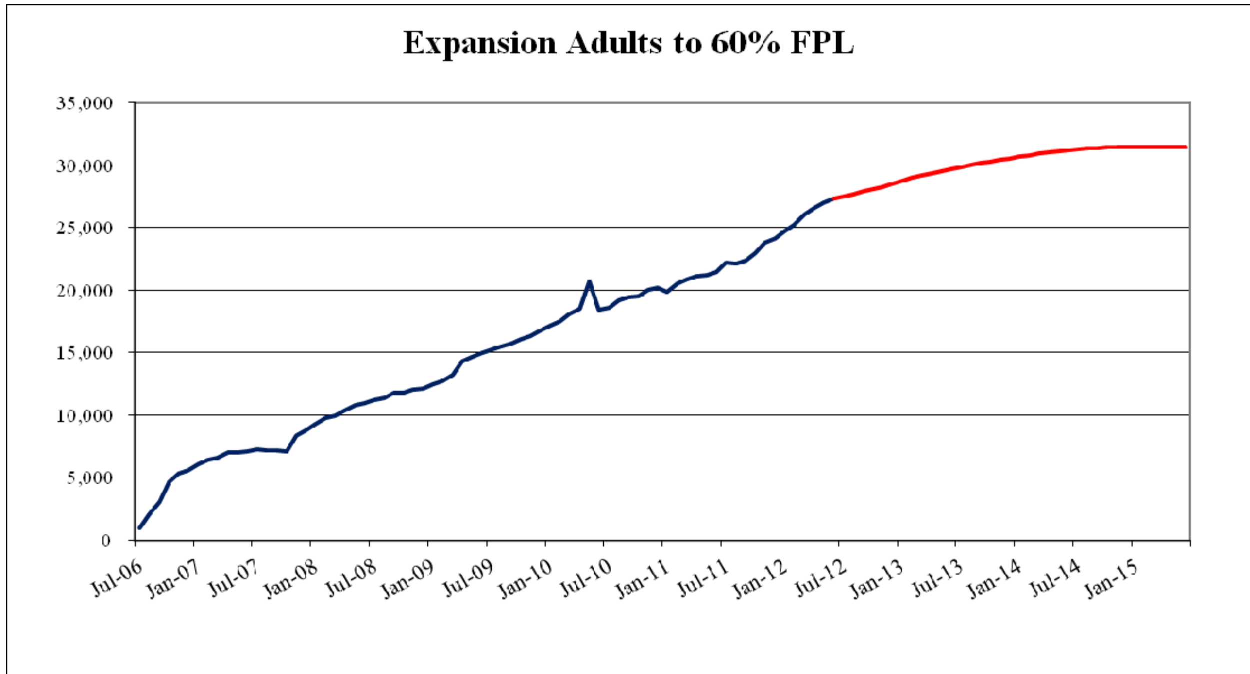
Monthly Average Growth Comparisons		
February 2012 Forecast	650	0.98%
FY 2011-12 Actuals	372	0.57%
FY 2011-12 1st Half	733	1.09%
FY 2011-12 2nd Half	12	0.06%
FY 2012-13 Forecast	395	0.60%
February 2012 Forecast	464	0.63%
FY 2013-14 Forecast	243	0.34%

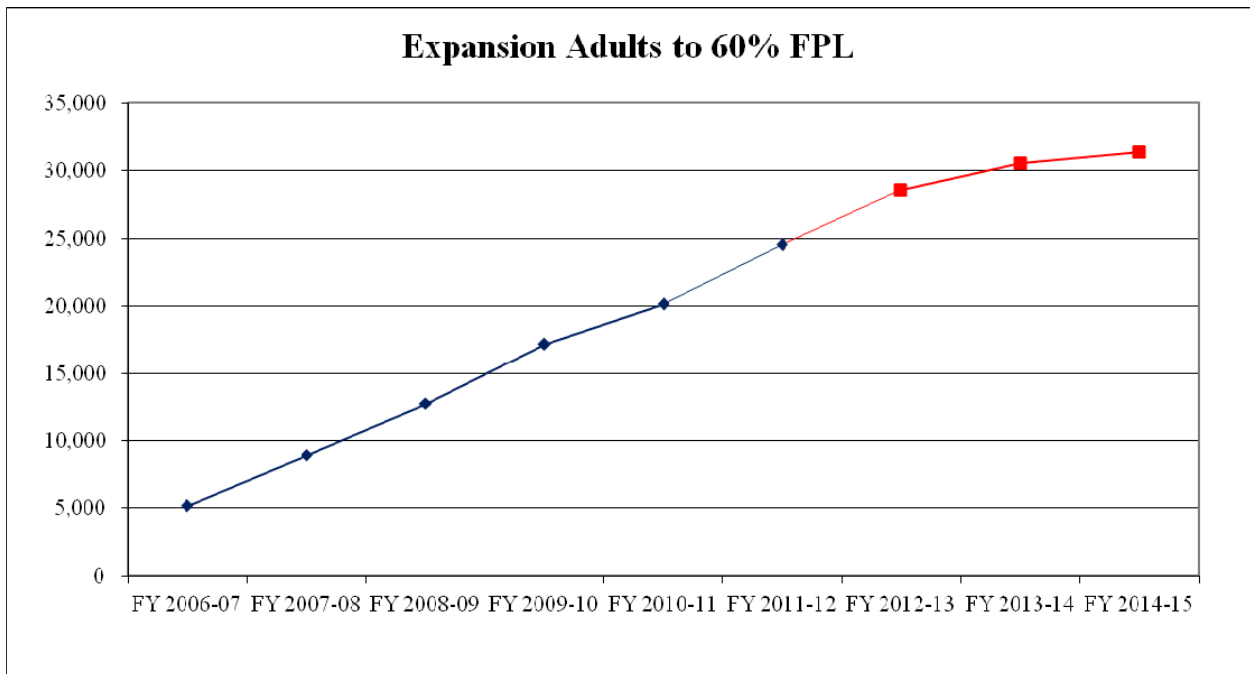
Base trend from June 2012 level			
FY 2012-13	70,837	3.13%	2,148

Expansion Adults to 60% FPL

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

Expansion Adults: Model Results





Expansion Adults to 60% FPL: Justification and Monthly Projections

- This population would be expected to have a high penetration rate, as these are parents of children in either the Children's Basic Health Plan or Medicaid, which have high enrollment rates.
- This population would be expected to be effected by the economy in similar ways as the AFDC-adult and children populations, although the effects are likely increased given that these clients are up to 60% of the federal poverty level, which would support higher growth rates.
- Growth in FY 2011-12 was much higher than the Department's February 2012 forecast, in which the annual caseload was projected to be 24,050 and average monthly growth was projected to be 358. The fluctuations in May and June 2010 are due to the implementation of the eligibility expansion for Medicaid Parents to 100% FPL in May 2010. When Family Medical cases were re-run with the implementation, a large number of clients were moved within Medicaid. The selected trend for FY 2012-13 is higher than that from the February 2012 forecast, and would yield average growth of 200 per month for FY 2012-13. This forecast is based on the projected monthly growth for the Categorically Eligible Low-Income Adults category, inflated for the higher average growth experienced in this eligibility category. The monthly growth rates for this eligibility group have converged with those experienced in the Categorically Eligible Low-Income Adults category over the last 18 months. As such, the Department has chosen to utilize the monthly trend from Categorically Eligible Low-Income Adults to project this population.
- Current forecasts indicate that the economic conditions should begin to improve at the end of 2012. The selected out-year trend reflects this, and the monthly increases are forecasted to moderate over the forecast period.

25.5-5-201 (1), C.R.S.

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

Expansion Adults to 60% FPL: Historical Caseload and Forecasts

Expansion Adults to 60% FPL: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	18,435	-	-
Jul-10	18,556	121	0.66%
Aug-10	19,176	620	3.34%
Sep-10	19,403	227	1.18%
Oct-10	19,490	87	0.45%
Nov-10	20,002	512	2.63%
Dec-10	20,182	180	0.90%
Jan-11	19,895	(287)	-1.42%
Feb-11	20,522	627	3.15%
Mar-11	20,877	355	1.73%
Apr-11	21,090	213	1.02%
May-11	21,194	104	0.49%
Jun-11	21,458	264	1.25%
Jul-11	22,184	726	3.38%
Aug-11	22,112	(72)	-0.32%
Sep-11	22,388	276	1.25%
Oct-11	22,985	597	2.67%
Nov-11	23,803	818	3.56%
Dec-11	24,150	347	1.46%
Jan-12	24,692	542	2.24%
Feb-12	25,224	532	2.15%
Mar-12	26,040	816	3.24%
Apr-12	26,578	538	2.07%
May-12	26,980	402	1.51%
Jun-12	27,283	303	1.12%

February 2012 Forecast	
Forecasted June 2012 Level	25,751

Actuals		
	Monthly Change	% Change
6-month average	522	2.06%
12-month average	485	2.03%
18-month average	395	1.70%
24-month average	369	1.65%

	Caseload	% Change	Level Change
FY 2006-07	5,162	-	-
FY 2007-08	8,918	72.76%	3,756
FY 2008-09	12,727	42.71%	3,809
FY 2009-10	17,178	34.97%	4,451
FY 2010-11	20,154	17.32%	2,976
FY 2011-12	24,535	21.74%	4,381
FY 2012-13	28,615	16.63%	4,080
FY 2013-14	30,573	6.84%	1,958
FY 2014-15	31,414	2.75%	841

February 2012 Trends			
FY 2011-12	24,050	19.33%	3,896
FY 2012-13	26,498	10.18%	2,448
FY 2013-14	27,831	5.03%	1,333

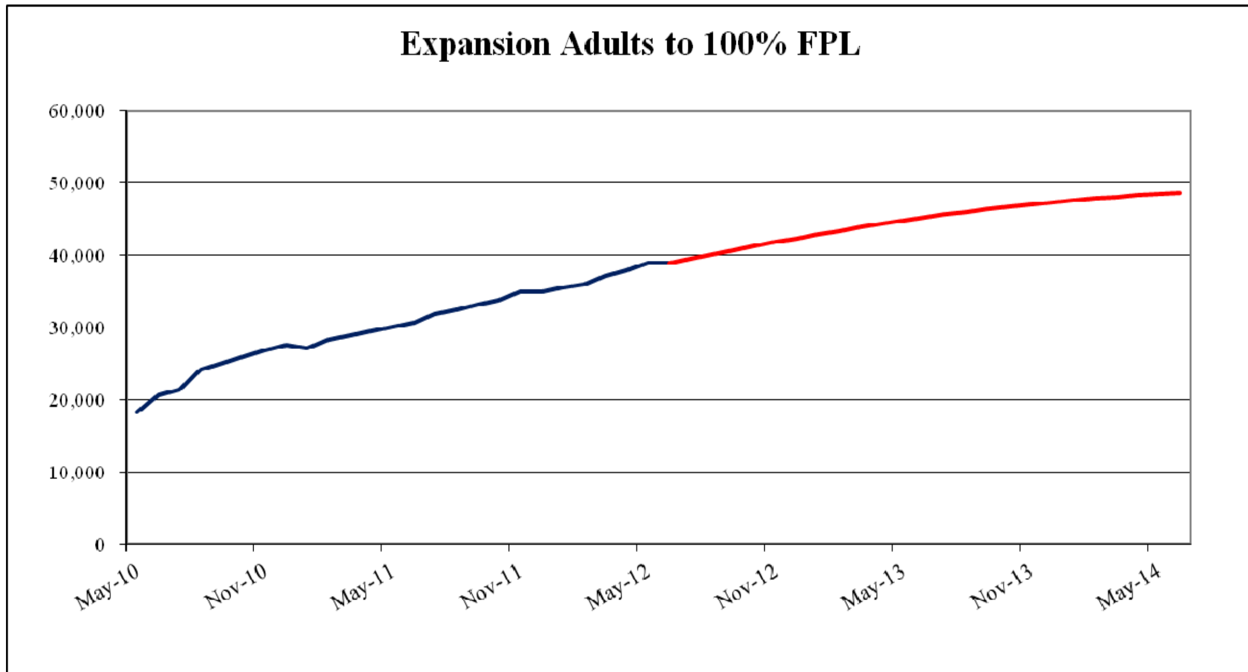
Monthly Average Growth Comparisons		
	Monthly Change	% Change
FY 2011-12	485	2.03%
FY 2012-13	200	0.70%
FY 2013-14	125	0.41%

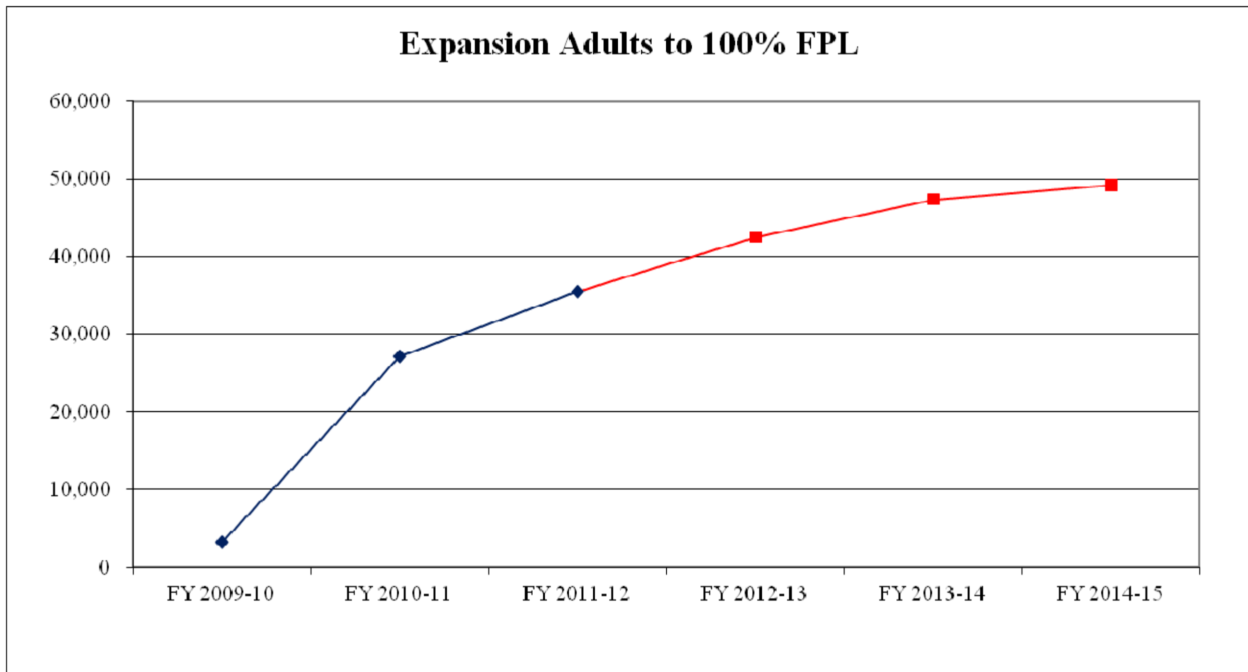
Monthly Average Growth Comparisons		
February 2012 Forecast	358	1.54%
FY 2011-12 Actuals	485	2.03%
FY 2011-12 1st Half	449	2.00%
FY 2011-12 2nd Half	522	2.06%
FY 2012-13 Forecast	200	0.70%
February 2012 Forecast	110	0.42%
FY 2013-14 Forecast	125	0.41%

Base trend from June 2012 level			
FY 2012-13	27,283	11.20%	2,748

Expansion Adults to 100% FPL

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





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

- The planned implementation for this group did not include redeterminations for current Family Medical cases. This population would have included only newly eligible individuals that had their applications processed on or after May 1, 2010. However, when the expansion was implemented, the Colorado Benefits Management System redetermined all existing Family Medical cases, as well as any cases that were denied in the previous three months. This resulted in a large number of individuals being immediately eligible for this population, and a May 2010 caseload of 18,253.
- Growth in FY 2011-12 was higher than the Department's February 2012 forecast, in which the annual caseload was projected to be 35,406 and average monthly growth was projected to be 679. The selected trend for FY 2012-13 is in line with that from the Department's February 2012 forecast, and would yield average growth of 526 per month for FY 2012-13. This forecast is based on the average monthly change experienced from September 2010 through June 2012. The forecast assumes that monthly growth will decrease over time as the population continues to mature, and will average 1.26% per month in FY 2012-13.
- The Department assumes that growth will continue to decrease throughout the forecast period, to an average of 0.60% per month in FY 2013-14 and 0.16% per month FY 2014-15. Though economic conditions may be partially responsible for the increased caseload in this group, monthly growth is expected to moderate as the eligibility category becomes established.

Expansion Adults to 100% FPL: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	20,607	-	-
Jul-10	21,446	839	4.07%
Aug-10	24,193	2,747	12.81%
Sep-10	25,071	878	3.63%
Oct-10	26,016	945	3.77%
Nov-10	26,924	908	3.49%
Dec-10	27,596	672	2.50%
Jan-11	27,188	(408)	-1.48%
Feb-11	28,323	1,135	4.17%
Mar-11	28,968	645	2.28%
Apr-11	29,451	483	1.67%
May-11	30,102	651	2.21%
Jun-11	30,724	622	2.07%
Jul-11	31,920	1,196	3.89%
Aug-11	32,462	542	1.70%
Sep-11	33,152	690	2.13%
Oct-11	33,838	686	2.07%
Nov-11	34,915	1,077	3.18%
Dec-11	34,886	(29)	-0.08%
Jan-12	35,481	595	1.71%
Feb-12	35,962	481	1.36%
Mar-12	37,141	1,179	3.28%
Apr-12	37,902	761	2.05%
May-12	38,955	1,053	2.78%
Jun-12	38,921	(34)	-0.09%

February 2012 Forecast	
Forecasted June 2012 Level	38,874

Monthly Growth Estimates		
FY 2012-13	526	1.26%
FY 2013-14	282	0.60%
FY 2014-15	81	0.16%

	Caseload	% Change	Level Change
FY 2009-10	3,238	-	-
FY 2010-11	27,167	739.01%	23,929
FY 2011-12	35,461	30.53%	8,294
FY 2012-13	42,531	19.94%	7,070
FY 2013-14	47,351	11.33%	4,820
FY 2014-15	49,210	3.93%	1,859

February 2012 Trends (BEFORE ADJUSTMENTS)			
FY 2011-12	35,406	30.33%	8,239
FY 2012-13	42,381	19.70%	6,975
FY 2013-14	46,835	10.51%	4,454

Monthly Average Growth Comparisons		
February 2012 Forecast	679	1.98%
FY 2011-12 Actuals	683	2.00%
FY 2011-12 1st Half	694	2.15%
FY 2011-12 2nd Half	673	1.85%
FY 2012-13 Forecast	526	1.26%
February 2012 Forecast	507	1.22%
FY 2013-14 Forecast	81	0.16%

Base trend from June 2012 level			
FY 2012-13	38,921	9.76%	3,460

Actuals	Monthly Change	% Change
6-month average	673	1.85%
12-month average	683	2.00%
18-month average	629	1.94%

Adults without Dependent Children

HB 09-1293 (Colorado Health Care Affordability Act) authorizes the Department to expand Medicaid eligibility to Adults without Dependent Children (AwDC) age 19 to 65 who are not eligible for Medicaid or Medicare with income up to 100% of the federal poverty level (FPL). The Department implemented the first stage of this expansion in May 2012, in which enrollment is initially opened to individuals with income up to 10% FPL and enrollment is limited to 10,000.

Adults without Dependent Children: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jul-11	0	-	-
Aug-11	0	0	0.00%
Sep-11	0	0	0.00%
Oct-11	0	0	0.00%
Nov-11	0	0	0.00%
Dec-11	0	0	0.00%
Jan-12	0	0	0.00%
Feb-12	0	0	0.00%
Mar-12	0	0	0.00%
Apr-12	0	0	0.00%
May-12	5,860	5,860	0.00%
Jun-12	7,753	1,893	32.30%

	Caseload	% Change	Level Change
FY 2011-12	1,134	-	-
FY 2012-13	10,000	781.83%	8,866
FY 2013-14	10,000	0.00%	0
FY 2014-15	10,000	0.00%	0

February 2012 Trends			
FY 2011-12	1,667	-	-
FY 2012-13	10,000	499.88%	8,333
FY 2013-14	10,000	0.00%	0

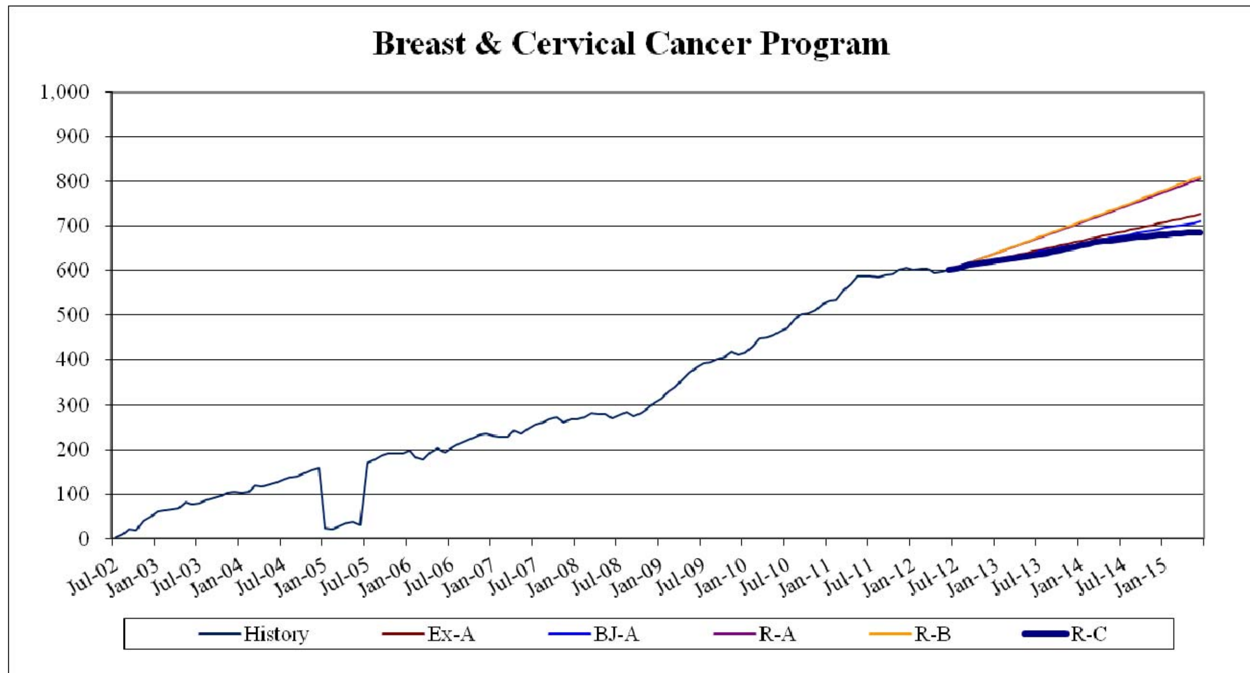
February 2012 Forecast	
Forecasted June 2012 Level	10,000

Monthly Growth Estimates		
FY 2012-13	187	2.42%
FY 2013-14	0	0.00%
FY 2014-15	0	0.00%

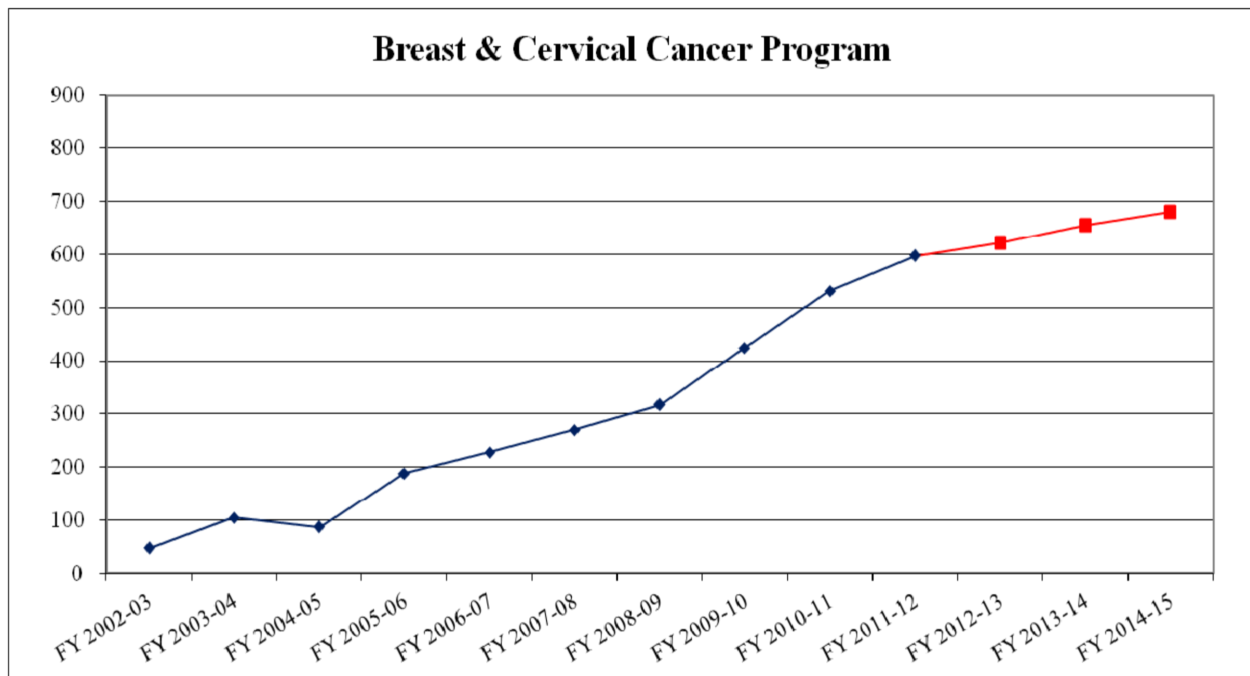
Breast and Cervical Cancer Program

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

Breast and Cervical Cancer Program: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A	0.9984	
Box-Jenkins A*	0.9984	
Regression A	0.9984	BCCP [-1], Female Population 19-59
Regression B	0.9984	BCCP [-1], Trend
Regression C	0.9984-6	BCCP [-1], Unemployment Rate, Total Wages, Total Population



Breast and Cervical Cancer Program: Model Results						
FY 2012-13	**FY 2010-11**	**FY 2011-12**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing	531	597	4.52%	624	27	3
Box Jenkins *	531	597	4.19%	622	25	3
Regression A	531	597	6.70%	637	40	6
Regression B	531	597	6.87%	638	41	6
Regression C	**531**	**597**	**4.02%**	**621**	**24**	**3**

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2013-14	FY 2011-12	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing	597	621	6.73%	663	42	3
Box Jenkins *	597	621	6.11%	659	38	3
Regression A	597	621	10.68%	687	66	6
Regression B	597	621	10.82%	688	67	6
Regression C	**597**	**621**	**5.48%**	**655**	**34**	**3**

FY 2014-15	Projected FY 2012-13 Caseload	Projected FY 2013-14 Caseload	Projected Growth Rate	Projected FY 2014-15 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing	621	655	6.31%	696	41	3
Box Jenkins *	621	655	5.30%	690	35	3
Regression A	621	655	9.93%	720	65	6
Regression B	621	655	10.04%	721	66	6
Regression C	**621**	**655**	**3.82%**	**680**	**25**	**1**

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

Breast and Cervical Cancer Program: Trend Selections

FY 2012-13: 4.02%
FY 2013-14: 5.48%
FY 2014-15: 3.82%

Breast and Cervical Cancer Program: Justifications

- Clients in this eligibility type exceed Medicaid income guidelines, so it is reasonable to expect that the caseload will continue to grow, as they are not affected by the economy as much as low-income adults and children, and they do not have alternative insurance to utilize. These clients may be affected by economic conditions, though it may be mitigated by the specificity of the diagnoses required for eligibility.
- This program receives ongoing Tobacco Tax funding to subcontract with clinics that provide screenings. The Department knows of no new clinics coming into the program during the forecast period.
- The graph above shows caseload steadily increasing from July of 2002 to December of 2004. At that time, the reported caseload decreased dramatically because of an issue within the Medicaid Management Information System that was used to report the data. Because of this issue within the Medicaid Management Information System, a more reliable source was utilized to create caseload figures. Until the problem was resolved, the Department obtained a caseload report directly from raw data in the Colorado Benefits Management System. This report was used from July 2005 through March 2006, when the reports from the Medicaid Management Information System and the Colorado Benefits Management System were synchronized. All subsequent monthly caseload data are obtained from the Medicaid Management Information System report that is used to report all other categories of Medicaid caseload. The caseload counts for the six months from January through June 2005 were left as originally reported. This explains the six months of unusually low figures that are shown in the graph.
- Growth in FY 2011-12 was lower than the Department's February 2012 forecast, in which the annual caseload was projected to be 610 and average monthly growth was projected to be 4. The selected trend for FY 2012-13 is lower than that from the February 2012 forecast, and would yield average growth of 3 per month for FY 2012-13.
- Out-year growth is projected to continue at historic levels. As a program matures, growth is expected to slow and stabilize. The Department believes that the Breast and Cervical Cancer program is approaching a level of maturity where, barring unforeseen circumstances, average growth of more than 2% per month should no longer expected.

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

Breast and Cervical Cancer Program: Historical Caseload and Forecasts

Breast and Cervical Cancer Program: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	466	-	-
Jul-10	471	5	1.07%
Aug-10	493	22	4.67%
Sep-10	503	10	2.03%
Oct-10	505	2	0.40%
Nov-10	511	6	1.19%
Dec-10	526	15	2.94%
Jan-11	532	6	1.14%
Feb-11	535	3	0.56%
Mar-11	556	21	3.93%
Apr-11	569	13	2.34%
May-11	587	18	3.16%
Jun-11	589	2	0.34%
Jul-11	587	(2)	-0.34%
Aug-11	586	(1)	-0.17%
Sep-11	590	4	0.68%
Oct-11	592	2	0.34%
Nov-11	602	10	1.69%
Dec-11	606	4	0.66%
Jan-12	603	(3)	-0.50%
Feb-12	604	1	0.17%
Mar-12	604	0	0.00%
Apr-12	596	(8)	-1.32%
May-12	597	1	0.17%
Jun-12	601	4	0.67%

	Caseload	% Change	Level Change
FY 2002-03	47	-	-
FY 2003-04	105	123.40%	58
FY 2004-05	87	-17.14%	(18)
FY 2005-06	188	116.09%	101
FY 2006-07	228	21.28%	40
FY 2007-08	270	18.42%	42
FY 2008-09	317	17.41%	47
FY 2009-10	425	34.07%	108
FY 2010-11	531	24.94%	106
FY 2011-12	597	12.43%	66
FY 2012-13	621	4.02%	24
FY 2013-14	655	5.48%	34
FY 2014-15	680	3.82%	25

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

February 2012 Trends			
FY 2011-12	610	14.88%	79
FY 2012-13	679	11.31%	69
FY 2013-14	743	9.43%	64

February 2012 Forecast	
Forecasted June 2012 Level	641

Monthly Average Growth Comparisons		
February 2012 Forecast	4	0.68%
FY 2011-12 Actuals	1	0.17%
FY 2011-12 1st Half	3	0.48%
FY 2011-12 2nd Half	(1)	-0.14%
FY 2012-13 Forecast	3	0.51%
February 2012 Forecast	6	0.92%
FY 2013-14 Forecast	3	0.50%

Actuals	Monthly Change	% Change
6-month average	(1)	-0.14%
12-month average	1	0.17%
18-month average	4	0.75%
24-month average	6	1.08%

Base trend from June 2012 level			
FY 2012-13	601	0.67%	4

Eligible Children

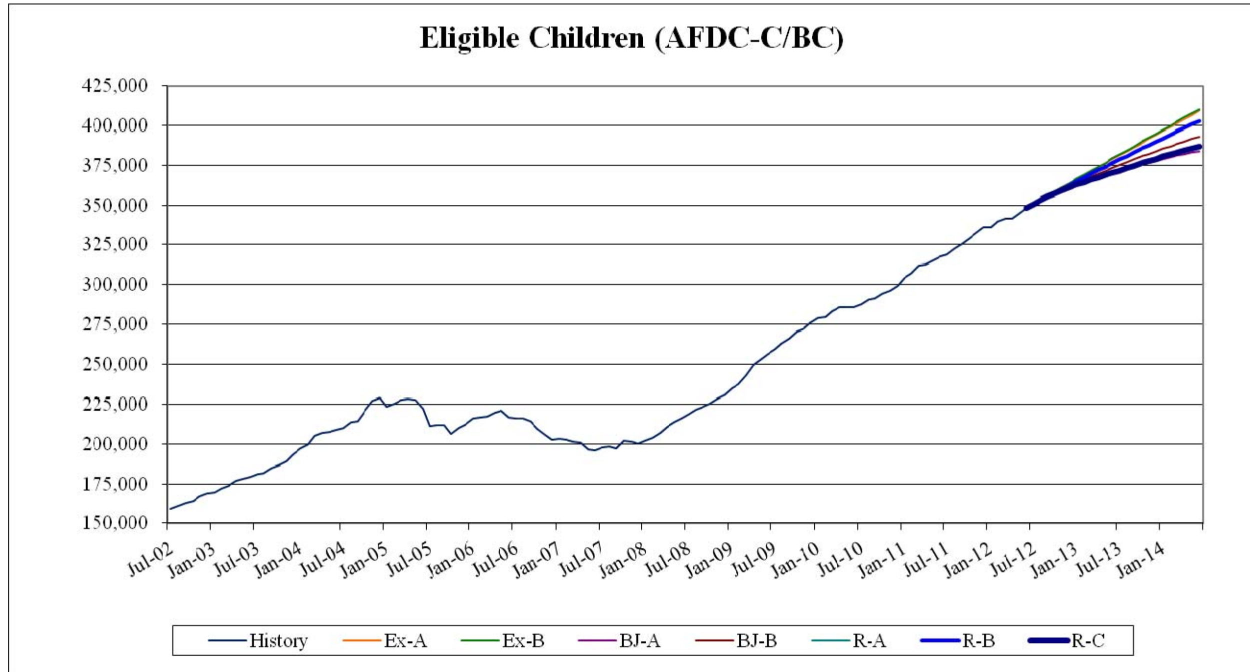
One of the primary ways that children qualify for Medicaid is through Section 1931 of the federal Medicaid statute. Under Section 1931, families who were eligible for cash welfare assistance under the Aid to Families with Dependent Children program are still eligible for Medicaid even after the Aid to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

This category also includes children on Transitional Medicaid. Transitional Medicaid is available to children in families who have received 1931 Medicaid three of the past six months and become ineligible due to an increase in earned income. Children receive Transitional Medicaid benefits for one year. In FY 2011-12, there were an average of 21,311 children on Transitional Medicaid. Although this program has been set to expire many times, it has been renewed regularly, most recently through December 31, 2012. While the future of Transitional Medicaid is unknown once the federal Affordable Care Act is implemented, the Department assumed that the federal Transitional Medicaid program would continue throughout FY 2014-15 for the purposes of projecting caseload.

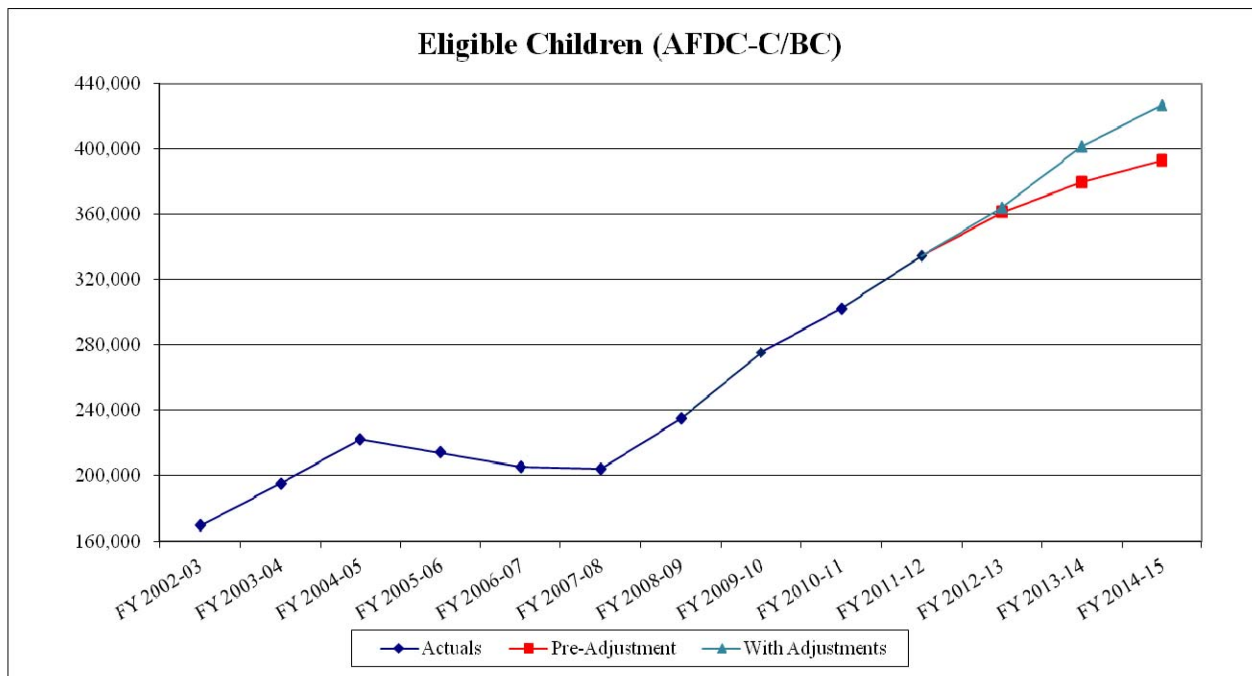
Children who are born to women enrolled in the Baby and Kid Care program are also included in this category. Between 1986 and 1991, Congress extended Medicaid to new groups of pregnant women and children. Referred to as Baby and Kid Care in Colorado, this program was authorized through the Medicare Catastrophic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

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

Eligible Children: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A*	0.9993	
Exponential Smoothing B*	0.9974	
Box-Jenkins A	0.9992	
Box-Jenkins B	0.9975	
Regression A	0.9994	KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, CBMS Dummy, Systems Dummy
Regression B	0.9993	KIDS [-1], KIDS [-7], Unemployment Rate, CBMS Dummy, CBMS Dummy [-1], Systems Dummy, Auto [-18]
Regression C	0.9895	KIDS [-1], KIDS [-7], Unemployment Rate, Total Wages, Trend, CBMS Dummy [-2], Systems Dummy, Auto [-1], Auto [-3]


Eligible Children (AFDC-C/BC)
440,000
400,000
360,000
320,000
280,000
240,000
200,000
160,000
FY 2002-03
FY 2003-04
FY 2004-05
FY 2005-06
FY 2006-07
FY 2007-08
FY 2008-09
FY 2009-10
FY 2010-11
FY 2011-12
FY 2012-13
FY 2013-14
FY 2014-15
Actuals
Pre-Adjustment
With Adjustments

Eligible Children: Model Results						
FY 2012-13	**FY 2010-11**	**FY 2011-12**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A*	302,410	334,633	9.00%	364,750	30,117	2,539
Exponential Smoothing B*	302,410	334,633	9.09%	365,051	30,418	2,583
Box Jenkins A	302,410	334,633	7.84%	360,868	26,235	1,820
Box Jenkins B	302,410	334,633	8.32%	362,474	27,841	2,093
Regression A	302,410	334,633	8.56%	363,278	28,645	2,315
Regression B	302,410	334,633	8.64%	363,545	28,912	2,348
Regression C	**302,410**	**334,633**	**7.98%**	**361,337**	**26,704**	**1,836**

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2013-14	FY 2011-12	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	334,633	361,337	8.35%	391,509	30,172	2,539
Exponential Smoothing B*	334,633	361,337	8.49%	392,015	30,678	2,583
Box Jenkins A	334,633	361,337	4.77%	378,573	17,236	1,146
Box Jenkins B	334,633	361,337	6.03%	383,126	21,789	1,631
Regression A	334,633	361,337	7.49%	388,401	27,064	2,202
Regression B	334,633	361,337	7.50%	388,437	27,100	2,187
Regression C	**334,633**	**361,337**	**5.07%**	**379,657**	**18,320**	**1,391**

FY 2014-15	Projected FY 2012-13 Caseload	Projected FY 2013-14 Caseload	Projected Growth Rate	Projected FY 2014-15 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	361,337	379,657	7.71%	408,929	29,272	2,539
Exponential Smoothing B*	361,337	379,657	7.83%	409,384	29,727	2,583
Box Jenkins A	361,337	379,657	2.82%	390,363	10,706	700
Box Jenkins B	361,337	379,657	4.49%	396,704	17,047	1,287
Regression A	361,337	379,657	6.44%	404,107	24,450	1,986
Regression B	361,337	379,657	6.30%	403,575	23,918	1,907
Regression C	**361,337**	**379,657**	**3.47%**	**392,831**	**13,174**	**809**

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

Eligible Children: Trend Selections

FY 2012-13: 7.98%
FY 2013-14: 5.07%
FY 2014-15: 3.47%

Eligible Children: Justifications

- This population is effected by economic conditions in similar ways as the Categorically Eligible Low-Income Adults and Baby Care-Adults, as children on Medicaid have eligibility granted as a function of a parent or guardian in most cases. Caseload trends in this category are highly affected by economic conditions, and tend to be positively correlated with the population of children aged 0 to 18. Growth in the 0 to 18 population dropped from around 2.3% per year from FY 1995-96 to FY 2001-02 to about 0.9% per year from FY 2002-03 to FY 2011-12. The expansion in this age group is projected to average 1.4% throughout the forecast period.[12] The economy is projected remain relatively weak over the forecast period, with the unemployment rate to average 7.6% between 2012 and 2014. Wage and salary income is projected to increase by an average of 4.1% between 2012 and 2014.[13]
- Caseload declines occurred from 1993 to 1999 due to economic expansion and effects from the Tatum lawsuit (see Categorically Eligible Low-Income Adults section for more information on the

[12] Department of Local Affairs, Demography Division
[13] Source: Office of State Planning and Budgeting, September 2012 Economic Forecast

lawsuit). When the Children's Basic Health Plan program was enacted in 1998, it required that children be screened for Medicaid before conferring Children's Basic Health Plan eligibility. As more children applied, many were found to be Medicaid eligible and were enrolled in Medicaid. Between FY 2002-03 and FY 2004-05, caseload in this category grew by 31.4%, which the Department believes is largely due to the state of the economy. The rate of growth fell drastically in FY 2005-06, and the caseload actually contracted by 3.74%. There were large and consistent declines between July 2006 and December 2007, which seems to indicate that the improved economy was having the expected effect on caseload. Similarly, large and consistent increases since January 2008 indicate that the weakening economic conditions are impacting caseload in this eligibility type.

- Recent changes to the rules regarding the citizenship requirements of the Deficit Reduction Act of 2005 may effect this population and result in higher growth. Children who cannot provide proper proof of citizenship will no longer automatically remain eligible for the Children's Basic Health Plan. This may increase growth in Medicaid as families find documents to ensure coverage of children.
- Growth in FY 2011-12 was lower than the Department's February 2012 forecast, in which the annual caseload was projected to be 336,582 and average monthly growth was projected to be 2,873. The selected trend for FY 2012-13 is lower than that from the Department's February 2012 forecast, and would yield average increases of 1,836 per month for FY 2012-13. This forecast is reflective of the consistent increases since the second half of FY 2007-08, which moderated in FY 2009-10 but increased in FY 2010-11. Because the economy is believed to be largely responsible this change, projected economic conditions give no indication that the trend will not continue to be positive throughout FY 2012-13. This eligibility category has had experienced volatile monthly growth since late 2011, which the Department believes may be related to the implementation of an automated income verification interface. The Department will continue to monitor caseload trends in this category, though overall positive caseload trends are expected to continue.
- Similar to the pattern seen in Categorically Eligible Low-Income Adults category, the out-year trend is expected to slow with declining monthly growth, reflective of projected moderating economic conditions beginning at the end of 2012. Growth in children is expected to be higher than that in the adult populations due to current outreach activities funded by the Department and a number of community initiatives to enroll eligibles, most of which target children.
- There are two bottom-line adjustments to this eligibility type. First, SB 11-008 increases eligibility for children age 6 to 19 in Medicaid from 100% of federal poverty line (FPL) to 133% FPL effective January 2013. Second, there is an adjustment for the conversion to the Modified Adjusted Gross Income (MAGI) pursuant to the Affordable Care Act (ACA) in January 2014, which standardizes income calculations between Medicaid and CHP+ and will transition children with income under 133% FPL currently in CHP+ to Medicaid. These adjustments have been updated in accordance with a revised CHP+ caseload forecast.

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

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

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

25.5-5-205 (3), C.R.S.
(a) On and after April 1, 1990, children under the age of six years and pregnant women shall be eligible for benefits under the baby and kid care program... (b) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this subsection (3) shall be one hundred thirty-three percent…;
(c) (I) On and after July 1, 1991, children born after September 30, 1983, who have attained age six but have not attained age nineteen shall be eligible for benefits under the baby and kid care program... (II) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this paragraph (c) shall be one hundred percent;

Eligible Children: Historical Caseload and Forecasts

Eligible Children: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	285,778	-	-
Jul-10	287,674	1,896	0.66%
Aug-10	290,871	3,197	1.11%
Sep-10	291,592	721	0.25%
Oct-10	294,155	2,563	0.88%
Nov-10	296,482	2,327	0.79%
Dec-10	299,499	3,017	1.02%
Jan-11	304,042	4,543	1.52%
Feb-11	307,032	2,990	0.98%
Mar-11	312,300	5,268	1.72%
Apr-11	312,603	303	0.10%
May-11	315,116	2,513	0.80%
Jun-11	317,551	2,435	0.77%
Jul-11	319,065	1,514	0.48%
Aug-11	322,779	3,714	1.16%
Sep-11	325,673	2,894	0.90%
Oct-11	328,632	2,959	0.91%
Nov-11	332,183	3,551	1.08%
Dec-11	336,053	3,870	1.17%
Jan-12	336,096	43	0.01%
Feb-12	339,523	3,427	1.02%
Mar-12	341,274	1,751	0.52%
Apr-12	341,546	272	0.08%
May-12	344,523	2,977	0.87%
Jun-12	348,253	3,730	1.08%

	Caseload*	% Change	Level Change
FY 1995-96	113,439	-	-
FY 1996-97	110,586	-2.52%	(2,853)
FY 1997-98	103,912	-6.04%	(6,674)
FY 1998-99	102,074	-1.77%	(1,838)
FY 1999-00	109,816	7.58%	7,742
FY 2000-01	123,221	12.21%	13,405
FY 2001-02	143,909	16.79%	20,688
FY 2002-03	169,311	17.65%	25,402
FY 2003-04	195,279	15.34%	25,968
FY 2004-05	222,472	13.93%	27,193
FY 2005-06	214,158	-3.74%	(8,314)
FY 2006-07	205,390	-4.09%	(8,768)
FY 2007-08	204,022	-0.67%	(1,368)
FY 2008-09	235,129	15.25%	31,107
FY 2009-10	275,672	17.24%	40,543
FY 2010-11	302,410	9.70%	26,738
FY 2011-12	334,633	10.66%	32,223
FY 2012-13	361,337	7.98%	26,704
FY 2013-14	379,657	5.07%	18,320
FY 2014-15	392,831	3.47%	13,174

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

Adjustments	
FY 2012-13	2,449
FY 2013-14	21,754
FY 2014-15	34,076

February 2012 Forecast	
Forecasted June 2012 Level	352,028

November 2012 Projections After Adjustments			
FY 2012-13	363,786	8.71%	29,153
FY 2013-14	401,411	10.34%	37,625
FY 2014-15	426,907	6.35%	25,496

Base trend from June 2012 level			
FY 2012-13	348,253	4.07%	13,620

February 2012 Trends (BEFORE ADJUSTMENTS)			
FY 2011-12	336,582	11.30%	34,172
FY 2012-13	365,528	8.60%	28,946
FY 2013-14	386,436	5.72%	20,908

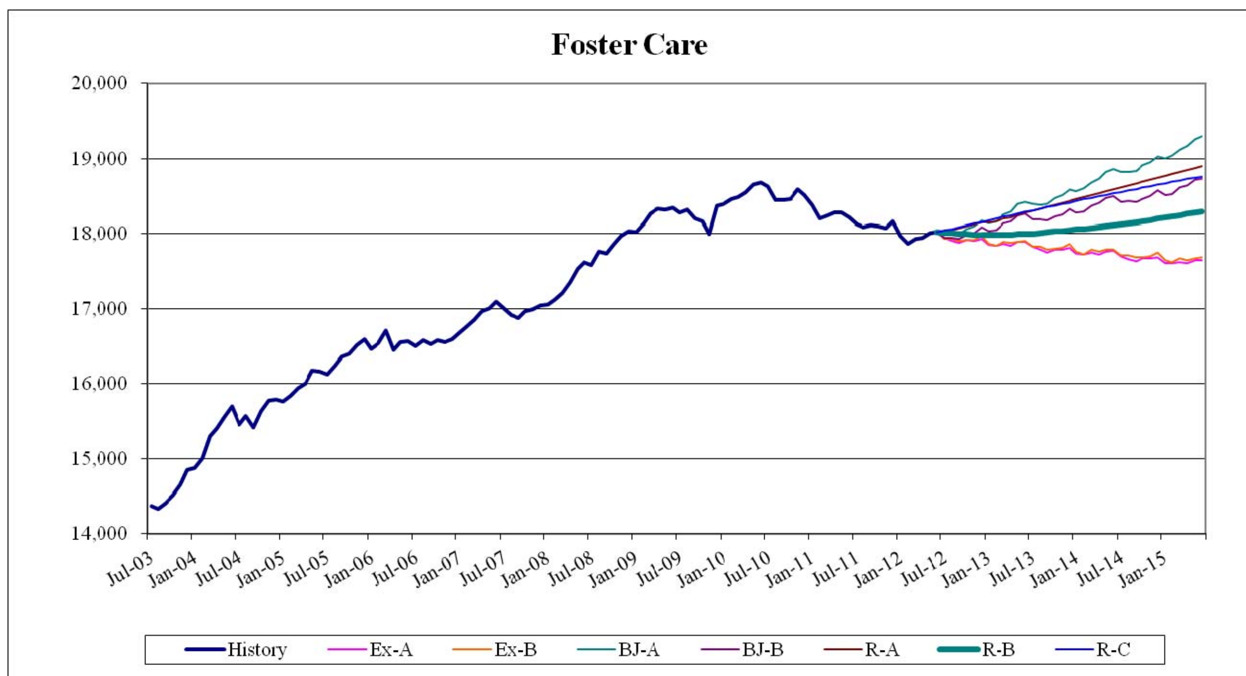
Monthly Average Growth Comparisons		
February 2012 Forecast	2,873	0.90%
FY 2011-12 Actuals	2,559	0.77%
FY 2011-12 1st Half	3,084	0.95%
FY 2011-12 2nd Half	2,033	0.60%
FY 2012-13 Forecast	1,836	0.58%
February 2012 Forecast	2,032	0.58%
FY 2013-14 Forecast	1,391	0.40%

Actuals	Monthly Change	% Change
6-month average	2,033	0.60%
12-month average	2,559	0.77%
18-month average	2,709	0.84%
24-month average	2,603	0.83%

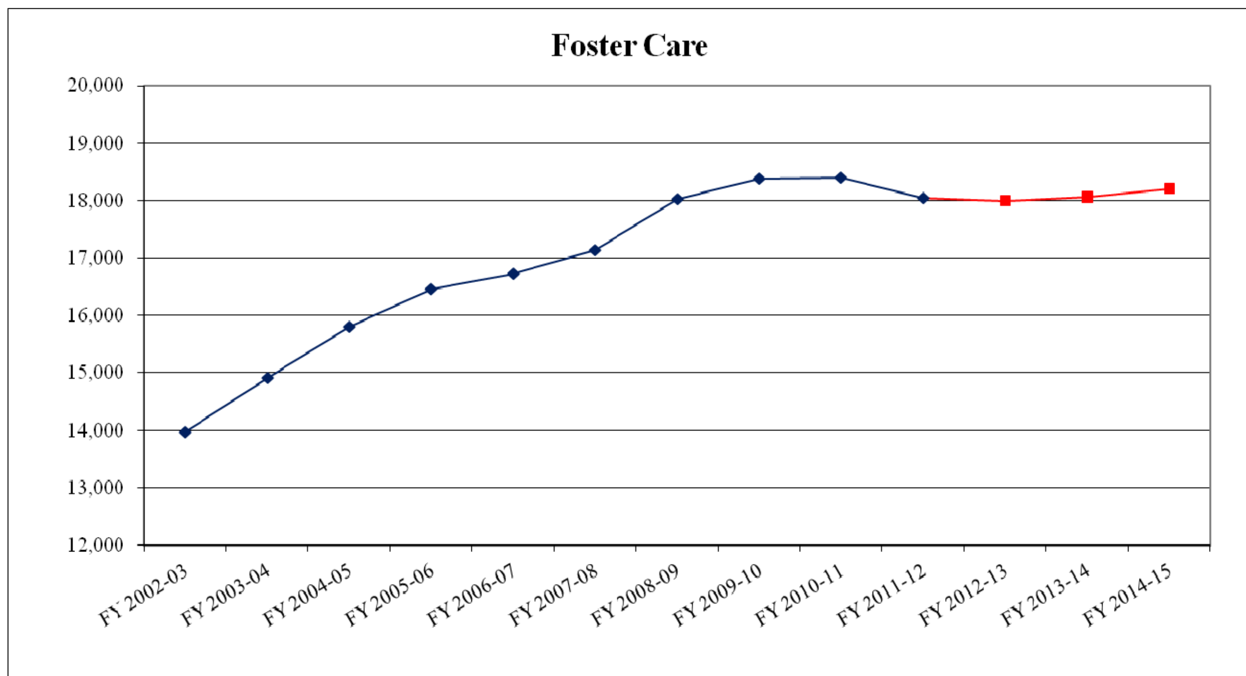
Foster Care

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

Foster Care: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A	0.9990	
Exponential Smoothing B	0.9934	
Box-Jenkins A*	0.9990	
Box-Jenkins B*	0.9935	
Regression A	0.9987	FOSTER [-1], Population Under 19, Auto [-12]
Regression B	0.9985	FOSTER [-1], FOSTER [-18], Auto [-1]
Regression C	0.9989	FOSTER [-1], Trend



Foster Care: Model Results

FY 2012-13	FY 2010-11	FY 2011-12	Projected Growth Rate	Projected FY 2012-13 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	18,393	18,034	-0.79%	17,892	(142)	(11)
Exponential Smoothing B	18,393	18,034	-0.69%	17,910	(124)	(9)
Box Jenkins A*	18,393	18,034	0.73%	18,166	132	34
Box Jenkins B*	18,393	18,034	0.19%	18,068	34	20
Regression A	18,393	18,034	0.66%	18,153	119	21
Regression B	**18,393**	**18,034**	**-0.22%**	**17,994**	**(40)**	**(2)**
Regression C	18,393	18,034	0.75%	18,169	135	22

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2013-14	FY 2011-12	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	18,034	17,994	-0.68%	17,872	(122)	(10)
Exponential Smoothing B	18,034	17,994	-0.63%	17,881	(113)	(9)
Box Jenkins A*	18,034	17,994	2.33%	18,413	419	36
Box Jenkins B*	18,034	17,994	1.34%	18,235	241	20
Regression A	18,034	17,994	1.62%	18,286	292	26
Regression B	**18,034**	**17,994**	**0.35%**	**18,057**	**63**	**10**
Regression C	18,034	17,994	1.41%	18,248	254	21

FY 2014-15	Projected FY 2012-13 Caseload	Projected FY 2013-14 Caseload	Projected Growth Rate	Projected FY 2014-15 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	17,994	18,057	-0.68%	17,934	(123)	(10)
Exponential Smoothing B	17,994	18,057	-0.63%	17,943	(114)	(9)
Box Jenkins A*	17,994	18,057	2.35%	18,481	424	36
Box Jenkins B*	17,994	18,057	1.31%	18,294	237	20
Regression A	17,994	18,057	1.71%	18,366	309	26
Regression B	**17,994**	**18,057**	**0.84%**	**18,209**	**152**	**15**
Regression C	17,994	18,057	1.28%	18,288	231	19

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

Foster Care: Trend Selections

FY 2012-13: -0.22%
FY 2013-14: 0.35%
FY 2014-15: 0.84%

Foster Care: Justifications

- Caseload in this category is affected by programmatic changes initiated by the Department of Human Services who oversee the Child Welfare system. In January 2001, the Department of Human Services converted to a new data reporting system for children in foster care called Trails. The conversion may be partially responsible for unusually slow growth experienced in this category in FY 2001-02. Legislation in 2003 (HB 03-1004) made the manufacturing of controlled substances in the presence of children a felony, and deemed such actions child abuse. This may positively affect caseload in subsequent years, as more children are placed into state custody.
- Caseload in this category is only weakly correlated with population of children aged 0 to 18 and economic indicators. The graph above shows that growth in this category since FY 2002-03 has been positive and stable, but has leveled out in the last three years. Growth at the end of FY 2007-08 began to increase, which is partially due to the implementation of SB 07-002 and SB 08-099, which expanded eligibility for Foster Care through age 20.
- Growth in FY 2011-12 was lower than the Department's February 2012 forecast, in which the annual caseload was projected to be 18,141 and average monthly declines were projected to be 5. The selected trend for FY 2012-13 is lower than that from the February 2012 forecast, and would yield average declines of 2 per month for FY 2012-13.
- Out-year growth reflects moderately positive growth, and a return to growth in line with historical trend.

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

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

Foster Care: Historical Caseload and Forecasts

Foster Care: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	18,678	-	-
Jul-10	18,628	(50)	-0.27%
Aug-10	18,455	(173)	-0.93%
Sep-10	18,451	(4)	-0.02%
Oct-10	18,464	13	0.07%
Nov-10	18,597	133	0.72%
Dec-10	18,510	(87)	-0.47%
Jan-11	18,386	(124)	-0.67%
Feb-11	18,200	(186)	-1.01%
Mar-11	18,244	44	0.24%
Apr-11	18,280	36	0.20%
May-11	18,279	(1)	-0.01%
Jun-11	18,221	(58)	-0.32%
Jul-11	18,125	(96)	-0.53%
Aug-11	18,084	(41)	-0.23%
Sep-11	18,119	35	0.19%
Oct-11	18,096	(23)	-0.13%
Nov-11	18,077	(19)	-0.10%
Dec-11	18,172	95	0.53%
Jan-12	17,968	(204)	-1.12%
Feb-12	17,863	(105)	-0.58%
Mar-12	17,930	67	0.38%
Apr-12	17,944	14	0.08%
May-12	18,012	68	0.38%
Jun-12	18,022	10	0.06%

	Caseload*	% Change	Level Change
FY 1995-96	8,376	-	-
FY 1996-97	9,261	10.57%	885
FY 1997-98	10,453	12.87%	1,192
FY 1998-99	11,526	10.26%	1,073
FY 1999-00	12,474	8.22%	948
FY 2000-01	13,076	4.83%	602
FY 2001-02	13,121	0.34%	45
FY 2002-03	13,967	6.45%	846
FY 2003-04	14,914	6.78%	947
FY 2004-05	15,795	5.91%	881
FY 2005-06	16,460	4.21%	665
FY 2006-07	16,724	1.60%	264
FY 2007-08	17,141	2.49%	417
FY 2008-09	18,033	5.20%	892
FY 2009-10	18,381	1.93%	348
FY 2010-11	18,393	0.07%	12
FY 2011-12	18,034	-1.95%	(359)
FY 2012-13	17,994	-0.22%	(40)
FY 2013-14	18,057	0.35%	63
FY 2014-15	18,209	0.84%	152

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

February 2012 Trends			
FY 2011-12	18,141	-1.37%	(252)
FY 2012-13	18,159	0.10%	18
FY 2013-14	18,264	0.58%	105

February 2012 Forecast	
Forecasted June 2012 Level	18,160

Actuals	Monthly Change	% Change
6-month average	(25)	-0.14%
12-month average	(17)	-0.09%
18-month average	(27)	-0.15%
24-month average	(27)	-0.15%

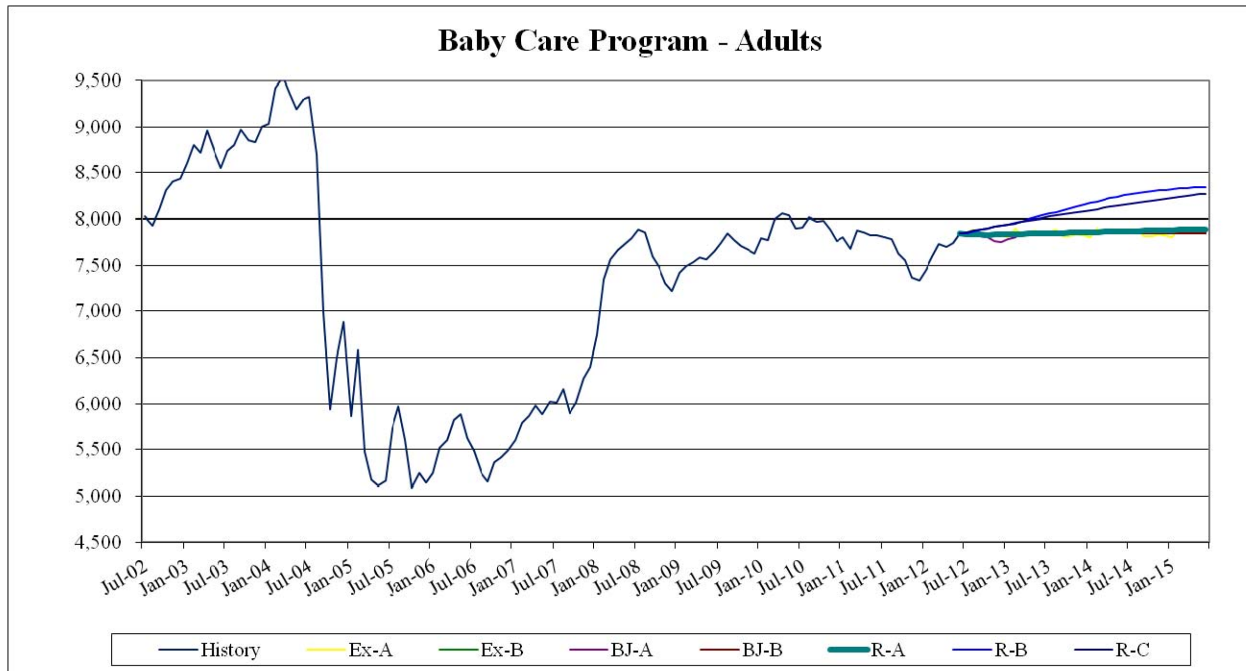
Monthly Average Growth Comparisons		
February 2012 Forecast	(5)	-0.03%
FY 2011-12 Actuals	(17)	-0.09%
FY 2011-12 1st Half	(8)	-0.04%
FY 2011-12 2nd Half	(25)	-0.14%
FY 2012-13 Forecast	(2)	-0.01%
February 2012 Forecast	2	0.01%
FY 2013-14 Forecast	10	0.06%

Base trend from June 2012 level			
FY 2012-13	18,022	-0.07%	(12)

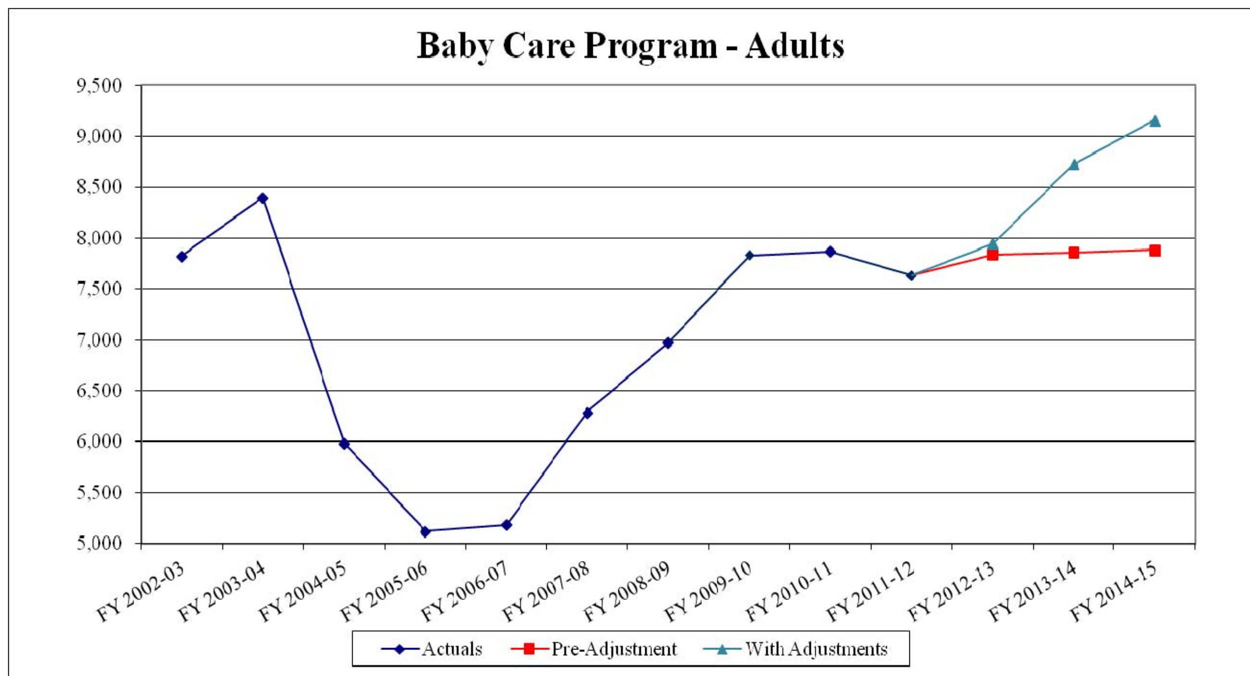
Baby Care-Adults

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

Baby Care Program- Adults: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A	0.9493	
Exponential Smoothing B*	0.9331	
Box-Jenkins A*	0.9504	
Box-Jenkins	0.9337	
Regression A	0.9528	BCA [-1], BCA Dummy, Auto [-4]
Regression B	0.9475	BCA [-1], Migration, Unemployment Rate, Auto [-3]
Regression C	0.9547	BCA [-1], Female Population 19-59, BCA Dummy



Baby Care Program-Adults: Model Results						
FY 2012-13	**FY 2010-11**	**FY 2011-12**	**Projected Growth Rate**	**Projected FY 2012-13 Caseload**	**Level Change**	**Average Monthly Change [1]**
Exponential Smoothing A	7,868	7,630	2.86%	7,848	218	0
Exponential Smoothing B	7,868	7,630	2.83%	7,846	216	0
Box Jenkins A*	7,868	7,630	2.45%	7,817	187	1
Box Jenkins B*	7,868	7,630	2.83%	7,846	216	0
Regression A	**7,868**	**7,630**	**2.74%**	**7,839**	**209**	**0**
Regression B	7,868	7,630	4.09%	7,942	312	16
Regression C	7,868	7,630	4.02%	7,937	307	14

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2013-14	FY 2011-12	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	7,630	7,839	0.00%	7,839	0	0
Exponential Smoothing B	7,630	7,839	0.00%	7,839	0	0
Box Jenkins A*	7,630	7,839	0.47%	7,876	37	0
Box Jenkins B*	7,630	7,839	0.00%	7,839	0	0
Regression A	**7,630**	**7,839**	**0.27%**	**7,860**	**21**	**2**
Regression B	7,630	7,839	2.72%	8,052	213	18
Regression C	7,630	7,839	1.89%	7,987	148	12

FY 2014-15	Projected FY 2012-13 Caseload	Projected FY 2013-14 Caseload	Projected Growth Rate	Projected FY 2014-15 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	7,839	7,860	0.00%	7,860	0	0
Exponential Smoothing B	7,839	7,860	0.00%	7,860	0	0
Box Jenkins A*	7,839	7,860	0.10%	7,868	8	0
Box Jenkins B*	7,839	7,860	0.00%	7,860	0	0
Regression A	**7,839**	**7,860**	**0.29%**	**7,883**	**23**	**2**
Regression B	7,839	7,860	1.91%	8,010	150	8
Regression C	7,839	7,860	1.62%	7,987	127	10

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

Baby Care Program- Adults: Trend Selections
FY 2012-13: 2.74%
FY 2013-14: 0.27%
FY 2014-15: 0.29%

Baby Care Program- Adults: Justifications

- This population is effected by the economy in similar ways as the Low-Income Adults and Children populations, although the effects may be increased given that these clients have incomes up to 133% of the federal poverty level.
- Presumptive eligibility allows pregnant women who had applied for Medicaid to receive services based on self-declaration until the status of their application has been determined. The State paid for all Medicaid costs during this time regardless of whether or not the woman was eventually found to be Medicaid eligible or not. On September 1, 2004, the Department discontinued this procedure, which explains the drop of nearly 2,500 clients in September and October 2004, as well as the corresponding decline in fiscal year average caseload. Presumptive eligibility was reinstated by HB 05-1262 (Tobacco Tax bill) effective July 1, 2005. Discounting these policy changes, caseload for this category is erratic and tends to be mired with spikes, as displayed in the graph above.
- Models in this aid category are heavily influenced by the caseload decline due to the end of the presumptive eligibility program in 2004. The exponential smoothing and Box-Jenkins models do not reflect the reimplementation of presumptive eligibility. The volatility in this population forces many forecasts to be flat, even after accounting for presumptive eligibility.
- In FY 2009-10, the Department received approval from the Centers for Medicare and Medicaid Services to grant full Medicaid eligibility to pregnant women who are legal permanent residents that have been in the country for less than 5 years, as authorized by the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA). As a result, the Department has restated the FY 2009-10 monthly caseload for this eligibility type to include clients who had previously been in the State-only Prenatal population. These clients are now included in the base caseload.
- Growth in FY 2011-12 was higher than the Department's February 2012 forecast, in which the annual base caseload was projected to be 7,472 and average monthly declines were projected to be 38. The selected trend for FY 2012-13 is higher than that from the February 2012 forecast, and would yield average growth of 0 per month for FY 2012-13. Caseload in this eligibility type has been volatile for four years, as can be seen in the tables on the next page. While the cause of the volatility is unknown at this time, the Department does not anticipate that either large decreases or increases will continue.
- The Colorado Department of Public Health & Environment Family Planning Initiative was awarded a grant for approximately $3.5 million to address the issue of unintended pregnancy in Colorado for Title X clients, the vast majority of which are under 200% of the federal poverty level. Out-year trends are moderate due to this Family Planning initiative.
- There are two bottom-line adjustments to this eligibility type. First, SB 11-250 increases eligibility for pregnant women in Medicaid from 133% of federal poverty line (FPL) to 185% FPL effective January 2013. Second, there is an adjustment for the conversion to the Modified Adjusted Gross Income (MAGI) pursuant to the Affordable Care Act (ACA) in January 2014, which standardizes income calculations between Medicaid and CHP+ and will transition pregnant women with income under 133% FPL currently in CHP+ to Medicaid. These adjustments have been updated in accordance with a revised CHP+ caseload forecast.

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

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

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

Baby Care Program- Adults: Historical Caseload and Forecasts

Baby Care Program-Adults: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	7,903	-	-
Jul-10	7,909	6	0.08%
Aug-10	8,014	105	1.33%
Sep-10	7,971	(43)	-0.54%
Oct-10	7,985	14	0.18%
Nov-10	7,891	(94)	-1.18%
Dec-10	7,764	(127)	-1.61%
Jan-11	7,804	40	0.52%
Feb-11	7,677	(127)	-1.63%
Mar-11	7,881	204	2.66%
Apr-11	7,864	(17)	-0.22%
May-11	7,830	(34)	-0.43%
Jun-11	7,828	(2)	-0.03%
Jul-11	7,810	(18)	-0.23%
Aug-11	7,786	(24)	-0.31%
Sep-11	7,628	(158)	-2.03%
Oct-11	7,558	(70)	-0.92%
Nov-11	7,371	(187)	-2.47%
Dec-11	7,333	(38)	-0.52%
Jan-12	7,445	112	1.53%
Feb-12	7,594	149	2.00%
Mar-12	7,734	140	1.84%
Apr-12	7,705	(29)	-0.37%
May-12	7,744	39	0.51%
Jun-12	7,846	102	1.32%

	Caseload*	% Change	Level Change
FY 1995-96	7,223	-	-
FY 1996-97	5,476	-24.19%	(1,747)
FY 1997-98	4,295	-21.57%	(1,181)
FY 1998-99	5,017	16.81%	722
FY 1999-00	6,174	23.06%	1,157
FY 2000-01	6,561	6.27%	387
FY 2001-02	7,131	8.69%	570
FY 2002-03	7,823	9.70%	692
FY 2003-04	8,398	7.35%	575
FY 2004-05	5,984	-28.74%	(2,414)
FY 2005-06	5,119	-14.46%	(865)
FY 2006-07	5,182	1.23%	63
FY 2007-08	6,288	21.34%	1,106
FY 2008-09	6,976	10.94%	688
FY 2009-10	7,830	12.24%	854
FY 2010-11	7,868	0.49%	38
FY 2011-12	7,630	-3.02%	(238)
FY 2012-13	7,839	2.74%	209
FY 2013-14	7,860	0.27%	21
FY 2014-15	7,883	0.29%	23

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

Adjustments	
FY 2012-13	372
FY 2013-14	941
FY 2014-15	1,274

November 2012 Projections After Adjustments			
FY 2012-13	8,211	7.62%	581
FY 2013-14	8,801	7.18%	590
FY 2014-15	9,157	4.04%	356

February 2012 Forecast	
Forecasted June 2012 Level	7,370

Base trend from June 2012 level			
FY 2012-13	7,846	2.83%	216

February 2012 Trends (BEFORE ADJUSTMENTS)			
FY 2011-12	7,472	-5.03%	(396)
FY 2012-13	7,365	-1.43%	(107)
FY 2013-14	7,360	-0.07%	(5)

Monthly Average Growth Comparisons		
February 2012 Forecast	(38)	-0.49%
FY 2011-12 Actuals	2	0.03%
FY 2011-12 1st Half	(83)	-1.08%
FY 2011-12 2nd Half	86	1.14%
FY 2012-13 Forecast	0	0.00%
February 2012 Forecast	(1)	-0.01%
FY 2013-14 Forecast	2	0.03%

Actuals		
	Monthly Change	% Change
6-month average	86	1.14%
12-month average	2	0.03%
18-month average	5	0.07%
24-month average	(2)	-0.02%

Non-Citizens

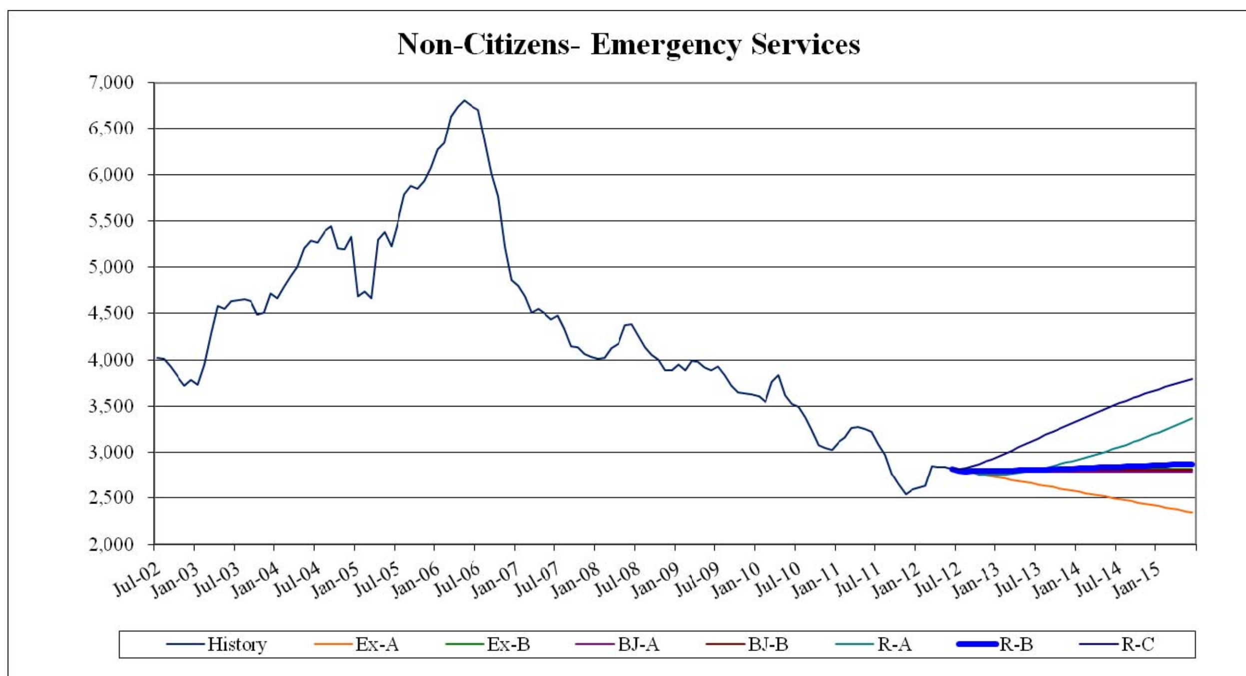
Section 403 of the Personal Responsibility Work Opportunity Reconciliation Act provides that certain immigrants arriving in the United States after August 22, 1996 are ineligible for full Medicaid benefits for their first five years of residence. The five-year ban only applies to immigrants who arrived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

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

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

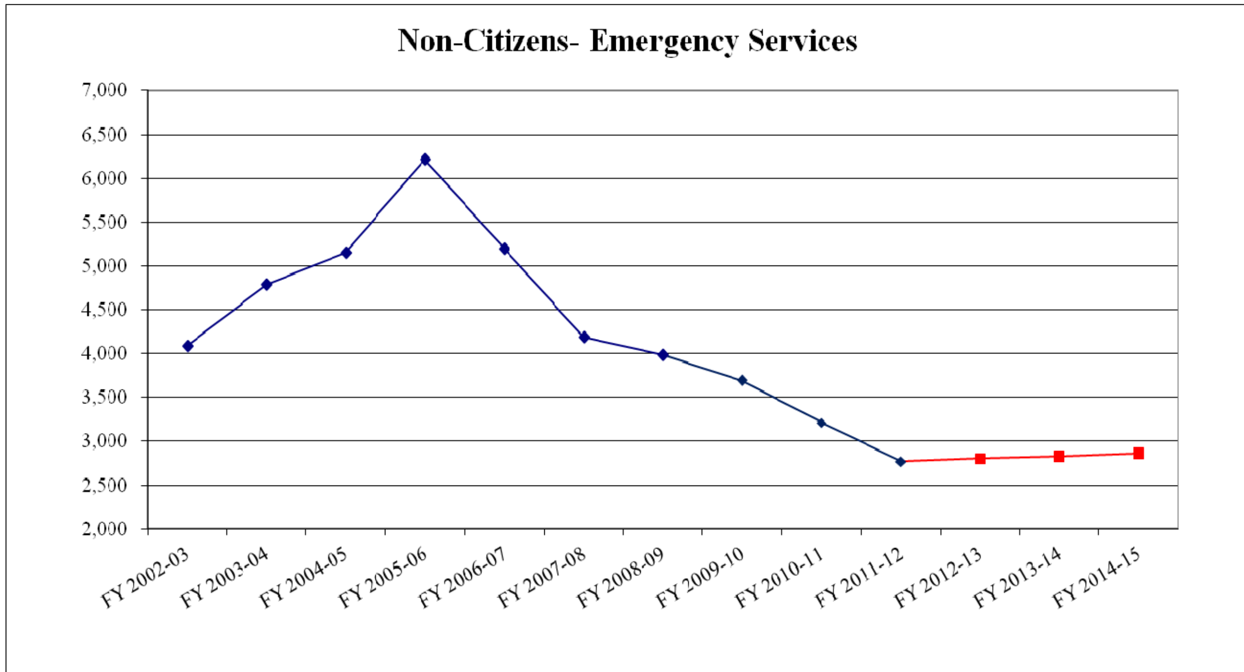
In April 2001, an eligibility policy change was implemented such that clients are now only counted as eligible in the months they receive emergency medical care. Prior to this policy change, eligibility for this group continued as it would for any other category, although only for emergency medical services.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

Non-Citizens: Model Results



	Adjusted R^2	Notes

Exponential Smoothing A	0.9676	
Exponential Smoothing B*	0.9779	
Box-Jenkins A*	0.9812	
Box-Jenkins B	0.9830	
Regression A	0.9870	ALIEN [-1], Female Population 19-59, Migration, Alien Dummy, Auto [-3], Auto [-7]
Regression B	0.9896	ALIEN [-1], ALIEN [-2], Alien Dummy, Auto [-3], Auto [-6]
Regression C	0.9893	ALIEN [-1], Unemployment Rate, Alien Dummy, Auto [-1], Auto [-2]



Non-Citizens- Emergency Services: Model Results

FY 2012-13	FY 2010-11	FY 2011-12	Projected Growth Rate	Projected FY 2012-13 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	3,213	2,770	-1.34%	2,733	(37)	(13)
Exponential Smoothing B	3,213	2,770	1.73%	2,818	48	0
Box Jenkins A*	3,213	2,770	0.79%	2,792	22	(2)
Box Jenkins B*	3,213	2,770	1.30%	2,806	36	(1)
Regression A	3,213	2,770	0.22%	2,776	6	(1)
Regression B	**3,213**	**2,770**	**1.12%**	**2,801**	**31**	**(1)**
Regression C	3,213	2,770	6.61%	2,953	183	25

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2013-14	FY 2011-12	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A	2,770	2,801	-5.74%	2,640	(161)	(13)
Exponential Smoothing B	2,770	2,801	0.00%	2,801	0	0
Box Jenkins A*	2,770	2,801	-0.11%	2,798	(3)	0
Box Jenkins B*	2,770	2,801	0.00%	2,801	0	0
Regression A	2,770	2,801	5.22%	2,947	146	19
Regression B	**2,770**	**2,801**	**0.93%**	**2,827**	**26**	**3**
Regression C	2,770	2,801	12.90%	3,162	361	32

FY 2014-15	Projected FY 2012-13 Caseload	Projected FY 2013-14 Caseload	Projected Growth Rate	Projected FY 2014-15 Caseload	Level Change	Average Monthly Change [1]

Exponential Smoothing A	2,801	2,827	-6.09%	2,655	(172)	(13)
Exponential Smoothing B	2,801	2,827	0.00%	2,827	0	0
Box Jenkins A*	2,801	2,827	0.00%	2,827	0	0
Box Jenkins B*	2,801	2,827	0.00%	2,827	0	0
Regression A	2,801	2,827	9.89%	3,107	280	28
Regression B	**2,801**	**2,827**	**1.20%**	**2,861**	**34**	**3**
Regression C	2,801	2,827	10.05%	3,111	284	24

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

Non-Citizens: Trend Selections
FY 2012-13: 1.12%
FY 2013-14: 0.93%
FY 2014-15: 1.20%

Non-Citizens: Justifications

- The graph above illustrates that the caseload in this category had a positive trend between FY 2002-03 and FY 2005-06. Caseload trends should be correlated with economic conditions and migration trends. As the economy recovers, more immigrants are expected to migrate to the State. Research shows that Mexican immigrants tend to have longer life expectancies than natives of the United States or of other Hispanic origins, and that the mortality advantage is higher for lower income immigrants.[14]
- Expenditures in this category did not decrease along with caseload in FY 2006-07 and FY 2007-08, indicating that the caseload decline was not occurring in clients that were utilizing services. Until October 2006, the eligibility spans for pregnant clients who delivered in Non-Citizens were left open for 60 days post-partum in case of an emergency. These clients, however, rarely utilized any services. The caseload declines in FY 2006-07 and FY 2007-08 may indicate that eligibility spans for the Non-Citizens clients are now being ended sooner, caused by eligibility technicians actively working more cases because they are required to collect citizenship information. In addition, it is possible that some undocumented citizens are not applying for Medicaid emergency services out of fear due to the Deficit Reduction Act and HB 06S-1023 identification requirements, even though the Medicaid application clearly states that emergency services are exempt. Although the effects of these state and federal legislations, as well as the 60-day post-partum policy change, are unquantifiable, the Department believes that these large declines are unlikely to continue.
- The Department believes that the caseload volatility in this eligibility type beginning in FY 2008-09 are somewhat related to those experienced in the Baby Care-Adults caseload, as a large portion of the Non-Citizens caseload are pregnant women. Though the cause of this volatility is unknown at this time, the Department does not anticipate that large decreases will continue.
- Growth in FY 2011-12 was higher than the Department's February 2012 forecast, in which the annual caseload was projected to be 2,659 and average monthly declines were projected to be 58. The selected trend for FY 2012-13 is much higher than that from the February 2012 forecast, and would yield average declines of 1 per month for FY 2012-13. The projected positive trend is reflective of the growth experienced in the second half of FY 2011-12, which leaves caseload at a relative high starting level in FY 2012-13.

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

- The out-year trends assume relatively slow caseload growth. As discussed in the Baby Care-Adults section, a number of Family Planning initiatives will be implemented during the forecast period, which may be expected to decrease the number of pregnancies.

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

Non-Citizens: Historical Caseload and Forecasts

Non-Citizens- Emergency Services: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	3,522	-	-
Jul-10	3,492	(30)	-0.85%
Aug-10	3,378	(114)	-3.26%
Sep-10	3,231	(147)	-4.35%
Oct-10	3,080	(151)	-4.67%
Nov-10	3,049	(31)	-1.01%
Dec-10	3,023	(26)	-0.85%
Jan-11	3,116	93	3.08%
Feb-11	3,161	45	1.44%
Mar-11	3,271	110	3.48%
Apr-11	3,274	3	0.09%
May-11	3,255	(19)	-0.58%
Jun-11	3,229	(26)	-0.80%
Jul-11	3,089	(140)	-4.34%
Aug-11	2,973	(116)	-3.76%
Sep-11	2,774	(199)	-6.69%
Oct-11	2,657	(117)	-4.22%
Nov-11	2,543	(114)	-4.29%
Dec-11	2,591	48	1.89%
Jan-12	2,617	26	1.00%
Feb-12	2,636	19	0.73%
Mar-12	2,852	216	8.19%
Apr-12	2,846	(6)	-0.21%
May-12	2,844	(2)	-0.07%
Jun-12	2,818	(26)	-0.91%

	Caseload*	% Change	Level Change
FY 1995-96	4,100	-	-
FY 1996-97	4,610	12.44%	510
FY 1997-98	5,032	9.15%	422
FY 1998-99	5,799	15.24%	767
FY 1999-00	9,065	56.32%	3,266
FY 2000-01	12,451	37.35%	3,386
FY 2001-02	4,028	-67.65%	(8,423)
FY 2002-03	4,084	1.39%	56
FY 2003-04	4,793	17.36%	709
FY 2004-05	5,150	7.45%	357
FY 2005-06	6,212	20.62%	1,062
FY 2006-07	5,201	-16.27%	(1,011)
FY 2007-08	4,191	-19.42%	(1,010)
FY 2008-09	3,987	-4.87%	(204)
FY 2009-10	3,693	-7.37%	(294)
FY 2010-11	3,213	-13.00%	(480)
FY 2011-12	2,770	-13.79%	(443)
FY 2012-13	2,801	1.12%	31
FY 2013-14	2,827	0.93%	26
FY 2014-15	2,861	1.20%	34

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

February 2012 Forecast	
Forecasted June 2012 Level	2,531

Actuals	Monthly Change	% Change
6-month average	38	1.45%
12-month average	(34)	-1.06%
18-month average	(11)	-0.33%
24-month average	(29)	-0.87%

Base trend from June 2012 level			
FY 2012-13	2,818	1.73%	48

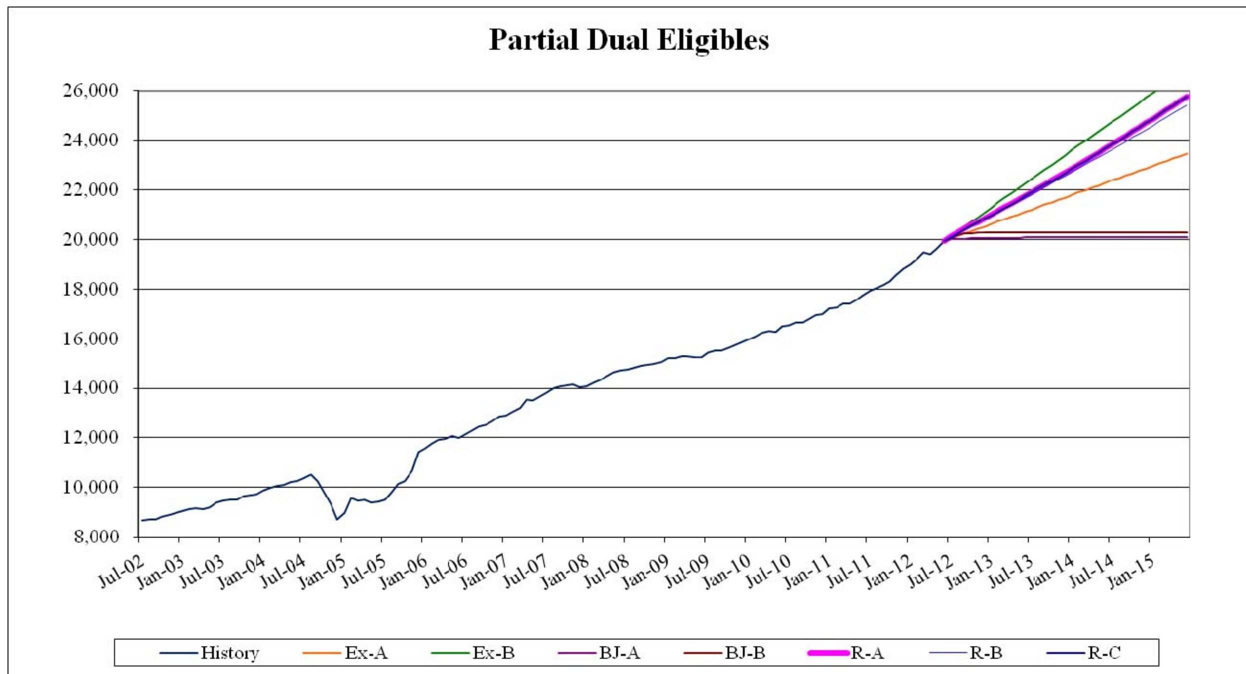
February 2012 Trends			
FY 2011-12	2,659	-17.24%	(554)
FY 2012-13	2,529	-4.89%	(130)
FY 2013-14	2,549	0.79%	20

Monthly Average Growth Comparisons		
February 2012 Forecast	(58)	-1.80%
FY 2011-12 Actuals	(34)	-1.06%
FY 2011-12 1st Half	(106)	-3.57%
FY 2011-12 2nd Half	38	1.45%
FY 2012-13 Forecast	(1)	-0.03%
February 2012 Forecast	0	0.00%
FY 2013-14 Forecast	3	0.11%

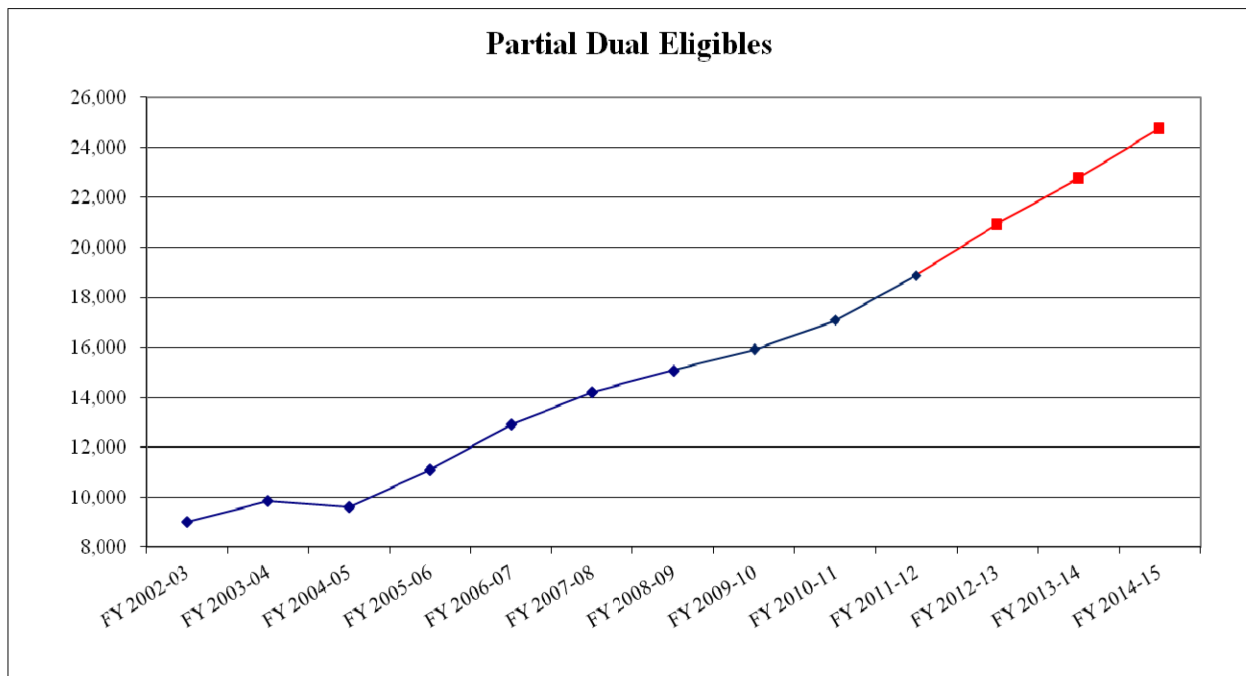
Partial Dual Eligibles

Medicare-eligible beneficiaries who have incomes at a certain federal poverty level and limited resources may qualify to have Medicaid cover some of their out-of-pocket expenses, such as their Medicare Part B premiums and other coinsurance and deductibles. The two groups of clients that qualify for this cost-sharing program are Qualified Medicare Beneficiaries and Special Low Income Medicare Beneficiaries. This group, formerly known as Qualified Medicare Beneficiaries/Special Low Income Medicare Beneficiaries, is now collectively known as Partial Dual Eligibles. Qualified Medicare Beneficiaries have incomes at or below 100% of the federal poverty level, and resources twice the standard allowed under the federal Supplemental Security Income program. These clients receive hospital insurance and supplementary medical insurance premium coverage along with Medicare coinsurance and deductibles. Special Low Income Medicare Beneficiaries have incomes greater than 100% of the federal poverty level, but less than 120%. For Special Low Income Medicare Beneficiaries, Medicaid only pays the supplementary medical insurance premiums.

Partial Dual Eligibles: Model Results



	Adjusted R^2	Notes
Exponential Smoothing A*	0.9986	
Exponential Smoothing B	0.9972	
Box-Jenkins A	0.9981	
Box-Jenkins B*	0.9973	
Regression A	0.9995	PDE [-1], PDE Dummy, CBMS Dummy, Auto [-1]
Regression B	0.9995	PDE [-1], Population 65+, PDE Dummy, CBMS Dummy, Auto [-1]
Regression C	0.9995	PDE [-1], PDE [-2], PDE Dummy, CBMS Dummy, Auto [-3]



Partial Dual Eligibles: Model Results

FY 2012-13	FY 2010-11	FY 2011-12	Projected Growth Rate	Projected FY 2012-13 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	17,090	18,871	8.98%	20,566	1,695	98
Exponential Smoothing B*	17,090	18,871	12.23%	21,179	2,308	192
Box Jenkins A	17,090	18,871	6.21%	20,043	1,172	12
Box Jenkins B	17,090	18,871	7.27%	20,243	1,372	29
Regression A	**17,090**	**18,871**	**10.92%**	**20,932**	**2,061**	**152**
Regression B	17,090	18,871	10.69%	20,888	2,017	145
Regression C	17,090	18,871	10.73%	20,896	2,025	150

* Denotes Expert Selection, Bold denotes Trend Selection

FY 2013-14	FY 2011-12	Projected FY 2012-13 Caseload	Projected Growth Rate	Projected FY 2013-14 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	18,871	20,932	5.70%	22,125	1,193	98
Exponential Smoothing B*	18,871	20,932	10.90%	23,214	2,282	192
Box Jenkins A	18,871	20,932	0.16%	20,965	33	0
Box Jenkins B	18,871	20,932	0.17%	20,968	36	0
Regression A	**18,871**	**20,932**	**8.81%**	**22,776**	**1,844**	**160**
Regression B	18,871	20,932	8.34%	22,678	1,746	150
Regression C	18,871	20,932	8.93%	22,801	1,869	161

FY 2014-15	Projected FY 2012-13 Caseload	Projected FY 2013-14 Caseload	Projected Growth Rate	Projected FY 2014-15 Caseload	Level Change	Average Monthly Change [1]
Exponential Smoothing A*	20,932	22,776	5.40%	24,006	1,230	98
Exponential Smoothing B*	20,932	22,776	9.83%	25,015	2,239	192
Box Jenkins A	20,932	22,776	0.00%	22,776	0	0
Box Jenkins B	20,932	22,776	0.00%	22,776	0	0
Regression A	**20,932**	**22,776**	**8.80%**	**24,780**	**2,004**	**174**
Regression B	20,932	22,776	8.29%	24,664	1,888	162
Regression C	20,932	22,776	8.87%	24,796	2,020	175

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

Partial Dual Eligibles: Trend Selections
FY 2012-13: 10.92%
FY 2013-14: 8.81%
FY 2014-15: 8.80%

Partial Dual Eligibles: Justification

- These clients have higher income than Adults 65 and Older or Disabled Adults 60 to 64, and are relatively healthy. Given the increased life expectancy, more people are living healthier longer, which would support strong growth rates in this population. In addition, this population may start to be effected by the "baby boomers", defined by the U.S. Census Bureau as the generation born between 1946 and 1964, beginning in calendar year 2006.
- Caseload trends are somewhat correlated with age and economic indicators. The assets and annuities provisions in the Deficit Reduction Act of 2005 may also contribute to growth in this category, as some clients who might have qualified for the Adults 65 and Older category now have too much income or assets.
- Caseload growth in this category was positive and steady between FY 1999-00 and FY 2003-04. Caseload experienced an unprecedented contraction on FY 2004-05, due to large monthly declines that occurred as a result of the court order regarding the Colorado Benefits Management System. The relatively strong growth since the beginning of FY 2005-06 may be due to a wood work effect from Medicare Modernization Act, under which Medicare Part D clients are screened for Medicaid as they apply for the low-income subsidy.
- Growth in FY 2011-12 was higher with the Department's February 2012 forecast, in which the annual caseload was projected to be 18,796 and average monthly growth was projected to be 158. The selected trend for FY 2012-13 is higher than the February 2012 forecast, and would yield average growth of 152 per month for FY 2012-13.
- Out-year trend selections are slightly higher than historic rates, reflecting the complete incorporation of baby boomers and any clients affected by the Medicare Modernization Act.

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

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

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

Partial Dual Eligibles: Historical Caseload and Forecasts

Partial Dual Eligibles: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	16,495	-	-
Jul-10	16,539	44	0.27%
Aug-10	16,634	95	0.57%
Sep-10	16,652	18	0.11%
Oct-10	16,794	142	0.85%
Nov-10	16,941	147	0.88%
Dec-10	17,002	61	0.36%
Jan-11	17,210	208	1.22%
Feb-11	17,249	39	0.23%
Mar-11	17,390	141	0.82%
Apr-11	17,399	9	0.05%
May-11	17,546	147	0.84%
Jun-11	17,727	181	1.03%
Jul-11	17,923	196	1.11%
Aug-11	18,046	123	0.69%
Sep-11	18,156	110	0.61%
Oct-11	18,314	158	0.87%
Nov-11	18,584	270	1.47%
Dec-11	18,798	214	1.15%
Jan-12	18,985	187	0.99%
Feb-12	19,220	235	1.24%
Mar-12	19,466	246	1.28%
Apr-12	19,396	(70)	-0.36%
May-12	19,640	244	1.26%
Jun-12	19,929	289	1.47%

	Caseload*	% Change	Level Change
FY 1995-96	3,937	-	-
FY 1996-97	4,316	9.63%	379
FY 1997-98	4,560	5.65%	244
FY 1998-99	6,104	33.86%	1,544
FY 1999-00	7,597	24.46%	1,493
FY 2000-01	8,157	7.37%	560
FY 2001-02	8,428	3.32%	271
FY 2002-03	8,988	6.64%	560
FY 2003-04	9,842	9.50%	854
FY 2004-05	9,605	-2.41%	(237)
FY 2005-06	11,092	15.48%	1,487
FY 2006-07	12,908	16.37%	1,816
FY 2007-08	14,214	10.12%	1,306
FY 2008-09	15,075	6.06%	861
FY 2009-10	15,919	5.60%	844
FY 2010-11	17,090	7.36%	1,171
FY 2011-12	18,871	10.42%	1,781
FY 2012-13	20,932	10.92%	2,061
FY 2013-14	22,776	8.81%	1,844
FY 2014-15	24,780	8.80%	2,004

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

February 2012 Forecast	
Forecasted June 2012 Level	19,617

Actuals	Monthly Change	% Change
6-month average	189	0.98%
12-month average	184	0.98%
18-month average	163	0.89%
24-month average	143	0.79%

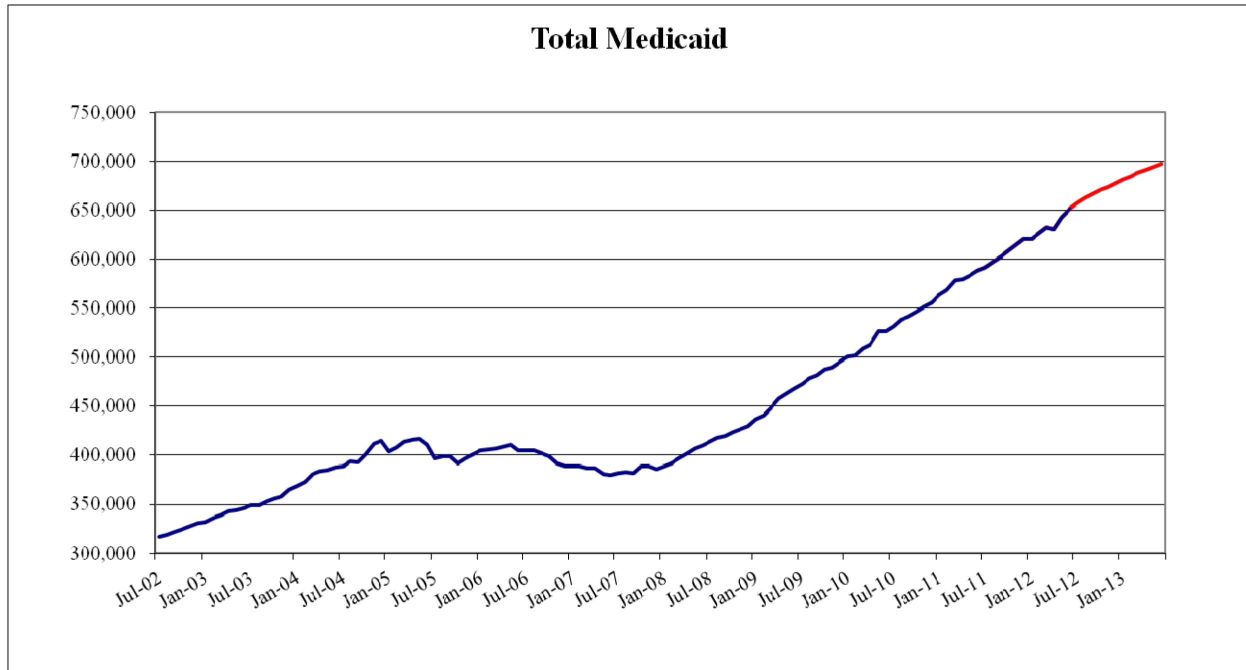
Base trend from June 2012 level			
FY 2012-13	19,929	5.61%	1,058

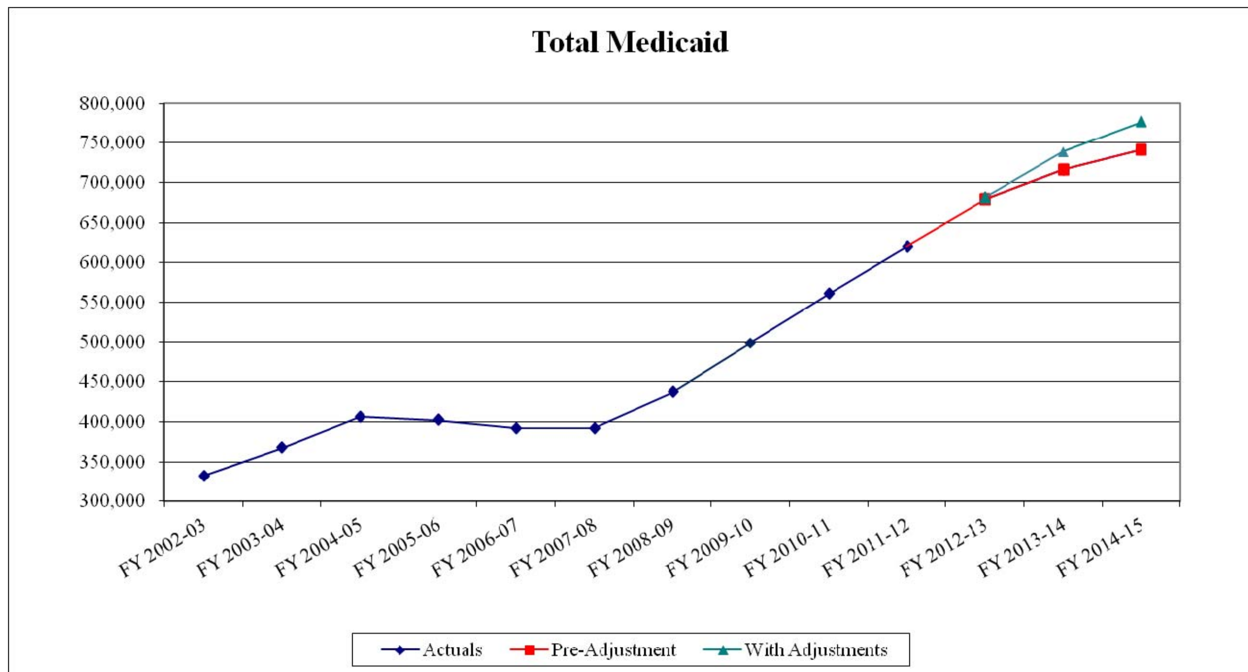
February 2012 Trends			
FY 2011-12	18,796	9.98%	1,706
FY 2012-13	20,503	9.08%	1,707
FY 2013-14	22,231	8.43%	1,728

Monthly Average Growth Comparisons		
February 2012 Forecast	158	0.89%
FY 2011-12 Actuals	184	0.98%
FY 2011-12 1st Half	179	0.98%
FY 2011-12 2nd Half	189	0.98%
FY 2012-13 Forecast	152	0.86%
February 2012 Forecast	138	0.71%
FY 2013-14 Forecast	160	0.80%

SUMMARY

The Department is forecasting a FY 2012-13 total Medicaid caseload of 681,535, a 9.93% increase from FY 2011-12. The trend is projected to moderate slightly in FY 2013-14 with caseload expected to increase by 8.35% to 738,413, with a large portion of the growth to come from the adjustments for SB 11-008, and SB 11-250, both of which are scheduled for implementation in January 2013, and the transition to MAGI, which begin January 1, 2014.





Total Medicaid: Historical Caseload and Projections

	Actuals	Monthly Change	% Change
Jun-10	526,776	-	-
Jul-10	531,445	4,669	0.89%
Aug-10	539,073	7,628	1.44%
Sep-10	541,285	2,212	0.41%
Oct-10	546,301	5,016	0.93%
Nov-10	551,168	4,867	0.89%
Dec-10	556,120	4,952	0.90%
Jan-11	564,115	7,995	1.44%
Feb-11	569,088	4,973	0.88%
Mar-11	578,192	9,104	1.60%
Apr-11	579,436	1,244	0.22%
May-11	583,951	4,515	0.78%
Jun-11	588,925	4,974	0.85%
Jul-11	591,843	2,918	0.50%
Aug-11	597,705	5,862	0.99%
Sep-11	602,910	5,205	0.87%
Oct-11	608,533	5,623	0.93%
Nov-11	614,146	5,613	0.92%
Dec-11	620,799	6,653	1.08%
Jan-12	620,542	(257)	-0.04%
Feb-12	626,106	5,564	0.90%
Mar-12	632,511	6,405	1.02%
Apr-12	630,699	(1,812)	-0.29%
May-12	642,649	11,950	1.89%
Jun-12	651,122	8,473	1.32%
Jul-12	**657,869**	**6,747**	**1.04%**
Aug-12	**662,202**	**4,333**	**0.66%**
Sep-12	**666,570**	**4,368**	**0.66%**
Oct-12	**670,101**	**3,531**	**0.53%**
Nov-12	**673,878**	**3,777**	**0.56%**
Dec-12	**677,788**	**3,910**	**0.58%**
Jan-13	**681,350**	**3,562**	**0.53%**
Feb-13	**684,690**	**3,340**	**0.49%**
Mar-13	**687,940**	**3,250**	**0.47%**
Apr-13	**691,063**	**3,123**	**0.45%**
May-13	**694,170**	**3,107**	**0.45%**
Jun-13	**697,221**	**3,051**	**0.44%**

**Bold denotes projection

	Caseload*	% Change	Level Change
FY 1995-96	254,083	-	-
FY 1996-97	250,098	-1.57%	(3,985)
FY 1997-98	238,594	-4.60%	(11,504)
FY 1998-99	237,598	-0.42%	(996)
FY 1999-00	253,254	6.59%	15,656
FY 2000-01	275,399	8.74%	22,145
FY 2001-02	295,413	7.27%	20,014
FY 2002-03	331,800	12.32%	36,387
FY 2003-04	367,559	10.78%	35,759
FY 2004-05	406,024	10.46%	38,465
FY 2005-06	402,218	-0.94%	(3,806)
FY 2006-07	392,228	-2.48%	(9,990)
FY 2007-08	391,962	-0.07%	(266)
FY 2008-09	436,812	11.44%	44,850
FY 2009-10	498,797	14.19%	61,985
FY 2010-11	560,759	12.42%	61,962
FY 2011-12	619,963	10.56%	59,204
FY 2012-13	678,739	9.48%	58,776
FY 2013-14	715,924	5.48%	37,185
FY 2014-15	741,171	3.53%	25,247

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

Adjustments	
FY 2012-13	2,558
FY 2013-14	22,617
FY 2014-15	35,350

Projections After Adjustments			
FY 2012-13	681,297	9.89%	61,334
FY 2013-14	738,541	8.40%	57,245
FY 2014-15	776,521	5.14%	37,980

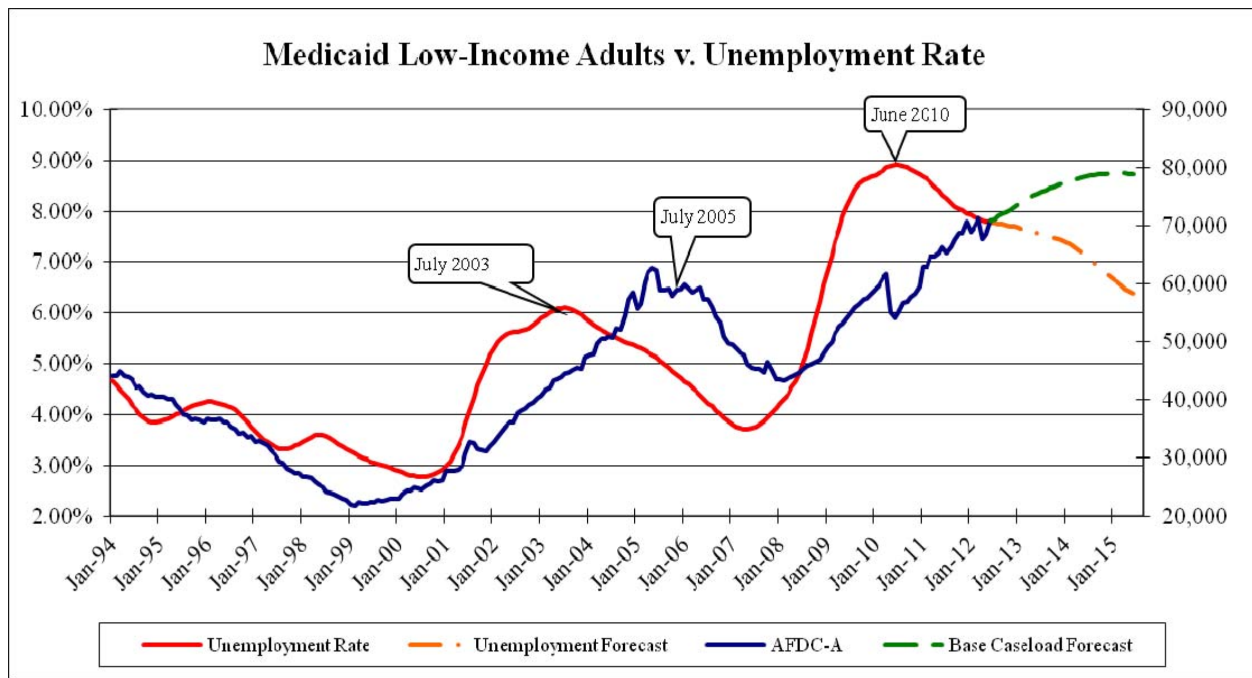
February 2012 Trends (BEFORE ADJUSTMENTS)			
FY 2011-12	621,870	10.90%	61,111
FY 2012-13	672,963	8.22%	51,093
FY 2013-14	709,189	5.38%	36,226

February 2012 Forecast	
Forecasted June 2012 Level	648,848

Monthly Average Growth Comparisons		
February 2012 Forecast	4,994	0.81%
FY 2011-12 Actuals	5,183	0.84%
FY 2011-12 1st Half	5,312	0.88%
FY 2011-12 2nd Half	5,054	0.80%
FY 2012-13 Forecast	3,842	0.57%
February 2012 Forecast	1,672	0.25%
FY 2013-14 Forecast	2,727	0.38%

Actuals	Monthly Change	% Change
6-month average	5,054	0.80%
12-month average	5,183	0.84%
18-month average	5,278	0.88%
24-month average	5,181	0.89%

Base trend from June 2012 level			
FY 2012-13	651,122	5.03%	31,159


Medicaid Low-Income Adults v. Unemployment Rate
10.00%
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
July 2003
July 2005
June 2010
Jan-94
Jan-95
Jan-96
Jan-97
Jan-98
Jan-99
Jan-00
Jan-01
Jan-02
Jan-03
Jan-04
Jan-05
Jan-06
Jan-07
Jan-08
Jan-09
Jan-10
Jan-11
Jan-12
Jan-13
Jan-14
Jan-15
Unemployment Rate
Unemployment Forecast
AFDC-A
Base Caseload Forecast

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(A) General Administration							
Personal Services							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$21,687,551	314.3	$7,916,146	$0	$2,038,599	$351,526	$11,381,280
HB 12-1339 Annualization "Colorado Benefits Management System Project"	$825,119	11.0	$0	$0	$0	$825,119	$0
HB 12-1246 "Reverse Payday Shift State Employees Paid Biweekly"	$28,498	0.0	$28,498	$0	$0	$0	$0
HB 12-1281 "Medicaid Payment Reform Pilot Program"	$47,538	0.8	$23,769	$0	$0	$0	$23,769
SB 12-060 "Improve Medicaid Fraud Prosecution"	$5,216	0.1	$2,608	$0	$0	$0	$2,608
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$22,593,922**	**326.2**	**$7,971,021**	**$0**	**$2,038,599**	**$1,176,645**	**$11,407,657**
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$16,904	0.2	$8,452	$0	$0	$0	$8,452
HB 12-1246 Annualization "Reverse Payday Shift State Employees Paid Biweekly"	($28,498)	0.0	($28,498)	$0	$0	$0	$0
HB 12-1281 Annualization "Medicaid Payment Reform Pilot Program"	$15,847	0.2	$7,924	$0	$0	$0	$7,923
HB 12-1339 Annualization "Colorado Benefits Management System Project" FY14	($117,874)	0.0	$0	$0	$0	($117,874)	$0
FY 2013-14 Statewide Indirect Cost Allocation	$1,160,738	0.0	$1,190,879	$0	$38,481	$10,784	($79,406)
FY 2013-14 Base Request	**$23,641,039**	**326.6**	**$9,149,778**	**$0**	**$2,077,080**	**$1,069,555**	**$11,344,626**
FY 2013-14 R#6: "Additional FTE to Restore Functionality"	$528,568	7.4	$264,285	$0	$0	$0	$264,283
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	$82,577	1.2	$0	$0	$41,289	$0	$41,288
FY 2013-14 R#11: "HB 12-1281 Departmental Differences Reconciliation"	$238,414	3.0	$119,207	$0	$0	$0	$119,207
FY 2013-14 November 1 Request	**$24,490,598**	**338.2**	**$9,533,270**	**$0**	**$2,118,369**	**$1,069,555**	**$11,769,404**
Health, Life, and Dental							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$2,160,056	0.0	$796,479	$0	$174,652	$55,084	$1,133,841
HB 12-1339 Annualization "Colorado Benefits Management System Project"	$56,737	0.0	$0	$0	$0	$56,737	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$2,216,793**	**0.0**	**$796,479**	**$0**	**$174,652**	**$111,821**	**$1,133,841**
HB 12-1339 Annualization "Colorado Benefits Management System Project" FY14	($8,106)	0.0	$0	$0	$0	($8,106)	$0
FY 2013-14 Common Policy Adjustment	$15,835	0.0	($35,385)	$0	($7,185)	($40,781)	$99,186
FY 2013-14 Base Request	**$2,224,522**	**0.0**	**$761,094**	**$0**	**$167,467**	**$62,934**	**$1,233,027**
FY 2013-14 R#6: "Additional FTE to Restore Functionality"	$39,789	0.0	$19,895	$0	$0	$0	$19,894
FY 2013-14 November 1 Request	**$2,264,311**	**0.0**	**$780,989**	**$0**	**$167,467**	**$62,934**	**$1,252,921**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Short-term Disability							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$32,188	0.0	$12,334	$0	$2,503	$0	$17,351
HB 12-1339 Annualization "Colorado Benefits Management System Project"	$1,309	0.0	$0	$0	$0	$1,309	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$33,497**	**0.0**	**$12,334**	**$0**	**$2,503**	**$1,309**	**$17,351**
HB 12-1339 Annualization "Colorado Benefits Management System Project" FY14	($187)	0.0	$0	$0	$0	($187)	$0
FY 2013-14 Common Policy Adjustment	$6,623	0.0	$1,316	$0	$310	($511)	$5,508
FY 2013-14 Base Request	**$39,933**	**0.0**	**$13,650**	**$0**	**$2,813**	**$611**	**$22,859**
FY 2013-14 R#6: "Additional FTE to Restore Functionality"	$838	0.0	$419	$0	$0	$0	$419
FY 2013-14 November 1 Request	**$40,771**	**0.0**	**$14,069**	**$0**	**$2,813**	**$611**	**$23,278**
S.B. 04-257 Amortization Equalization Disbursement							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$704,439	0.0	$283,141	$0	$53,468	$11,380	$356,450
HB 12-1339 Annualization "Colorado Benefits Management System Project"	$26,194	0.0	$0	$0	$0	$26,194	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$730,633**	**0.0**	**$283,141**	**$0**	**$53,468**	**$37,574**	**$356,450**
HB 12-1339 Annualization "Colorado Benefits Management System Project" FY14	($3,379)	0.0	$0	$0	$0	($3,379)	$0
FY 2013-14 Common Policy Adjustment	$82,204	0.0	($7,151)	$0	$3,755	($21,420)	$107,020
FY 2013-14 Base Request	**$809,458**	**0.0**	**$275,990**	**$0**	**$57,223**	**$12,775**	**$463,470**
FY 2013-14 R#6: "Additional FTE to Restore Functionality"	$17,050	0.0	$8,525	$0	$0	$0	$8,525
FY 2013-14 November 1 Request	**$826,508**	**0.0**	**$284,515**	**$0**	**$57,223**	**$12,775**	**$471,995**
S.B. 06-235 Supplemental Amortization Equalization Disbursement							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$604,213	0.0	$242,160	$0	$45,949	$9,780	$306,324
HB 12-1339 Annualization "Colorado Benefits Management System Project"	$23,500	0.0	$0	$0	$0	$23,500	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$627,713**	**0.0**	**$242,160**	**$0**	**$45,949**	**$33,280**	**$306,324**
HB 12-1339 Annualization "Colorado Benefits Management System Project" FY14	($2,904)	0.0	$0	$0	$0	($2,904)	$0
FY 2013-14 Common Policy Adjustment	$106,098	0.0	$6,998	$0	$5,710	($18,697)	$112,087
FY 2013-14 Base Request	**$730,907**	**0.0**	**$249,158**	**$0**	**$51,659**	**$11,679**	**$418,411**
FY 2013-14 R#6: "Additional FTE to Restore Functionality"	$15,394	0.0	$7,697	$0	$0	$0	$7,697
FY 2013-14 November 1 Request	**$746,301**	**0.0**	**$256,855**	**$0**	**$51,659**	**$11,679**	**$426,108**
Salary Survey and Senior Executive Service							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Common Policy Adjustment	$568,180	0.0	$176,323	$0	$45,753	$8,388	$337,716
FY 2013-14 Base Request	**$568,180**	**0.0**	**$176,323**	**$0**	**$45,753**	**$8,388**	**$337,716**
FY 2013-14 November 1 Request	**$568,180**	**0.0**	**$176,323**	**$0**	**$45,753**	**$8,388**	**$337,716**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Merit Pay							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Common Policy Adjustment	$384,021	0.0	$130,300	$0	$28,429	$9,888	$215,404
FY 2013-14 Base Request	**$384,021**	**0.0**	**$130,300**	**$0**	**$28,429**	**$9,888**	**$215,404**
FY 2013-14 November 1 Request	**$384,021**	**0.0**	**$130,300**	**$0**	**$28,429**	**$9,888**	**$215,404**
Workers' Compensation							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$30,843	0.0	$15,422	$0	$0	$0	$15,421
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$30,843**	**0.0**	**$15,422**	**$0**	**$0**	**$0**	**$15,421**
FY 2013-14 Common Policy Adjustment	$16,077	0.0	$8,039	$0	$0	$0	$8,038
FY 2013-14 Base Request	**$46,920**	**0.0**	**$23,461**	**$0**	**$0**	**$0**	**$23,459**
FY 2013-14 November 1 Request	**$46,920**	**0.0**	**$23,461**	**$0**	**$0**	**$0**	**$23,459**
Operating Expenses							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$1,555,016	0.0	$712,585	$0	$53,049	$13,461	$775,921
HB 12-1339 Annualization "Colorado Benefits Management System Project"	$64,796	0.0	$0	$0	$0	$64,796	$0
HB 12-1281 "Medicaid Payment Reform Pilot Program"	$5,541	0.0	$2,771	$0	$0	$0	$2,770
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$1,625,353**	**0.0**	**$715,356**	**$0**	**$53,049**	**$78,257**	**$778,691**
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($9,406)	0.0	($4,703)	$0	$0	$0	($4,703)
HB 12-1281 Annualization "Medicaid Payment Reform Pilot Program"	($4,591)	0.0	($2,295)	$0	$0	$0	($2,296)
HB 12-1339 Annualization "Colorado Benefits Management System Project" FY14	($54,347)	0.0	$0	$0	$0	($54,347)	$0
FY 2013-14 Base Request	**$1,557,009**	**0.0**	**$708,358**	**$0**	**$53,049**	**$23,910**	**$771,692**
FY 2013-14 R#6: "Additional FTE to Restore Functionality"	$41,832	0.0	$20,916	$0	$0	$0	$20,916
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	$10,514	0.0	$0	$0	$5,257	$0	$5,257
FY 2013-14 R#11: "HB 12-1281 Departmental Differences Reconciliation"	($1,741)	0.0	($870)	$0	$0	$0	($871)
FY 2013-14 November 1 Request	**$1,607,614**	**0.0**	**$728,404**	**$0**	**$58,306**	**$23,910**	**$796,994**
Legal Services							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$1,049,982	0.0	$355,006	$0	$169,986	$0	$524,990
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$1,049,982**	**0.0**	**$355,006**	**$0**	**$169,986**	**$0**	**$524,990**
FY 2013-14 Base Request	**$1,049,982**	**0.0**	**$355,006**	**$0**	**$169,986**	**$0**	**$524,990**
FY 2013-14 November 1 Request	**$1,049,982**	**0.0**	**$355,006**	**$0**	**$169,986**	**$0**	**$524,990**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Administrative Law Judge Services							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$510,957	0.0	$212,115	$0	$43,364	$0	$255,478
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$510,957**	**0.0**	**$212,115**	**$0**	**$43,364**	**$0**	**$255,478**
FY 2013-14 Common Policy Adjustment	$21,211	0.0	$10,606	$0	$0	$0	$10,605
FY 2013-14 Base Request	**$532,168**	**0.0**	**$222,721**	**$0**	**$43,364**	**$0**	**$266,083**
FY 2013-14 November 1 Request	**$532,168**	**0.0**	**$222,721**	**$0**	**$43,364**	**$0**	**$266,083**
Purchase of Services from Computer Center							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$1,001,906	0.0	$496,930	$0	$0	$4,046	$500,930
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$1,001,906**	**0.0**	**$496,930**	**$0**	**$0**	**$4,046**	**$500,930**
FY 2013-14 Common Policy Adjustment	($155,900)	0.0	($81,237)	$0	$0	$0	($74,663)
FY 2013-14 Base Request	**$846,006**	**0.0**	**$415,693**	**$0**	**$0**	**$4,046**	**$426,267**
FY 2013-14 NP-R#6: "OIT Enterprise Asset Management"	$6,260	0.0	$3,130	$0	$0	$0	$3,130
FY 2013-14 November 1 Request	**$852,266**	**0.0**	**$418,823**	**$0**	**$0**	**$4,046**	**$429,397**
Multiuse Network Payments							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$245,162	0.0	$122,581	$0	$0	$0	$122,581
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$245,162**	**0.0**	**$122,581**	**$0**	**$0**	**$0**	**$122,581**
FY 2013-14 Common Policy Adjustment	($146,281)	0.0	($73,141)	$0	$0	$0	($73,140)
FY 2013-14 Base Request	**$98,881**	**0.0**	**$49,440**	**$0**	**$0**	**$0**	**$49,441**
FY 2013-14 November 1 Request	**$98,881**	**0.0**	**$49,440**	**$0**	**$0**	**$0**	**$49,441**
Management and Administration of OIT							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Common Policy Adjustment	$48,307	0.0	$24,154	$0	$0	$0	$24,153
FY 2013-14 Base Request	**$48,307**	**0.0**	**$24,154**	**$0**	**$0**	**$0**	**$24,153**
FY 2013-14 November 1 Request	**$48,307**	**0.0**	**$24,154**	**$0**	**$0**	**$0**	**$24,153**
COFRS Modernization							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$1,006,098	0.0	$329,397	$0	$173,190	$2,052	$501,459
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$1,006,098**	**0.0**	**$329,397**	**$0**	**$173,190**	**$2,052**	**$501,459**
FY 2013-14 Common Policy Adjustment	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$1,006,098**	**0.0**	**$329,397**	**$0**	**$173,190**	**$2,052**	**$501,459**
FY 2013-14 November 1 Request	**$1,006,098**	**0.0**	**$329,397**	**$0**	**$173,190**	**$2,052**	**$501,459**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Payment to Risk Management and Property Funds							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$84,444	0.0	$42,222	$0	$0	$0	$42,222
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$84,444**	**0.0**	**$42,222**	**$0**	**$0**	**$0**	**$42,222**
FY 2013-14 Common Policy Adjustment	$45,584	0.0	$22,792	$0	$0	$0	$22,792
FY 2013-14 Base Request	**$130,028**	**0.0**	**$65,014**	**$0**	**$0**	**$0**	**$65,014**
FY 2013-14 NP-R#5: "Employee Engagement Survey Adjustment"	$3,463	0.0	$1,732	$0	$0	$0	$1,731
FY 2013-14 November 1 Request	**$133,491**	**0.0**	**$66,746**	**$0**	**$0**	**$0**	**$66,745**
Leased Space							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$696,564	0.0	$197,119	$0	$151,164	$0	$348,281
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$696,564**	**0.0**	**$197,119**	**$0**	**$151,164**	**$0**	**$348,281**
FY 2013-14 Base Request	**$696,564**	**0.0**	**$197,119**	**$0**	**$151,164**	**$0**	**$348,281**
FY 2013-14 R#6: "Additional FTE to Restore Functionality"	$60,870	0.0	$30,435	$0	$0	$0	$30,435
FY 2013-14 R#10: "Leased Space Rent Increase and True-up"	$92,115	0.0	$92,402	$0	($46,344)	$0	$46,057
FY 2013-14 November 1 Request	**$849,549**	**0.0**	**$319,956**	**$0**	**$104,820**	**$0**	**$424,773**
Capitol Complex Leased Space							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$394,600	0.0	$197,300	$0	$0	$0	$197,300
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$394,600**	**0.0**	**$197,300**	**$0**	**$0**	**$0**	**$197,300**
FY 2013-14 Common Policy Adjustment	$66,736	0.0	$33,368	$0	$0	$0	$33,368
FY 2013-14 Base Request	**$461,336**	**0.0**	**$230,668**	**$0**	**$0**	**$0**	**$230,668**
FY 2013-14 NP-R#4: "Capitol Complex Building Upgrade, Repair, and Replacement"	$28,985	0.0	$14,493	$0	$0	$0	$14,492
FY 2013-14 November 1 Request	**$490,321**	**0.0**	**$245,161**	**$0**	**$0**	**$0**	**$245,160**
General Professional Services and Special Projects							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$5,780,552	0.0	$1,232,418	$0	$437,500	$0	$4,110,634
HB 12-1281 "Medicaid Payment Reform Pilot Program"	$160,000	0.0	$80,000	$0	$0	$0	$80,000
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$5,940,552**	**0.0**	**$1,312,418**	**$0**	**$437,500**	**$0**	**$4,190,634**
HB 12-1281 Annualization "Medicaid Payment Reform Pilot Program"	($100,000)	0.0	($50,000)	$0	$0	$0	($50,000)
SB 12-159 Annualization "Evaluation Children With Autism Medicaid Waiver"	$62,000	0.0	$0	$0	$31,000	$0	$31,000
FY 2013-14 Base Request	**$5,902,552**	**0.0**	**$1,262,418**	**$0**	**$468,500**	**$0**	**$4,171,634**
FY 2013-14 R#7: "Substance Use Disorder Benefit"	$100,000	0.0	$50,000	$0	$0	$0	$50,000
FY 2013-14 R#11: "HB 12-1281 Departmental Differences Reconciliation"	$390,000	0.0	$195,000	$0	$0	$0	$195,000
FY 2013-14 R#12: "Customer Service Technology Improvements"	$1,800,000	0.0	$900,000	$0	$0	$0	$900,000
FY 2013-14 November 1 Request	**$8,192,552**	**0.0**	**$2,407,418**	**$0**	**$468,500**	**$0**	**$5,316,634**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(B) Transfers to Other Departments							
Transfer to Department of Public Health and Environment Facility for Survey and Certification							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$5,205,465	0.0	$1,568,883	$0	$0	$0	$3,636,582
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$5,205,465**	**0.0**	**$1,568,883**	**$0**	**$0**	**$0**	**$3,636,582**
HB 12-1268 "Health Facility Safety Inspection Transfer To CDPS"	($292,124)	0.0	($99,114)	$0	$0	$0	($193,010)
FY 2013-14 Common Policy Adjustment	$122,934	0.0	$46,441	$0	$0	$0	$76,493
FY 2013-14 Base Request	**$5,036,275**	**0.0**	**$1,516,210**	**$0**	**$0**	**$0**	**$3,520,065**
FY 2013-14 November 1 Request	**$5,036,275**	**0.0**	**$1,516,210**	**$0**	**$0**	**$0**	**$3,520,065**
Transfer to Department of Public Safety for Life Safety Code Inspections for Health Facilities *(new line)*							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
HB 12-1268 "Health Facility Safety Inspection Transfer To CDPS"	$336,639	0.0	$114,694	$0	$0	$0	$221,945
FY 2013-14 Base Request	**$336,639**	**0.0**	**$114,694**	**$0**	**$0**	**$0**	**$221,945**
FY 2013-14 November 1 Request	**$336,639**	**0.0**	**$114,694**	**$0**	**$0**	**$0**	**$221,945**
Transfer to Department of Public Health and Environment for Nurse Home Visitor Program							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$3,010,000	0.0	$0	$0	$0	$1,505,000	$1,505,000
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$3,010,000**	**0.0**	**$0**	**$0**	**$0**	**$1,505,000**	**$1,505,000**
FY 2013-14 Base Request	**$3,010,000**	**0.0**	**$0**	**$0**	**$0**	**$1,505,000**	**$1,505,000**
FY 2013-14 November 1 Request	**$3,010,000**	**0.0**	**$0**	**$0**	**$0**	**$1,505,000**	**$1,505,000**
Transfer to Department of Public Health and Environment for Prenatal Statistical Information							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$5,887	0.0	$2,944	$0	$0	$0	$2,943
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$5,887**	**0.0**	**$2,944**	**$0**	**$0**	**$0**	**$2,943**
FY 2012-13 Total with Supplemental Requests	**$5,887**	**0.0**	**$2,944**	**$0**	**$0**	**$0**	**$2,943**
FY 2013-14 Common Policy Adjustment	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$5,887**	**0.0**	**$2,944**	**$0**	**$0**	**$0**	**$2,943**
FY 2013-14 November 1 Request	**$5,887**	**0.0**	**$2,944**	**$0**	**$0**	**$0**	**$2,943**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Transfers to the Department of Regulatory Agencies for Nurse Aide Certification							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$324,041	0.0	$147,369	$0	$0	$14,652	$162,020
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$324,041**	**0.0**	**$147,369**	**$0**	**$0**	**$14,652**	**$162,020**
FY 2013-14 Base Request	**$324,041**	**0.0**	**$147,369**	**$0**	**$0**	**$14,652**	**$162,020**
FY 2013-14 November 1 Request	**$324,041**	**0.0**	**$147,369**	**$0**	**$0**	**$14,652**	**$162,020**
Transfers to the Department of Regulatory Agencies for Reviews							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$14,000	0.0	$7,000	$0	$0	$0	$7,000
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$14,000**	**0.0**	**$7,000**	**$0**	**$0**	**$0**	**$7,000**
FY 2013-14 Base Request	**$14,000**	**0.0**	**$7,000**	**$0**	**$0**	**$0**	**$7,000**
FY 2013-14 November 1 Request	**$14,000**	**0.0**	**$7,000**	**$0**	**$0**	**$0**	**$7,000**
Transfer to Department of Education for Public School Health Services Administration							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$139,940	0.0	$0	$0	$0	$0	$139,940
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$139,940**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$139,940**
Technical correction to align with CDE appropriation	$2,133	0.0	$0	$0	$0	$0	$2,133
FY 2013-14 Base Request	**$142,073**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$142,073**
FY 2013-14 November 1 Request	**$142,073**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$142,073**
(C) Information Technology Contracts and Projects							
Information Technology Contracts							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$31,899,317	0.0	$6,379,650	$0	$1,566,666	$100,328	$23,852,673
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$31,899,317**	**0.0**	**$6,379,650**	**$0**	**$1,566,666**	**$100,328**	**$23,852,673**
Annualization of FY 2009-10 BA#16: "MMIS Funding for HIPAA and Transitions v5010/D.0"	($546,020)	0.0	($58,697)	$0	$0	$0	($487,323)
Annualization of FY 2010-11 BA#12: "Evidence Guided Utilization Review"	($627,984)	0.0	($156,996)	$0	$0	$0	($470,988)
Annualization of FY 2010-11 BA#15: "MMIS Adjustments"	($1,364,572)	0.0	($143,953)	$0	$0	$0	($1,220,619)
Annualization of FY 2012-13 BA#6: "MMIS Technical Adjustments"	($965,033)	0.0	$0	$0	($206,927)	$0	($758,106)
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$1,204,749	0.0	$0	$0	$301,187	$0	$903,562
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	($6,930)	0.0	($1,733)	$0	$0	$0	($5,197)
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	($6,930)	0.0	($1,681)	$0	($73)	$0	($5,176)
FY 2013-14 Base Request	**$29,586,597**	**0.0**	**$6,016,590**	**$0**	**$1,660,853**	**$100,328**	**$21,808,826**
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	$1,707,678	0.0	$0	$0	$426,919	$0	$1,280,759
FY 2013-14 R#9: "Dental ASO for Children"	$1,152,144	0.0	$288,036	$0	$0	$0	$864,108
FY 2013-14 November 1 Request	**$32,446,419**	**0.0**	**$6,304,626**	**$0**	**$2,087,772**	**$100,328**	**$23,953,693**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
MMIS Reprocurement Contracts *(new line item)*							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 R#5: "Medicaid Management Information System Reprocurement"	$12,625,032	0.0	$1,165,817	$0	$232,837	$0	$11,226,378
FY 2013-14 November 1 Request	**$12,625,032**	**0.0**	**$1,165,817**	**$0**	**$232,837**	**$0**	**$11,226,378**
MMIS Reprocurement Contracted Staff *(new line item)*							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 R#5: "Medicaid Management Information System Reprocurement"	$2,999,371	0.0	$273,255	$0	$54,997	$0	$2,671,119
FY 2013-14 November 1 Request	**$2,999,371**	**0.0**	**$273,255**	**$0**	**$54,997**	**$0**	**$2,671,119**
Fraud Detection Software Contract							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$250,000	0.0	$62,500	$0	$0	$0	$187,500
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$250,000**	**0.0**	**$62,500**	**$0**	**$0**	**$0**	**$187,500**
FY 2013-14 Base Request	**$250,000**	**0.0**	**$62,500**	**$0**	**$0**	**$0**	**$187,500**
FY 2013-14 November 1 Request	**$250,000**	**0.0**	**$62,500**	**$0**	**$0**	**$0**	**$187,500**
Centralized Eligibility Vendor Contract Project							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$5,098,787	0.0	$0	$0	$2,534,204	$0	$2,564,583
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$5,098,787**	**0.0**	**$0**	**$0**	**$2,534,204**	**$0**	**$2,564,583**
Annualization of FY 2012-13 R#12: "Hospital Provider Fee Administrative True-	$1,051,158				$525,579		$525,579
FY 2013-14 Base Request	**$6,149,945**	**0.0**	**$0**	**$0**	**$3,059,783**	**$0**	**$3,090,162**
FY 2013-14 November 1 Request	**$6,149,945**	**0.0**	**$0**	**$0**	**$3,059,783**	**$0**	**$3,090,162**
(D) Eligibility Determinations and Client Services							
Medical Identification Cards							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$129,240	0.0	$59,203	$0	$4,620	$1,593	$63,824
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$129,240**	**0.0**	**$59,203**	**$0**	**$4,620**	**$1,593**	**$63,824**
FY 2013-14 Base Request	**$129,240**	**0.0**	**$59,203**	**$0**	**$4,620**	**$1,593**	**$63,824**
FY 2013-14 November 1 Request	**$129,240**	**0.0**	**$59,203**	**$0**	**$4,620**	**$1,593**	**$63,824**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Contracts for Special Eligibility Determinations							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$7,761,238	0.0	$828,091	$0	$2,806,268	$0	$4,126,879
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$7,761,238**	**0.0**	**$828,091**	**$0**	**$2,806,268**	**$0**	**$4,126,879**
FY 2013-14 Base Request	**$7,761,238**	**0.0**	**$828,091**	**$0**	**$2,806,268**	**$0**	**$4,126,879**
FY 2013-14 November 1 Request	**$7,761,238**	**0.0**	**$828,091**	**$0**	**$2,806,268**	**$0**	**$4,126,879**
County Administration							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$31,427,701	0.0	$10,373,188	$0	$5,380,796	$0	$15,673,717
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$31,427,701**	**0.0**	**$10,373,188**	**$0**	**$5,380,796**	**$0**	**$15,673,717**
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	$737,198	0.0	$221,159	$0	$147,440	$0	$368,599
FY 2013-14 Base Request	**$32,164,899**	**0.0**	**$10,594,347**	**$0**	**$5,528,236**	**$0**	**$16,042,316**
FY 2013-14 November 1 Request	**$32,164,899**	**0.0**	**$10,594,347**	**$0**	**$5,528,236**	**$0**	**$16,042,316**
Hospital Provider Fee County Administration							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$2,581,071	0.0	$0	$0	$1,290,536	$0	$1,290,535
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$2,581,071**	**0.0**	**$0**	**$0**	**$1,290,536**	**$0**	**$1,290,535**
FY 2013-14 Base Request	**$2,581,071**	**0.0**	**$0**	**$0**	**$1,290,536**	**$0**	**$1,290,535**
FY 2013-14 November 1 Request	**$2,581,071**	**0.0**	**$0**	**$0**	**$1,290,536**	**$0**	**$1,290,535**
Administrative Case Management							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$869,744	0.0	$434,872	$0	$0	$0	$434,872
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$869,744**	**0.0**	**$434,872**	**$0**	**$0**	**$0**	**$434,872**
FY 2013-14 Base Request	**$869,744**	**0.0**	**$434,872**	**$0**	**$0**	**$0**	**$434,872**
FY 2013-14 November 1 Request	**$869,744**	**0.0**	**$434,872**	**$0**	**$0**	**$0**	**$434,872**
Customer Outreach							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$4,927,018	0.0	$2,376,649	$0	$86,861	$0	$2,463,508
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$4,927,018**	**0.0**	**$2,376,649**	**$0**	**$86,861**	**$0**	**$2,463,508**
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	$121,711	0.0	$60,855	$0	$0	$0	$60,856
FY 2013-14 Base Request	**$5,048,729**	**0.0**	**$2,437,504**	**$0**	**$86,861**	**$0**	**$2,524,364**
FY 2013-14 R#11: "HB 12-1281 Departmental Differences Reconciliation"	$267,220	0.0	$133,610	$0	$0	$0	$133,610
FY 2013-14 November 1 Request	**$5,315,949**	**$0**	**$2,571,114**	**$0**	**$86,861**	**$0**	**$2,657,974**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(E) Utilization and Quality Review Contracts							
Professional Services Contracts							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$8,414,451	0.0	$2,225,370	$0	$114,332	$0	$6,074,749
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$8,414,451**	**0.0**	**$2,225,370**	**$0**	**$114,332**	**$0**	**$6,074,749**
FY 2013-14 Base Request	**$8,414,451**	**0.0**	**$2,225,370**	**$0**	**$114,332**	**$0**	**$6,074,749**
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	$355,000	0.0	$0	$0	$88,750	$0	$266,250
FY 2013-14 R#11: "HB 12-1281 Departmental Differences Reconciliation"	$202,856	0.0	$50,714	$0	$0	$0	$152,142
FY 2013-14 November 1 Request	**$8,972,307**	**0.0**	**$2,276,084**	**$0**	**$203,082**	**$0**	**$6,493,141**
(F) Provider Audits and Services							
Professional Audit Contracts							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$2,463,406	0.0	$969,283	$0	$262,420	$0	$1,231,703
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$2,463,406**	**0.0**	**$969,283**	**$0**	**$262,420**	**$0**	**$1,231,703**
Annualization of FY 2007-08 S#5: "Revised Federal Rule for Payment Error Rate Measurement Program"	$588,501	0.0	$147,125	$0	$102,988	$0	$338,388
FY 2013-14 Base Request	**$3,051,907**	**0.0**	**$1,116,408**	**$0**	**$365,408**	**$0**	**$1,570,091**
FY 2013-14 November 1 Request	**$3,051,907**	**0.0**	**$1,116,408**	**$0**	**$365,408**	**$0**	**$1,570,091**
(G) Recoveries and Recoupment Contract Costs							
Estate Recovery							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$700,000	0.0	$0	$0	$350,000	$0	$350,000
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$700,000**	**0.0**	**$0**	**$0**	**$350,000**	**$0**	**$350,000**
FY 2013-14 Base Request	**$700,000**	**0.0**	**$0**	**$0**	**$350,000**	**$0**	**$350,000**
FY 2013-14 November 1 Request	**$700,000**	**0.0**	**$0**	**$0**	**$350,000**	**$0**	**$350,000**
(1) Executive Director's Office							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$142,765,877	314.3	$38,598,357	$0	$17,740,127	$2,068,902	$84,358,491
HB 12-1246 "Reverse Payday Shift State Employees Paid Biweekly"	$28,498	0.0	$28,498	$0	$0	$0	$0
SB 12-060 "Improve Medicaid Fraud Prosecution"	$5,216	0.1	$2,608	$0	$0	$0	$2,608
HB 12-1281 "Medicaid Payment Reform Pilot Program"	$213,079	0.8	$106,540	$0	$0	$0	$106,539
HB 12-1339 Annualization "Colorado Benefits Management System Project"	$997,655	11.0	$0	$0	$0	$997,655	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$144,010,325**	**326.2**	**$38,736,003**	**$0**	**$17,740,127**	**$3,066,557**	**$84,467,638**
Annualization of FY 2007-08 S#5: "Revised Federal Rule for Payment Error Rate Measurement Program"	$588,501	0.0	$147,125	$0	$102,988	$0	$338,388
Annualization of FY 2009-10 BA#16: "MMIS Funding for HIPAA and Transitions v5010/D.0"	($546,020)	0.0	($58,697)	$0	$0	$0	($487,323)

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Annualization of FY 2010-11 BA#12: "Evidence Guided Utilization Review"	($627,984)	0.0	($156,996)	$0	$0	$0	($470,988)
Annualization of FY 2010-11 BA#15: "MMIS Adjustments"	($1,364,572)	0.0	($143,953)	$0	$0	$0	($1,220,619)
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$7,498	0.2	$3,749	$0	$0	$0	$3,749
Annualization of FY 2012-13 R#12: "Hospital Provider Fee Administrative True-	$1,051,158	0.0	$0	$0	$525,579	$0	$525,579
Annualization of FY 2012-13 BA#6: "MMIS Technical Adjustments"	($965,033)	0.0	$0	$0	($206,927)	$0	($758,106)
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$1,204,749	0.0	$0	$0	$301,187	$0	$903,562
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	$851,979	0.0	$280,281	$0	$147,440	$0	$424,258
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	($6,930)	0.0	($1,681)	$0	($73)	$0	($5,176)
HB 12-1246 Annualization "Reverse Payday Shift State Employees Paid Biweekly"	($28,498)	0.0	($28,498)	$0	$0	$0	$0
HB 12-1268 "Health Facility Safety Inspection Transfer To CDPS"	$44,515	0.0	$15,580	$0	$0	$0	$28,935
HB 12-1281 Annualization "Medicaid Payment Reform Pilot Program"	($88,744)	0.2	($44,371)	$0	$0	$0	($44,373)
SB 12-159 Annualization "Evaluation Children With Autism Medicaid Waiver"	$62,000	0.0	$0	$0	$31,000	$0	$31,000
Technical correction to align with CDE appropriation	$2,133	0.0	$0	$0	$0	$0	$2,133
HB 12-1339 Annualization "Colorado Benefits Management System Project" FY14	($186,797)	0.0	$0	$0	$0	($186,797)	$0
FY 2013-14 Statewide Indirect Cost Allocation	$1,160,738	0.0	$1,190,879	$0	$38,481	$10,784	($79,406)
FY 2013-14 Common Policy Adjustment	$1,181,629	0.0	$263,423	$0	$76,772	($63,133)	$904,567
FY 2013-14 Base Request	**$146,350,647**	**326.6**	**$40,202,844**	**$0**	**$18,756,574**	**$2,827,411**	**$84,563,818**
FY 2013-14 R#5: "Medicaid Management Information System Reprocurement"	$15,624,403	0.0	$1,439,072	$0	$287,834	$0	$13,897,497
FY 2013-14 R#6: "Additional FTE to Restore Functionality"	$704,341	7.4	$352,172	$0	$0	$0	$352,169
FY 2013-14 R#7: "Substance Use Disorder Benefit"	$100,000	0.0	$50,000	$0	$0	$0	$50,000
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	$2,155,769	1.2	$0	$0	$562,215	$0	$1,593,554
FY 2013-14 R#9: "Dental ASO for Children"	$1,152,144	0.0	$288,036	$0	$0	$0	$864,108
FY 2013-14 R#10: "Leased Space Rent Increase and True-up"	$92,115	0.0	$92,402	$0	($46,344)	$0	$46,057
FY 2013-14 R#11: "HB 12-1281 Departmental Differences Reconciliation"	$1,096,749	3.0	$497,661	$0	$0	$0	$599,088
FY 2013-14 R#12: "Customer Service Technology Improvements"	$1,800,000	0.0	$900,000	$0	$0	$0	$900,000
FY 2013-14 NP-R#4: "Capitol Complex Building Upgrade, Repair, and Replacement"	$28,985	0.0	$14,493	$0	$0	$0	$14,492
FY 2013-14 NP-R#5: "Employee Engagement Survey Adjustment"	$3,463	0.0	$1,732	$0	$0	$0	$1,731
FY 2013-14 NP-R#6: "OIT Enterprise Asset Management"	$6,260	0.0	$3,130	$0	$0	$0	$3,130
FY 2013-14 November 1 Request	**$169,114,876**	**338.2**	**$43,841,542**	**$0**	**$19,560,279**	**$2,827,411**	**$102,885,644**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(2) Medical Services Premiums

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
Medical Services Premiums						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$3,994,685,293	0.0	$1,055,118,623	$312,202,624	$651,202,864	$3,215,340
HB 12-1340 "Nursing Facility Reduction Per Diem Rate"	($9,024,676)	0.0	($4,512,338)	$0	$0	$0
SB 12-060 "Improve Medicaid Fraud Prosecution"	($54,156)	0.0	($2,608)	$0	($24,470)	$0
SB 12-159 "Evaluation Children With Autism Medicaid Waiver"	$6,925	0.0	$0	$0	$3,463	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$3,985,613,386**	**0.0**	**$1,050,603,677**	**$312,202,624**	**$651,181,857**	**$3,215,340**
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($1,404,115)	0.0	($663,592)	$0	($38,466)	$0
Annualization of FY 2012-13 R#6: "Medicaid Budget Reductions"	($1,751,563)	0.0	($863,801)	$0	($11,981)	$0
Annualization of FY 2012-13 R#10: "Utilize Supplemental Payments for General Fund Relief"	($8,477)	0.0	($8,477)	$0	$0	$0
Annualization of FY 2012-13 BA#3: "Smoking Cessation Quitline for Medicaid Clients"	($92,430)	0.0	$0	$0	($46,215)	$0
SB 08-118 Annualization "Transfer for Medicaid Disease Management"	$0	0.0	$2,000,000	$0	$0	($2,000,000)
HB 10-1146 Annualization "State-funded Public Assistance Programs"	($102,745)	0.0	($51,373)	$0	$0	$0
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	$26,454,555	0.0	$9,259,094	$0	$0	$0
SB 11-212 Annualization "Use Provider Fee Offset GF Medicaid"	$0	0.0	$25,000,000	$0	($25,000,000)	$0
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	$8,803,834	0.0	$3,081,341	$0	$0	$0
HB 12-1340 Annualization "Nursing Facility Reduction Per Diem Rate"	$9,024,676	0.0	$4,512,338	$0	$0	$0
SB 12-060 Annualization "Improve Medicaid Fraud Prosecution"	($4,448)	0.0	$0	$0	($2,224)	$0
FY 2013-14 Base Request	**$4,026,532,673**	**0.0**	**$1,092,869,207**	**$312,202,624**	**$626,082,971**	**$1,215,340**
FY 2013-14 R#1: "Medical Services Premiums"	$255,256,258	0.0	$78,363,224	$0	($1,837,669)	$0
FY 2013-14 R#7: "Substance Use Disorder Benefit"	$415,440	0.0	($11,820)	$0	($282)	$0
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	$30,803,647	0.0	($747,621)	$0	$13,131,511	$0
FY 2013-14 R#9: "Dental ASO for Children"	($576,072)	0.0	($288,036)	$0	$0	$0
FY 2013-14 R#13: "1.5% Provider Rate Increase"	$33,054,416	0.0	$14,547,876	$0	$1,227,138	$0
FY 2013-14 November 1 Request	**$4,345,486,362**	**0.0**	**$1,184,732,830**	**$312,202,624**	**$638,603,669**	**$1,215,340**
(2) Medical Services Premiums						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$3,994,685,293	0.0	$1,055,118,623	$312,202,624	$651,202,864	$3,215,340
HB 12-1340 "Nursing Facility Reduction Per Diem Rate"	($9,024,676)	0.0	($4,512,338)	$0	$0	$0
SB 12-060 "Improve Medicaid Fraud Prosecution"	($54,156)	0.0	($2,608)	$0	($24,470)	$0
SB 12-159 "Evaluation Children With Autism Medicaid Waiver"	$6,925	0.0	$0	$0	$3,463	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$3,985,613,386**	**0.0**	**$1,050,603,677**	**$312,202,624**	**$651,181,857**	**$3,215,340**
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($1,404,115)	0.0	($663,592)	$0	($38,466)	$0
Annualization of FY 2012-13 R#6: "Medicaid Budget Reductions"	($1,751,563)	0.0	($863,801)	$0	($11,981)	$0
Annualization of FY 2012-13 R#10: "Utilize Supplemental Payments for General Fund Relief"	($8,477)	0.0	($8,477)	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(2) Medical Services Premiums

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
Annualization of FY 2012-13 BA#3: "Smoking Cessation Quitline for Medicaid Clients"	($92,430)	0.0	$0	$0	($46,215)	$0
SB 08-118 Annualization "Transfer for Medicaid Disease Management"	$0	0.0	$2,000,000	$0	$0	($2,000,000)
HB 10-1146 Annualization "State-funded Public Assistance Programs"	($102,745)	0.0	($51,373)	$0	$0	$0
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	$26,454,555	0.0	$9,259,094	$0	$0	$0
SB 11-212 Annualization "Use Provider Fee Offset GF Medicaid"	$0	0.0	$25,000,000	$0	($25,000,000)	$0
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	$8,803,834	0.0	$3,081,341	$0	$0	$0
HB 12-1340 Annualization "Nursing Facility Reduction Per Diem Rate"	$9,024,676	0.0	$4,512,338	$0	$0	$0
SB 12-060 Annualization "Improve Medicaid Fraud Prosecution"	($4,448)	0.0	$0	$0	($2,224)	$0
FY 2013-14 Base Request	**$4,026,532,673**	**0.0**	**$1,092,869,207**	**$312,202,624**	**$626,082,971**	**$1,215,340**
FY 2013-14 R#1: "Medical Services Premiums"	$255,256,258	0.0	$78,363,224	$0	($1,837,669)	$0
FY 2013-14 R#7: "Substance Use Disorder Benefit"	$415,440	0.0	($11,820)	$0	($282)	$0
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	$30,803,647	0.0	($747,621)	$0	$13,131,511	$0
FY 2013-14 R#9: "Dental ASO for Children"	($576,072)	0.0	($288,036)	$0	$0	$0
FY 2013-14 R#13: "1.5% Provider Rate Increase"	$33,054,416	0.0	$14,547,876	$0	$1,227,138	$0
FY 2013-14 November 1 Request	**$4,345,486,362**	**0.0**	**$1,184,732,830**	**$312,202,624**	**$638,603,669**	**$1,215,340**

Federal Funds
$1,972,945,842
($4,512,338)
($27,078)
$3,462
$1,968,409,888
($702,057)
($875,781)
$0
($46,215)
$0
($51,372)
$17,195,461
$0
$5,722,493
$4,512,338
($2,224)
$1,994,162,531
$178,730,703
$427,542
$18,419,757
($288,036)
$17,279,402
$2,208,731,899
$1,972,945,842
($4,512,338)
($27,078)
$3,462
$1,968,409,888
($702,057)
($875,781)
$0

Federal Funds
($46,215)
$0
($51,372)
$17,195,461
$0
$5,722,493
$4,512,338
($2,224)
$1,994,162,531
$178,730,703
$427,542
$18,419,757
($288,036)
$17,279,402
$2,208,731,899

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(3) Medicaid Mental Health Community Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
Mental Health Capitation Payments						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$312,580,712	0.0	$142,712,972	$0	$13,648,932	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$312,580,712**	**0.0**	**$142,712,972**	**$0**	**$13,648,932**	**$0**
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	$3,218,931	0.0	$1,126,626	$0	$0	$0
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	$215,864	0.0	$75,552	$0	$0	$0
FY 2013-14 Base Request	**$316,015,507**	**0.0**	**$143,915,150**	**$0**	**$13,648,932**	**$0**
FY 2013-14 R#2: "Medicaid Mental Health Community Programs"	$31,839,522	0.0	$10,012,117	$0	($1,313,268)	$0
FY 2013-14 R#7: "Substance Use Disorder Benefit"	$5,272,628	0.0	$1,779,950	$0	$42,317	$0
FY 2013-14 November 1 Request	**$353,127,657**	**0.0**	**$155,707,217**	**$0**	**$12,377,981**	**$0**
Medicaid Mental Health Fee for Service Payments						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$4,147,628	0.0	$2,073,815	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$4,147,628**	**0.0**	**$2,073,815**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$4,147,628**	**0.0**	**$2,073,815**	**$0**	**$0**	**$0**
FY 2013-14 R#2: "Medicaid Mental Health Community Programs"	$545,466	0.0	$272,732	$0	$0	$0
FY 2013-14 R#13: "1.5% Provider Rate Increase"	$62,214	0.0	$31,107	$0	$0	$0
FY 2013-14 November 1 Request	**$4,755,308**	**0.0**	**$2,377,654**	**$0**	**$0**	**$0**
(3) Medicaid Mental Health Community Programs						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$316,728,340	0.0	$144,786,787	$0	$13,648,932	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$316,728,340**	**0.0**	**$144,786,787**	**$0**	**$13,648,932**	**$0**
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	$3,218,931	0.0	$1,126,626	$0	$0	$0
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	$215,864	0.0	$75,552	$0	$0	$0
FY 2013-14 Base Request	**$320,163,135**	**0.0**	**$145,988,965**	**$0**	**$13,648,932**	**$0**
FY 2013-14 R#2: "Medicaid Mental Health Community Programs"	$32,384,988	0.0	$10,284,849	$0	($1,313,268)	$0
FY 2013-14 R#7: "Substance Use Disorder Benefit"	$5,272,628	0.0	$1,779,950	$0	$42,317	$0
FY 2013-14 R#13: "1.5% Provider Rate Increase"	$62,214	0.0	$31,107	$0	$0	$0
FY 2013-14 November 1 Request	**$357,882,965**	**0.0**	**$158,084,871**	**$0**	**$12,377,981**	**$0**

Federal Funds
$156,218,808
$156,218,808
$2,092,305
$140,312
$158,451,425
$23,140,673
$3,450,361
$185,042,459
$2,073,813
$2,073,813
$2,073,813
$272,734
$31,107
$2,377,654
$158,292,621
$158,292,621
$2,092,305
$140,312
$160,525,238
$23,413,407
$3,450,361
$31,107
$187,420,113

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST
(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
Safety Net Provider Payments						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$287,055,532	0.0	$0	$0	$143,527,766	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$287,055,532**	**0.0**	**$0**	**$0**	**$143,527,766**	**$0**
FY 2013-14 Base Request	**$287,055,532**	**0.0**	**$0**	**$0**	**$143,527,766**	**$0**
FY 2013-14 November 1 Request	**$287,055,532**	**0.0**	**$0**	**$0**	**$143,527,766**	**$0**
Clinic Based Indigent Care						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$6,119,760	0.0	$3,059,880	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$6,119,760**	**0.0**	**$3,059,880**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$6,119,760**	**0.0**	**$3,059,880**	**$0**	**$0**	**$0**
FY 2013-14 November 1 Request	**$6,119,760**	**0.0**	**$3,059,880**	**$0**	**$0**	**$0**
Pediatric Specialty Hospital						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$11,799,938	0.0	$5,899,969	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$11,799,938**	**0.0**	**$5,899,969**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$11,799,938**	**0.0**	**$5,899,969**	**$0**	**$0**	**$0**
FY 2013-14 November 1 Request	**$11,799,938**	**0.0**	**$5,899,969**	**$0**	**$0**	**$0**
Appropriation from Tobacco Tax Cash Fund to the General Fund						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$441,600	0.0	$0	$0	$441,600	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$441,600**	**0.0**	**$0**	**$0**	**$441,600**	**$0**
FY 2013-14 Base Request	**$441,600**	**0.0**	**$0**	**$0**	**$441,600**	**$0**
FY 2013-14 November 1 Request	**$441,600**	**0.0**	**$0**	**$0**	**$441,600**	**$0**
Primary Care Fund Program						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$27,968,000	0.0	$0	$0	$27,968,000	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$27,968,000**	**0.0**	**$0**	**$0**	**$27,968,000**	**$0**
FY 2013-14 Base Request	**$27,968,000**	**0.0**	**$0**	**$0**	**$27,968,000**	**$0**
FY 2013-14 November 1 Request	**$27,968,000**	**0.0**	**$0**	**$0**	**$27,968,000**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
Children's Basic Health Plan Administration						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$5,134,993	0.0	$0	$0	$2,305,152	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$5,134,993**	**0.0**	**$0**	**$0**	**$2,305,152**	**$0**
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	($814,914)	0.0	$0	$0	($285,220)	$0
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	($1,000)		$0	$0	($350)	$0
FY 2013-14 Base Request	**$4,319,079**	**0.0**	**$0**	**$0**	**$2,019,582**	**$0**
FY 2013-14 November 1 Request	**$4,319,079**	**0.0**	**$0**	**$0**	**$2,019,582**	**$0**
Children's Basic Health Plan Medical and Dental Costs						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$182,543,053	0.0	$21,787,355	$441,600	$42,220,291	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$182,543,053**	**0.0**	**$21,787,355**	**$441,600**	**$42,220,291**	**$0**
Annualization of FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	($256,885)	0.0	($68,824)	$0	$331	$0
Annualization of FY 2012-13 JBC Staff Recommendation CHP+ Trust Financing	$0	0.0	$3,000,000	$0	($3,000,000)	$0
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	($37,750,557)	0.0	$0	$0	($13,212,695)	$0
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	($11,249,291)	0.0	($3,937,252)	$0	$0	$0
FY 2013-14 Base Request	**$133,286,320**	**0.0**	**$20,781,279**	**$441,600**	**$26,007,927**	**$0**
FY 2013-14 R#3: "Children's Basic Health Plan Medical and Dental Costs"	$60,591,910	0.0	$1,923,755	$0	$19,735,056	$0
FY 2013-14 November 1 Request	**$193,878,230**	**0.0**	**$22,705,034**	**$441,600**	**$45,742,983**	**$0**
(4) Indigent Care Program						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$521,062,876	0.0	$30,747,204	$441,600	$216,462,809	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$521,062,876**	**0.0**	**$30,747,204**	**$441,600**	**$216,462,809**	**$0**
Annualization of FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	($256,885)	0.0	($68,824)	$0	$331	$0
Annualization of FY 2012-13 JBC Staff Recommendation CHP+ Trust Financing	$0	0.0	$3,000,000	$0	($3,000,000)	$0
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	($38,565,471)	0.0	$0	$0	($13,497,915)	$0
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	($11,250,291)	0.0	($3,937,252)	$0	($350)	$0
FY 2013-14 Base Request	**$470,990,229**	**0.0**	**$29,741,128**	**$441,600**	**$199,964,875**	**$0**
FY 2013-14 R#3: "Children's Basic Health Plan Medical and Dental Costs"	$60,591,910	0.0	$1,923,755	$0	$19,735,056	$0
FY 2013-14 November 1 Request	**$531,582,139**	**0.0**	**$31,664,883**	**$441,600**	**$219,699,931**	**$0**

Federal Funds
$143,527,766
$143,527,766
$143,527,766
$143,527,766
$3,059,880
$3,059,880
$3,059,880
$3,059,880
$5,899,969
$5,899,969
$5,899,969
$5,899,969
$0
$0
$0
$0
$0
$0
$0
$0

Federal Funds
$2,829,841
$2,829,841
($529,694)
($650)
$2,299,497
$2,299,497
$118,093,807
$118,093,807
($188,392)
$0
($24,537,862)
($7,312,039)
$86,055,514
$38,933,099
$124,988,613
$273,411,263
$273,411,263
($188,392)
$0
($25,067,556)
($7,312,689)
$240,842,626
$38,933,099
$279,775,725

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(5) Other Medical Services

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Services for Old Age Pension State Medical Program Clients							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$12,400,000	0.0	$2,400,000	$0	$10,000,000	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$12,400,000**	**0.0**	**$2,400,000**	**$0**	**$10,000,000**	**$0**	**$0**
FY 2013-14 Base Request	**$12,400,000**	**0.0**	**$2,400,000**	**$0**	**$10,000,000**	**$0**	**$0**
FY 2013-14 November 1 Request	**$12,400,000**	**0.0**	**$2,400,000**	**$0**	**$10,000,000**	**$0**	**$0**
Commission on Family Medicine Residency Training Programs							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$1,741,077	0.0	$870,538	$0	$0	$0	$870,539
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$0**	**$870,539**
FY 2013-14 Base Request	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$0**	**$870,539**
FY 2013-14 November 1 Request	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$0**	**$870,539**
State University Teaching Hospitals - Denver Health and Hospital Authority							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$1,831,714	0.0	$915,857	$0	$0	$0	$915,857
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$1,831,714**	**0.0**	**$915,857**	**$0**	**$0**	**$0**	**$915,857**
FY 2013-14 Base Request	**$1,831,714**	**0.0**	**$915,857**	**$0**	**$0**	**$0**	**$915,857**
FY 2013-14 November 1 Request	**$1,831,714**	**0.0**	**$915,857**	**$0**	**$0**	**$0**	**$915,857**
State University Teaching Hospitals - University of Colorado Hospital Authority							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$633,314	0.0	$316,657	$0	$0	$0	$316,657
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$633,314**	**0.0**	**$316,657**	**$0**	**$0**	**$0**	**$316,657**
FY 2013-14 Base Request	**$633,314**	**0.0**	**$316,657**	**$0**	**$0**	**$0**	**$316,657**
FY 2013-14 November 1 Request	**$633,314**	**0.0**	**$316,657**	**$0**	**$0**	**$0**	**$316,657**
Medicare Modernization Act of 2003 State Contribution Payment							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$90,656,176	0.0	$50,609,286	$0	$0	$0	$40,046,890
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$90,656,176**	**0.0**	**$50,609,286**	**$0**	**$0**	**$0**	**$40,046,890**
Annualization of FY 2012-13 R#11: "CHIPRA Bonus Payment True-up"	$0	0.0	($2,983,119)	$0	$0	$0	$2,983,119
Technical Correction for Annualization of FY 2011-12 BA#11: "Cash Fund Insolvency True-Up"	$6,018,686	0.0	$0	$0	$0	$0	$6,018,686
FY 2013-14 Base Request	**$96,674,862**	**0.0**	**$47,626,167**	**$0**	**$0**	**$0**	**$49,048,695**
FY 2013-14 R#4: "Medicare Modernization Act of 2003 State Contribution Payment"	$14,603,355	0.0	$14,603,355	$0	$0	$0	$0
FY 2013-14 November 1 Request	**$111,278,217**	**0.0**	**$62,229,522**	**$0**	**$0**	**$0**	**$49,048,695**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(5) Other Medical Services

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Public School Health Services Contract Administration							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$1,138,549	0.0	$0	$0	$0	$0	$1,138,549
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$1,138,549**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$1,138,549**
FY 2013-14 Base Request	**$1,138,549**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$1,138,549**
FY 2013-14 November 1 Request	**$1,138,549**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$1,138,549**
Public School Health Services							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$30,446,344	0.0	$0	$0	$16,010,155	$0	$14,436,189
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$30,446,344**	**0.0**	**$0**	**$0**	**$16,010,155**	**$0**	**$14,436,189**
FY 2013-14 Base Request	**$30,446,344**	**0.0**	**$0**	**$0**	**$16,010,155**	**$0**	**$14,436,189**
FY 2013-14 November 1 Request	**$30,446,344**	**0.0**	**$0**	**$0**	**$16,010,155**	**$0**	**$14,436,189**
(5) Other Medical Services							
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$138,847,174	0.0	$55,112,338	$0	$26,010,155	$0	$57,724,681
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$138,847,174**	**0.0**	**$55,112,338**	**$0**	**$26,010,155**	**$0**	**$57,724,681**
Annualization of FY 2012-13 R#11: "CHIPRA Bonus Payment True-up"	$0	0.0	($2,983,119)	$0	$0	$0	$2,983,119
Technical Correction for Annualization of FY 2011-12 BA#11: "Cash Fund Insolvency True-Up"	$6,018,686	0.0	$0	$0	$0	$0	$6,018,686
FY 2013-14 Base Request	**$144,865,860**	**0.0**	**$52,129,219**	**$0**	**$26,010,155**	**$0**	**$66,726,486**
FY 2013-14 R#4: "Medicare Modernization Act of 2003 State Contribution Payment"	$14,603,355	0.0	$14,603,355	$0	$0	$0	$0
FY 2013-14 November 1 Request	**$159,469,215**	**0.0**	**$66,732,574**	**$0**	**$26,010,155**	**$0**	**$66,726,486**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
(A) Executive Director's Office - Medicaid Funding						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$15,173,536	0.0	$7,586,768	$0	$0	$0
HB 12-1246 "Reverse Payday Shift State Employees Paid Biweekly"	$62,776	0.0	$31,388	$0	$0	$0
HB 12-1339 Annualization "Colorado Benefits Management System Project"	$39,762	0.0	$19,881	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$15,276,074**	**0.0**	**$7,638,037**	**$0**	**$0**	**$0**
HB 12-1246 Annualization "Reverse Payday Shift State Employees Paid Biweekly"	($62,776)	0.0	($31,388)	$0	$0	$0
HB 12-1339 Annualization "Colorado Benefits Management System Project" FY14	$34,381	0.0	$17,191	$0	$0	$0
FY 2013-14 Common Policy Adjustment	$1,751,988	0.0	$876,332	$0	$0	$0
FY 2013-14 Base Request	**$16,999,667**	**0.0**	**$8,500,172**	**$0**	**$0**	**$0**
FY 2013-14 NP-R#10: "DHS - DPA - Employee Engagement Survey Adjustment"	$7,736	0.0	$3,868	$0	$0	$0
FY 2013-14 November 1 Request	**$17,007,403**	**0.0**	**$8,504,040**	**$0**	**$0**	**$0**
(B) Office of Information Technology Services - Medicaid Funding						
Colorado Benefits Management System						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$9,040,363	0.0	$4,489,039	$0	$14,481	$20,577
HB 12-1339 Annualization "Colorado Benefits Management System Project"	$7,591,074	0.0	$3,287,514	$0	$10,708	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$16,631,437**	**0.0**	**$7,776,553**	**$0**	**$25,189**	**$20,577**
Annualization of FY 2012-13 R#13: "CBMS Electronic Document Management System"	($431,611)	0.0	($214,546)	$0	($429)	($1,294)
SB 10-061 Annualization "Medicaid Hospice Room And Board Charges"	($151,453)	0.0	($75,103)	$0	($310)	($362)
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	($25,728)	0.0	($12,777)	$0	($41)	($56)
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	($25,728)	0.0	($12,777)	$0	($41)	($56)
HB 12-1339 Annualization "Colorado Benefits Management System Project" FY14	($7,026,961)	0.0	($3,007,252)	$0	($8,314)	$0
FY 2013-14 Base Request	**$8,969,956**	**0.0**	**$4,454,098**	**$0**	**$16,054**	**$18,809**
FY 2013-14 November 1 Request	**$8,969,956**	**0.0**	**$4,454,098**	**$0**	**$16,054**	**$18,809**
Colorado Benefits Management System - HCPF Only						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$611,520	0.0	$0	$0	$305,760	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$611,520**	**0.0**	**$0**	**$0**	**$305,760**	**$0**
FY 2013-14 Base Request	**$611,520**	**0.0**	**$0**	**$0**	**$305,760**	**$0**
FY 2013-14 November 1 Request	**$611,520**	**0.0**	**$0**	**$0**	**$305,760**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
CBMS SAS-70 Audit						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$55,204	0.0	$27,416	$0	$89	$119
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$55,204**	**0.0**	**$27,416**	**$0**	**$89**	**$119**
FY 2013-14 Base Request	**$55,204**	**0.0**	**$27,416**	**$0**	**$89**	**$119**
FY 2013-14 November 1 Request	**$55,204**	**0.0**	**$27,416**	**$0**	**$89**	**$119**
Other Office of Information Technology Services line items						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$500,820	0.0	$250,410	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$500,820**	**0.0**	**$250,410**	**$0**	**$0**	**$0**
FY 2013-14 Common Policy Adjustment	($17,421)	0.0	($8,711)	$0	$0	$0
FY 2013-14 Base Request	**$483,399**	**0.0**	**$241,699**	**$0**	**$0**	**$0**
FY 2013-14 NP-R#8: "DHS - OIT - Enterprise Asset Management"	$1,532	0.0	$766	$0	$0	$0
FY 2013-14 November 1 Request	**$484,931**	**0.0**	**$242,465**	**$0**	**$0**	**$0**
(C) Office of Operations - Medicaid Funding						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$4,814,610	0.0	$2,407,305	$0	$0	$0
HB 12-1246 "Reverse Payday Shift State Employees Paid Biweekly"	$9,915	0.0	$4,958	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$4,824,525**	**0.0**	**$2,412,263**	**$0**	**$0**	**$0**
HB 12-1246 Annualization "Reverse Payday Shift State Employees Paid Biweekly"	($9,915)	0.0	($4,958)	$0	$0	$0
FY 2013-14 Common Policy Adjustment	$3,393	0.0	$1,697	$0	$0	$0
FY 2013-14 Base Request	**$4,818,003**	**0.0**	**$2,409,002**	**$0**	**$0**	**$0**
FY 2013-14 NP-R#9: "DHS - DPA - Capitol Complex Building Upgrade, Repair, and Replacement"	$1,460	0.0	$730	$0	$0	$0
FY 2013-14 November 1 Request	**$4,819,463**	**0.0**	**$2,409,732**	**$0**	**$0**	**$0**
(D) Division of Child Welfare - Medicaid Funding						
Administration						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$133,070	0.0	$66,535	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$133,070**	**0.0**	**$66,535**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$133,070**	**0.0**	**$66,535**	**$0**	**$0**	**$0**
FY 2013-14 November 1 Request	**$133,070**	**0.0**	**$66,535**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
Child Welfare Services						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$14,293,272	0.0	$7,146,636	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$14,293,272**	**0.0**	**$7,146,636**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$14,293,272**	**0.0**	**$7,146,636**	**$0**	**$0**	**$0**
FY 2013-14 NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$214,399	0.0	$107,200	$0	$0	$0
FY 2013-14 November 1 Request	**$14,507,671**	**0.0**	**$7,253,836**	**$0**	**$0**	**$0**
(E) Office of Self Sufficiency - Medicaid Funding						
Systematic Alien Verification for Eligibility						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$33,951	0.0	$16,976	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$33,951**	**0.0**	**$16,976**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$33,951**	**0.0**	**$16,976**	**$0**	**$0**	**$0**
FY 2013-14 November 1 Request	**$33,951**	**0.0**	**$16,976**	**$0**	**$0**	**$0**
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding						
Administration						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$388,784	0.0	$194,392	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$388,784**	**0.0**	**$194,392**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$388,784**	**0.0**	**$194,392**	**$0**	**$0**	**$0**
FY 2013-14 November 1 Request	**$388,784**	**0.0**	**$194,392**	**$0**	**$0**	**$0**
Residential Treatment for Youth (H.B. 99-1116)						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$116,840	0.0	$58,420	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$116,840**	**0.0**	**$58,420**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$116,840**	**0.0**	**$58,420**	**$0**	**$0**	**$0**
FY 2013-14 NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$1,753	0.0	$877	$0	$0	$0
FY 2013-14 November 1 Request	**$118,593**	**0.0**	**$59,297**	**$0**	**$0**	**$0**
Mental Health Institutes						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$5,322,778	0.0	$2,661,389	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$5,322,778**	**0.0**	**$2,661,389**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$5,322,778**	**0.0**	**$2,661,389**	**$0**	**$0**	**$0**
FY 2013-14 November 1 Request	**$5,322,778**	**0.0**	**$2,661,389**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
Alcohol and Drug Abuse Division, High Risk Pregnant Women Program						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$1,999,146	0.0	$999,573	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$1,999,146**	**0.0**	**$999,573**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$1,999,146**	**0.0**	**$999,573**	**$0**	**$0**	**$0**
FY 2013-14 NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$29,987	0.0	$14,994	$0	$0	$0
FY 2013-14 November 1 Request	**$2,029,133**	**0.0**	**$1,014,567**	**$0**	**$0**	**$0**
(G) Services for People with Disabilities - Medicaid Funding						
Community Services for People with Developmental Disabilities, Administration						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$2,897,037	0.0	$1,448,519	$0	$0	$0
HB 12-1246 "Reverse Payday Shift State Employees Paid Biweekly"	$3,308	0.0	$1,654	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$2,900,345**	**0.0**	**$1,450,173**	**$0**	**$0**	**$0**
HB 12-1246 Annualization "Reverse Payday Shift State Employees Paid Biweekly"	($3,308)	0.0	($1,654)	$0	$0	$0
FY 2013-14 Base Request	**$2,897,037**	**0.0**	**$1,448,519**	**$0**	**$0**	**$0**
FY 2013-14 November 1 Request	**$2,897,037**	**0.0**	**$1,448,519**	**$0**	**$0**	**$0**
Community Services for People with Developmental Disabilities, Program Costs						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$340,502,802	0.0	$170,251,400	$0	$1	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$340,502,802**	**0.0**	**$170,251,400**	**$0**	**$1**	**$0**
Annualization of FY 2012-13 NP-R#1: "DHS - New Funding – Developmental Disabilities Services"	$4,071,470	0.0	$2,035,735	$0	$0	$0
FY 2013-14 Base Request	**$344,574,272**	**0.0**	**$172,287,135**	**$0**	**$1**	**$0**
FY 2013-14 NP-R#1: "DHS - Developmental Disabilities Services for New Resources"	$13,055,339	0.0	$6,527,670	$0	$0	$0
FY 2013-14 NP-R#2: "DHS - Technical Changes for Developmental Disabilities Programs"	$301,732	0.0	$150,866	$0	$0	$0
FY 2013-14 NP-R#3: "DHS - Early Intervention Services Caseload Growth and Associated Case Management"	$1,635,843	0.0	$817,922	$0	$0	$0
FY 2013-14 NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$5,393,507	0.0	$2,696,754	$0	$0	$0
FY 2013-14 November 1 Request	**$364,960,693**	**0.0**	**$182,480,347**	**$0**	**$1**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
Regional Centers						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$47,801,815	0.0	$22,033,253	$0	$0	$1,867,655
HB 12-1246 "Reverse Payday Shift State Employees Paid Biweekly"	$181,222	0.0	$90,611	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$47,983,037**	**0.0**	**$22,123,864**	**$0**	**$0**	**$1,867,655**
HB 12-1246 Annualization "Reverse Payday Shift State Employees Paid Biweekly"	($181,222)	0.0	($90,611)	$0	$0	$0
FY 2013-14 Base Request	**$47,801,815**	**0.0**	**$22,033,253**	**$0**	**$0**	**$1,867,655**
FY 2013-14 NP-R#2: "DHS - Technical Changes for Developmental Disabilities Programs"	($301,732)	0.0	($150,866)	$0	$0	$0
FY 2013-14 November 1 Request	**$47,500,083**	**0.0**	**$21,882,387**	**$0**	**$0**	**$1,867,655**
Regional Center Depreciation and Annual Adjustments						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$1,187,825	0.0	$593,913	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$1,187,825**	**0.0**	**$593,913**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$1,187,825**	**0.0**	**$593,913**	**$0**	**$0**	**$0**
FY 2013-14 November 1 Request	**$1,187,825**	**0.0**	**$593,913**	**$0**	**$0**	**$0**
(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$1,800	0.0	$900	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$1,800**	**0.0**	**$900**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$1,800**	**0.0**	**$900**	**$0**	**$0**	**$0**
FY 2013-14 November 1 Request	**$1,800**	**0.0**	**$900**	**$0**	**$0**	**$0**
(I) Division of Youth Corrections - Medicaid Funding						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$1,632,783	0.0	$816,392	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$1,632,783**	**0.0**	**$816,392**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$1,632,783**	**0.0**	**$816,392**	**$0**	**$0**	**$0**
FY 2013-14 NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$23,806	0.0	$11,903	$0	$0	$0
FY 2013-14 November 1 Request	**$1,656,589**	**0.0**	**$828,295**	**$0**	**$0**	**$0**

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
(J) Other						
Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$500,000	0.0	$0	$0	$0	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$500,000**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Base Request	**$500,000**	**0.0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 November 1 Request	**$500,000**	**0.0**	**$0**	**$0**	**$0**	**$0**
(6) Department of Human Services Medicaid-Funded Programs						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$447,007,956	0.0	$221,049,236	$0	$320,331	$1,888,351
HB 12-1246 "Reverse Payday Shift State Employees Paid Biweekly"	$257,221	0.0	$128,611	$0	$0	$0
HB 12-1339 Annualization "Colorado Benefits Management System Project"	$7,630,836	0.0	$3,307,395	$0	$10,708	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$454,896,013**	**0.0**	**$224,485,242**	**$0**	**$331,039**	**$1,888,351**
Annualization of FY 2012-13 R#13: "CBMS Electronic Document Management System"	($431,611)	0.0	($214,546)	$0	($429)	($1,294)
Annualization of FY 2012-13 NP-R#1: "DHS - New Funding – Developmental Disabilities Services"	$4,071,470	0.0	$2,035,735	$0	$0	$0
SB 10-061 Annualization "Medicaid Hospice Room And Board Charges"	($151,453)	0.0	($75,103)	$0	($310)	($362)
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	($25,728)	0.0	($12,777)	$0	($41)	($56)
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	($25,728)	0.0	($12,777)	$0	($41)	($56)
HB 12-1339 Annualization "Colorado Benefits Management System Project" FY14	($6,992,580)	0.0	($2,990,061)	$0	($8,314)	$0
HB 12-1246 Annualization "Reverse Payday Shift State Employees Paid Biweekly"	($257,221)	0.0	($128,611)	$0	$0	$0
FY 2013-14 Common Policy Adjustment	$1,737,960	0.0	$869,318	$0	$0	$0
FY 2013-14 Base Request	**$452,821,122**	**0.0**	**$223,956,420**	**$0**	**$321,904**	**$1,886,583**
FY 2013-14 NP-R#1: "DHS - Developmental Disabilities Services for New Resources"	$13,055,339	0.0	$6,527,670	$0	$0	$0
FY 2013-14 NP-R#2: "DHS - Technical Changes for Developmental Disabilities Programs"	$0	0.0	$0	$0	$0	$0
FY 2013-14 NP-R#3: "DHS - Early Intervention Services Caseload Growth and Associated Case Management"	$1,635,843	0.0	$817,922	$0	$0	$0
FY 2013-14 NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$5,663,452	0.0	$2,831,728	$0	$0	$0
FY 2013-14 NP-R#8: "DHS - OIT - Enterprise Asset Management"	$1,532	0.0	$766	$0	$0	$0
FY 2013-14 NP-R#9: "DHS - DPA - Capitol Complex Building Upgrade, Repair, and Replacement"	$1,460	0.0	$730	$0	$0	$0
FY 2013-14 NP-R#10: "DHS - DPA - Employee Engagement Survey Adjustment"	$7,736	0.0	$3,868	$0	$0	$0
FY 2013-14 November 1 Request	**$473,186,484**	**0.0**	**$234,139,104**	**$0**	**$321,904**	**$1,886,583**

Federal Funds
$7,586,768
$31,388
$19,881
$7,638,037
($31,388)
$17,190
$875,656
$8,499,495
$3,868
$8,503,363
$4,516,266
$4,292,852
$8,809,118
($215,342)
($75,678)
($12,854)
($12,854)
($4,011,395)
$4,480,995
$4,480,995
$305,760
$305,760
$305,760
$305,760

Federal Funds
$27,580
$27,580
$27,580
$27,580
$250,410
$250,410
($8,710)
$241,700
$766
$242,466
$2,407,305
$4,957
$2,412,262
($4,957)
$1,696
$2,409,001
$730
$2,409,731
$66,535
$66,535
$66,535
$66,535

Federal Funds
$7,146,636
$7,146,636
$7,146,636
$107,199
$7,253,835
$16,975
$16,975
$16,975
$16,975
$194,392
$194,392
$194,392
$194,392
$58,420
$58,420
$58,420
$876
$59,296
$2,661,389
$2,661,389
$2,661,389
$2,661,389

Federal Funds
$999,573
$999,573
$999,573
$14,993
$1,014,566
$1,448,518
$1,654
$1,450,172
($1,654)
$1,448,518
$1,448,518
$170,251,401
$170,251,401
$2,035,735
$172,287,136
$6,527,669
$150,866
$817,921
$2,696,753
$182,480,345

Federal Funds
$23,900,907
$90,611
$23,991,518
($90,611)
$23,900,907
($150,866)
$23,750,041
$593,912
$593,912
$593,912
$593,912
$900
$900
$900
$900
$816,391
$816,391
$816,391
$11,903
$828,294

Federal Funds
$500,000
$500,000
$500,000
$500,000
$223,750,038
$128,610
$4,312,733
$228,191,381
($215,342)
$2,035,735
($75,678)
($12,854)
($12,854)
($3,994,205)
($128,610)
$868,642
$226,656,215
$6,527,669
$0
$817,921
$2,831,724
$766
$730
$3,868
$236,838,893

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

Department Summary

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
Department Summary						
FY 2012-13 Long Bill Appropriation (HB 12-1335)	$5,561,097,516	314.3	$1,545,412,545	$312,644,224	$925,385,218	$7,172,593
HB 12-1339 Annualization "Colorado Benefits Management System Project"	$8,628,491	11.0	$3,307,395	$0	$10,708	$997,655
HB 12-1246 "Reverse Payday Shift State Employees Paid Biweekly"	$285,719	0.0	$157,109	$0	$0	$0
HB 12-1281 "Medicaid Payment Reform Pilot Program"	$213,079	0.8	$106,540	$0	$0	$0
HB 12-1340 "Nursing Facility Reduction Per Diem Rate"	($9,024,676)	0.0	($4,512,338)	$0	$0	$0
SB 12-060 "Improve Medicaid Fraud Prosecution"	($48,940)	0.1	$0	$0	($24,470)	$0
SB 12-159 "Evaluation Children With Autism Medicaid Waiver"	$6,925	0.0	$0	$0	$3,463	$0
FY 2012-13 Total Appropriation (Long Bill plus Special Bills)	**$5,561,158,114**	**326.2**	**$1,544,471,251**	**$312,644,224**	**$925,374,919**	**$8,170,248**
Annualization of FY 2007-08 S#5: "Revised Federal Rule for Payment Error Rate Measurement Program"	$588,501	0.0	$147,125	$0	$102,988	$0
Annualization of FY 2009-10 BA#16: "MMIS Funding for HIPAA and Transitions v5010/D.0"	($546,020)	0.0	($58,697)	$0	$0	$0
Annualization of FY 2010-11 BA#12: "Evidence Guided Utilization Review"	($627,984)	0.0	($156,996)	$0	$0	$0
Annualization of FY 2010-11 BA#15: "MMIS Adjustments"	($1,364,572)	0.0	($143,953)	$0	$0	$0
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($1,396,617)	0.2	($659,843)	$0	($38,466)	$0
Annualization of FY 2012-13 R#6: "Medicaid Budget Reductions"	($1,751,563)	0.0	($863,801)	$0	($11,981)	$0
Annualization of FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	($256,885)	0.0	($68,824)	$0	$331	$0
Annualization of FY 2012-13 R#10: "Utilize Supplemental Payments for General Fund Relief"	($8,477)	0.0	($8,477)	$0	$0	$0
Annualization of FY 2012-13 R#11: "CHIPRA Bonus Payment True-up"	$0	0.0	($2,983,119)	$0	$0	$0
Annualization of FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$1,051,158	0.0	$0	$0	$525,579	$0
Annualization of FY 2012-13 R#13: "CBMS Electronic Document Management System"	($431,611)	0.0	($214,546)	$0	($429)	($1,294)
Annualization of FY 2012-13 NP-R#1: "DHS - New Funding – Developmental Disabilities Services"	$4,071,470	0.0	$2,035,735	$0	$0	$0
Annualization of FY 2012-13 BA#3: "Smoking Cessation Quitline for Medicaid Clients"	($92,430)	0.0	$0	$0	($46,215)	$0
Annualization of FY 2012-13 BA#6: "MMIS Technical Adjustments"	($965,033)	0.0	$0	$0	($206,927)	$0
Annualization of FY 2012-13 JBC Staff Recommendation CHP+ Trust Financing	$0	0.0	$3,000,000	$0	($3,000,000)	$0
SB 08-118 Annualization "Transfer for Medicaid Disease Management"	$0	0.0	$2,000,000	$0	$0	($2,000,000)
HB 09-1293 Annualization "Health Care Affordability Act of 2009"	$1,204,749	0.0	$0	$0	$301,187	$0
HB 10-1146 Annualization "State-funded Public Assistance Programs"	($102,745)	0.0	($51,373)	$0	$0	$0
SB 10-061 Annualization "Medicaid Hospice Room And Board Charges"	($151,453)	0.0	($75,103)	$0	($310)	($362)
SB 11-008 Annualization "Aligning Children's Medicaid Eligibility"	($8,065,734)	0.0	$10,653,224	$0	($13,350,516)	($56)
SB 11-212 Annualization "Use Provider Fee Offset GF Medicaid"	$0	0.0	$25,000,000	$0	($25,000,000)	$0
SB 11-250 Annualization "Pregnant Women Medicaid Eligibility"	($2,263,251)	0.0	($794,817)	$0	($464)	($56)
HB 12-1246 Annualization "Reverse Payday Shift State Employees Paid Biweekly"	($285,719)	0.0	($157,109)	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

Department Summary

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
HB 12-1268 "Health Facility Safety Inspection Transfer To CDPS"	$44,515	0.0	$15,580	$0	$0	$0
HB 12-1281 Annualization "Medicaid Payment Reform Pilot Program"	($88,744)	0.2	($44,371)	$0	$0	$0
HB 12-1339 Annualization "Colorado Benefits Management System Project" FY14	($7,179,377)	0.0	($2,990,061)	$0	($8,314)	($186,797)
HB 12-1340 Annualization "Nursing Facility Reduction Per Diem Rate"	$9,024,676	0.0	$4,512,338	$0	$0	$0
SB 12-060 Annualization "Improve Medicaid Fraud Prosecution"	($4,448)	0.0	$0	$0	($2,224)	$0
SB 12-159 Annualization "Evaluation Children With Autism Medicaid Waiver"	$62,000	0.0	$0	$0	$31,000	$0
Technical correction to align with CDE appropriation	$2,133	0.0	$0	$0	$0	$0
Technical Correction for Annualization of FY 2011-12 BA#11: "Cash Fund Insolvency True-Up"	$6,018,686	0.0	$0	$0	$0	$0
FY 2013-14 Statewide Indirect Cost Allocation	$1,160,738	0.0	$1,190,879	$0	$38,481	$10,784
FY 2013-14 Common Policy Adjustment	$2,919,589	0.0	$1,132,741	$0	$76,772	($63,133)
FY 2013-14 Base Request	**$5,561,723,666**	**326.6**	**$1,584,887,783**	**$312,644,224**	**$884,785,411**	**$5,929,334**
FY 2013-14 R#1: "Medical Services Premiums"	$255,256,258	0.0	$78,363,224	$0	($1,837,669)	$0
FY 2013-14 R#2: "Medicaid Mental Health Community Programs"	$32,384,988	0.0	$10,284,849	$0	($1,313,268)	$0
FY 2013-14 R#3: "Children's Basic Health Plan Medical and Dental Costs"	$60,591,910	0.0	$1,923,755	$0	$19,735,056	$0
FY 2013-14 R#4: "Medicare Modernization Act of 2003 State Contribution Payment"	$14,603,355	0.0	$14,603,355	$0	$0	$0
FY 2013-14 R#5: "Medicaid Management Information System Reprocurement"	$15,624,403	0.0	$1,439,072	$0	$287,834	$0
FY 2013-14 R#6: "Additional FTE to Restore Functionality"	$704,341	7.4	$352,172	$0	$0	$0
FY 2013-14 R#7: "Substance Use Disorder Benefit"	$5,788,068	0.0	$1,818,130	$0	$42,035	$0
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	$32,959,416	1.2	($747,621)	$0	$13,693,726	$0
FY 2013-14 R#9: "Dental ASO for Children"	$576,072	0.0	$0	$0	$0	$0
FY 2013-14 R#10: "Leased Space Rent Increase and True-up"	$92,115	0.0	$92,402	$0	($46,344)	$0
FY 2013-14 R#11: "HB 12-1281 Departmental Differences Reconciliation"	$1,096,749	3.0	$497,661	$0	$0	$0
FY 2013-14 R#12: "Customer Service Technology Improvements"	$1,800,000	0.0	$900,000	$0	$0	$0
FY 2013-14 R#13: "1.5% Provider Rate Increase"	$33,116,630	0.0	$14,578,983	$0	$1,227,138	$0
FY 2013-14 NP-R#1: "DHS - Developmental Disabilities Services for New Resources"	$13,055,339	0.0	$6,527,670	$0	$0	$0
FY 2013-14 NP-R#2: "DHS - Technical Changes for Developmental Disabilities Programs"	$0	0.0	$0	$0	$0	$0
FY 2013-14 NP-R#3: "DHS - Early Intervention Services Caseload Growth and Associated Case Management"	$1,635,843	0.0	$817,922	$0	$0	$0
FY 2013-14 NP-R#4: "Capitol Complex Building Upgrade, Repair, and Replacement"	$28,985	0.0	$14,493	$0	$0	$0
FY 2013-14 NP-R#5: "Employee Engagement Survey Adjustment"	$3,463	0.0	$1,732	$0	$0	$0
FY 2013-14 NP-R#6: "OIT Enterprise Asset Management"	$6,260	0.0	$3,130	$0	$0	$0
FY 2013-14 NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$5,663,452	0.0	$2,831,728	$0	$0	$0
FY 2013-14 NP-R#8: "DHS - OIT - Enterprise Asset Management"	$1,532	0.0	$766	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 RECONCILIATION OF DEPARTMENT REQUEST

Department Summary

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
FY 2013-14 NP-R#9: "DHS - DPA - Capitol Complex Building Upgrade, Repair, and Replacement"	$1,460	0.0	$730	$0	$0	$0
FY 2013-14 NP-R#10: "DHS - DPA - Employee Engagement Survey Adjustment"	$7,736	0.0	$3,868	$0	$0	$0
FY 2013-14 November 1 Request	**$6,036,722,041**	**338.2**	**$1,719,195,804**	**$312,644,224**	**$916,573,919**	**$5,929,334**

Federal Funds
$2,770,482,936
$4,312,733
$128,610
$106,539
($4,512,338)
($24,470)
$3,462
$2,770,497,472
$338,388
($487,323)
($470,988)
($1,220,619)
($698,308)
($875,781)
($188,392)
$0
$2,983,119
$525,579
($215,342)
$2,035,735
($46,215)
($758,106)
$0
$0
$903,562
($51,372)
($75,678)
($5,368,386)
$0
($1,467,914)
($128,610)

Federal Funds
$28,935
($44,373)
($3,994,205)
$4,512,338
($2,224)
$31,000
$2,133
$6,018,686
($79,406)
$1,773,209
$2,773,476,914
$178,730,703
$23,413,407
$38,933,099
$0
$13,897,497
$352,169
$3,927,903
$20,013,311
$576,072
$46,057
$599,088
$900,000
$17,310,509
$6,527,669
$0
$817,921
$14,492
$1,731
$3,130
$2,831,724
$766

Federal Funds
$730
$3,868
$3,082,378,760

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 2

	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2010-11 Actual Expenditures							
(1) Executive Director's Office	$104,917,911	270.6	$33,633,591	$0	$9,480,297	$1,105,012	$60,699,011
(2) Medical Services Premiums	$3,395,627,672	0.0	$601,033,287	$279,344,485	$518,533,477	$7,414,327	$1,989,302,096
(3) Medicaid Mental Health Programs	$253,223,259	0.0	$96,589,817	$0	$9,559,892	$13,000	$147,060,550
(4) Indigent Care Programs	$540,812,589	0.0	$21,683,804	$436,728	$204,672,234	$7,293,608	$306,726,215
(5) Other Medical Services	$110,290,101	0.0	$60,423,086	$0	$19,509,080	$0	$30,357,935
(6) DHS Medicaid-Funded Programs	$438,883,396	0.0	$175,667,660	$0	$467,856	$1,870,759	$260,877,121
FY 2010-11 Total Actual Expenditures	**$4,843,754,928**	**270.6**	**$989,031,245**	**$279,781,213**	**$762,222,836**	**$17,696,706**	**$2,795,022,928**
FY 2011-12 Actual Expenditures							
(1) Executive Director's Office	$122,254,301	293.4	$36,713,896	$0	$12,305,515	$1,060,838	$72,174,052
(2) Medical Services Premiums	$3,642,032,762	0.0	$833,239,176	$373,508,751	$629,762,743	$6,445,828	$1,799,076,264
(3) Medicaid Mental Health Programs	$277,270,653	0.0	$133,700,167	$0	$5,791,948	$25,046	$137,753,492
(4) Indigent Care Programs	$519,857,810	0.0	$38,645,550	$446,100	$195,742,810	$0	$285,023,350
(5) Other Medical Services	$152,542,868	0.0	$62,950,314	$0	$31,539,245	$0	$58,053,309
(6) DHS Medicaid-Funded Programs	$423,061,699	0.0	$211,088,878	$0	$849,714	$25,674	$211,097,433
FY 2011-12 Total Actual Expenditures	**$5,137,020,093**	**293.4**	**$1,316,337,981**	**$373,954,851**	**$875,991,975**	**$7,557,386**	**$2,563,177,900**
FY 2012-13 Appropriation							
(1) Executive Director's Office	$144,010,325	326.2	$38,736,003	$0	$17,740,127	$3,066,557	$84,467,638
(2) Medical Services Premiums	$3,985,613,386	0.0	$1,050,603,677	$312,202,624	$651,181,857	$3,215,340	$1,968,409,888
(3) Medicaid Mental Health Programs	$316,728,340	0.0	$144,786,787	$0	$13,648,932	$0	$158,292,621
(4) Indigent Care Programs	$521,062,876	0.0	$30,747,204	$441,600	$216,462,809	$0	$273,411,263
(5) Other Medical Services	$138,847,174	0.0	$55,112,338	$0	$26,010,155	$0	$57,724,681
(6) DHS Medicaid-Funded Programs	$454,896,013	0.0	$224,485,242	$0	$331,039	$1,888,351	$228,191,381
FY 2012-13 Total Appropriation	**$5,561,158,114**	**326.2**	**$1,544,471,251**	**$312,644,224**	**$925,374,919**	**$8,170,248**	**$2,770,497,472**
FY 2013-14 Request							
(1) Executive Director's Office	$169,114,876	338.2	$43,841,542	$0	$19,560,279	$2,827,411	$102,885,644
(2) Medical Services Premiums	$4,345,486,362	0.0	$1,184,732,830	$312,202,624	$638,603,669	$1,215,340	$2,208,731,899
(3) Medicaid Mental Health Programs	$357,882,965	0.0	$158,084,871	$0	$12,377,981	$0	$187,420,113
(4) Indigent Care Programs	$531,582,139	0.0	$31,664,883	$441,600	$219,699,931	$0	$279,775,725
(5) Other Medical Services	$159,469,215	0.0	$66,732,574	$0	$26,010,155	$0	$66,726,486
(6) DHS Medicaid-Funded Programs	$473,186,484	0.0	$234,139,104	$0	$321,904	$1,886,583	$236,838,893
FY 2013-14 Total Request	**$6,036,722,041**	**338.2**	**$1,719,195,804**	**$312,644,224**	**$916,573,919**	**$5,929,334**	**$3,082,378,760**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

Department Summary

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Department Summary							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$4,624,843,298	287.8	$1,181,133,827	$161,891,485	$530,725,328	$16,416,251	$2,734,676,407
HB 10-1005, Home Health Care, FY11	$123,270	0.0	$0	$0	$47,348	$0	$75,922
HB 10-1027, Medicaid Hospice Life Expectancy, FY11	$25,000	0.0	$0	$0	$12,500	$0	$12,500
HB 10-1033, Screening Brief Intervention Referral, FY11	$870,155	0.0	$334,227	$0	$0	$0	$535,928
HB 10-1053, Medicaid Community Long-term Care Saving, FY11	$75,000	0.0	$0	$0	$37,500	$0	$37,500
HB 10-1146, State-funded Public Assistance Programs, FY11	($520,034)	0.0	($778,408)	$0	$818	$0	$257,556
HB 10-1338, Probation Eligible Two Prior Felony, FY11	$75,209	0.0	$28,887	$0	$0	$0	$46,322
HB 10-1378, Transfers for Health Care Services, FY11	$4,895,145	0.0	($12,800,000)	$0	$0	$0	$17,695,145
HB 10-1379, 2010 Nursing Facility Rate Reductions, FY11	($6,234,689)	0.0	($8,211,333)	$0	$5,806,343	$0	($3,829,699)
HB 10-1380, Use Supplemental OAP Health Fund for	$0	0.0	($4,850,000)	$0	$4,850,000	$0	$0
HB 10-1381, Tobacco Revenues Offset Medical Services,	$0	0.0	($25,691,418)	$0	$21,200,983	$4,490,435	$0
HB 10-1382, Repeal Delay of Public Medical Assistance Program Payments, FY11	($40,566,633)	0.0	($12,125,302)	$0	($2,023,356)	($17,380)	($26,400,595)
HB 10-1384, Alignment of Eligibility for the Old Age Pension Program, FY11	$17,220	0.0	$8,539	$0	$76	$0	$8,605
SB 10-061, Medicaid Hospice Room And Board Charges, FY11	$102,570	0.0	$0	$0	$51,285	$0	$51,285
SB 10-167, Medicaid Efficiency & False Claims, FY11	($1,062,209)	7.0	($414,513)	$0	$0	$0	($647,696)
SB 10-169, Provider Fee Enhanced Match, FY11	$0	0.0	($46,329,388)	$0	$46,329,388	$0	$0
Long Bill Add-ons, SB 11-209, FY11	$291,774,206	0.0	($18,682,399)	$117,900,000	$103,578,112	($2,358,374)	$91,336,867
Supplemental Appropriation, SB 11-139, FY11	($24,790,931)	0.0	($64,659,222)	$0	$42,950,228	($4,100)	($3,077,837)
Final FY 2010-11 Appropriation	$4,849,626,577	294.8	$986,963,497	$279,791,485	$753,566,553	$18,526,832	$2,810,778,210
FY11 Federal Grant	$2,000,000	0.0	$0	$0	$0	$0	$2,000,000
FY11 Year-End Transfers	($1,433,369)	0.0	($940,684)	$0	$0	$0	($492,685)
FY11 Allocated Pots	$2	0.0	$3	$0	$0	$0	($1)
Restricted Funds from FY 2009-10	($1,410)	0.0	($1,410)	$0	$0	$0	$0
FY11 Total Available Spending Authority	$4,850,191,800	294.8	$986,021,406	$279,791,485	$753,566,553	$18,526,832	$2,812,285,524
FY11 Expenditures	$4,843,754,928	270.6	$989,031,245	$279,781,213	$762,222,836	$17,696,706	$2,795,022,928
FY 2010-11 Reversion \ (Overexpenditure)	**$6,436,872**	**24.2**	**($3,009,839)**	**$10,272**	**($8,656,283)**	**$830,126**	**$17,262,596**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

Department Summary

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$5,086,626,060	312.2	$1,494,116,123	$284,621,517	$780,942,590	$7,535,223	$2,519,410,607
HB 12-1202, Allow HCPF Approps For Quitline Matching Funds, FY12	$577,316	0.0	$0	$0	$288,658	$0	$288,658
HB 11-1242, Medicaid Provider Integration Of Service, FY12	$113,500	0.0	$0	$0	$56,750	$0	$56,750
HB 12-1339, Colorado Benefits Management System Project, FY12	$3,654,755	0.0	$1,820,992	$0	$8,521	$0	$1,825,242
SB 11-076, PERA Contribution Rates, FY12	($1,630,244)	0.0	($714,347)	$0	($56,118)	$0	($859,779)
SB 11-125, Nursing Home Fees & Order of Payments, FY12	$31,054,411	0.0	$30,000	$0	$15,497,206	$0	$15,527,205
SB 11-177, Repeal Sunset Teen Pregnancy & Dropout Program, FY12	$197,635	1.0	$0	$0	$19,763	$0	$177,872
SB 11-210, Phase Out Supplemental OAP Health Fund, FY12	($2,230,500)	0.0	($2,230,500)	$0	$0	$0	$0
SB 11-211, Tobacco Revenues Offset Medical Services, FY12	$0	0.0	($33,000,000)	$0	$29,713,649	$3,286,351	$0
SB 11-212, Use Provider Fee Offset GF Medicaid, FY12	$0	0.0	($50,000,000)	$0	$50,000,000	$0	$0
SB 11-215, 2011 Nursing Facility Rate Reduction, FY12	($8,865,830)	0.0	($4,432,915)	$0	$0	$0	($4,432,915)
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	($4,663,402)	(0.2)	($3,449,967)	$0	($24,363)	($446,100)	($742,972)
SB 11-219, 2011 Transfers For Health Care Services, FY12	($2,607,170)	0.0	($15,775,670)	$0	$1,413,500	$0	$11,755,000
Supplemental Appropriation, HB 12-1184, FY12	($7,901,075)	0.0	($22,462,053)	$0	$13,409,842	($1,868,305)	$3,019,441
Long Bill Add-ons, HB 12-1335, FY12	$71,988,135	(0.5)	($38,919,032)	$89,333,334	($11,637,452)	$69,271	$33,142,014
Final FY 2011-12 Appropriation	$5,166,313,591	312.5	$1,324,982,631	$373,954,851	$879,632,546	$8,576,440	$2,579,167,123
FY12 Year-End Transfers	($850,352)	0.0	($433,466)	$0	$0	$0	($416,886)
FY12 1331 Emergency Funding for the Public School Health Services Program	$15,486,243	0.0	$0	$0	$4,766,682	$0	$10,719,561
FY12 Roll-forward	$4,558,926	0.0	$0	$487,762	$271,905	$0	$3,799,259
FY12 Allocated Pots	$0	0.0	($2)	$0	$0	$0	$2
FY12 Total Available Spending Authority	$5,185,508,408	312.5	$1,324,549,163	$374,442,613	$884,671,133	$8,576,440	$2,593,269,059
FY12 Expenditures	$5,137,020,093	293.4	$1,316,337,981	$373,954,851	$875,991,975	$7,557,386	$2,563,177,900
FY 2011-12 Reversion \ (Overexpenditure)	**$48,488,315**	**19.1**	**$8,211,182**	**$487,762**	**$8,679,158**	**$1,019,054**	**$30,091,159**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

Department Summary

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$5,561,097,516	314.3	$1,545,412,545	$312,644,224	$925,385,218	$7,172,593	$2,770,482,936
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY13	$285,719	0.0	$157,109	$0	$0	$0	$128,610
HB 12-1281, Medicaid Payment Reform Pilot Program, FY13	$213,079	0.8	$106,540	$0	$0	$0	$106,539
HB 12-1339, Colorado Benefits Management System Project, FY13	$8,628,491	11.0	$3,307,395	$0	$10,708	$997,655	$4,312,733
HB 12-1340, Nursing Facility Reduction Per Diem Rate, FY13	($9,024,676)	0.0	($4,512,338)	$0	$0	$0	($4,512,338)
SB 12-060, Improve Medicaid Fraud Prosecution, FY13	($48,940)	0.1	$0	$0	($24,470)	$0	($24,470)
SB 12-159, Evaluation Children With Autism Medicaid Waiver, FY13	$6,925	0.0	$0	$0	$3,463	$0	$3,462
FY 2012-13 Total Appropriation	**$5,561,158,114**	**326.2**	**$1,544,471,251**	**$312,644,224**	**$925,374,919**	**$8,170,248**	**$2,770,497,472**
FY13 Roll-forward	$3,406,043	0.0	$1,697,240	$0	$7,837	$0	$1,700,966
FY 2012-13 Total Available Spending Authority	**$5,564,564,157**	**326.2**	**$1,546,168,491**	**$312,644,224**	**$925,382,756**	**$8,170,248**	**$2,772,198,438**
FY13 Personal Services allocation	$22,593,922	326.2	$7,971,021	$0	$2,038,599	$1,176,645	$11,407,657
FY13 Operating allocation	$1,625,353	0.0	$715,356	$0	$53,049	$78,257	$778,691
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$5,561,158,114	326.2	$1,544,471,251	$312,644,224	$925,374,919	$8,170,248	$2,770,497,472
HB 09-1293, Health Care Affordability Act of 2009, FY14	$1,204,749	0.0	$0	$0	$301,187	$0	$903,562
HB 10-1146, State-funded Public Assistance Programs, FY14	($102,745)	0.0	($51,373)	$0	$0	$0	($51,372)
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY14	($285,719)	0.0	($157,109)	$0	$0	$0	($128,610)
HB 12-1268, Health Facility Safety Inspection Transfer To CDPS, FY14	$44,515	0.0	$15,580	$0	$0	$0	$28,935
HB 12-1281, Medicaid Payment Reform Pilot Program, FY14	($88,744)	0.2	($44,371)	$0	$0	$0	($44,373)
HB 12-1339, Colorado Benefits Management System Project, FY14	($7,179,377)	0.0	($2,990,061)	$0	($8,314)	($186,797)	($3,994,205)
HB 12-1340, Nursing Facility Reduction Per Diem Rate, FY14	$9,024,676	0.0	$4,512,338	$0	$0	$0	$4,512,338
SB 08-118, Transfer for Medicaid Disease Management, FY14	$0	0.0	$2,000,000	$0	$0	($2,000,000)	$0
SB 10-061, Medicaid Hospice Room and Board Charges, FY14	($151,453)	0.0	($75,103)	$0	($310)	($362)	($75,678)

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3
Department Summary

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	($8,065,734)	0.0	$10,653,224	$0	($13,350,516)	($56)	($5,368,386)
SB 11-212, Use Provider Fee Offset GF Medicaid, FY14	$0	0.0	$25,000,000	$0	($25,000,000)	$0	$0
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	($2,263,251)	0.0	($794,817)	$0	($464)	($56)	($1,467,914)
SB 12-060, Improve Medicaid Fraud Prosecution, FY14	($4,448)	0.0	$0	$0	($2,224)	$0	($2,224)
SB 12-159, Evaluation Children With Autism Medicaid Waiver, FY14	$62,000	0.0	$0	$0	$31,000	$0	$31,000
Annualization of FY 2007-08 S#5: "Revised Federal Rule for Payment Error Rate Measurement Program"	$588,501	0.0	$147,125	$0	$102,988	$0	$338,388
Annualization of FY 2009-10 BA#16: "MMIS Funding for HIPAA and Transitions v5010/D.0"	($546,020)	0.0	($58,697)	$0	$0	$0	($487,323)
Annualization of FY 2010-11 BA#12: "Evidence Guided Utilization Review"	($627,984)	0.0	($156,996)	$0	$0	$0	($470,988)
Annualization of FY 2010-11 BA#15: "MMIS Adjustments"	($1,364,572)	0.0	($143,953)	$0	$0	$0	($1,220,619)
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($1,396,617)	0.2	($659,843)	$0	($38,466)	$0	($698,308)
Annualization of FY 2012-13 R#6: "Medicaid Budget Reductions"	($1,751,563)	0.0	($863,801)	$0	($11,981)	$0	($875,781)
Annualization of FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	($256,885)	0.0	($68,824)	$0	$331	$0	($188,392)
Annualization of FY 2012-13 R#10: "Utilize Supplemental Payments for General Fund Relief"	($8,477)	0.0	($8,477)	$0	$0	$0	$0
Annualization of FY 2012-13 R#11: "CHIPRA Bonus Payment True-up"	$0	0.0	($2,983,119)	$0	$0	$0	$2,983,119
Annualization of FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$1,051,158	0.0	$0	$0	$525,579	$0	$525,579
Annualization of FY 2012-13 R#13: "CBMS Electronic Document Management System"	($431,611)	0.0	($214,546)	$0	($429)	($1,294)	($215,342)
Annualization of FY 2012-13 NP-R#1: "DHS - New Funding – Developmental Disabilities Services"	$4,071,470	0.0	$2,035,735	$0	$0	$0	$2,035,735
Annualization of FY 2012-13 BA#3: "Smoking Cessation Quitline for Medicaid Clients"	($92,430)	0.0	$0	$0	($46,215)	$0	($46,215)
Annualization of FY 2012-13 BA#6: "MMIS Technical Adjustments"	($965,033)	0.0	$0	$0	($206,927)	$0	($758,106)
Annualization of FY 2012-13 JBC Staff Recommendation CHP+ Trust Financing	$0	0.0	$3,000,000	$0	($3,000,000)	$0	$0
Technical correction to align with CDE appropriation	$2,133	0.0	$0	$0	$0	$0	$2,133

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

Department Summary

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Technical Correction for Annualization of FY 2011-12 BA#11: "Cash Fund Insolvency True-up"	$6,018,686	0.0	$0	$0	$0	$0	$6,018,686
FY14 Statewide Indirect Cost Allocation	$1,160,738	0.0	$1,190,879	$0	$38,481	$10,784	($79,406)
FY14 Common Policy Adjustment	$2,919,589	0.0	$1,132,741	$0	$76,772	($63,133)	$1,773,209
FY 2013-14 Base Request	**$5,561,723,666**	**326.6**	**$1,584,887,783**	**$312,644,224**	**$884,785,411**	**$5,929,334**	**$2,773,476,914**
R#1: "Medical Services Premiums"	$255,256,258	0.0	$78,363,224	$0	($1,837,669)	$0	$178,730,703
R#2: "Medicaid Mental Health Community Programs"	$32,384,988	0.0	$10,284,849	$0	($1,313,268)	$0	$23,413,407
R#3: "Children's Basic Health Plan Medical and Dental Costs"	$60,591,910	0.0	$1,923,755	$0	$19,735,056	$0	$38,933,099
R#4: "Medicare Modernization Act of 2003 State Contribution Payment"	$14,603,355	0.0	$14,603,355	$0	$0	$0	$0
R#5: "Medicaid Management Information System Reprocurement"	$15,624,403	0.0	$1,439,072	$0	$287,834	$0	$13,897,497
R#6: "Additional FTE to Restore Functionality"	$704,341	7.4	$352,172	$0	$0	$0	$352,169
R#7: "Substance Use Disorder Benefit"	$5,788,068	0.0	$1,818,130	$0	$42,035	$0	$3,927,903
R#8: "Medicaid Dental Benefit for Adults"	$32,959,416	1.2	($747,621)	$0	$13,693,726	$0	$20,013,311
R#9: "Dental ASO for Children"	$576,072	0.0	$0	$0	$0	$0	$576,072
R#10: "Leased Space Rent Increase and True-up"	$92,115	0.0	$92,402	$0	($46,344)	$0	$46,057
R#11: "HB 12-1281 Departmental Differences Reconciliation"	$1,096,749	3.0	$497,661	$0	$0	$0	$599,088
R#12: "Customer Service Technology Improvements"	$1,800,000	0.0	$900,000	$0	$0	$0	$900,000
R#13: "1.5% Provider Rate Increase"	$33,116,630	0.0	$14,578,983	$0	$1,227,138	$0	$17,310,509
NP-R#1: "DHS - Developmental Disabiliities Services for New Resources"	$13,055,339	0.0	$6,527,670	$0	$0	$0	$6,527,669
NP-R#2: "DHS - Technical Changes for Developmental Disabilities Programs"	$0	0.0	$0	$0	$0	$0	$0
NP-R#3: "DHS - Early Intervention Services Caseload Growth and Associated Case Management"	$1,635,843	0.0	$817,922	$0	$0	$0	$817,921
NP-R#4: "Capitol Complex Building Upgrade, Repair, and Replacement"	$28,985	0.0	$14,493	$0	$0	$0	$14,492
NP-R#5: "Employee Engagement Survey Adjustment"	$3,463	0.0	$1,732	$0	$0	$0	$1,731
NP-R#6: "OIT Enterprise Asset Management"	$6,260	0.0	$3,130	$0	$0	$0	$3,130
NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$5,663,452	0.0	$2,831,728	$0	$0	$0	$2,831,724
NP-R#8: "DHS - OIT - Enterprise Asset Management"	$1,532	0.0	$766	$0	$0	$0	$766

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

Department Summary

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
NP-R#9: "DHS - DPA - Capitol Complex Building Upgrade, Repair, and Replacement"	$1,460	0.0	$730	$0	$0	$0	$730
NP-R#10: "DHS - DPA - Employee Engagement Survey Adjustment"	$7,736	0.0	$3,868	$0	$0	$0	$3,868
FY 2013-14 Total Request	**$6,036,722,041**	**338.2**	**$1,719,195,804**	**$312,644,224**	**$916,573,919**	**$5,929,334**	**$3,082,378,760**
FY14 Personal Services allocation	$24,490,598	338.2	$9,533,270	$0	$2,118,369	$1,069,555	$11,769,404
FY14 Operating allocation	$1,607,614	0.0	$728,404	$0	$58,306	$23,910	$796,994

Department Summary							
FY 2012-13 Total Appropriation	**$5,561,158,114**	**326.2**	**$1,544,471,251**	**$312,644,224**	**$925,374,919**	**$8,170,248**	**$2,770,497,472**
FY 2013-14 Base Request	**$5,561,723,666**	**326.6**	**$1,584,887,783**	**$312,644,224**	**$884,785,411**	**$5,929,334**	**$2,773,476,914**
FY 2013-14 Total Request	**$6,036,722,041**	**338.2**	**$1,719,195,804**	**$312,644,224**	**$916,573,919**	**$5,929,334**	**$3,082,378,760**
Percentage Change FY 2012-13 to FY 2013-14	**8.55%**	**3.68%**	**11.31%**	**0.00%**	**-0.95%**	**-27.43%**	**11.26%**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(A) General Administration, Personal Services							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$20,016,423	287.8	$7,391,048	$0	$1,652,353	$524,403	$10,448,619
SB 10-167, Medicaid Efficiency & False Claims, FY11	$447,118	7.0	$223,559	$0	$0	$0	$223,559
Supplemental Appropriation, SB 11-139, FY11	($80,422)	0.0	($76,146)	$0	$0	($4,276)	$0
Final FY 2010-11 Appropriation	$20,383,119	294.8	$7,538,461	$0	$1,652,353	$520,127	$10,672,178
FY11 Year-End Transfers	$19,872	0.0	$9,936	$0	$0	$0	$9,936
FY11 Total Available Spending Authority	$20,402,991	294.8	$7,548,397	$0	$1,652,353	$520,127	$10,682,114
FY11 Expenditures	$19,017,761	270.6	$7,559,246	$0	$1,289,520	$520,127	$9,648,868
FY 2010-11 Reversion \ (Overexpenditure)	$1,385,230	24.2	($10,849)	$0	$362,833	$0	$1,033,246
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$21,775,206	312.2	$7,817,694	$0	$2,054,145	$448,289	$11,455,078
SB 11-076, PERA Contribution Rates, FY12	($508,843)	0.0	($166,362)	$0	($56,118)	$0	($286,363)
SB 11-177, Repeal Sunset Teen Pregnancy & Dropout Program, FY12	$47,817	1.0	$23,909	$0	$0	$0	$23,908
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	($23,494)	(0.2)	$0	$0	($23,494)	$0	$0
Long Bill Add-ons, HB 12-1335, FY12	($31,693)	(0.5)	($15,847)	$0	$0	$0	($15,846)
Final FY 2011-12 Appropriation	$21,258,993	312.5	$7,659,394	$0	$1,974,533	$448,289	$11,176,777
FY12 Total Available Spending Authority	$21,258,993	312.5	$7,659,394	$0	$1,974,533	$448,289	$11,176,777
FY12 Expenditures	$20,609,604	293.4	$7,727,247	$0	$1,371,016	$448,289	$11,063,052
FY 2011-12 Reversion \ (Overexpenditure)	$649,389	19.1	($67,853)	$0	$603,517	$0	$113,725
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$21,687,551	314.3	$7,916,146	$0	$2,038,599	$351,526	$11,381,280
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY13	$28,498	0.0	$28,498	$0	$0	$0	$0
HB 12-1281, Medicaid Payment Reform Pilot Program, FY13	$47,538	0.8	$23,769	$0	$0	$0	$23,769
HB 12-1339, Colorado Benefits Management System Project, FY13	$825,119	11.0	$0	$0	$0	$825,119	$0
SB 12-060, Improve Medicaid Fraud Prosecution, FY13	$5,216	0.1	$2,608	$0	$0	$0	$2,608
FY 2012-13 Total Appropriation	**$22,593,922**	**326.2**	**$7,971,021**	**$0**	**$2,038,599**	**$1,176,645**	**$11,407,657**
FY13 Personal Services allocation	**$22,593,922**	**326.2**	**$7,971,021**	**$0**	**$2,038,599**	**$1,176,645**	**$11,407,657**
FY13 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Final FY 2012-13 Appropriation	$22,593,922	326.2	$7,971,021	$0	$2,038,599	$1,176,645	$11,407,657
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY14	($28,498)	0.0	($28,498)	$0	$0	$0	$0
HB 12-1281, Medicaid Payment Reform Pilot Program, FY14	$15,847	0.2	$7,924	$0	$0	$0	$7,923
HB 12-1339, Colorado Benefits Management System Project, FY14	($117,874)	0.0	$0	$0	$0	($117,874)	$0
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$16,904	0.2	$8,452	$0	$0	$0	$8,452
FY14 Statewide Indirect Cost Allocation	$1,160,738	0.0	$1,190,879	$0	$38,481	$10,784	($79,406)
FY 2013-14 Base Request	**$23,641,039**	**326.6**	**$9,149,778**	**$0**	**$2,077,080**	**$1,069,555**	**$11,344,626**
R#6: "Additional FTE to Restore Functionality"	$528,568	7.4	$264,285	$0	$0	$0	$264,283
R#8: "Medicaid Dental Benefit for Adults"	$82,577	1.2	$0	$0	$41,289	$0	$41,288
R#11: "HB 12-1281 Departmental Differences Reconciliation"	$238,414	3.0	$119,207	$0	$0	$0	$119,207
FY 2013-14 Total Request	**$24,490,598**	**338.2**	**$9,533,270**	**$0**	**$2,118,369**	**$1,069,555**	**$11,769,404**
FY14 Personal Services allocation	**$24,490,598**	**338.2**	**$9,533,270**	**$0**	**$2,118,369**	**$1,069,555**	**$11,769,404**
FY14 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
(A) General Administration, Health, Life, and Dental							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$1,706,057	0.0	$611,752	$0	$205,744	$15,219	$873,342
Final FY 2010-11 Appropriation	$1,706,057	0.0	$611,752	$0	$205,744	$15,219	$873,342
FY11 Total Available Spending Authority	$1,706,057	0.0	$611,752	$0	$205,744	$15,219	$873,342
FY11 Expenditures	$1,706,057	0.0	$611,752	$0	$205,744	$15,219	$873,342
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$2,024,577	0.0	$627,749	$0	$255,164	$0	$1,141,664
Final FY 2011-12 Appropriation	$2,024,577	0.0	$627,749	$0	$255,164	$0	$1,141,664
FY12 Total Available Spending Authority	$2,024,577	0.0	$627,749	$0	$255,164	$0	$1,141,664
FY12 Expenditures	$2,024,577	0.0	$627,749	$0	$255,164	$0	$1,141,664
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$2,160,056	0.0	$796,479	$0	$174,652	$55,084	$1,133,841
HB 12-1339, Colorado Benefits Management System Project, FY13	$56,737	0.0	$0	$0	$0	$56,737	$0
FY 2012-13 Total Appropriation	**$2,216,793**	**0.0**	**$796,479**	**$0**	**$174,652**	**$111,821**	**$1,133,841**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$2,216,793	0.0	$796,479	$0	$174,652	$111,821	$1,133,841
HB 12-1339, Colorado Benefits Management System Project, FY14	($8,106)	0.0	$0	$0	$0	($8,106)	$0
FY14 Common Policy Adjustment	$15,835	0.0	($35,385)	$0	($7,185)	($40,781)	$99,186
FY 2013-14 Base Request	**$2,224,522**	**0.0**	**$761,094**	**$0**	**$167,467**	**$62,934**	**$1,233,027**
R#6: "Additional FTE to Restore Functionality"	$39,789	0.0	$19,895	$0	$0	$0	$19,894
FY 2013-14 Total Request	**$2,264,311**	**0.0**	**$780,989**	**$0**	**$167,467**	**$62,934**	**$1,252,921**
FY14 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY14 Operating allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
(A) General Administration, Short-term Disability							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$26,138	0.0	$9,539	$0	$2,174	$737	$13,688
Final FY 2010-11 Appropriation	$26,138	0.0	$9,539	$0	$2,174	$737	$13,688
FY11 Total Available Spending Authority	$26,138	0.0	$9,539	$0	$2,174	$737	$13,688
FY11 Expenditures	$26,138	0.0	$9,539	$0	$2,174	$737	$13,688
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$32,206	0.0	$12,334	$0	$2,521	$0	$17,351
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	($18)	0.0	$0	$0	($18)	$0	$0
Final FY 2011-12 Appropriation	$32,188	0.0	$12,334	$0	$2,503	$0	$17,351
FY12 Total Available Spending Authority	$32,188	0.0	$12,334	$0	$2,503	$0	$17,351
FY12 Expenditures	$32,188	0.0	$12,334	$0	$2,503	$0	$17,351
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$32,188	0.0	$12,334	$0	$2,503	$0	$17,351
HB 12-1339, Colorado Benefits Management System Project, FY13	$1,309	0.0	$0	$0	$0	$1,309	$0
FY 2012-13 Total Appropriation	**$33,497**	**0.0**	**$12,334**	**$0**	**$2,503**	**$1,309**	**$17,351**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$33,497	0.0	$12,334	$0	$2,503	$1,309	$17,351
HB 12-1339, Colorado Benefits Management System Project, FY14	($187)	0.0	$0	$0	$0	($187)	$0
FY14 Common Policy Adjustment	$6,623	0.0	$1,316	$0	$310	($511)	$5,508
FY 2013-14 Base Request	**$39,933**	**0.0**	**$13,650**	**$0**	**$2,813**	**$611**	**$22,859**
R#6: "Additional FTE to Restore Functionality"	$838	0.0	$419	$0	$0	$0	$419
FY 2013-14 Total Request	**$40,771**	**0.0**	**$14,069**	**$0**	**$2,813**	**$611**	**$23,278**
(A) General Administration, S.B. 04-257 Amortization Equalization Disbursement							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$402,667	0.0	$145,650	$0	$33,664	$11,411	$211,942
Final FY 2010-11 Appropriation	$402,667	0.0	$145,650	$0	$33,664	$11,411	$211,942
FY11 Total Available Spending Authority	$402,667	0.0	$145,650	$0	$33,664	$11,411	$211,942
FY11 Expenditures	$402,667	0.0	$145,650	$0	$33,664	$11,411	$211,942
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$533,397	0.0	$190,728	$0	$53,691	$0	$288,978
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	($543)	0.0	$0	$0	($543)	$0	$0
Final FY 2011-12 Appropriation	$532,854	0.0	$190,728	$0	$53,148	$0	$288,978
FY12 Total Available Spending Authority	$532,854	0.0	$190,728	$0	$53,148	$0	$288,978
FY12 Expenditures	$532,854	0.0	$190,728	$0	$53,148	$0	$288,978
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$704,439	0.0	$283,141	$0	$53,468	$11,380	$356,450
HB 12-1339, Colorado Benefits Management System Project, FY13	$26,194	0.0	$0	$0	$0	$26,194	$0
FY 2012-13 Total Appropriation	**$730,633**	**0.0**	**$283,141**	**$0**	**$53,468**	**$37,574**	**$356,450**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$730,633	0.0	$283,141	$0	$53,468	$37,574	$356,450
HB 12-1339, Colorado Benefits Management System Project, FY14	($3,379)	0.0	$0	$0	$0	($3,379)	$0
FY14 Common Policy Adjustment	$82,204	0.0	($7,151)	$0	$3,755	($21,420)	$107,020
FY 2013-14 Base Request	**$809,458**	**0.0**	**$275,990**	**$0**	**$57,223**	**$12,775**	**$463,470**
R#6: "Additional FTE to Restore Functionality"	$17,050	0.0	$8,525	$0	$0	$0	$8,525
FY 2013-14 Total Request	**$826,508**	**0.0**	**$284,515**	**$0**	**$57,223**	**$12,775**	**$471,995**
(A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$292,544	0.0	$105,135	$0	$24,547	$8,321	$154,541
Final FY 2010-11 Appropriation	$292,544	0.0	$105,135	$0	$24,547	$8,321	$154,541
FY11 Total Available Spending Authority	$292,544	0.0	$105,135	$0	$24,547	$8,321	$154,541
FY11 Expenditures	$292,544	0.0	$105,135	$0	$24,547	$8,321	$154,541
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$427,633	0.0	$151,785	$0	$42,790	$0	$233,058
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	($308)	0.0	$0	$0	($308)	$0	$0
Final FY 2011-12 Appropriation	$427,325	0.0	$151,785	$0	$42,482	$0	$233,058
FY12 Total Available Spending Authority	$427,325	0.0	$151,785	$0	$42,482	$0	$233,058
FY12 Expenditures	$427,325	0.0	$151,785	$0	$42,482	$0	$233,058
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$604,213	0.0	$242,160	$0	$45,949	$9,780	$306,324
HB 12-1339, Colorado Benefits Management System Project, FY13	$23,500	0.0	$0	$0	$0	$23,500	$0
FY 2012-13 Total Appropriation	**$627,713**	**0.0**	**$242,160**	**$0**	**$45,949**	**$33,280**	**$306,324**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$627,713	0.0	$242,160	$0	$45,949	$33,280	$306,324
HB 12-1339, Colorado Benefits Management System Project, FY14	($2,904)	0.0	$0	$0	$0	($2,904)	$0
FY14 Common Policy Adjustment	$106,098	0.0	$6,998	$0	$5,710	($18,697)	$112,087
FY 2013-14 Base Request	**$730,907**	**0.0**	**$249,158**	**$0**	**$51,659**	**$11,679**	**$418,411**
R#6: "Additional FTE to Restore Functionality"	$15,394	0.0	$7,697	$0	$0	$0	$7,697
FY 2013-14 Total Request	**$746,301**	**0.0**	**$256,855**	**$0**	**$51,659**	**$11,679**	**$426,108**
(A) General Administration, Salary Survey and Senior Executive Service							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY14 Common Policy Adjustment	$568,180	0.0	$176,323	$0	$45,753	$8,388	$337,716
FY 2013-14 Base Request	**$568,180**	**0.0**	**$176,323**	**$0**	**$45,753**	**$8,388**	**$337,716**
FY 2013-14 Total Request	**$568,180**	**0.0**	**$176,323**	**$0**	**$45,753**	**$8,388**	**$337,716**

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(A) General Administration, Merit Pay							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY14 Common Policy Adjustment	$384,021	0.0	$130,300	$0	$28,429	$9,888	$215,404
FY 2013-14 Base Request	**$384,021**	**0.0**	**$130,300**	**$0**	**$28,429**	**$9,888**	**$215,404**
FY 2013-14 Total Request	**$384,021**	**0.0**	**$130,300**	**$0**	**$28,429**	**$9,888**	**$215,404**
(A) General Administration, Workers' Compensation							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$34,748	0.0	$17,374	$0	$0	$0	$17,374
Final FY 2010-11 Appropriation	$34,748	0.0	$17,374	$0	$0	$0	$17,374
FY11 Total Available Spending Authority	$34,748	0.0	$17,374	$0	$0	$0	$17,374
FY11 Expenditures	$34,748	0.0	$17,374	$0	$0	$0	$17,374
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$29,652	0.0	$14,826	$0	$0	$0	$14,826
Final FY 2011-12 Appropriation	$29,652	0.0	$14,826	$0	$0	$0	$14,826
FY12 Total Available Spending Authority	$29,652	0.0	$14,826	$0	$0	$0	$14,826
FY12 Expenditures	$29,652	0.0	$14,826	$0	$0	$0	$14,826
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Long Bill Appropriation, HB 12-1335	$30,843	0.0	$15,422	$0	$0	$0	$15,421
FY 2012-13 Total Appropriation	**$30,843**	**0.0**	**$15,422**	**$0**	**$0**	**$0**	**$15,421**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$30,843	0.0	$15,422	$0	$0	$0	$15,421
FY14 Common Policy Adjustment	$16,077	0.0	$8,039	$0	$0	$0	$8,038
FY 2013-14 Base Request	**$46,920**	**0.0**	**$23,461**	**$0**	**$0**	**$0**	**$23,459**
FY 2013-14 Total Request	**$46,920**	**0.0**	**$23,461**	**$0**	**$0**	**$0**	**$23,459**
(A) General Administration, Operating Expenses							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$1,587,445	0.0	$660,958	$0	$120,297	$13,461	$792,729
SB 10-167, Medicaid Efficiency & False Claims, FY11	$39,340	0.0	$19,670	$0	$0	$0	$19,670
Final FY 2010-11 Appropriation	$1,626,785	0.0	$680,628	$0	$120,297	$13,461	$812,399
FY11 Total Available Spending Authority	$1,626,785	0.0	$680,628	$0	$120,297	$13,461	$812,399
FY11 Expenditures	$1,345,966	0.0	$652,128	$0	$15,244	$0	$678,594
FY 2010-11 Reversion \ (Overexpenditure)	$280,819	0.0	$28,500	$0	$105,053	$13,461	$133,805
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$1,580,579	0.0	$677,168	$0	$101,248	$13,461	$788,702
SB 11-177, Repeal Sunset Teen Pregnancy & Dropout Program, FY12	$5,653	0.0	$2,826	$0	$0	$0	$2,827
Long Bill Add-ons, HB 12-1335, FY12	($475)	0.0	($238)	$0	$0	$0	($237)
Final FY 2011-12 Appropriation	$1,585,757	0.0	$679,756	$0	$101,248	$13,461	$791,292
FY12 Total Available Spending Authority	$1,585,757	0.0	$679,756	$0	$101,248	$13,461	$791,292
FY12 Expenditures	$1,503,581	0.0	$677,693	$0	$71,657	$0	$754,231
FY 2011-12 Reversion \ (Overexpenditure)	$82,176	0.0	$2,063	$0	$29,591	$13,461	$37,061

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$1,555,016	0.0	$712,585	$0	$53,049	$13,461	$775,921
HB 12-1281, Medicaid Payment Reform Pilot Program, FY13	$5,541	0.0	$2,771	$0	$0	$0	$2,770
HB 12-1339, Colorado Benefits Management System Project, FY13	$64,796	0.0	$0	$0	$0	$64,796	$0
FY 2012-13 Total Appropriation	**$1,625,353**	**0.0**	**$715,356**	**$0**	**$53,049**	**$78,257**	**$778,691**
FY13 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY13 Operating allocation	**$1,625,353**	**0.0**	**$715,356**	**$0**	**$53,049**	**$78,257**	**$778,691**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$1,625,353	0.0	$715,356	$0	$53,049	$78,257	$778,691
HB 12-1281, Medicaid Payment Reform Pilot Program, FY14	($4,591)	0.0	($2,295)	$0	$0	$0	($2,296)
HB 12-1339, Colorado Benefits Management System Project, FY14	($54,347)	0.0	$0	$0	$0	($54,347)	$0
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($9,406)	0.0	($4,703)	$0	$0	$0	($4,703)
FY 2013-14 Base Request	**$1,557,009**	**0.0**	**$708,358**	**$0**	**$53,049**	**$23,910**	**$771,692**
R#6: "Additional FTE to Restore Functionality"	$41,832	0.0	$20,916	$0	$0	$0	$20,916
R#8: "Medicaid Dental Benefit for Adults"	$10,514	0.0	$0	$0	$5,257	$0	$5,257
R#11: "HB 12-1281 Departmental Differences Reconciliation"	($1,741)	0.0	($870)	$0	$0	$0	($871)
FY 2013-14 Total Request	**$1,607,614**	**0.0**	**$728,404**	**$0**	**$58,306**	**$23,910**	**$796,994**
FY14 Personal Services allocation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY14 Operating allocation	**$1,607,614**	**0.0**	**$728,404**	**$0**	**$58,306**	**$23,910**	**$796,994**
(A) General Administration, Legal Services							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$872,590	0.0	$337,174	$0	$99,121	$0	$436,295
Final FY 2010-11 Appropriation	$872,590	0.0	$337,174	$0	$99,121	$0	$436,295
FY11 Total Available Spending Authority	$872,590	0.0	$337,174	$0	$99,121	$0	$436,295
FY11 Expenditures	$816,265	0.0	$316,867	$0	$89,525	$0	$409,873
FY 2010-11 Reversion \ (Overexpenditure)	$56,325	0.0	$20,307	$0	$9,596	$0	$26,422

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$956,823	0.0	$347,930	$0	$130,482	$0	$478,411
Final FY 2011-12 Appropriation	$956,823	0.0	$347,930	$0	$130,482	$0	$478,411
FY12 Total Available Spending Authority	$956,823	0.0	$347,930	$0	$130,482	$0	$478,411
FY12 Expenditures	$903,975	0.0	$334,195	$0	$123,284	$0	$446,496
FY 2011-12 Reversion \ (Overexpenditure)	$52,848	0.0	$13,735	$0	$7,198	$0	$31,915
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$1,049,982	0.0	$355,006	$0	$169,986	$0	$524,990
FY 2012-13 Total Appropriation	**$1,049,982**	**0.0**	**$355,006**	**$0**	**$169,986**	**$0**	**$524,990**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$1,049,982	0.0	$355,006	$0	$169,986	$0	$524,990
FY 2013-14 Base Request	**$1,049,982**	**0.0**	**$355,006**	**$0**	**$169,986**	**$0**	**$524,990**
FY 2013-14 Total Request	**$1,049,982**	**0.0**	**$355,006**	**$0**	**$169,986**	**$0**	**$524,990**
(A) General Administration, Administrative Law Judge Services							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$442,378	0.0	$206,884	$0	$14,305	$0	$221,189
Final FY 2010-11 Appropriation	$442,378	0.0	$206,884	$0	$14,305	$0	$221,189
FY11 Total Available Spending Authority	$442,378	0.0	$206,884	$0	$14,305	$0	$221,189
FY11 Expenditures	$442,378	0.0	$206,884	$0	$14,305	$0	$221,189
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$422,830	0.0	$186,717	$0	$24,698	$0	$211,415
Supplemental Appropriation, HB 12-1184, FY12	$26,297	0.0	$13,148	$0	$0	$0	$13,149
Final FY 2011-12 Appropriation	$449,127	0.0	$199,865	$0	$24,698	$0	$224,564
FY12 Total Available Spending Authority	$449,127	0.0	$199,865	$0	$24,698	$0	$224,564
FY12 Expenditures	$449,127	0.0	$199,865	$0	$24,698	$0	$224,564
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$510,957	0.0	$212,115	$0	$43,364	$0	$255,478
FY 2012-13 Total Appropriation	**$510,957**	**0.0**	**$212,115**	**$0**	**$43,364**	**$0**	**$255,478**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$510,957	0.0	$212,115	$0	$43,364	$0	$255,478

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY14 Common Policy Adjustment	$21,211	0.0	$10,606	$0	$0	$0	$10,605
FY 2013-14 Base Request	**$532,168**	**0.0**	**$222,721**	**$0**	**$43,364**	**$0**	**$266,083**
FY 2013-14 Total Request	**$532,168**	**0.0**	**$222,721**	**$0**	**$43,364**	**$0**	**$266,083**
(A) General Administration, Purchases of Services from Computer Center							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$298,386	0.0	$145,856	$0	$0	$3,337	$149,193
Final FY 2010-11 Appropriation	$298,386	0.0	$145,856	$0	$0	$3,337	$149,193
FY11 Total Available Spending Authority	$298,386	0.0	$145,856	$0	$0	$3,337	$149,193
FY11 Expenditures	$298,151	0.0	$145,739	$0	$0	$3,337	$149,075
FY 2010-11 Reversion \ (Overexpenditure)	$235	0.0	$117	$0	$0	$0	$118
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$835,843	0.0	$414,566	$0	$0	$3,375	$417,902
Final FY 2011-12 Appropriation	$835,843	0.0	$414,566	$0	$0	$3,375	$417,902
FY12 Total Available Spending Authority	$835,843	0.0	$414,566	$0	$0	$3,375	$417,902
FY12 Expenditures	$835,844	0.0	$414,547	$0	$0	$3,375	$417,922
FY 2011-12 Reversion \ (Overexpenditure)	($1)	0.0	$19	$0	$0	$0	($20)
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$1,001,906	0.0	$496,930	$0	$0	$4,046	$500,930
FY 2012-13 Total Appropriation	**$1,001,906**	**0.0**	**$496,930**	**$0**	**$0**	**$4,046**	**$500,930**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$1,001,906	0.0	$496,930	$0	$0	$4,046	$500,930
FY14 Common Policy Adjustment	($155,900)	0.0	($81,237)	$0	$0	$0	($74,663)
FY 2013-14 Base Request	**$846,006**	**0.0**	**$415,693**	**$0**	**$0**	**$4,046**	**$426,267**
NP-R#6: "OIT Enterprise Asset Management"	$6,260	0.0	$3,130	$0	$0	$0	$3,130
FY 2013-14 Total Request	**$852,266**	**0.0**	**$418,823**	**$0**	**$0**	**$4,046**	**$429,397**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(A) General Administration, Multiuse Network Payments							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$199,438	0.0	$99,719	$0	$0	$0	$99,719
Final FY 2010-11 Appropriation	$199,438	0.0	$99,719	$0	$0	$0	$99,719
FY11 Total Available Spending Authority	$199,438	0.0	$99,719	$0	$0	$0	$99,719
FY11 Expenditures	$160,412	0.0	$80,206	$0	$0	$0	$80,206
FY 2010-11 Reversion \ (Overexpenditure)	$39,026	0.0	$19,513	$0	$0	$0	$19,513
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$227,900	0.0	$113,950	$0	$0	$0	$113,950
Final FY 2011-12 Appropriation	$227,900	0.0	$113,950	$0	$0	$0	$113,950
FY12 Total Available Spending Authority	$227,900	0.0	$113,950	$0	$0	$0	$113,950
FY12 Expenditures	$227,900	0.0	$113,950	$0	$0	$0	$113,950
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$245,162	0.0	$122,581	$0	$0	$0	$122,581
FY 2012-13 Total Appropriation	**$245,162**	**0.0**	**$122,581**	**$0**	**$0**	**$0**	**$122,581**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$245,162	0.0	$122,581	$0	$0	$0	$122,581
FY14 Common Policy Adjustment	($146,281)	0.0	($73,141)	$0	$0	$0	($73,140)
FY 2013-14 Base Request	**$98,881**	**0.0**	**$49,440**	**$0**	**$0**	**$0**	**$49,441**
FY 2013-14 Total Request	**$98,881**	**0.0**	**$49,440**	**$0**	**$0**	**$0**	**$49,441**
(A) General Administration, Management and Administration of OIT							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$624,180	0.0	$312,090	$0	$0	$0	$312,090
Final FY 2010-11 Appropriation	$624,180	0.0	$312,090	$0	$0	$0	$312,090
FY11 Total Available Spending Authority	$624,180	0.0	$312,090	$0	$0	$0	$312,090
FY11 Expenditures	$561,419	0.0	$280,710	$0	$0	$0	$280,709
FY 2010-11 Reversion \ (Overexpenditure)	$62,761	0.0	$31,380	$0	$0	$0	$31,381

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$631,234	0.0	$315,617	$0	$0	$0	$315,617
Final FY 2011-12 Appropriation	$631,234	0.0	$315,617	$0	$0	$0	$315,617
FY12 Total Available Spending Authority	$631,234	0.0	$315,617	$0	$0	$0	$315,617
FY12 Expenditures	$631,234	0.0	$315,617	$0	$0	$0	$315,617
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY14 Common Policy Adjustment	$48,307	0.0	$24,154	$0	$0	$0	$24,153
FY 2013-14 Base Request	**$48,307**	**0.0**	**$24,154**	**$0**	**$0**	**$0**	**$24,153**
FY 2013-14 Total Request	**$48,307**	**0.0**	**$24,154**	**$0**	**$0**	**$0**	**$24,153**
(A) General Administration, COFRS Modernization							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$1,006,098	0.0	$329,397	$0	$173,190	$2,052	$501,459
FY 2012-13 Total Appropriation	**$1,006,098**	**0.0**	**$329,397**	**$0**	**$173,190**	**$2,052**	**$501,459**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$1,006,098	0.0	$329,397	$0	$173,190	$2,052	$501,459
FY14 Common Policy Adjustment	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$1,006,098**	**0.0**	**$329,397**	**$0**	**$173,190**	**$2,052**	**$501,459**
FY 2013-14 Total Request	**$1,006,098**	**0.0**	**$329,397**	**$0**	**$173,190**	**$2,052**	**$501,459**
(A) General Administration, Payment to Risk Management and Property Funds							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$24,418	0.0	$12,209	$0	$0	$0	$12,209
Final FY 2010-11 Appropriation	$24,418	0.0	$12,209	$0	$0	$0	$12,209
FY11 Total Available Spending Authority	$24,418	0.0	$12,209	$0	$0	$0	$12,209
FY11 Expenditures	$24,418	0.0	$12,209	$0	$0	$0	$12,209
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$77,888	0.0	$38,944	$0	$0	$0	$38,944
Final FY 2011-12 Appropriation	$77,888	0.0	$38,944	$0	$0	$0	$38,944
FY12 Total Available Spending Authority	$77,888	0.0	$38,944	$0	$0	$0	$38,944
FY12 Expenditures	$77,888	0.0	$38,944	$0	$0	$0	$38,944
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$84,444	0.0	$42,222	$0	$0	$0	$42,222
FY 2012-13 Total Appropriation	**$84,444**	**0.0**	**$42,222**	**$0**	**$0**	**$0**	**$42,222**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$84,444	0.0	$42,222	$0	$0	$0	$42,222
FY14 Common Policy Adjustment	$45,584	0.0	$22,792	$0	$0	$0	$22,792
FY 2013-14 Base Request	**$130,028**	**0.0**	**$65,014**	**$0**	**$0**	**$0**	**$65,014**
NP-R#5: "Employee Engagement Survey Adjustment"	$3,463	0.0	$1,732	$0	$0	$0	$1,731
FY 2013-14 Total Request	**$133,491**	**0.0**	**$66,746**	**$0**	**$0**	**$0**	**$66,745**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(A) General Administration, Leased Space							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$696,564	0.0	$191,619	$0	$156,664	$0	$348,281
Final FY 2010-11 Appropriation	$696,564	0.0	$191,619	$0	$156,664	$0	$348,281
FY11 Total Available Spending Authority	$696,564	0.0	$191,619	$0	$156,664	$0	$348,281
FY11 Expenditures	$554,505	0.0	$173,962	$0	$103,290	$0	$277,253
FY 2010-11 Reversion \ (Overexpenditure)	$142,059	0.0	$17,657	$0	$53,374	$0	$71,028
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$696,564	0.0	$197,119	$0	$151,164	$0	$348,281
Final FY 2011-12 Appropriation	$696,564	0.0	$197,119	$0	$151,164	$0	$348,281
FY12 Total Available Spending Authority	$696,564	0.0	$197,119	$0	$151,164	$0	$348,281
FY12 Expenditures	$628,141	0.0	$197,846	$0	$116,224	$0	$314,071
FY 2011-12 Reversion \ (Overexpenditure)	$68,423	0.0	($727)	$0	$34,940	$0	$34,210
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$696,564	0.0	$197,119	$0	$151,164	$0	$348,281
FY 2012-13 Total Appropriation	**$696,564**	**0.0**	**$197,119**	**$0**	**$151,164**	**$0**	**$348,281**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$696,564	0.0	$197,119	$0	$151,164	$0	$348,281
FY 2013-14 Base Request	**$696,564**	**0.0**	**$197,119**	**$0**	**$151,164**	**$0**	**$348,281**
R#6: "Additional FTE to Restore Functionality"	$60,870	0.0	$30,435	$0	$0	$0	$30,435
R#10: "Leased Space Rent Increase and True-up"	$92,115	0.0	$92,402	$0	($46,344)	$0	$46,057
FY 2013-14 Total Request	**$849,549**	**0.0**	**$319,956**	**$0**	**$104,820**	**$0**	**$424,773**
(A) General Administration, Capital Complex Leased Space							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$388,228	0.0	$194,114	$0	$0	$0	$194,114
Final FY 2010-11 Appropriation	$388,228	0.0	$194,114	$0	$0	$0	$194,114
FY11 Total Available Spending Authority	$388,228	0.0	$194,114	$0	$0	$0	$194,114
FY11 Expenditures	$388,228	0.0	$194,114	$0	$0	$0	$194,114
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$397,928	0.0	$198,964	$0	$0	$0	$198,964
Final FY 2011-12 Appropriation	$397,928	0.0	$198,964	$0	$0	$0	$198,964
FY12 Total Available Spending Authority	$397,928	0.0	$198,964	$0	$0	$0	$198,964
FY12 Expenditures	$397,925	0.0	$198,962	$0	$0	$0	$198,963
FY 2011-12 Reversion \ (Overexpenditure)	$3	0.0	$2	$0	$0	$0	$1
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$394,600	0.0	$197,300	$0	$0	$0	$197,300
FY 2012-13 Total Appropriation	**$394,600**	**0.0**	**$197,300**	**$0**	**$0**	**$0**	**$197,300**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$394,600	0.0	$197,300	$0	$0	$0	$197,300
FY14 Common Policy Adjustment	$66,736	0.0	$33,368	$0	$0	$0	$33,368
FY 2013-14 Base Request	**$461,336**	**0.0**	**$230,668**	**$0**	**$0**	**$0**	**$230,668**
NP-R#4: "Capitol Complex Building Upgrade, Repair, and Replacement"	$28,985	0.0	$14,493	$0	$0	$0	$14,492
FY 2013-14 Total Request	**$490,321**	**0.0**	**$245,161**	**$0**	**$0**	**$0**	**$245,160**
(A) General Administration, General Professional Services and Special Projects							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$4,316,995	0.0	$1,480,361	$0	$572,500	$0	$2,264,134
HB 10-1027, Medicaid Hospice Life Expectancy, FY11	$25,000	0.0	$0	$0	$12,500	$0	$12,500
HB 10-1053, Medicaid Community Long-term Care Saving, FY11	$75,000	0.0	$0	$0	$37,500	$0	$37,500
SB 10-061, Medicaid Hospice Room And Board Charges, FY11	$102,570	0.0	$0	$0	$51,285	$0	$51,285
Final FY 2010-11 Appropriation	$4,519,565	0.0	$1,480,361	$0	$673,785	$0	$2,365,419
FY11 Federal Grant	$2,000,000	0.0	$0	$0	$0	$0	$2,000,000
FY11 Year-End Transfers	($19,872)	0.0	($9,936)	$0	$0	$0	($9,936)
FY11 Total Available Spending Authority	$6,499,693	0.0	$1,470,425	$0	$673,785	$0	$4,355,483
FY11 Expenditures	$2,963,577	0.0	$1,074,923	$0	$310,465	$0	$1,578,189
FY 2010-11 Reversion \ (Overexpenditure)	$3,536,116	0.0	$395,502	$0	$363,320	$0	$2,777,294

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$6,422,552	0.0	$1,400,918	$0	$665,000	$0	$4,356,634
HB 11-1242, Medicaid Provider Integration Of Service, FY12	$113,500	0.0	$0	$0	$56,750	$0	$56,750
SB 11-125, Nursing Home Fees & Order of Payments, FY12	$60,000	0.0	$30,000	$0	$0	$0	$30,000
Supplemental Appropriation, HB 12-1184, FY12	($120,000)	0.0	$0	$0	($60,000)	$0	($60,000)
Final FY 2011-12 Appropriation	$6,476,052	0.0	$1,430,918	$0	$661,750	$0	$4,383,384
FY12 Total Available Spending Authority	$6,476,052	0.0	$1,430,918	$0	$661,750	$0	$4,383,384
FY12 Expenditures	$3,971,819	0.0	$1,094,416	$0	$449,206	$0	$2,428,197
FY 2011-12 Reversion \ (Overexpenditure)	$2,504,233	0.0	$336,502	$0	$212,544	$0	$1,955,187
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$5,780,552	0.0	$1,232,418	$0	$437,500	$0	$4,110,634
HB 12-1281, Medicaid Payment Reform Pilot Program, FY13	$160,000	0.0	$80,000	$0	$0	$0	$80,000
FY 2012-13 Total Appropriation	**$5,940,552**	**0.0**	**$1,312,418**	**$0**	**$437,500**	**$0**	**$4,190,634**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$5,940,552	0.0	$1,312,418	$0	$437,500	$0	$4,190,634
HB 12-1281, Medicaid Payment Reform Pilot Program, FY14	($100,000)	0.0	($50,000)	$0	$0	$0	($50,000)
SB 12-159, Evaluation Children With Autism Medicaid Waiver, FY14	$62,000	0.0	$0	$0	$31,000	$0	$31,000
FY 2013-14 Base Request	**$5,902,552**	**0.0**	**$1,262,418**	**$0**	**$468,500**	**$0**	**$4,171,634**
R#7: "Substance Use Disorder Benefit"	$100,000	0.0	$50,000	$0	$0	$0	$50,000
R#11: "HB 12-1281 Departmental Differences Reconciliation"	$390,000	0.0	$195,000	$0	$0	$0	$195,000
R#12: "Customer Service Technology Improvements"	$1,800,000	0.0	$900,000	$0	$0	$0	$900,000
FY 2013-14 Total Request	**$8,192,552**	**0.0**	**$2,407,418**	**$0**	**$468,500**	**$0**	**$5,316,634**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(A) General Administration, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$31,929,199	287.8	$11,921,482	$0	$2,881,369	$576,889	$16,549,459
HB 10-1027, Medicaid Hospice Life Expectancy, FY11	$25,000	0.0	$0	$0	$12,500	$0	$12,500
HB 10-1053, Medicaid Community Long-term Care Saving, FY11	$75,000	0.0	$0	$0	$37,500	$0	$37,500
SB 10-061, Medicaid Hospice Room And Board Charges, FY11	$102,570	0.0	$0	$0	$51,285	$0	$51,285
SB 10-167, Medicaid Efficiency & False Claims, FY11	$486,458	7.0	$243,229	$0	$0	$0	$243,229
Supplemental Appropriation, SB 11-139, FY11	($80,422)	0.0	($76,146)	$0	$0	($4,276)	$0
Final FY 2010-11 Appropriation	$32,537,805	294.8	$12,088,565	$0	$2,982,654	$572,613	$16,893,973
FY11 Federal Grant	$2,000,000	0.0	$0	$0	$0	$0	$2,000,000
FY11 Total Available Spending Authority	$34,537,805	294.8	$12,088,565	$0	$2,982,654	$572,613	$18,893,973
FY11 Expenditures	$29,035,234	270.6	$11,586,438	$0	$2,088,478	$559,152	$14,801,166
FY 2010-11 Reversion \ (Overexpenditure)	$5,502,571	24.2	$502,127	$0	$894,176	$13,461	$4,092,807
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$37,072,812	312.2	$12,707,009	$0	$3,480,903	$465,125	$20,419,775
HB 11-1242, Medicaid Provider Integration Of Service, FY12	$113,500	0.0	$0	$0	$56,750	$0	$56,750
SB 11-076, PERA Contribution Rates, FY12	($508,843)	0.0	($166,362)	$0	($56,118)	$0	($286,363)
SB 11-125, Nursing Home Fees & Order of Payments, FY12	$60,000	0.0	$30,000	$0	$0	$0	$30,000
SB 11-177, Repeal Sunset Teen Pregnancy & Dropout Program, FY12	$53,470	1.0	$26,735	$0	$0	$0	$26,735
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	($24,363)	(0.2)	$0	$0	($24,363)	$0	$0
Supplemental Appropriation, HB 12-1184, FY12	($93,703)	0.0	$13,148	$0	($60,000)	$0	($46,851)
Long Bill Add-ons, HB 12-1335, FY12	($32,168)	(0.5)	($16,085)	$0	$0	$0	($16,083)
Final FY 2011-12 Appropriation	$36,640,705	312.5	$12,594,445	$0	$3,397,172	$465,125	$20,183,963
FY12 Total Available Spending Authority	$36,640,705	312.5	$12,594,445	$0	$3,397,172	$465,125	$20,183,963
FY12 Expenditures	$33,283,634	293.4	$12,310,704	$0	$2,509,382	$451,664	$18,011,884
FY 2011-12 Reversion \ (Overexpenditure)	$3,357,071	19.1	$283,741	$0	$887,790	$13,461	$2,172,079

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$37,544,571	314.3	$13,163,355	$0	$3,343,424	$447,329	$20,590,463
HB 12-1246, Reverse Payday Shift State Employees Paid	$28,498	0.0	$28,498	$0	$0	$0	$0
HB 12-1281, Medicaid Payment Reform Pilot Program, FY13	$213,079	0.8	$106,540	$0	$0	$0	$106,539
HB 12-1339, Colorado Benefits Management System Project,	$997,655	11.0	$0	$0	$0	$997,655	$0
SB 12-060, Improve Medicaid Fraud Prosecution, FY13	$5,216	0.1	$2,608	$0	$0	$0	$2,608
FY 2012-13 Total Appropriation	**$38,789,019**	**326.2**	**$13,301,001**	**$0**	**$3,343,424**	**$1,444,984**	**$20,699,610**
FY13 Personal Services allocation	**$22,593,922**	**326.2**	**$7,971,021**	**$0**	**$2,038,599**	**$1,176,645**	**$11,407,657**
FY13 Operating allocation	**$1,625,353**	**0.0**	**$715,356**	**$0**	**$53,049**	**$78,257**	**$778,691**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$38,789,019	326.2	$13,301,001	$0	$3,343,424	$1,444,984	$20,699,610
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY14	($28,498)	0.0	($28,498)	$0	$0	$0	$0
HB 12-1281, Medicaid Payment Reform Pilot Program, FY14	($88,744)	0.2	($44,371)	$0	$0	$0	($44,373)
HB 12-1339, Colorado Benefits Management System Project, FY14	($186,797)	0.0	$0	$0	$0	($186,797)	$0
SB 12-159, Evaluation Children With Autism Medicaid Waiver, FY14	$62,000	0.0	$0	$0	$31,000	$0	$31,000
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$7,498	0.2	$3,749	$0	$0	$0	$3,749
FY14 Statewide Indirect Cost Allocation	$1,160,738	0.0	$1,190,879	$0	$38,481	$10,784	($79,406)
FY14 Common Policy Adjustment	$1,058,695	0.0	$216,982	$0	$76,772	($63,133)	$828,074
FY 2013-14 Base Request	**$40,773,911**	**326.6**	**$14,639,742**	**$0**	**$3,489,677**	**$1,205,838**	**$21,438,654**
R#6: "Additional FTE to Restore Functionality"	$704,341	7.4	$352,172	$0	$0	$0	$352,169
R#7: "Substance Use Disorder Benefit"	$100,000	0.0	$50,000	$0	$0	$0	$50,000
R#8: "Medicaid Dental Benefit for Adults"	$93,091	1.2	$0	$0	$46,546	$0	$46,545
R#10: "Leased Space Rent Increase and True-up"	$92,115	0.0	$92,402	$0	($46,344)	$0	$46,057
R#11: "HB 12-1281 Departmental Differences Reconciliation"	$626,673	3.0	$313,337	$0	$0	$0	$313,336
R#12: "Customer Service Technology Improvements"	$1,800,000	0.0	$900,000	$0	$0	$0	$900,000

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
NP-R#4: "Capitol Complex Building Upgrade, Repair, and Replacement"	$28,985	0.0	$14,493	$0	$0	$0	$14,492
NP-R#5: "Employee Engagement Survey Adjustment"	$3,463	0.0	$1,732	$0	$0	$0	$1,731
NP-R#6: "OIT Enterprise Asset Management"	$6,260	0.0	$3,130	$0	$0	$0	$3,130
FY 2013-14 Total Request	**$44,228,839**	**338.2**	**$16,367,008**	**$0**	**$3,489,879**	**$1,205,838**	**$23,166,114**
FY14 Personal Services allocation	**$24,490,598**	**338.2**	**$9,533,270**	**$0**	**$2,118,369**	**$1,069,555**	**$11,769,404**
FY14 Operating allocation	**$1,607,614**	**0.0**	**$728,404**	**$0**	**$58,306**	**$23,910**	**$796,994**
(B) Transfers to Other Departments, Transfer to Department of Public Health and Environment Facility for Survey and Certification							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$4,917,090	0.0	$1,475,127	$0	$0	$0	$3,441,963
Supplemental Appropriation, SB 11-139, FY11	($36,092)	0.0	($12,632)	$0	$0	$0	($23,460)
Final FY 2010-11 Appropriation	$4,880,998	0.0	$1,462,495	$0	$0	$0	$3,418,503
FY11 Total Available Spending Authority	$4,880,998	0.0	$1,462,495	$0	$0	$0	$3,418,503
FY11 Expenditures	$4,707,033	0.0	$1,443,433	$0	$0	$0	$3,263,600
FY 2010-11 Reversion \ (Overexpenditure)	$173,965	0.0	$19,062	$0	$0	$0	$154,903
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$5,024,611	0.0	$1,567,498	$0	$0	$0	$3,457,113
SB 11-076, PERA Contribution Rates, FY12	($79,170)	0.0	($27,710)	$0	$0	$0	($51,460)
Supplemental Appropriation, HB 12-1184, FY12	$217,047	0.0	$0	$0	$0	$0	$217,047
Final FY 2011-12 Appropriation	$5,162,488	0.0	$1,539,788	$0	$0	$0	$3,622,700
FY12 Total Available Spending Authority	$5,162,488	0.0	$1,539,788	$0	$0	$0	$3,622,700
FY12 Expenditures	$4,671,998	0.0	$1,438,076	$0	$0	$0	$3,233,922
FY 2011-12 Reversion \ (Overexpenditure)	$490,490	0.0	$101,712	$0	$0	$0	$388,778
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$5,205,465	0.0	$1,568,883	$0	$0	$0	$3,636,582
FY 2012-13 Total Appropriation	**$5,205,465**	**0.0**	**$1,568,883**	**$0**	**$0**	**$0**	**$3,636,582**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$5,205,465	0.0	$1,568,883	$0	$0	$0	$3,636,582
HB 12-1268, Health Facility Safety Inspection Transfer To CDPS, FY14	($292,124)	0.0	($99,114)	$0	$0	$0	($193,010)
FY14 Common Policy Adjustment	$122,934	0.0	$46,441	$0	$0	$0	$76,493
FY 2013-14 Base Request	**$5,036,275**	**0.0**	**$1,516,210**	**$0**	**$0**	**$0**	**$3,520,065**
FY 2013-14 Total Request	**$5,036,275**	**0.0**	**$1,516,210**	**$0**	**$0**	**$0**	**$3,520,065**
(B) Transfers to Other Departments, Transfer to Department of Public Safety for Life Safety Code Inspections for Health Facilities							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
HB 12-1268, Health Facility Safety Inspection Transfer To CDPS, FY14	$336,639	0.0	$114,694	$0	$0	$0	$221,945
FY 2013-14 Base Request	**$336,639**	**0.0**	**$114,694**	**$0**	**$0**	**$0**	**$221,945**
FY 2013-14 Total Request	**$336,639**	**0.0**	**$114,694**	**$0**	**$0**	**$0**	**$221,945**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(B) Transfers to Other Departments, Transfer to Department of Public Health and Environment for Nurse Home Visitor Program							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$3,010,000	0.0	$0	$0	$0	$1,156,141	$1,853,859
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$0	$0	$0	$56,588	($56,588)
Final FY 2010-11 Appropriation	$3,010,000	0.0	$0	$0	$0	$1,212,729	$1,797,271
FY11 Total Available Spending Authority	$3,010,000	0.0	$0	$0	$0	$1,212,729	$1,797,271
FY11 Expenditures	$1,064,517	0.0	$0	$0	$0	$429,287	$635,230
FY 2010-11 Reversion \ (Overexpenditure)	$1,945,483	0.0	$0	$0	$0	$783,442	$1,162,041
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$3,010,000	0.0	$0	$0	$0	$1,505,000	$1,505,000
Final FY 2011-12 Appropriation	$3,010,000	0.0	$0	$0	$0	$1,505,000	$1,505,000
FY12 Total Available Spending Authority	$3,010,000	0.0	$0	$0	$0	$1,505,000	$1,505,000
FY12 Expenditures	$1,001,532	0.0	$0	$0	$0	$500,766	$500,766
FY 2011-12 Reversion \ (Overexpenditure)	$2,008,468	0.0	$0	$0	$0	$1,004,234	$1,004,234
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$3,010,000	0.0	$0	$0	$0	$1,505,000	$1,505,000
FY 2012-13 Total Appropriation	**$3,010,000**	**0.0**	**$0**	**$0**	**$0**	**$1,505,000**	**$1,505,000**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$3,010,000	0.0	$0	$0	$0	$1,505,000	$1,505,000
FY 2013-14 Base Request	**$3,010,000**	**0.0**	**$0**	**$0**	**$0**	**$1,505,000**	**$1,505,000**
FY 2013-14 Total Request	**$3,010,000**	**0.0**	**$0**	**$0**	**$0**	**$1,505,000**	**$1,505,000**
(B) Transfers to Other Departments, Transfer to Department of Public Health and Environment for Prenatal Statistical Information							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Long Bill Appropriation,SB 11-209	$6,000	0.0	$3,000	$0	$0	$0	$3,000
Final FY 2011-12 Appropriation	$6,000	0.0	$3,000	$0	$0	$0	$3,000
FY12 Total Available Spending Authority	$6,000	0.0	$3,000	$0	$0	$0	$3,000
FY 2011-12 Reversion \ (Overexpenditure)	$6,000	0.0	$3,000	$0	$0	$0	$3,000
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$5,887	0.0	$2,944	$0	$0	$0	$2,943
FY 2012-13 Total Appropriation	**$5,887**	**0.0**	**$2,944**	**$0**	**$0**	**$0**	**$2,943**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$5,887	0.0	$2,944	$0	$0	$0	$2,943
FY 2013-14 Base Request	**$5,887**	**0.0**	**$2,944**	**$0**	**$0**	**$0**	**$2,943**
FY 2013-14 Total Request	**$5,887**	**0.0**	**$2,944**	**$0**	**$0**	**$0**	**$2,943**
(B) Transfers to Other Departments, Transfer to Department of Public Health and Environment for Enhanced Prenatal Care Training and Technical Assistance							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$119,006	0.0	$58,752	$0	$0	$0	$60,254
Supplemental Appropriation, SB 11-139, FY11	($779)	0.0	($390)	$0	$0	$0	($389)
Final FY 2010-11 Appropriation	$118,227	0.0	$58,362	$0	$0	$0	$59,865
FY11 Total Available Spending Authority	$118,227	0.0	$58,362	$0	$0	$0	$59,865
FY11 Expenditures	$82,286	0.0	$41,143	$0	$0	$0	$41,143
FY 2010-11 Reversion \ (Overexpenditure)	$35,941	0.0	$17,219	$0	$0	$0	$18,722
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14

Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
(B) Transfers to Other Departments, Transfers to the Department of Regulatory Agencies for Nurse Aide Certification							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$325,343	0.0	$148,020	$0	$0	$14,652	$162,671
Final FY 2010-11 Appropriation	$325,343	0.0	$148,020	$0	$0	$14,652	$162,671
FY11 Total Available Spending Authority	$325,343	0.0	$148,020	$0	$0	$14,652	$162,671
FY11 Expenditures	$325,343	0.0	$148,020	$0	$0	$14,652	$162,671
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$324,041	0.0	$147,369	$0	$0	$14,652	$162,020
Final FY 2011-12 Appropriation	$324,041	0.0	$147,369	$0	$0	$14,652	$162,020
FY12 Total Available Spending Authority	$324,041	0.0	$147,369	$0	$0	$14,652	$162,020
FY12 Expenditures	$324,041	0.0	$147,369	$0	$0	$14,652	$162,020
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$324,041	0.0	$147,369	$0	$0	$14,652	$162,020
FY 2012-13 Total Appropriation	**$324,041**	**0.0**	**$147,369**	**$0**	**$0**	**$14,652**	**$162,020**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$324,041	0.0	$147,369	$0	$0	$14,652	$162,020
FY 2013-14 Base Request	**$324,041**	**0.0**	**$147,369**	**$0**	**$0**	**$14,652**	**$162,020**
FY 2013-14 Total Request	**$324,041**	**0.0**	**$147,369**	**$0**	**$0**	**$14,652**	**$162,020**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(B) Transfers to Other Departments, Transfers to the Department of Regulatory Agencies for Reviews							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$14,000	0.0	$6,500	$0	$500	$0	$7,000
Final FY 2010-11 Appropriation	$14,000	0.0	$6,500	$0	$500	$0	$7,000
FY11 Total Available Spending Authority	$14,000	0.0	$6,500	$0	$500	$0	$7,000
FY11 Expenditures	$5,998	0.0	$2,999	$0	$0	$0	$2,999
FY 2010-11 Reversion \ (Overexpenditure)	$8,002	0.0	$3,501	$0	$500	$0	$4,001
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$14,000	0.0	$7,000	$0	$0	$0	$7,000
Final FY 2011-12 Appropriation	$14,000	0.0	$7,000	$0	$0	$0	$7,000
FY12 Total Available Spending Authority	$14,000	0.0	$7,000	$0	$0	$0	$7,000
FY 2011-12 Reversion \ (Overexpenditure)	$14,000	0.0	$7,000	$0	$0	$0	$7,000
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$14,000	0.0	$7,000	$0	$0	$0	$7,000
FY 2012-13 Total Appropriation	**$14,000**	**0.0**	**$7,000**	**$0**	**$0**	**$0**	**$7,000**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$14,000	0.0	$7,000	$0	$0	$0	$7,000
FY 2013-14 Base Request	**$14,000**	**0.0**	**$7,000**	**$0**	**$0**	**$0**	**$7,000**
FY 2013-14 Total Request	**$14,000**	**0.0**	**$7,000**	**$0**	**$0**	**$0**	**$7,000**
(B) Transfers to Other Departments, Transfer to Department of Education for Public School Health Services Administration							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$150,388	0.0	$0	$0	$0	$0	$150,388
Final FY 2010-11 Appropriation	$150,388	0.0	$0	$0	$0	$0	$150,388
FY11 Total Available Spending Authority	$150,388	0.0	$0	$0	$0	$0	$150,388
FY11 Expenditures	$71,662	0.0	$0	$0	$0	$0	$71,662
FY 2010-11 Reversion \ (Overexpenditure)	$78,726	0.0	$0	$0	$0	$0	$78,726

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$142,073	0.0	$0	$0	$0	$0	$142,073
SB 11-076, PERA Contribution Rates, FY12	($1,685)	0.0	$0	$0	$0	$0	($1,685)
Final FY 2011-12 Appropriation	$140,388	0.0	$0	$0	$0	$0	$140,388
FY12 Total Available Spending Authority	$140,388	0.0	$0	$0	$0	$0	$140,388
FY12 Expenditures	$139,649	0.0	$0	$0	$0	$0	$139,649
FY 2011-12 Reversion \ (Overexpenditure)	$739	0.0	$0	$0	$0	$0	$739
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$139,940	0.0	$0	$0	$0	$0	$139,940
FY 2012-13 Total Appropriation	**$139,940**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$139,940**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$139,940	0.0	$0	$0	$0	$0	$139,940
Technical correction to align with CDE appropriation	$2,133	0.0	$0	$0	$0	$0	$2,133
FY 2013-14 Base Request	**$142,073**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$142,073**
FY 2013-14 Total Request	**$142,073**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$142,073**
(B) Transfers to Other Departments, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$8,535,827	0.0	$1,688,399	$0	$500	$1,170,793	$5,676,135
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$0	$0	$0	$56,588	($56,588)
Supplemental Appropriation, SB 11-139, FY11	($36,871)	0.0	($13,022)	$0	$0	$0	($23,849)
Final FY 2010-11 Appropriation	$8,498,956	0.0	$1,675,377	$0	$500	$1,227,381	$5,595,698
FY11 Total Available Spending Authority	$8,498,956	0.0	$1,675,377	$0	$500	$1,227,381	$5,595,698
FY11 Expenditures	$6,256,839	0.0	$1,635,595	$0	$0	$443,939	$4,177,305
FY 2010-11 Reversion \ (Overexpenditure)	$2,242,117	0.0	$39,782	$0	$500	$783,442	$1,418,393
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$8,520,725	0.0	$1,724,867	$0	$0	$1,519,652	$5,276,206
SB 11-076, PERA Contribution Rates, FY12	($80,855)	0.0	($27,710)	$0	$0	$0	($53,145)
Supplemental Appropriation, HB 12-1184, FY12	$217,047	0.0	$0	$0	$0	$0	$217,047
Final FY 2011-12 Appropriation	$8,656,917	0.0	$1,697,157	$0	$0	$1,519,652	$5,440,108
FY12 Total Available Spending Authority	$8,656,917	0.0	$1,697,157	$0	$0	$1,519,652	$5,440,108
FY12 Expenditures	$6,137,220	0.0	$1,585,445	$0	$0	$515,418	$4,036,357
FY 2011-12 Reversion \ (Overexpenditure)	$2,519,697	0.0	$111,712	$0	$0	$1,004,234	$1,403,751

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$8,699,333	0.0	$1,726,196	$0	$0	$1,519,652	$5,453,485
FY 2012-13 Total Appropriation	**$8,699,333**	**0.0**	**$1,726,196**	**$0**	**$0**	**$1,519,652**	**$5,453,485**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$8,699,333	0.0	$1,726,196	$0	$0	$1,519,652	$5,453,485
HB 12-1268, Health Facility Safety Inspection Transfer To CDPS, FY14	$44,515	0.0	$15,580	$0	$0	$0	$28,935
Technical correction to align with CDE appropriation	$2,133	0.0	$0	$0	$0	$0	$2,133
FY 2013-14 Base Request	**$8,868,915**	**0.0**	**$1,788,217**	**$0**	**$0**	**$1,519,652**	**$5,561,046**
FY 2013-14 Total Request	**$8,868,915**	**0.0**	**$1,788,217**	**$0**	**$0**	**$1,519,652**	**$5,561,046**
(C) Information Technology Contracts and Projects, Information Technology Contracts							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$33,911,866	0.0	$5,973,827	$0	$2,433,429	$100,328	$25,404,282
SB 10-167, Medicaid Efficiency & False Claims, FY11	$641,903	0.0	$160,476	$0	$0	$0	$481,427
Supplemental Appropriation, SB 11-139, FY11	($211,316)	0.0	($96,766)	$0	$0	$0	($114,550)
Final FY 2010-11 Appropriation	$34,342,453	0.0	$6,037,537	$0	$2,433,429	$100,328	$25,771,159
FY11 Total Available Spending Authority	$34,342,453	0.0	$6,037,537	$0	$2,433,429	$100,328	$25,771,159
FY11 Expenditures	$23,713,491	0.0	$5,498,109	$0	$642,824	$100,328	$17,472,230
FY 2010-11 Reversion \ (Overexpenditure)	$10,628,962	0.0	$539,428	$0	$1,790,605	$0	$8,298,929
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$32,412,990	0.0	$6,581,901	$0	$1,479,670	$100,328	$24,251,091
Final FY 2011-12 Appropriation	$32,412,990	0.0	$6,581,901	$0	$1,479,670	$100,328	$24,251,091
FY12 Roll-forward	$4,558,926	0.0	$0	$487,762	$271,905	$0	$3,799,259
FY12 Total Available Spending Authority	$36,971,916	0.0	$6,581,901	$487,762	$1,751,575	$100,328	$28,050,350
FY12 Expenditures	$29,272,031	0.0	$6,054,212	$0	$1,269,332	$92,163	$21,856,324
FY 2011-12 Reversion \ (Overexpenditure)	$7,699,885	0.0	$527,689	$487,762	$482,243	$8,165	$6,194,026
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$31,899,317	0.0	$6,379,650	$0	$1,566,666	$100,328	$23,852,673
FY 2012-13 Total Appropriation	**$31,899,317**	**0.0**	**$6,379,650**	**$0**	**$1,566,666**	**$100,328**	**$23,852,673**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$31,899,317	0.0	$6,379,650	$0	$1,566,666	$100,328	$23,852,673
HB 09-1293, Health Care Affordability Act of 2009, FY14	$1,204,749	0.0	$0	$0	$301,187	$0	$903,562
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	($6,930)	0.0	($1,733)	$0	$0	$0	($5,197)
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	($6,930)	0.0	($1,681)	$0	($73)	$0	($5,176)
Annualization of FY 2009-10 BA#16: "MMIS Funding for HIPAA and Transitions v5010/D.0"	($546,020)	0.0	($58,697)	$0	$0	$0	($487,323)
Annualization of FY 2010-11 BA#12: "Evidence Guided Utilization Review"	($627,984)	0.0	($156,996)	$0	$0	$0	($470,988)
Annualization of FY 2010-11 BA#15: "MMIS Adjustments"	($1,364,572)	0.0	($143,953)	$0	$0	$0	($1,220,619)
Annualization of FY 2012-13 BA#6: "MMIS Technical Adjustments"	($965,033)	0.0	$0	$0	($206,927)	$0	($758,106)
FY 2013-14 Base Request	**$29,586,597**	**0.0**	**$6,016,590**	**$0**	**$1,660,853**	**$100,328**	**$21,808,826**
R#8: "Medicaid Dental Benefit for Adults"	$1,707,678	0.0	$0	$0	$426,919	$0	$1,280,759
R#9: "Dental ASO for Children"	$1,152,144		$288,036	$0	$0	$0	$864,108
FY 2013-14 Total Request	**$32,446,419**	**0.0**	**$6,304,626**	**$0**	**$2,087,772**	**$100,328**	**$23,953,693**
Current Roll-forward reporting requirements result in overstated reversions of $4,558,926 TF in FY 2010-11 and overstated spending authority of $4,558,926 TF in FY 2011-12.							
(C) Information Technology Contracts and Projects, MMIS Reprocurement Contracts (new line item)							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
R#5: "Medicaid Management Information System Reprocurement"	$12,625,032	0.0	$1,165,817	$0	$232,837	$0	$11,226,378
FY 2013-14 Total Request	**$12,625,032**	**0.0**	**$1,165,817**	**$0**	**$232,837**	**$0**	**$11,226,378**
(C) Information Technology Contracts and Projects, MMIS Reprocurement Contracted Staff (new line item)							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
R#5: "Medicaid Management Information System Reprocurement"	$2,999,371	0.0	$273,255	$0	$54,997	$0	$2,671,119
FY 2013-14 Total Request	**$2,999,371**	**0.0**	**$273,255**	**$0**	**$54,997**	**$0**	**$2,671,119**

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(C) Information Technology Contracts and Projects, Fraud Detection Software Contract							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$250,000	0.0	$62,500	$0	$0	$0	$187,500
Final FY 2010-11 Appropriation	$250,000	0.0	$62,500	$0	$0	$0	$187,500
FY11 Total Available Spending Authority	$250,000	0.0	$62,500	$0	$0	$0	$187,500
FY11 Expenditures	$164,833	0.0	$41,208	$0	$0	$0	$123,625
FY 2010-11 Reversion \ (Overexpenditure)	$85,167	0.0	$21,292	$0	$0	$0	$63,875
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$250,000	0.0	$62,500	$0	$0	$0	$187,500
Final FY 2011-12 Appropriation	$250,000	0.0	$62,500	$0	$0	$0	$187,500
FY12 Total Available Spending Authority	$250,000	0.0	$62,500	$0	$0	$0	$187,500
FY12 Expenditures	$208,931	0.0	$54,565	$0	$0	$0	$154,366
FY 2011-12 Reversion \ (Overexpenditure)	$41,069	0.0	$7,935	$0	$0	$0	$33,134
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$250,000	0.0	$62,500	$0	$0	$0	$187,500
FY 2012-13 Total Appropriation	**$250,000**	**0.0**	**$62,500**	**$0**	**$0**	**$0**	**$187,500**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$250,000	0.0	$62,500	$0	$0	$0	$187,500
FY 2013-14 Base Request	**$250,000**	**0.0**	**$62,500**	**$0**	**$0**	**$0**	**$187,500**
FY 2013-14 Total Request	**$250,000**	**0.0**	**$62,500**	**$0**	**$0**	**$0**	**$187,500**
(C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$760,000	0.0	$0	$0	$366,320	$0	$393,680
Final FY 2010-11 Appropriation	$760,000	0.0	$0	$0	$366,320	$0	$393,680
FY11 Total Available Spending Authority	$760,000	0.0	$0	$0	$366,320	$0	$393,680
FY 2010-11 Reversion \ (Overexpenditure)	$760,000	0.0	$0	$0	$366,320	$0	$393,680

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 **Schedule 3**

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$2,221,482	0.0	$0	$0	$964,169	$0	$1,257,313
Supplemental Appropriation, HB 12-1184, FY12	$2,230,940	0.0	$0	$0	$1,246,853	$0	$984,087
Final FY 2011-12 Appropriation	$4,452,422	0.0	$0	$0	$2,211,022	$0	$2,241,400
FY12 Total Available Spending Authority	$4,452,422	0.0	$0	$0	$2,211,022	$0	$2,241,400
FY12 Expenditures	$2,556,603	0.0	$0	$0	$1,263,293	$0	$1,293,310
FY 2011-12 Reversion \ (Overexpenditure)	$1,895,819	0.0	$0	$0	$947,729	$0	$948,090
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$5,098,787	0.0	$0	$0	$2,534,204	$0	$2,564,583
FY 2012-13 Total Appropriation	**$5,098,787**	**0.0**	**$0**	**$0**	**$2,534,204**	**$0**	**$2,564,583**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$5,098,787	0.0	$0	$0	$2,534,204	$0	$2,564,583
Annualization of FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$1,051,158	0.0	$0	$0	$525,579	$0	$525,579
FY 2013-14 Base Request	**$6,149,945**	**0.0**	**$0**	**$0**	**$3,059,783**	**$0**	**$3,090,162**
FY 2013-14 Total Request	**$6,149,945**	**0.0**	**$0**	**$0**	**$3,059,783**	**$0**	**$3,090,162**
(C) Information Technology Contracts and Projects, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$34,921,866	0.0	$6,036,327	$0	$2,799,749	$100,328	$25,985,462
SB 10-167, Medicaid Efficiency & False Claims, FY11	$641,903	0.0	$160,476	$0	$0	$0	$481,427
Supplemental Appropriation, SB 11-139, FY11	($211,316)	0.0	($96,766)	$0	$0	$0	($114,550)
Final FY 2010-11 Appropriation	$35,352,453	0.0	$6,100,037	$0	$2,799,749	$100,328	$26,352,339
FY11 Total Available Spending Authority	$35,352,453	0.0	$6,100,037	$0	$2,799,749	$100,328	$26,352,339
FY11 Expenditures	$23,878,324	0.0	$5,539,317	$0	$642,824	$100,328	$17,595,855
FY 2010-11 Reversion \ (Overexpenditure)	$11,474,129	0.0	$560,720	$0	$2,156,925	$0	$8,756,484

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$34,884,472	0.0	$6,644,401	$0	$2,443,839	$100,328	$25,695,904
Supplemental Appropriation, HB 12-1184, FY12	$2,230,940	0.0	$0	$0	$1,246,853	$0	$984,087
Final FY 2011-12 Appropriation	$37,115,412	0.0	$6,644,401	$0	$3,690,692	$100,328	$26,679,991
FY12 Roll-forward	$4,558,926	0.0	$0	$487,762	$271,905	$0	$3,799,259
FY12 Total Available Spending Authority	$41,674,338	0.0	$6,644,401	$487,762	$3,962,597	$100,328	$30,479,250
FY12 Expenditures	$32,037,565	0.0	$6,108,777	$0	$2,532,625	$92,163	$23,304,000
FY 2011-12 Reversion \ (Overexpenditure)	$9,636,773	0.0	$535,624	$487,762	$1,429,972	$8,165	$7,175,250
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$37,248,104	0.0	$6,442,150	$0	$4,100,870	$100,328	$26,604,756
FY 2012-13 Total Appropriation	**$37,248,104**	**0.0**	**$6,442,150**	**$0**	**$4,100,870**	**$100,328**	**$26,604,756**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$37,248,104	0.0	$6,442,150	$0	$4,100,870	$100,328	$26,604,756
HB 09-1293, Health Care Affordability Act of 2009, FY14	$1,204,749	0.0	$0	$0	$301,187	$0	$903,562
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	($6,930)	0.0	($1,733)	$0	$0	$0	($5,197)
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	($6,930)	0.0	($1,681)	$0	($73)	$0	($5,176)
Annualization of FY 2009-10 BA#16: "MMIS Funding for HIPAA and Transitions v5010/D.0"	($546,020)	0.0	($58,697)	$0	$0	$0	($487,323)
Annualization of FY 2010-11 BA#12: "Evidence Guided Utilization Review"	($627,984)	0.0	($156,996)	$0	$0	$0	($470,988)
Annualization of FY 2010-11 BA#15: "MMIS Adjustments"	($1,364,572)	0.0	($143,953)	$0	$0	$0	($1,220,619)
Annualization of FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$1,051,158	0.0	$0	$0	$525,579	$0	$525,579
Annualization of FY 2012-13 BA#6: "MMIS Technical Adjustments"	($965,033)	0.0	$0	$0	($206,927)	$0	($758,106)
FY 2013-14 Base Request	**$35,986,542**	**0.0**	**$6,079,090**	**$0**	**$4,720,636**	**$100,328**	**$25,086,488**
R#5: "Medicaid Management Information System Reprocurement"	$15,624,403	0.0	$1,439,072	$0	$287,834	$0	$13,897,497
R#8: "Medicaid Dental Benefit for Adults"	$1,707,678	0.0	$0	$0	$426,919	$0	$1,280,759
R#9: "Dental ASO for Children"	$1,152,144	0.0	$288,036	$0	$0	$0	$864,108
FY 2013-14 Total Request	**$54,470,767**	**0.0**	**$7,806,198**	**$0**	**$5,435,389**	**$100,328**	**$41,128,852**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(D) Eligibility Determinations and Client Services, Medical Identification Cards							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$120,000	0.0	$48,444	$0	$10,759	$1,593	$59,204
Final FY 2010-11 Appropriation	$120,000	0.0	$48,444	$0	$10,759	$1,593	$59,204
FY11 Total Available Spending Authority	$120,000	0.0	$48,444	$0	$10,759	$1,593	$59,204
FY11 Expenditures	$110,562	0.0	$43,726	$0	$10,759	$1,593	$54,484
FY 2010-11 Reversion \ (Overexpenditure)	$9,438	0.0	$4,718	$0	$0	$0	$4,720
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$120,000	0.0	$59,203	$0	$0	$1,593	$59,204
Supplemental Appropriation, HB 12-1184, FY12	$9,240	0.0	$0	$0	$4,620	$0	$4,620
Final FY 2011-12 Appropriation	$129,240	0.0	$59,203	$0	$4,620	$1,593	$63,824
FY12 Total Available Spending Authority	$129,240	0.0	$59,203	$0	$4,620	$1,593	$63,824
FY12 Expenditures	$115,591	0.0	$52,867	$0	$4,132	$1,593	$56,999
FY 2011-12 Reversion \ (Overexpenditure)	$13,649	0.0	$6,336	$0	$488	$0	$6,825
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$129,240	0.0	$59,203	$0	$4,620	$1,593	$63,824
FY 2012-13 Total Appropriation	**$129,240**	**0.0**	**$59,203**	**$0**	**$4,620**	**$1,593**	**$63,824**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$129,240	0.0	$59,203	$0	$4,620	$1,593	$63,824
FY 2013-14 Base Request	**$129,240**	**0.0**	**$59,203**	**$0**	**$4,620**	**$1,593**	**$63,824**
FY 2013-14 Total Request	**$129,240**	**0.0**	**$59,203**	**$0**	**$4,620**	**$1,593**	**$63,824**
(D) Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$5,233,102	0.0	$828,091	$0	$1,542,200	$0	$2,862,811
Final FY 2010-11 Appropriation	$5,233,102	0.0	$828,091	$0	$1,542,200	$0	$2,862,811
FY11 Total Available Spending Authority	$5,233,102	0.0	$828,091	$0	$1,542,200	$0	$2,862,811
FY11 Expenditures	$2,141,327	0.0	$823,747	$0	$5,000	$0	$1,312,580
FY 2010-11 Reversion \ (Overexpenditure)	$3,091,775	0.0	$4,344	$0	$1,537,200	$0	$1,550,231

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$7,761,238	0.0	$828,091	$0	$2,806,268	$0	$4,126,879
Final FY 2011-12 Appropriation	$7,761,238	0.0	$828,091	$0	$2,806,268	$0	$4,126,879
FY12 Total Available Spending Authority	$7,761,238	0.0	$828,091	$0	$2,806,268	$0	$4,126,879
FY12 Expenditures	$3,509,989	0.0	$828,091	$0	$661,117	$0	$2,020,781
FY 2011-12 Reversion \ (Overexpenditure)	$4,251,249	0.0	$0	$0	$2,145,151	$0	$2,106,098
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$7,761,238	0.0	$828,091	$0	$2,806,268	$0	$4,126,879
FY 2012-13 Total Appropriation	**$7,761,238**	**0.0**	**$828,091**	**$0**	**$2,806,268**	**$0**	**$4,126,879**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$7,761,238	0.0	$828,091	$0	$2,806,268	$0	$4,126,879
FY 2013-14 Base Request	**$7,761,238**	**0.0**	**$828,091**	**$0**	**$2,806,268**	**$0**	**$4,126,879**
FY 2013-14 Total Request	**$7,761,238**	**0.0**	**$828,091**	**$0**	**$2,806,268**	**$0**	**$4,126,879**
(D) Eligibility Determinations and Client Services, County Administration							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$32,858,207	0.0	$9,794,550	$0	$6,674,686	$0	$16,388,971
SB 10-167, Medicaid Efficiency & False Claims, FY11	$200,000	0.0	$100,000	$0	$0	$0	$100,000
Final FY 2010-11 Appropriation	$33,058,207	0.0	$9,894,550	$0	$6,674,686	$0	$16,488,971
FY11 Year-End Transfers	($693,497)	0.0	($693,497)	$0	$0	$0	$0
FY11 Total Available Spending Authority	$32,364,710	0.0	$9,201,053	$0	$6,674,686	$0	$16,488,971
FY11 Expenditures	$31,110,742	0.0	$9,201,053	$0	$6,354,318	$0	$15,555,371
FY 2010-11 Reversion \ (Overexpenditure)	$1,253,968	0.0	$0	$0	$320,368	$0	$933,600
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$33,547,878	0.0	$10,300,790	$0	$6,513,282	$0	$16,733,806
Supplemental Appropriation, HB 12-1184, FY12	($2,361,502)	0.0	$0	$0	($1,180,751)	$0	($1,180,751)
Final FY 2011-12 Appropriation	$31,186,376	0.0	$10,300,790	$0	$5,332,531	$0	$15,553,055
FY12 Total Available Spending Authority	$31,186,376	0.0	$10,300,790	$0	$5,332,531	$0	$15,553,055
FY12 Expenditures	$30,602,852	0.0	$10,157,979	$0	$5,299,296	$0	$15,145,577
FY 2011-12 Reversion \ (Overexpenditure)	$583,524	0.0	$142,811	$0	$33,235	$0	$407,478

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$31,427,701	0.0	$10,373,188	$0	$5,380,796	$0	$15,673,717
FY 2012-13 Total Appropriation	**$31,427,701**	**0.0**	**$10,373,188**	**$0**	**$5,380,796**	**$0**	**$15,673,717**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$31,427,701	0.0	$10,373,188	$0	$5,380,796	$0	$15,673,717
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	$737,198	0.0	$221,159	$0	$147,440	$0	$368,599
FY 2013-14 Base Request	**$32,164,899**	**0.0**	**$10,594,347**	**$0**	**$5,528,236**	**$0**	**$16,042,316**
FY 2013-14 Total Request	**$32,164,899**	**0.0**	**$10,594,347**	**$0**	**$5,528,236**	**$0**	**$16,042,316**
(D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
Supplemental Appropriation, HB 12-1184, FY12	$2,361,502	0.0	$0	$0	$1,180,751	$0	$1,180,751
Final FY 2011-12 Appropriation	$2,361,502	0.0	$0	$0	$1,180,751	$0	$1,180,751
FY12 Total Available Spending Authority	$2,361,502	0.0	$0	$0	$1,180,751	$0	$1,180,751
FY12 Expenditures	$1,939,544	0.0	$0	$0	$969,772	$0	$969,772
FY 2011-12 Reversion \ (Overexpenditure)	$421,958	0.0	$0	$0	$210,979	$0	$210,979
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$2,581,071	0.0	$0	$0	$1,290,536	$0	$1,290,535
FY 2012-13 Total Appropriation	**$2,581,071**	**0.0**	**$0**	**$0**	**$1,290,536**	**$0**	**$1,290,535**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$2,581,071	0.0	$0	$0	$1,290,536	$0	$1,290,535
FY 2013-14 Base Request	**$2,581,071**	**0.0**	**$0**	**$0**	**$1,290,536**	**$0**	**$1,290,535**
FY 2013-14 Total Request	**$2,581,071**	**0.0**	**$0**	**$0**	**$1,290,536**	**$0**	**$1,290,535**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(D) Eligibility Determinations and Client Services, Administrative Case Management							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$869,744	0.0	$434,872	$0	$0	$0	$434,872
Final FY 2010-11 Appropriation	$869,744	0.0	$434,872	$0	$0	$0	$434,872
FY11 Year-End Transfers	$123,100	0.0	$123,100	$0	$0	$0	$0
FY11 Total Available Spending Authority	$992,844	0.0	$557,972	$0	$0	$0	$434,872
FY11 Expenditures	$1,115,944	0.0	$557,972	$0	$0	$0	$557,972
FY 2010-11 Reversion \ (Overexpenditure)	($123,100)	0.0	$0	$0	$0	$0	($123,100)
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$869,744	0.0	$434,872	$0	$0	$0	$434,872
Final FY 2011-12 Appropriation	$869,744	0.0	$434,872	$0	$0	$0	$434,872
FY12 Total Available Spending Authority	$869,744	0.0	$434,872	$0	$0	$0	$434,872
FY12 Expenditures	$1,391,668	0.0	$695,834	$0	$0	$0	$695,834
FY 2011-12 Reversion \ (Overexpenditure)	($521,924)	0.0	($260,962)	$0	$0	$0	($260,962)
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$869,744	0.0	$434,872	$0	$0	$0	$434,872
FY 2012-13 Total Appropriation	**$869,744**	**0.0**	**$434,872**	**$0**	**$0**	**$0**	**$434,872**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$869,744	0.0	$434,872	$0	$0	$0	$434,872
FY 2013-14 Base Request	**$869,744**	**0.0**	**$434,872**	**$0**	**$0**	**$0**	**$434,872**
FY 2013-14 Total Request	**$869,744**	**0.0**	**$434,872**	**$0**	**$0**	**$0**	**$434,872**
(D) Eligibility Determinations and Client Services, Customer Outreach							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$3,947,598	0.0	$1,900,033	$0	$73,766	$0	$1,973,799
Final FY 2010-11 Appropriation	$3,947,598	0.0	$1,900,033	$0	$73,766	$0	$1,973,799
FY11 Total Available Spending Authority	$3,947,598	0.0	$1,900,033	$0	$73,766	$0	$1,973,799
FY11 Expenditures	$3,912,885	0.0	$1,882,676	$0	$73,766	$0	$1,956,443
FY 2010-11 Reversion \ (Overexpenditure)	$34,713	0.0	$17,357	$0	$0	$0	$17,356

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$5,213,157	0.0	$2,550,470	$0	$56,109	$0	$2,606,578
Supplemental Appropriation, HB 12-1184, FY12	$90,506	0.0	$0	$0	$45,253	$0	$45,253
Final FY 2011-12 Appropriation	$5,303,663	0.0	$2,550,470	$0	$101,362	$0	$2,651,831
FY12 Total Available Spending Authority	$5,303,663	0.0	$2,550,470	$0	$101,362	$0	$2,651,831
FY12 Expenditures	$4,694,853	0.0	$2,259,497	$0	$101,362	$0	$2,333,994
FY 2011-12 Reversion \ (Overexpenditure)	$608,810	0.0	$290,973	$0	$0	$0	$317,837
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$4,927,018	0.0	$2,376,649	$0	$86,861	$0	$2,463,508
FY 2012-13 Total Appropriation	**$4,927,018**	**0.0**	**$2,376,649**	**$0**	**$86,861**	**$0**	**$2,463,508**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$4,927,018	0.0	$2,376,649	$0	$86,861	$0	$2,463,508
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	$121,711	0.0	$60,855	$0	$0	$0	$60,856
FY 2013-14 Base Request	**$5,048,729**	**0.0**	**$2,437,504**	**$0**	**$86,861**	**$0**	**$2,524,364**
R#11: "HB 12-1281 Departmental Differences Reconciliation"	$267,220	0.0	$133,610	$0	$0	$0	$133,610
FY 2013-14 Total Request	**$5,315,949**	**0.0**	**$2,571,114**	**$0**	**$86,861**	**$0**	**$2,657,974**
(D) Eligibility Determinations and Client Services, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$43,028,651	0.0	$13,005,990	$0	$8,301,411	$1,593	$21,719,657
SB 10-167, Medicaid Efficiency & False Claims, FY11	$200,000	0.0	$100,000	$0	$0	$0	$100,000
Final FY 2010-11 Appropriation	$43,228,651	0.0	$13,105,990	$0	$8,301,411	$1,593	$21,819,657
FY11 Year-End Transfers	($570,397)	0.0	($570,397)	$0	$0	$0	$0
FY11 Total Available Spending Authority	$42,658,254	0.0	$12,535,593	$0	$8,301,411	$1,593	$21,819,657
FY11 Expenditures	$38,391,460	0.0	$12,509,174	$0	$6,443,843	$1,593	$19,436,850
FY 2010-11 Reversion \ (Overexpenditure)	$4,266,794	0.0	$26,419	$0	$1,857,568	$0	$2,382,807
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$47,512,017	0.0	$14,173,426	$0	$9,375,659	$1,593	$23,961,339
Supplemental Appropriation, HB 12-1184, FY12	$99,746	0.0	$0	$0	$49,873	$0	$49,873
Final FY 2011-12 Appropriation	$47,611,763	0.0	$14,173,426	$0	$9,425,532	$1,593	$24,011,212
FY12 Total Available Spending Authority	$47,611,763	0.0	$14,173,426	$0	$9,425,532	$1,593	$24,011,212
FY12 Expenditures	$42,254,497	0.0	$13,994,268	$0	$7,035,679	$1,593	$21,222,957
FY 2011-12 Reversion \ (Overexpenditure)	$5,357,266	0.0	$179,158	$0	$2,389,853	$0	$2,788,255

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$47,696,012	0.0	$14,072,003	$0	$9,569,081	$1,593	$24,053,335
FY 2012-13 Total Appropriation	**$47,696,012**	**0.0**	**$14,072,003**	**$0**	**$9,569,081**	**$1,593**	**$24,053,335**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$47,696,012	0.0	$14,072,003	$0	$9,569,081	$1,593	$24,053,335
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	$858,909	0.0	$282,014	$0	$147,440	$0	$429,455
FY 2013-14 Base Request	**$48,554,921**	**0.0**	**$14,354,017**	**$0**	**$9,716,521**	**$1,593**	**$24,482,790**
R#11: "HB 12-1281 Departmental Differences Reconciliation"	$267,220	0.0	$133,610	$0	$0	$0	$133,610
FY 2013-14 Total Request	**$48,822,141**	**0.0**	**$14,487,627**	**$0**	**$9,716,521**	**$1,593**	**$24,616,400**
(E) Utilization and Quality Review Contracts, Professional Services Contracts							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$6,462,871	0.0	$1,766,994	$0	$86,596	$0	$4,609,281
Final FY 2010-11 Appropriation	$6,462,871	0.0	$1,766,994	$0	$86,596	$0	$4,609,281
FY11 Total Available Spending Authority	$6,462,871	0.0	$1,766,994	$0	$86,596	$0	$4,609,281
FY11 Expenditures	$4,802,408	0.0	$1,345,699	$0	$71,505	$0	$3,385,204
FY 2010-11 Reversion \ (Overexpenditure)	$1,660,463	0.0	$421,295	$0	$15,091	$0	$1,224,077
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$7,670,839	0.0	$2,100,370	$0	$60,537	$0	$5,509,932
Supplemental Appropriation, HB 12-1184, FY12	$493,612	0.0	$62,500	$0	$53,795	$0	$377,317
Final FY 2011-12 Appropriation	$8,164,451	0.0	$2,162,870	$0	$114,332	$0	$5,887,249
FY12 Total Available Spending Authority	$8,164,451	0.0	$2,162,870	$0	$114,332	$0	$5,887,249
FY12 Expenditures	$6,384,617	0.0	$1,806,527	$0	$57,620	$0	$4,520,470
FY 2011-12 Reversion \ (Overexpenditure)	$1,779,834	0.0	$356,343	$0	$56,712	$0	$1,366,779
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$8,414,451	0.0	$2,225,370	$0	$114,332	$0	$6,074,749
FY 2012-13 Total Appropriation	**$8,414,451**	**0.0**	**$2,225,370**	**$0**	**$114,332**	**$0**	**$6,074,749**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$8,414,451	0.0	$2,225,370	$0	$114,332	$0	$6,074,749
FY 2013-14 Base Request	**$8,414,451**	**0.0**	**$2,225,370**	**$0**	**$114,332**	**$0**	**$6,074,749**
R#8: "Medicaid Dental Benefit for Adults"	$355,000	0.0	$0	$0	$88,750	$0	$266,250
R#11: "HB 12-1281 Departmental Differences Reconciliation"	$202,856	0.0	$50,714	$0	$0	$0	$152,142
FY 2013-14 Total Request	**$8,972,307**	**0.0**	**$2,276,084**	**$0**	**$203,082**	**$0**	**$6,493,141**
(F) Provider Audits and Services, Professional Audit Contracts							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$3,306,813	0.0	$1,256,281	$0	$352,988	$0	$1,697,544
Final FY 2010-11 Appropriation	$3,306,813	0.0	$1,256,281	$0	$352,988	$0	$1,697,544
FY11 Total Available Spending Authority	$3,306,813	0.0	$1,256,281	$0	$352,988	$0	$1,697,544
FY11 Expenditures	$2,202,544	0.0	$1,017,368	$0	$58,096	$0	$1,127,080
FY 2010-11 Reversion \ (Overexpenditure)	$1,104,269	0.0	$238,913	$0	$294,892	$0	$570,464
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$2,463,406	0.0	$969,283	$0	$262,420	$0	$1,231,703
Final FY 2011-12 Appropriation	$2,463,406	0.0	$969,283	$0	$262,420	$0	$1,231,703
FY12 Total Available Spending Authority	$2,463,406	0.0	$969,283	$0	$262,420	$0	$1,231,703
FY12 Expenditures	$1,841,190	0.0	$908,175	$0	$12,420	$0	$920,595
FY 2011-12 Reversion \ (Overexpenditure)	$622,216	0.0	$61,108	$0	$250,000	$0	$311,108
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$2,463,406	0.0	$969,283	$0	$262,420	$0	$1,231,703
FY 2012-13 Total Appropriation	**$2,463,406**	**0.0**	**$969,283**	**$0**	**$262,420**	**$0**	**$1,231,703**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$2,463,406	0.0	$969,283	$0	$262,420	$0	$1,231,703
Annualization of FY 2007-08 S#5: "Revised Federal Rule for Payment Error Rate Measurement Program"	$588,501	0.0	$147,125	$0	$102,988	$0	$338,388
FY 2013-14 Base Request	**$3,051,907**	**0.0**	**$1,116,408**	**$0**	**$365,408**	**$0**	**$1,570,091**
FY 2013-14 Total Request	**$3,051,907**	**0.0**	**$1,116,408**	**$0**	**$365,408**	**$0**	**$1,570,091**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(G) Recoveries and Recoupment Contract Costs, Estate Recovery							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$700,000	0.0	$0	$0	$350,000	$0	$350,000
Final FY 2010-11 Appropriation	$700,000	0.0	$0	$0	$350,000	$0	$350,000
FY11 Total Available Spending Authority	$700,000	0.0	$0	$0	$350,000	$0	$350,000
FY11 Expenditures	$351,102	0.0	$0	$0	$175,551	$0	$175,551
FY 2010-11 Reversion \ (Overexpenditure)	$348,898	0.0	$0	$0	$174,449	$0	$174,449
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$700,000	0.0	$0	$0	$350,000	$0	$350,000
Final FY 2011-12 Appropriation	$700,000	0.0	$0	$0	$350,000	$0	$350,000
FY12 Total Available Spending Authority	$700,000	0.0	$0	$0	$350,000	$0	$350,000
FY12 Expenditures	$315,578	0.0	$0	$0	$157,789	$0	$157,789
FY 2011-12 Reversion \ (Overexpenditure)	$384,422	0.0	$0	$0	$192,211	$0	$192,211
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$700,000	0.0	$0	$0	$350,000	$0	$350,000
FY 2012-13 Total Appropriation	**$700,000**	**0.0**	**$0**	**$0**	**$350,000**	**$0**	**$350,000**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$700,000	0.0	$0	$0	$350,000	$0	$350,000
FY 2013-14 Base Request	**$700,000**	**0.0**	**$0**	**$0**	**$350,000**	**$0**	**$350,000**
FY 2013-14 Total Request	**$700,000**	**0.0**	**$0**	**$0**	**$350,000**	**$0**	**$350,000**
(1) Executive Director's Office, Total							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$128,885,227	287.8	$35,675,473	$0	$14,772,613	$1,849,603	$76,587,538
HB 10-1027, Medicaid Hospice Life Expectancy, FY11	$25,000	0.0	$0	$0	$12,500	$0	$12,500
HB 10-1053, Medicaid Community Long-term Care Saving, FY11	$75,000	0.0	$0	$0	$37,500	$0	$37,500
SB 10-061, Medicaid Hospice Room And Board Charges, FY11	$102,570	0.0	$0	$0	$51,285	$0	$51,285
SB 10-167, Medicaid Efficiency & False Claims, FY11	$1,328,361	7.0	$503,705	$0	$0	$0	$824,656
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$0	$0	$0	$56,588	($56,588)
Supplemental Appropriation, SB 11-139, FY11	($328,609)	0.0	($185,934)	$0	$0	($4,276)	($138,399)
Final FY 2010-11 Appropriation	$130,087,549	294.8	$35,993,244	$0	$14,873,898	$1,901,915	$77,318,492
FY11 Federal Grant	$2,000,000	0.0	$0	$0	$0	$0	$2,000,000
FY11 Year-End Transfers	($570,397)	0.0	($570,397)	$0	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY11 Total Available Spending Authority	$131,517,152	294.8	$35,422,847	$0	$14,873,898	$1,901,915	$79,318,492
FY11 Expenditures	$104,917,911	270.6	$33,633,591	$0	$9,480,297	$1,105,012	$60,699,011
FY 2010-11 Reversion \ (Overexpenditure)	$26,599,241	24.2	$1,789,256	$0	$5,393,601	$796,903	$18,619,481
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$138,824,271	312.2	$38,319,356	$0	$15,973,358	$2,086,698	$82,444,859
HB 11-1242, Medicaid Provider Integration Of Service, FY12	$113,500	0.0	$0	$0	$56,750	$0	$56,750
SB 11-076, PERA Contribution Rates, FY12	($589,698)	0.0	($194,072)	$0	($56,118)	$0	($339,508)
SB 11-125, Nursing Home Fees & Order of Payments, FY12	$60,000	0.0	$30,000	$0	$0	$0	$30,000
SB 11-177, Repeal Sunset Teen Pregnancy & Dropout Program, FY12	$53,470	1.0	$26,735	$0	$0	$0	$26,735
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	($24,363)	(0.2)	$0	$0	($24,363)	$0	$0
Supplemental Appropriation, HB 12-1184, FY12	$2,947,642	0.0	$75,648	$0	$1,290,521	$0	$1,581,473
Long Bill Add-ons, HB 12-1335, FY12	($32,168)	(0.5)	($16,085)	$0	$0	$0	($16,083)
Final FY 2011-12 Appropriation	$141,352,654	312.5	$38,241,582	$0	$17,240,148	$2,086,698	$83,784,226
FY12 Roll-forward	$4,558,926	0.0	$0	$487,762	$271,905	$0	$3,799,259
FY12 Total Available Spending Authority	$145,911,580	312.5	$38,241,582	$487,762	$17,512,053	$2,086,698	$87,583,485
FY12 Expenditures	$122,254,301	293.4	$36,713,896	$0	$12,305,515	$1,060,838	$72,174,052
FY 2011-12 Reversion \ (Overexpenditure)	$23,657,279	19.1	$1,527,686	$487,762	$5,206,538	$1,025,860	$15,409,433
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$142,765,877	314.3	$38,598,357	$0	$17,740,127	$2,068,902	$84,358,491
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY13	$28,498	0.0	$28,498	$0	$0	$0	$0
HB 12-1281, Medicaid Payment Reform Pilot Program, FY13	$213,079	0.8	$106,540	$0	$0	$0	$106,539
HB 12-1339, Colorado Benefits Management System Project, FY13	$997,655	11.0	$0	$0	$0	$997,655	$0
SB 12-060, Improve Medicaid Fraud Prosecution, FY13	$5,216	0.1	$2,608	$0	$0	$0	$2,608
FY 2012-13 Total Appropriation	**$144,010,325**	**326.2**	**$38,736,003**	**$0**	**$17,740,127**	**$3,066,557**	**$84,467,638**
FY13 Personal Services allocation	$22,593,922	326.2	$7,971,021	$0	$2,038,599	$1,176,645	$11,407,657
FY13 Operating allocation	$1,625,353	0.0	$715,356	$0	$53,049	$78,257	$778,691
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$144,010,325	326.2	$38,736,003	$0	$17,740,127	$3,066,557	$84,467,638
HB 09-1293, Health Care Affordability Act of 2009, FY14	$1,204,749	0.0	$0	$0	$301,187	$0	$903,562

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY14	($28,498)	0.0	($28,498)	$0	$0	$0	$0
HB 12-1268, Health Facility Safety Inspection Transfer To CDPS, FY14	$44,515	0.0	$15,580	$0	$0	$0	$28,935
HB 12-1281, Medicaid Payment Reform Pilot Program, FY14	($88,744)	0.2	($44,371)	$0	$0	$0	($44,373)
HB 12-1339, Colorado Benefits Management System Project, FY14	($186,797)	0.0	$0	$0	$0	($186,797)	$0
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	$851,979	0.0	$280,281	$0	$147,440	$0	$424,258
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	($6,930)	0.0	($1,681)	$0	($73)	$0	($5,176)
SB 12-159, Evaluation Children With Autism Medicaid Waiver, FY14	$62,000	0.0	$0	$0	$31,000	$0	$31,000
Annualization of FY 2007-08 S#5: "Revised Federal Rule for Payment Error Rate Measurement Program"	$588,501	0.0	$147,125	$0	$102,988	$0	$338,388
Annualization of FY 2009-10 BA#16: "MMIS Funding for HIPAA and Transitions v5010/D.0"	($546,020)	0.0	($58,697)	$0	$0	$0	($487,323)
Annualization of FY 2010-11 BA#12: "Evidence Guided Utilization Review"	($627,984)	0.0	($156,996)	$0	$0	$0	($470,988)
Annualization of FY 2010-11 BA#15: "MMIS Adjustments"	($1,364,572)	0.0	($143,953)	$0	$0	$0	($1,220,619)
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	$7,498	0.2	$3,749	$0	$0	$0	$3,749
Annualization of FY 2012-13 R#12: "Hospital Provider Fee Administrative True-up"	$1,051,158	0.0	$0	$0	$525,579	$0	$525,579
Annualization of FY 2012-13 BA#6: "MMIS Technical Adjustments"	($965,033)	0.0	$0	$0	($206,927)	$0	($758,106)
Technical correction to align with CDE appropriation	$2,133	0.0	$0	$0	$0	$0	$2,133
FY14 Statewide Indirect Cost Allocation	$1,160,738	0.0	$1,190,879	$0	$38,481	$10,784	($79,406)
FY14 Common Policy Adjustment	$1,181,629	0.0	$263,423	$0	$76,772	($63,133)	$904,567
FY 2013-14 Base Request	**$146,350,647**	**326.6**	**$40,202,844**	**$0**	**$18,756,574**	**$2,827,411**	**$84,563,818**
R#5: "Medicaid Management Information System Reprocurement"	$15,624,403	0.0	$1,439,072	$0	$287,834	$0	$13,897,497
R#6: "Additional FTE to Restore Functionality"	$704,341	7.4	$352,172	$0	$0	$0	$352,169
R#7: "Substance Use Disorder Benefit"	$100,000	0.0	$50,000	$0	$0	$0	$50,000
R#8: "Medicaid Dental Benefit for Adults"	$2,155,769	1.2	$0	$0	$562,215	$0	$1,593,554
R#9: "Dental ASO for Children"	$1,152,144	0.0	$288,036	$0	$0	$0	$864,108
R#10: "Leased Space Rent Increase and True-up"	$92,115	0.0	$92,402	$0	($46,344)	$0	$46,057
R#11: "HB 12-1281 Departmental Differences Reconciliation"	$1,096,749	3.0	$497,661	$0	$0	$0	$599,088
R#12: "Customer Service Technology Improvements"	$1,800,000	0.0	$900,000	$0	$0	$0	$900,000

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(1) Executive Director's Office

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
NP-R#4: "Capitol Complex Building Upgrade, Repair, and Replacement"	$28,985	0.0	$14,493	$0	$0	$0	$14,492
NP-R#5: "Employee Engagement Survey Adjustment"	$3,463	0.0	$1,732	$0	$0	$0	$1,731
NP-R#6: "OIT Enterprise Asset Management"	$6,260	0.0	$3,130	$0	$0	$0	$3,130
FY 2013-14 Total Request	**$169,114,876**	**338.2**	**$43,841,542**	**$0**	**$19,560,279**	**$2,827,411**	**$102,885,644**
FY14 Personal Services allocation	**$24,490,598**	**338.20000**	**$9,533,270**	**$0**	**$2,118,369**	**$1,069,555**	**$11,769,404**
FY14 Operating allocation	**$1,607,614**	**0.0**	**$728,404**	**$0**	**$58,306**	**$23,910**	**$796,994**

(1) Executive Director's Office							
FY 2012-13 Total Appropriation	**$144,010,325**	**326.2**	**$38,736,003**	**$0**	**$17,740,127**	**$3,066,557**	**$84,467,638**
FY 2013-14 Base Request	**$146,350,647**	**326.6**	**$40,202,844**	**$0**	**$18,756,574**	**$2,827,411**	**$84,563,818**
FY 2013-14 Total Request	**$169,114,876**	**338.2**	**$43,841,542**	**$0**	**$19,560,279**	**$2,827,411**	**$102,885,644**
Percentage Change FY 2012-13 to FY 2013-14	**17.43%**	**3.68%**	**13.18%**	**0.00%**	**10.26%**	**-7.80%**	**21.80%**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2012-13 — Schedule 3

(2) Medical Services Premiums

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(2) Medical Services Premiums							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$3,158,315,617	0.0	$814,622,298	$161,444,485	$250,622,514	$3,122,188	$1,928,504,132
HB 10-1005, Home Health Care, FY11	$123,270	0.0	$0	$0	$47,348	$0	$75,922
HB 10-1033, Screening Brief Intervention Referral, FY11	$870,155	0.0	$334,227	$0	$0	$0	$535,928
HB 10-1146, State-funded Public Assistance Programs, FY11	($704,421)	0.0	($869,842)	$0	$0	$0	$165,421
HB 10-1378, Transfers for Health Care Services, FY11	$0	0.0	($12,800,000)	$0	$12,800,000	$0	$0
HB 10-1379, 2010 Nursing Facility Rate Reductions, FY11	($6,234,689)	0.0	($8,211,333)	$0	$5,806,343	$0	($3,829,699)
HB 10-1380, Use Supplemental OAP Health Fund for Medicaid,	$0	0.0	($4,850,000)	$0	$4,850,000	$0	$0
HB 10-1381, Tobacco Revenues Offset Medical Services, FY11	$0	0.0	($25,691,418)	$0	$21,200,983	$4,490,435	$0
HB 10-1382, Repeal Delay of Public Medical Assistance Program Payments, FY11	($43,121,235)	0.0	($14,679,904)	$0	($2,023,356)	($17,380)	($26,400,595)
SB 10-167, Medicaid Efficiency & False Claims, FY11	($2,390,570)	0.0	($918,218)	$0	$0	$0	($1,472,352)
SB 10-169, Provider Fee Enhanced Match, FY11	$0	0.0	($46,329,388)	$0	$46,329,388	$0	$0
Long Bill Add-ons, SB 11-209, FY11	$237,436,847	0.0	($54,936,910)	$117,900,000	$97,223,834	($180,916)	$77,430,839
Supplemental Appropriation, SB 11-139, FY11	$0	0.0	($51,000,000)	$0	$51,000,000	$0	$0
Long Bill Add-ons, HB 12-1335, FY11	$0	0.0	$3,976,005	($3,976,005)	$0	$0	$0
Final FY 2010-11 Appropriation	$3,344,294,974	0.0	$598,645,517	$275,368,480	$487,857,054	$7,414,327	$1,975,009,596
FY11 Total Available Spending Authority	$3,344,294,974	0.0	$598,645,517	$275,368,480	$487,857,054	$7,414,327	$1,975,009,596
FY11 Expenditures	$3,395,627,672	0.0	$601,033,287	$279,344,485	$518,533,477	$7,414,327	$1,989,302,096
FY 2010-11 Reversion \ (Overexpenditure)	($51,332,698)	0.0	($2,387,770)	($3,976,005)	($30,676,423)	$0	($14,292,500)
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$3,521,401,973	0.0	$1,004,304,853	$284,175,417	$495,061,484	$3,101,708	$1,734,758,511
HB 12-1202, Allow HCPF Approps For Quitline Matching Funds, FY12	$577,316	0.0	$0	$0	$288,658	$0	$288,658
SB 11-125, Nursing Home Fees & Order of Payments, FY12	$30,994,411	0.0	$0	$0	$15,497,206	$0	$15,497,205
SB 11-177, Repeal Sunset Teen Pregnancy & Dropout Program, FY12	$144,165	0.0	($26,735)	$0	$19,763	$0	$151,137
SB 11-210, Phase Out Supplemental OAP Health Fund, FY12	$0	0.0	($2,230,500)	$0	$2,230,500	$0	$0
SB 11-211, Tobacco Revenues Offset Medical Services, FY12	$0	0.0	($33,000,000)	$0	$29,713,649	$3,286,351	$0
SB 11-212, Use Provider Fee Offset GF Medicaid, FY12	$0	0.0	($50,000,000)	$0	$50,000,000	$0	$0
SB 11-215, 2011 Nursing Facility Rate Reduction, FY12	($8,865,830)	0.0	($4,432,915)	$0	$0	$0	($4,432,915)
SB 11-219, 2011 Transfers For Health Care Services, FY12	$0	0.0	($15,775,670)	$0	$15,775,670	$0	$0
Supplemental Appropriation, HB 12-1184, FY12	$2,220,236	0.0	($18,323,616)	$0	$18,322,469	$0	$2,221,383
Long Bill Add-ons, HB 12-1335, FY12	$101,141,841	0.0	($47,259,656)	$89,333,334	$5,431,445	$57,769	$53,578,949
Final FY 2011-12 Appropriation	$3,647,614,112	0.0	$833,255,761	$373,508,751	$632,340,844	$6,445,828	$1,802,062,928

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2012-13 — Schedule 3

(2) Medical Services Premiums

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY12 Total Available Spending Authority	$3,647,614,112	0.0	$833,255,761	$373,508,751	$632,340,844	$6,445,828	$1,802,062,928
FY12 Expenditures	$3,642,032,762	0.0	$833,239,176	$373,508,751	$629,762,743	$6,445,828	$1,799,076,264
FY 2011-12 Reversion \ (Overexpenditure)	$5,581,350	0.0	$16,585	$0	$2,578,101	$0	$2,986,664
Pursuant to Executive Order, FY 2011-12 expenditures include transfers to the Disaster Emergency Fund.							
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$3,994,685,293	0.0	$1,055,118,623	$312,202,624	$651,202,864	$3,215,340	$1,972,945,842
HB 12-1340, Nursing Facility Reduction Per Diem Rate, FY13	($9,024,676)	0.0	($4,512,338)	$0	$0	$0	($4,512,338)
SB 12-060, Improve Medicaid Fraud Prosecution, FY13	($54,156)	0.0	($2,608)	$0	($24,470)	$0	($27,078)
FY13	$6,925	0.0	$0	$0	$3,463	$0	$3,462
FY 2012-13 Total Appropriation	**$3,985,613,386**	**0.0**	**$1,050,603,677**	**$312,202,624**	**$651,181,857**	**$3,215,340**	**$1,968,409,888**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$3,985,613,386	0.0	$1,050,603,677	$312,202,624	$651,181,857	$3,215,340	$1,968,409,888
HB 10-1146, State-funded Public Assistance Programs, FY14	($102,745)	0.0	($51,373)	$0	$0	$0	($51,372)
HB 12-1340, Nursing Facility Reduction Per Diem Rate, FY14	$9,024,676	0.0	$4,512,338	$0	$0	$0	$4,512,338
SB 08-118, Transfer for Medicaid Disease Management, FY14	$0	0.0	$2,000,000	$0	$0	($2,000,000)	$0
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	$26,454,555	0.0	$9,259,094	$0	$0	$0	$17,195,461
SB 11-212, Use Provider Fee Offset GF Medicaid, FY14	$0	0.0	$25,000,000	$0	($25,000,000)	$0	$0
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	$8,803,834	0.0	$3,081,341	$0	$0	$0	$5,722,493
SB 12-060, Improve Medicaid Fraud Prosecution, FY14	($4,448)	0.0	$0	$0	($2,224)	$0	($2,224)
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($1,404,115)	0.0	($663,592)	$0	($38,466)	$0	($702,057)
Annualization of FY 2012-13 R#6: "Medicaid Budget Reductions"	($1,751,563)	0.0	($863,801)	$0	($11,981)	$0	($875,781)
Annualization of FY 2012-13 R#10: "Utilize Supplemental Payments for General Fund Relief"	($8,477)	0.0	($8,477)	$0	$0	$0	$0
Annualization of FY 2012-13 BA#3: "Smoking Cessation Quitline for Medicaid Clients"	($92,430)	0.0	$0	$0	($46,215)	$0	($46,215)
FY 2013-14 Base Request	**$4,026,532,673**	**0.0**	**$1,092,869,207**	**$312,202,624**	**$626,082,971**	**$1,215,340**	**$1,994,162,531**
R#1: "Medical Services Premiums"	$255,256,258	0.0	$78,363,224	$0	($1,837,669)	$0	$178,730,703
R#7: "Substance Use Disorder Benefit"	$415,440	0.0	($11,820)	$0	($282)	$0	$427,542
R#8: "Medicaid Dental Benefit for Adults"	$30,803,647	0.0	($747,621)	$0	$13,131,511	$0	$18,419,757
R#9: "Dental ASO for Children"	($576,072)	0.0	($288,036)	$0	$0	$0	($288,036)
R#13: "1.5% Provider Rate Increase"	$33,054,416	0.0	$14,547,876	$0	$1,227,138	$0	$17,279,402
FY 2013-14 Total Request	**$4,345,486,362**	**0.0**	**$1,184,732,830**	**$312,202,624**	**$638,603,669**	**$1,215,340**	**$2,208,731,899**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2012-13 Schedule 3

(2) Medical Services Premiums

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(2) Medical Services Premiums, Total							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$3,158,315,617	0.0	$814,622,298	$161,444,485	$250,622,514	$3,122,188	$1,928,504,132
HB 10-1005, Home Health Care, FY11	$123,270	0.0	$0	$0	$47,348	$0	$75,922
HB 10-1033, Screening Brief Intervention Referral, FY11	$870,155	0.0	$334,227	$0	$0	$0	$535,928
HB 10-1146, State-funded Public Assistance Programs, FY11	($704,421)	0.0	($869,842)	$0	$0	$0	$165,421
HB 10-1378, Transfers for Health Care Services, FY11	$0	0.0	($12,800,000)	$0	$12,800,000	$0	$0
HB 10-1379, 2010 Nursing Facility Rate Reductions, FY11	($6,234,689)	0.0	($8,211,333)	$0	$5,806,343	$0	($3,829,699)
HB 10-1380, Use Supplemental OAP Health Fund for Medicaid,	$0	0.0	($4,850,000)	$0	$4,850,000	$0	$0
HB 10-1381, Tobacco Revenues Offset Medical Services, FY11	$0	0.0	($25,691,418)	$0	$21,200,983	$4,490,435	$0
HB 10-1382, Repeal Delay of Public Medical Assistance Program Payments, FY11	($43,121,235)	0.0	($14,679,904)	$0	($2,023,356)	($17,380)	($26,400,595)
SB 10-167, Medicaid Efficiency & False Claims, FY11	($2,390,570)	0.0	($918,218)	$0	$0	$0	($1,472,352)
SB 10-169, Provider Fee Enhanced Match, FY11	$0	0.0	($46,329,388)	$0	$46,329,388	$0	$0
Long Bill Add-ons, SB 11-209, FY11	$237,436,847	0.0	($54,936,910)	$117,900,000	$97,223,834	($180,916)	$77,430,839
Supplemental Appropriation, SB 11-139, FY11	$0	0.0	($51,000,000)	$0	$51,000,000	$0	$0
Long Bill Add-ons, HB 12-1335, FY11	$0	0.0	$3,976,005	($3,976,005)	$0	$0	$0
Final FY 2010-11 Appropriation	$3,344,294,974	0.0	$598,645,517	$275,368,480	$487,857,054	$7,414,327	$1,975,009,596
FY11 Total Available Spending Authority	$3,344,294,974	0.0	$598,645,517	$275,368,480	$487,857,054	$7,414,327	$1,975,009,596
FY11 Expenditures	$3,395,627,672	0.0	$601,033,287	$279,344,485	$518,533,477	$7,414,327	$1,989,302,096
FY 2010-11 Reversion \ (Overexpenditure)	($51,332,698)	0.0	($2,387,770)	($3,976,005)	($30,676,423)	$0	($14,292,500)
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$3,521,401,973	0.0	$1,004,304,853	$284,175,417	$495,061,484	$3,101,708	$1,734,758,511
HB 12-1202, Allow HCPF Approps For Quitline Matching Funds, FY12	$577,316	0.0	$0	$0	$288,658	$0	$288,658
SB 11-125, Nursing Home Fees & Order of Payments, FY12	$30,994,411	0.0	$0	$0	$15,497,206	$0	$15,497,205
SB 11-177, Repeal Sunset Teen Pregnancy & Dropout Program, FY12	$144,165	0.0	($26,735)	$0	$19,763	$0	$151,137
SB 11-210, Phase Out Supplemental OAP Health Fund, FY12	$0	0.0	($2,230,500)	$0	$2,230,500	$0	$0
SB 11-211, Tobacco Revenues Offset Medical Services, FY12	$0	0.0	($33,000,000)	$0	$29,713,649	$3,286,351	$0
SB 11-212, Use Provider Fee Offset GF Medicaid, FY12	$0	0.0	($50,000,000)	$0	$50,000,000	$0	$0
SB 11-215, 2011 Nursing Facility Rate Reduction, FY12	($8,865,830)	0.0	($4,432,915)	$0	$0	$0	($4,432,915)
SB 11-219, 2011 Transfers For Health Care Services, FY12	$0	0.0	($15,775,670)	$0	$15,775,670	$0	$0
Supplemental Appropriation, HB 12-1184, FY12	$2,220,236	0.0	($18,323,616)	$0	$18,322,469	$0	$2,221,383
Long Bill Add-ons, HB 12-1335, FY12	$101,141,841	0.0	($47,259,656)	$89,333,334	$5,431,445	$57,769	$53,578,949
Final FY 2011-12 Appropriation	$3,647,614,112	0.0	$833,255,761	$373,508,751	$632,340,844	$6,445,828	$1,802,062,928

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2012-13 — Schedule 3

(2) Medical Services Premiums

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY12 Total Available Spending Authority	$3,647,614,112	0.0	$833,255,761	$373,508,751	$632,340,844	$6,445,828	$1,802,062,928
FY12 Expenditures	$3,642,032,762	0.0	$833,239,176	$373,508,751	$629,762,743	$6,445,828	$1,799,076,264
FY 2011-12 Reversion \ (Overexpenditure)	$5,581,350	0.0	$16,585	$0	$2,578,101	$0	$2,986,664
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$3,994,685,293	0.0	$1,055,118,623	$312,202,624	$651,202,864	$3,215,340	$1,972,945,842
HB 12-1340, Nursing Facility Reduction Per Diem Rate, FY13	($9,024,676)	0.0	($4,512,338)	$0	$0	$0	($4,512,338)
SB 12-060, Improve Medicaid Fraud Prosecution, FY13	($54,156)	0.0	($2,608)	$0	($24,470)	$0	($27,078)
SB 12-159, Evaluation Children With Autism Medicaid Waiver,	$6,925	0.0	$0	$0	$3,463	$0	$3,462
FY 2012-13 Total Appropriation	**$3,985,613,386**	**0.0**	**$1,050,603,677**	**$312,202,624**	**$651,181,857**	**$3,215,340**	**$1,968,409,888**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$3,985,613,386	0.0	$1,050,603,677	$312,202,624	$651,181,857	$3,215,340	$1,968,409,888
HB 10-1146, State-funded Public Assistance Programs, FY14	($102,745)	0.0	($51,373)	$0	$0	$0	($51,372)
HB 12-1340, Nursing Facility Reduction Per Diem Rate, FY14	$9,024,676	0.0	$4,512,338	$0	$0	$0	$4,512,338
SB 08-118, Transfer for Medicaid Disease Management, FY14	$0	0.0	$2,000,000	$0	$0	($2,000,000)	$0
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	$26,454,555	0.0	$9,259,094	$0	$0	$0	$17,195,461
SB 11-212, Use Provider Fee Offset GF Medicaid, FY14	$0	0.0	$25,000,000	$0	($25,000,000)	$0	$0
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	$8,803,834	0.0	$3,081,341	$0	$0	$0	$5,722,493
SB 12-060, Improve Medicaid Fraud Prosecution, FY14	($4,448)	0.0	$0	$0	($2,224)	$0	($2,224)
Annualization of FY 2012-13 R#5: "Medicaid Fee-for-Service Payment Reform"	($1,404,115)	0.0	($663,592)	$0	($38,466)	$0	($702,057)
Annualization of FY 2012-13 R#6: "Medicaid Budget Reductions"	($1,751,563)	0.0	($863,801)	$0	($11,981)	$0	($875,781)
Annualization of FY 2012-13 R#10: "Utilize Supplemental Payments for General Fund Relief"	($8,477)	0.0	($8,477)	$0	$0	$0	$0
Annualization of FY 2012-13 BA#3: "Smoking Cessation Quitline for Medicaid Clients"	($92,430)	0.0	$0	$0	($46,215)	$0	($46,215)
FY 2013-14 Base Request	**$4,026,532,673**	**0.0**	**$1,092,869,207**	**$312,202,624**	**$626,082,971**	**$1,215,340**	**$1,994,162,531**
R#1: "Medical Services Premiums"	$255,256,258	0.0	$78,363,224	$0	($1,837,669)	$0	$178,730,703
R#7: "Substance Use Disorder Benefit"	$415,440	0.0	($11,820)	$0	($282)	$0	$427,542
R#8: "Medicaid Dental Benefit for Adults"	$30,803,647	0.0	($747,621)	$0	$13,131,511	$0	$18,419,757
R#9: "Dental ASO for Children"	($576,072)	0.0	($288,036)	$0	$0	$0	($288,036)
R#13: "1.5% Provider Rate Increase"	$33,054,416	0.0	$14,547,876	$0	$1,227,138	$0	$17,279,402
FY 2013-14 Total Request	**$4,345,486,362**	**0.0**	**$1,184,732,830**	**$312,202,624**	**$638,603,669**	**$1,215,340**	**$2,208,731,899**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2012-13 — Schedule 3

(2) Medical Services Premiums

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(2) Medical Services Premiums							
FY 2012-13 Total Appropriation	**$3,985,613,386**	**0.0**	**$1,050,603,677**	**$312,202,624**	**$651,181,857**	**$3,215,340**	**$1,968,409,888**
FY 2013-14 Base Request	**$4,026,532,673**	**0.0**	**$1,092,869,207**	**$312,202,624**	**$626,082,971**	**$1,215,340**	**$1,994,162,531**
FY 2013-14 Total Request	**$4,345,486,362**	**0.0**	**$1,184,732,830**	**$312,202,624**	**$638,603,669**	**$1,215,340**	**$2,208,731,899**
Percentage Change FY 2012-13 to FY 2013-14	**9.03%**	**0.00%**	**12.77%**	**0.00%**	**-1.93%**	**-62.20%**	**12.21%**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(3) Medicaid Mental Health Community Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Mental Health Capitation Payments							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$247,616,458	0.0	$85,931,156	$0	$9,555,600	$12,046	$152,117,656
Long Bill Add-ons, SB 11-209, FY11	$504,513	0.0	$6,216,220	$0	$2,096,032	$954	($7,808,693)
Final FY 2010-11 Appropriation	$248,120,971	0.0	$92,147,376	$0	$11,651,632	$13,000	$144,308,963
FY11 Total Available Spending Authority	$248,120,971	0.0	$92,147,376	$0	$11,651,632	$13,000	$144,308,963
FY11 Expenditures	$249,352,665	0.0	$95,057,227	$0	$9,559,892	$13,000	$144,722,546
FY 2010-11 Reversion \ (Overexpenditure)	($1,231,694)	0.0	($2,909,851)	$0	$2,091,740	$0	($413,583)
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$272,492,157	0.0	$125,823,308	$0	$10,510,223	$13,544	$136,145,082
Long Bill Add-ons, HB 12-1335, FY12	$2,653,058	0.0	$5,986,391	$0	($4,738,434)	$11,502	$1,393,599
Final FY 2011-12 Appropriation	$275,145,215	0.0	$131,809,699	$0	$5,771,789	$25,046	$137,538,681
FY12 Total Available Spending Authority	$275,145,215	0.0	$131,809,699	$0	$5,771,789	$25,046	$137,538,681
FY12 Expenditures	$273,376,614	0.0	$131,782,602	$0	$5,791,948	$25,046	$135,777,018
FY 2011-12 Reversion \ (Overexpenditure)	$1,768,601	0.0	$27,097	$0	($20,159)	$0	$1,761,663
Pursuant to Executive Order, FY 2011-12 expenditures include transfers to the Disaster Emergency Fund.							
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$312,580,712	0.0	$142,712,972	$0	$13,648,932	$0	$156,218,808
FY 2012-13 Total Appropriation	**$312,580,712**	**0.0**	**$142,712,972**	**$0**	**$13,648,932**	**$0**	**$156,218,808**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$312,580,712	0.0	$142,712,972	$0	$13,648,932	$0	$156,218,808
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	$3,218,931	0.0	$1,126,626	$0	$0	$0	$2,092,305
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	$215,864	0.0	$75,552	$0	$0	$0	$140,312
FY 2013-14 Base Request	**$316,015,507**	**0.0**	**$143,915,150**	**$0**	**$13,648,932**	**$0**	**$158,451,425**
R#2: "Medicaid Mental Health Community Programs"	$31,839,522	0.0	$10,012,117	$0	($1,313,268)	$0	$23,140,673
R#7: "Substance Use Disorder Benefit"	$5,272,628	0.0	$1,779,950	$0	$42,317	$0	$3,450,361
FY 2013-14 Total Request	**$353,127,657**	**0.0**	**$155,707,217**	**$0**	**$12,377,981**	**$0**	**$185,042,459**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(3) Medicaid Mental Health Community Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Medicaid Mental Health Fee for Services Payments							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$2,965,758	0.0	$1,139,148	$0	$0	$0	$1,826,610
Long Bill Add-ons, SB 11-209, FY11	$503,380	0.0	$257,478	$0	$0	$0	$245,902
Final FY 2010-11 Appropriation	$3,469,138	0.0	$1,396,626	$0	$0	$0	$2,072,512
FY11 Total Available Spending Authority	$3,469,138	0.0	$1,396,626	$0	$0	$0	$2,072,512
FY11 Expenditures	$3,870,594	0.0	$1,532,590	$0	$0	$0	$2,338,004
FY 2010-11 Reversion \ (Overexpenditure)	($401,456)	0.0	($135,964)	$0	$0	$0	($265,492)
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$3,908,827	0.0	$1,954,414	$0	$0	$0	$1,954,413
Final FY 2011-12 Appropriation	$3,908,827	0.0	$1,954,414	$0	$0	$0	$1,954,413
FY12 Total Available Spending Authority	$3,908,827	0.0	$1,954,414	$0	$0	$0	$1,954,413
FY12 Expenditures	$3,894,039	0.0	$1,917,565	$0	$0	$0	$1,976,474
FY 2011-12 Reversion \ (Overexpenditure)	$14,788	0.0	$36,849	$0	$0	$0	($22,061)
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$4,147,628	0.0	$2,073,815	$0	$0	$0	$2,073,813
FY 2012-13 Total Appropriation	**$4,147,628**	**0.0**	**$2,073,815**	**$0**	**$0**	**$0**	**$2,073,813**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$4,147,628	0.0	$2,073,815	$0	$0	$0	$2,073,813
FY 2013-14 Base Request	**$4,147,628**	**0.0**	**$2,073,815**	**$0**	**$0**	**$0**	**$2,073,813**
R#2: "Medicaid Mental Health Community Programs"	$545,466	0.0	$272,732	$0	$0	$0	$272,734
R#13: "1.5% Provider Rate Increase"	$62,214	0.0	$31,107	$0	$0	$0	$31,107
FY 2013-14 Total Request	**$4,755,308**	**0.0**	**$2,377,654**	**$0**	**$0**	**$0**	**$2,377,654**
(3) Medicaid Mental Health Community Programs, Total							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$250,582,216	0.0	$87,070,304	$0	$9,555,600	$12,046	$153,944,266
Long Bill Add-ons, SB 11-209, FY11	$1,007,893	0.0	$6,473,698	$0	$2,096,032	$954	($7,562,791)
Final FY 2010-11 Appropriation	$251,590,109	0.0	$93,544,002	$0	$11,651,632	$13,000	$146,381,475
FY11 Total Available Spending Authority	$251,590,109	0.0	$93,544,002	$0	$11,651,632	$13,000	$146,381,475
FY11 Expenditures	$253,223,259	0.0	$96,589,817	$0	$9,559,892	$13,000	$147,060,550
FY 2010-11 Reversion \ (Overexpenditure)	($1,633,150)	0.0	($3,045,815)	$0	$2,091,740	$0	($679,075)

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(3) Medicaid Mental Health Community Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$276,400,984	0.0	$127,777,722	$0	$10,510,223	$13,544	$138,099,495
Long Bill Add-ons, HB 12-1335, FY12	$2,653,058	0.0	$5,986,391	$0	($4,738,434)	$11,502	$1,393,599
Final FY 2011-12 Appropriation	$279,054,042	0.0	$133,764,113	$0	$5,771,789	$25,046	$139,493,094
FY12 Total Available Spending Authority	$279,054,042	0.0	$133,764,113	$0	$5,771,789	$25,046	$139,493,094
FY12 Expenditures	$277,270,653	0.0	$133,700,167	$0	$5,791,948	$25,046	$137,753,492
FY 2011-12 Reversion \ (Overexpenditure)	$1,783,389	0.0	$63,946	$0	($20,159)	$0	$1,739,602
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$316,728,340	0.0	$144,786,787	$0	$13,648,932	$0	$158,292,621
FY 2012-13 Total Appropriation	**$316,728,340**	**0.0**	**$144,786,787**	**$0**	**$13,648,932**	**$0**	**$158,292,621**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$316,728,340	0.0	$144,786,787	$0	$13,648,932	$0	$158,292,621
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	$3,218,931	0.0	$1,126,626	$0	$0	$0	$2,092,305
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	$215,864	0.0	$75,552	$0	$0	$0	$140,312
FY 2013-14 Base Request	**$320,163,135**	**0.0**	**$145,988,965**	**$0**	**$13,648,932**	**$0**	**$160,525,238**
R#2: "Medicaid Mental Health Community Programs"	$32,384,988	0.0	$10,284,849	$0	($1,313,268)	$0	$23,413,407
R#7: "Substance Use Disorder Benefit"	$5,272,628	0.0	$1,779,950	$0	$42,317	$0	$3,450,361
R#13: "1.5% Provider Rate Increase"	$62,214	0.0	$31,107	$0	$0	$0	$31,107
FY 2013-14 Total Request	**$357,882,965**	**0.0**	**$158,084,871**	**$0**	**$12,377,981**	**$0**	**$187,420,113**

(3) Medicaid Mental Health Community Programs							
FY 2012-13 Total Appropriation	**$316,728,340**	**0.0**	**$144,786,787**	**$0**	**$13,648,932**	**$0**	**$158,292,621**
FY 2013-14 Base Request	**$320,163,135**	**0.0**	**$145,988,965**	**$0**	**$13,648,932**	**$0**	**$160,525,238**
FY 2013-14 Total Request	**$357,882,965**	**0.0**	**$158,084,871**	**$0**	**$12,377,981**	**$0**	**$187,420,113**
Percentage Change FY 2012-13 to FY 2013-14	**12.99%**	**0.00%**	**9.18%**	**0.00%**	**-9.31%**	**0.00%**	**18.40%**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Safety Net Provider Payments							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$277,769,968	0.0	$0	$0	$124,368,097	$0	$153,401,871
Long Bill Add-ons, SB 11-209, FY11	$12,119,174	0.0	$0	$0	$6,499,834	$0	$5,619,340
Final FY 2010-11 Appropriation	$289,889,142	0.0	$0	$0	$130,867,931	$0	$159,021,211
FY11 Total Available Spending Authority	$289,889,142	0.0	$0	$0	$130,867,931	$0	$159,021,211
FY11 Expenditures	$289,889,142	0.0	$0	$0	$130,867,920	$0	$159,021,222
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$11	$0	($11)
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$309,825,106	0.0	$0	$0	$154,912,553	$0	$154,912,553
Supplemental Appropriation, HB 12-1184, FY12	($15,896,240)	0.0	$0	$0	($7,948,120)	$0	($7,948,120)
Long Bill Add-ons, HB 12-1335, FY12	($4,555,560)	0.0	$0	$0	($2,277,780)	$0	($2,277,780)
Final FY 2011-12 Appropriation	$289,373,306	0.0	$0	$0	$144,686,653	$0	$144,686,653
FY12 Total Available Spending Authority	$289,373,306	0.0	$0	$0	$144,686,653	$0	$144,686,653
FY12 Expenditures	$288,633,447	0.0	$0	$0	$144,316,724	$0	$144,316,723
FY 2011-12 Reversion \ (Overexpenditure)	$739,859	0.0	$0	$0	$369,929	$0	$369,930
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$287,055,532	0.0	$0	$0	$143,527,766	$0	$143,527,766
FY 2012-13 Total Appropriation	**$287,055,532**	**0.0**	**$0**	**$0**	**$143,527,766**	**$0**	**$143,527,766**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$287,055,532	0.0	$0	$0	$143,527,766	$0	$143,527,766
FY 2013-14 Base Request	**$287,055,532**	**0.0**	**$0**	**$0**	**$143,527,766**	**$0**	**$143,527,766**
FY 2013-14 Total Request	**$287,055,532**	**0.0**	**$0**	**$0**	**$143,527,766**	**$0**	**$143,527,766**
Clinic Based Indigent Care							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$6,119,760	0.0	$2,350,600	$0	$0	$0	$3,769,160
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$115,051	$0	$0	$0	($115,051)
Final FY 2010-11 Appropriation	$6,119,760	0.0	$2,465,651	$0	$0	$0	$3,654,109
FY11 Total Available Spending Authority	$6,119,760	0.0	$2,465,651	$0	$0	$0	$3,654,109
FY11 Expenditures	$6,119,760	0.0	$2,465,822	$0	$0	$0	$3,653,938
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	($171)	$0	$0	$0	$171

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$6,119,760	0.0	$3,059,880	$0	$0	$0	$3,059,880
Final FY 2011-12 Appropriation	$6,119,760	0.0	$3,059,880	$0	$0	$0	$3,059,880
FY12 Total Available Spending Authority	$6,119,760	0.0	$3,059,880	$0	$0	$0	$3,059,880
FY12 Expenditures	$6,119,760	0.0	$3,059,880	$0	$0	$0	$3,059,880
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$6,119,760	0.0	$3,059,880	$0	$0	$0	$3,059,880
FY 2012-13 Total Appropriation	**$6,119,760**	**0.0**	**$3,059,880**	**$0**	**$0**	**$0**	**$3,059,880**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$6,119,760	0.0	$3,059,880	$0	$0	$0	$3,059,880
FY 2013-14 Base Request	**$6,119,760**	**0.0**	**$3,059,880**	**$0**	**$0**	**$0**	**$3,059,880**
FY 2013-14 Total Request	**$6,119,760**	**0.0**	**$3,059,880**	**$0**	**$0**	**$0**	**$3,059,880**
Health Care Services Fund Programs							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
HB 10-1378, Transfers for Health Care Services, FY11	$29,635,145	0.0	$0	$0	$11,940,000	$0	$17,695,145
Final FY 2010-11 Appropriation	$29,635,145	0.0	$0	$0	$11,940,000	$0	$17,695,145
FY11 Total Available Spending Authority	$29,635,145	0.0	$0	$0	$11,940,000	$0	$17,695,145
FY11 Expenditures	$29,635,144	0.0	$0	$0	$11,909,853	$0	$17,725,291
FY 2010-11 Reversion \ (Overexpenditure)	$1	0.0	$0	$0	$30,147	$0	($30,146)
FY 2011-12 Actual							
SB 11-219, 2011 Transfers For Health Care Services, FY12	$23,510,000	0.0	$0	$0	$11,755,000	$0	$11,755,000
Final FY 2011-12 Appropriation	$23,510,000	0.0	$0	$0	$11,755,000	$0	$11,755,000
FY12 Total Available Spending Authority	$23,510,000	0.0	$0	$0	$11,755,000	$0	$11,755,000
FY12 Expenditures	$23,510,000	0.0	$0	$0	$11,755,000	$0	$11,755,000
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
Pediatric Specialty Hospital							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$14,821,994	0.0	$4,939,128	$0	$307,000	$447,000	$9,128,866
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$278,653	$0	$0	$0	($278,653)
Final FY 2010-11 Appropriation	$14,821,994	0.0	$5,217,781	$0	$307,000	$447,000	$8,850,213
FY11 Total Available Spending Authority	$14,821,994	0.0	$5,217,781	$0	$307,000	$447,000	$8,850,213
FY11 Expenditures	$14,755,860	0.0	$5,201,789	$0	$307,000	$436,728	$8,810,343
FY 2010-11 Reversion \ (Overexpenditure)	$66,134	0.0	$15,992	$0	$0	$10,272	$39,870
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$13,285,882	0.0	$5,899,969	$0	$296,872	$446,100	$6,642,941
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	($1,485,944)	0.0	$0	$0	($296,872)	($446,100)	($742,972)
Final FY 2011-12 Appropriation	$11,799,938	0.0	$5,899,969	$0	$0	$0	$5,899,969
FY12 Total Available Spending Authority	$11,799,938	0.0	$5,899,969	$0	$0	$0	$5,899,969
FY12 Expenditures	$11,799,938	0.0	$5,899,969	$0	$0	$0	$5,899,969
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$11,799,938	0.0	$5,899,969	$0	$0	$0	$5,899,969
FY 2012-13 Total Appropriation	**$11,799,938**	**0.0**	**$5,899,969**	**$0**	**$0**	**$0**	**$5,899,969**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$11,799,938	0.0	$5,899,969	$0	$0	$0	$5,899,969
FY 2013-14 Base Request	**$11,799,938**	**0.0**	**$5,899,969**	**$0**	**$0**	**$0**	**$5,899,969**
FY 2013-14 Total Request	**$11,799,938**	**0.0**	**$5,899,969**	**$0**	**$0**	**$0**	**$5,899,969**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Appropriation from General Fund to Pediatric Specialty Hospital							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$447,000	0.0	$0	$447,000	$0	$0	$0
Final FY 2010-11 Appropriation	$447,000	0.0	$0	$447,000	$0	$0	$0
FY11 Total Available Spending Authority	$447,000	0.0	$0	$447,000	$0	$0	$0
FY11 Expenditures	$436,728	0.0	$0	$436,728	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$10,272	0.0	$0	$10,272	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$446,100	0.0	$0	$446,100	$0	$0	$0
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	($446,100)	0.0	$0	($446,100)	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
Appropriation from Tobacco Tax Cash Fund to the General Fund							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$447,000	0.0	$0	$0	$447,000	$0	$0
Final FY 2010-11 Appropriation	$447,000	0.0	$0	$0	$447,000	$0	$0
FY11 Total Available Spending Authority	$447,000	0.0	$0	$0	$447,000	$0	$0
FY11 Expenditures	$436,728	0.0	$0	$0	$436,728	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$10,272	0.0	$0	$0	$10,272	$0	$0

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$446,100	0.0	$0	$0	$446,100	$0	$0
Final FY 2011-12 Appropriation	$446,100	0.0	$0	$0	$446,100	$0	$0
FY12 Total Available Spending Authority	$446,100	0.0	$0	$0	$446,100	$0	$0
FY12 Expenditures	$445,214	0.0	$0	$0	$445,214	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$886	0.0	$0	$0	$886	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$441,600	0.0	$0	$0	$441,600	$0	$0
FY 2012-13 Total Appropriation	**$441,600**	**0.0**	**$0**	**$0**	**$441,600**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$441,600	0.0	$0	$0	$441,600	$0	$0
FY 2013-14 Base Request	**$441,600**	**0.0**	**$0**	**$0**	**$441,600**	**$0**	**$0**
FY 2013-14 Total Request	**$441,600**	**0.0**	**$0**	**$0**	**$441,600**	**$0**	**$0**
Primary Care Fund Program							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$28,300,000	0.0	$0	$0	$28,300,000	$0	$0
HB 10-1378, Transfers for Health Care Services, FY11	($28,300,000)	0.0	$0	$0	($28,300,000)	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$28,253,000	0.0	$0	$0	$28,253,000	$0	$0
SB 11-219, 2011 Transfers For Health Care Services, FY12	($28,253,000)	0.0	$0	$0	($28,253,000)	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$27,968,000	0.0	$0	$0	$27,968,000	$0	$0
FY 2012-13 Total Appropriation	**$27,968,000**	**0.0**	**$0**	**$0**	**$27,968,000**	**$0**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$27,968,000	0.0	$0	$0	$27,968,000	$0	$0
FY 2013-14 Base Request	**$27,968,000**	**0.0**	**$0**	**$0**	**$27,968,000**	**$0**	**$0**
FY 2013-14 Total Request	**$27,968,000**	**0.0**	**$0**	**$0**	**$27,968,000**	**$0**	**$0**
Primary Care Grant Program Special Distribution							
FY 2010-11 Actual							
HB 10-1378, Transfers for Health Care Services, FY11	$3,560,000	0.0	$0	$0	$3,560,000	$0	$0
Final FY 2010-11 Appropriation	$3,560,000	0.0	$0	$0	$3,560,000	$0	$0
FY11 Total Available Spending Authority	$3,560,000	0.0	$0	$0	$3,560,000	$0	$0
FY11 Expenditures	$3,560,000	0.0	$0	$0	$3,560,000	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
SB 11-219, 2011 Transfers For Health Care Services, FY12	$2,135,830	0.0	$0	$0	$2,135,830	$0	$0
Final FY 2011-12 Appropriation	$2,135,830	0.0	$0	$0	$2,135,830	$0	$0
FY12 Total Available Spending Authority	$2,135,830	0.0	$0	$0	$2,135,830	$0	$0
FY12 Expenditures	$2,135,830	0.0	$0	$0	$2,135,830	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
H.B. 97-1304 Children's Basic Health Plan Trust							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$6,856,880	0.0	$6,856,880	$0	$0	$0	$0
HB 10-1382, Repeal Delay of Public Medical Assistance Program Payments, FY11	$2,554,602	0.0	$2,554,602	$0	$0	$0	$0
Long Bill Add-ons, SB 11-209, FY11	$4,604,711	0.0	$4,604,711	$0	$0	$0	$0
Supplemental Appropriation, SB 11-139, FY11	$1,500,000	0.0	$0	$0	$1,500,000	$0	$0
Final FY 2010-11 Appropriation	$15,516,193	0.0	$14,016,193	$0	$1,500,000	$0	$0
FY11 Total Available Spending Authority	$15,516,193	0.0	$14,016,193	$0	$1,500,000	$0	$0
FY11 Expenditures	$14,016,193	0.0	$14,016,193	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$1,500,000	0.0	$0	$0	$1,500,000	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
Comprehensive Primary and Preventive Care Grants Program							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$2,706,995	0.0	$0	$0	$2,706,995	$0	$0
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	($2,706,995)	0.0	$0	$0	($2,706,995)	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
Children's Basic Health Plan Administration							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$4,889,503	0.0	$0	$0	$2,219,230	$0	$2,670,273
Final FY 2010-11 Appropriation	$4,889,503	0.0	$0	$0	$2,219,230	$0	$2,670,273
FY11 Total Available Spending Authority	$4,889,503	0.0	$0	$0	$2,219,230	$0	$2,670,273
FY11 Expenditures	$4,679,134	0.0	$0	$0	$2,107,643	$0	$2,571,491
FY 2010-11 Reversion \ (Overexpenditure)	$210,369	0.0	$0	$0	$111,587	$0	$98,782
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$4,894,410	0.0	$272,494	$0	$1,948,454	$0	$2,673,462
Final FY 2011-12 Appropriation	$4,894,410	0.0	$272,494	$0	$1,948,454	$0	$2,673,462
FY12 Total Available Spending Authority	$4,894,410	0.0	$272,494	$0	$1,948,454	$0	$2,673,462
FY12 Expenditures	$4,759,499	0.0	$272,494	$0	$1,941,946	$0	$2,545,059
FY 2011-12 Reversion \ (Overexpenditure)	$134,911	0.0	$0	$0	$6,508	$0	$128,403
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$5,134,993	0.0	$0	$0	$2,305,152	$0	$2,829,841
FY 2012-13 Total Appropriation	**$5,134,993**	**0.0**	**$0**	**$0**	**$2,305,152**	**$0**	**$2,829,841**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$5,134,993	0.0	$0	$0	$2,305,152	$0	$2,829,841
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	($814,914)	0.0	$0	$0	($285,220)	$0	($529,694)
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	($1,000)	0.0	$0	$0	($350)	$0	($650)
FY 2013-14 Base Request	**$4,319,079**	**0.0**	**$0**	**$0**	**$2,019,582**	**$0**	**$2,299,497**
FY 2013-14 Total Request	**$4,319,079**	**0.0**	**$0**	**$0**	**$2,019,582**	**$0**	**$2,299,497**
Children's Basic Health Plan Premium Costs							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$202,521,966	0.0	$0	$0	$64,352,642	$6,856,880	$131,312,444
Supplemental Appropriation, SB 11-139, FY11	($202,521,966)	0.0	$0	$0	($64,352,642)	($6,856,880)	($131,312,444)
Long Bill Add-ons, HB 12-1335, FY11	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Children's Basic Health Plan Dental Benefits Costs							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$13,878,070	0.0	$0	$0	$4,857,325	$0	$9,020,745
Supplemental Appropriation, SB 11-139, FY11	($13,878,070)	0.0	$0	$0	($4,857,325)	$0	($9,020,745)
Long Bill Add-ons, HB 12-1335, FY11	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
Children's Basic Health Plan Medical and Dental Costs							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
Long Bill Add-ons, SB 11-209, FY11	($1,182,054)	0.0	$0	$0	($413,718)	$0	($768,336)
Supplemental Appropriation, SB 11-139, FY11	$189,263,210	0.0	$0	$0	$59,385,244	$6,856,880	$123,021,086
Final FY 2010-11 Appropriation	$188,081,156	0.0	$0	$0	$58,971,526	$6,856,880	$122,252,750
FY11 Total Available Spending Authority	$188,081,156	0.0	$0	$0	$58,971,526	$6,856,880	$122,252,750
FY11 Expenditures	$177,283,900	0.0	$0	$0	$55,483,090	$6,856,880	$114,943,930
FY 2010-11 Reversion \ (Overexpenditure)	$10,797,256	0.0	$0	$0	$3,488,436	$0	$7,308,820

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$213,086,149	0.0	$33,001,775	$0	$41,578,378	$0	$138,505,996
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	$0	0.0	($3,449,967)	$446,100	$3,003,867	$0	$0
Supplemental Appropriation, HB 12-1184, FY12	$1,385,723	0.0	($138,601)	$0	$713,695	$0	$810,629
Long Bill Add-ons, HB 12-1335, FY12	($29,603,573)	0.0	$0	$0	($10,052,683)	$0	($19,550,890)
Final FY 2011-12 Appropriation	$184,868,299	0.0	$29,413,207	$446,100	$35,243,257	$0	$119,765,735
FY12 Total Available Spending Authority	$184,868,299	0.0	$29,413,207	$446,100	$35,243,257	$0	$119,765,735
FY12 Expenditures	$182,454,122	0.0	$29,413,207	$446,100	$35,148,096	$0	$117,446,719
FY 2011-12 Reversion \ (Overexpenditure)	$2,414,177	0.0	$0	$0	$95,161	$0	$2,319,016
Pursuant to Executive Order, FY 2011-12 expenditures include transfers to the Disaster Emergency Fund.							
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$182,543,053	0.0	$21,787,355	$441,600	$42,220,291	$0	$118,093,807
FY 2012-13 Total Appropriation	**$182,543,053**	**0.0**	**$21,787,355**	**$441,600**	**$42,220,291**	**$0**	**$118,093,807**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$182,543,053	0.0	$21,787,355	$441,600	$42,220,291	$0	$118,093,807
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	($37,750,557)	0.0	$0	$0	($13,212,695)	$0	($24,537,862)
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	($11,249,291)	0.0	($3,937,252)	$0	$0	$0	($7,312,039)
Annualization of FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	($256,885)	0.0	($68,824)	$0	$331	$0	($188,392)
Annualization of FY 2012-13 JBC Staff Recommendation CHP+ Trust Financing	$0	0.0	$3,000,000	$0	($3,000,000)	$0	$0
FY 2013-14 Base Request	**$133,286,320**	**0.0**	**$20,781,279**	**$441,600**	**$26,007,927**	**$0**	**$86,055,514**
R#3: "Children's Basic Health Plan Medical and Dental Costs"	$60,591,910	0.0	$1,923,755	$0	$19,735,056	$0	$38,933,099
FY 2013-14 Total Request	**$193,878,230**	**0.0**	**$22,705,034**	**$441,600**	**$45,742,983**	**$0**	**$124,988,613**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(4) Indigent Care Program, Total							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$556,052,141	0.0	$14,146,608	$447,000	$224,851,294	$7,303,880	$309,303,359
HB 10-1378, Transfers for Health Care Services, FY11	$4,895,145	0.0	$0	$0	($12,800,000)	$0	$17,695,145
HB 10-1382, Repeal Delay of Public Medical Assistance Program Payments, FY11	$2,554,602	0.0	$2,554,602	$0	$0	$0	$0
Long Bill Add-ons, SB 11-209, FY11	$15,541,831	0.0	$4,998,415	$0	$6,086,116	$0	$4,457,300
Supplemental Appropriation, SB 11-139, FY11	($25,636,826)	0.0	$0	$0	($8,324,723)	$0	($17,312,103)
Final FY 2010-11 Appropriation	$553,406,893	0.0	$21,699,625	$447,000	$209,812,687	$7,303,880	$314,143,701
FY11 Total Available Spending Authority	$553,406,893	0.0	$21,699,625	$447,000	$209,812,687	$7,303,880	$314,143,701
FY11 Expenditures	$540,812,589	0.0	$21,683,804	$436,728	$204,672,234	$7,293,608	$306,726,215
FY 2010-11 Reversion \ (Overexpenditure)	$12,594,304	0.0	$15,821	$10,272	$5,140,453	$10,272	$7,417,486
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$579,063,502	0.0	$42,234,118	$446,100	$230,142,352	$446,100	$305,794,832
SB 11-216, Children's Basic Health Plan General Fund Appropriation, FY12	($4,639,039)	0.0	($3,449,967)	$0	$0	($446,100)	($742,972)
SB 11-219, 2011 Transfers For Health Care Services, FY12	($2,607,170)	0.0	$0	$0	($14,362,170)	$0	$11,755,000
Supplemental Appropriation, HB 12-1184, FY12	($14,510,517)	0.0	($138,601)	$0	($7,234,425)	$0	($7,137,491)
Long Bill Add-ons, HB 12-1335, FY12	($34,159,133)	0.0	$0	$0	($12,330,463)	$0	($21,828,670)
Final FY 2011-12 Appropriation	$523,147,643	0.0	$38,645,550	$446,100	$196,215,294	$0	$287,840,699
FY12 Total Available Spending Authority	$523,147,643	0.0	$38,645,550	$446,100	$196,215,294	$0	$287,840,699
FY12 Expenditures	$519,857,810	0.0	$38,645,550	$446,100	$195,742,810	$0	$285,023,350
FY 2011-12 Reversion \ (Overexpenditure)	$3,289,833	0.0	$0	$0	$472,484	$0	$2,817,349
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$521,062,876	0.0	$30,747,204	$441,600	$216,462,809	$0	$273,411,263
FY 2012-13 Total Appropriation	**$521,062,876**	**0.0**	**$30,747,204**	**$441,600**	**$216,462,809**	**$0**	**$273,411,263**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(4) Indigent Care Program

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$521,062,876	0.0	$30,747,204	$441,600	$216,462,809	$0	$273,411,263
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	($38,565,471)	0.0	$0	$0	($13,497,915)	$0	($25,067,556)
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	($11,250,291)	0.0	($3,937,252)	$0	($350)	$0	($7,312,689)
Annualization of FY 2012-13 R#7: "Medicaid and CHP Cost-Sharing"	($256,885)	0.0	($68,824)	$0	$331	$0	($188,392)
Annualization of FY 2012-13 JBC Staff Recommendation CHP+ Trust Financing	$0	0.0	$3,000,000	$0	($3,000,000)	$0	$0
FY 2013-14 Base Request	**$470,990,229**	**0.0**	**$29,741,128**	**$441,600**	**$199,964,875**	**$0**	**$240,842,626**
R#3: "Children's Basic Health Plan Medical and Dental Costs"	$60,591,910	0.0	$1,923,755	$0	$19,735,056	$0	$38,933,099
FY 2013-14 Total Request	**$531,582,139**	**0.0**	**$31,664,883**	**$441,600**	**$219,699,931**	**$0**	**$279,775,725**

(4) Indigent Care Program							
FY 2012-13 Total Appropriation	**$521,062,876**	**0.0**	**$30,747,204**	**$441,600**	**$216,462,809**	**$0**	**$273,411,263**
FY 2013-14 Base Request	**$470,990,229**	**0.0**	**$29,741,128**	**$441,600**	**$199,964,875**	**$0**	**$240,842,626**
FY 2013-14 Total Request	**$531,582,139**	**0.0**	**$31,664,883**	**$441,600**	**$219,699,931**	**$0**	**$279,775,725**
Percentage Change FY 2012-13 to FY 2013-14	**2.02%**	**0.00%**	**2.98%**	**0.00%**	**1.50%**	**0.00%**	**2.33%**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(5) Other Medical Services

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
Services for Old Age Pension State Medical Program Clients							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$15,083,483	0.0	$0	$0	$12,848,483	$2,235,000	$0
Long Bill Add-ons, SB 11-209, FY11	($4,083,483)	0.0	$0	$0	($1,848,483)	($2,235,000)	$0
Final FY 2010-11 Appropriation	$11,000,000	0.0	$0	$0	$11,000,000	$0	$0
FY11 Total Available Spending Authority	$11,000,000	0.0	$0	$0	$11,000,000	$0	$0
FY11 Expenditures	$8,206,192	0.0	$0	$0	$8,206,192	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$2,793,808	0.0	$0	$0	$2,793,808	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$11,000,000	0.0	$0	$0	$11,000,000	$0	$0
Final FY 2011-12 Appropriation	$11,000,000	0.0	$0	$0	$11,000,000	$0	$0
FY12 Total Available Spending Authority	$11,000,000	0.0	$0	$0	$11,000,000	$0	$0
FY12 Expenditures	$9,148,285	0.0	$0	$0	$9,148,285	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$1,851,715	0.0	$0	$0	$1,851,715	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$12,400,000	0.0	$2,400,000	$0	$10,000,000	$0	$0
FY 2012-13 Total Appropriation	**$12,400,000**	**0.0**	**$2,400,000**	**$0**	**$10,000,000**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$12,400,000	0.0	$2,400,000	$0	$10,000,000	$0	$0
FY 2013-14 Base Request	**$12,400,000**	**0.0**	**$2,400,000**	**$0**	**$10,000,000**	**$0**	**$0**
FY 2013-14 Total Request	**$12,400,000**	**0.0**	**$2,400,000**	**$0**	**$10,000,000**	**$0**	**$0**
Transfer of Tobacco Tax Cash Fund into the Supplemental Old Age Pension State Medical Fund							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$2,235,000	0.0	$0	$0	$2,235,000	$0	$0
Final FY 2010-11 Appropriation	$2,235,000	0.0	$0	$0	$2,235,000	$0	$0
FY11 Total Available Spending Authority	$2,235,000	0.0	$0	$0	$2,235,000	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$2,235,000	0.0	$0	$0	$2,235,000	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(5) Other Medical Services

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$2,230,500	0.0	$0	$0	$2,230,500	$0	$0
SB 11-210, Phase Out Supplemental OAP Health Fund, FY12	($2,230,500)	0.0	$0	$0	($2,230,500)	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
Commission on Family Medicine Residency Training Programs							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$1,738,846	0.0	$667,891	$0	$0	$0	$1,070,955
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$32,690	$0	$0	$0	($32,690)
Final FY 2010-11 Appropriation	$1,738,846	0.0	$700,581	$0	$0	$0	$1,038,265
FY11 Total Available Spending Authority	$1,738,846	0.0	$700,581	$0	$0	$0	$1,038,265
FY11 Expenditures	$1,738,846	0.0	$700,624	$0	$0	$0	$1,038,222
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	($43)	$0	$0	$0	$43
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$1,391,077	0.0	$695,538	$0	$0	$0	$695,539
Supplemental Appropriation, HB 12-1184, FY12	$350,000	0.0	$175,000	$0	$0	$0	$175,000
Final FY 2011-12 Appropriation	$1,741,077	0.0	$870,538	$0	$0	$0	$870,539
FY12 Total Available Spending Authority	$1,741,077	0.0	$870,538	$0	$0	$0	$870,539
FY12 Expenditures	$1,741,077	0.0	$870,538	$0	$0	$0	$870,539
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$1,741,077	0.0	$870,538	$0	$0	$0	$870,539
FY 2012-13 Total Appropriation	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$0**	**$870,539**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(5) Other Medical Services

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$1,741,077	0.0	$870,538	$0	$0	$0	$870,539
FY 2013-14 Base Request	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$0**	**$870,539**
FY 2013-14 Total Request	**$1,741,077**	**0.0**	**$870,538**	**$0**	**$0**	**$0**	**$870,539**
State University Teaching Hospitals, Denver Health and Hospital Authority							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$1,831,714	0.0	$703,561	$0	$0	$0	$1,128,153
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$34,437	$0	$0	$0	($34,437)
Final FY 2010-11 Appropriation	$1,831,714	0.0	$737,998	$0	$0	$0	$1,093,716
FY11 Total Available Spending Authority	$1,831,714	0.0	$737,998	$0	$0	$0	$1,093,716
FY11 Expenditures	$1,831,714	0.0	$738,043	$0	$0	$0	$1,093,671
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	($45)	$0	$0	$0	$45
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$1,831,714	0.0	$915,857	$0	$0	$0	$915,857
Final FY 2011-12 Appropriation	$1,831,714	0.0	$915,857	$0	$0	$0	$915,857
FY12 Total Available Spending Authority	$1,831,714	0.0	$915,857	$0	$0	$0	$915,857
FY12 Expenditures	$1,831,714	0.0	$915,857	$0	$0	$0	$915,857
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$1,831,714	0.0	$915,857	$0	$0	$0	$915,857
FY 2012-13 Total Appropriation	**$1,831,714**	**0.0**	**$915,857**	**$0**	**$0**	**$0**	**$915,857**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$1,831,714	0.0	$915,857	$0	$0	$0	$915,857
FY 2013-14 Base Request	**$1,831,714**	**0.0**	**$915,857**	**$0**	**$0**	**$0**	**$915,857**
FY 2013-14 Total Request	**$1,831,714**	**0.0**	**$915,857**	**$0**	**$0**	**$0**	**$915,857**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(5) Other Medical Services

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
State University Teaching Hospitals, University of Colorado Hospital Authority							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$676,785	0.0	$259,953	$0	$0	$0	$416,832
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$12,724	$0	$0	$0	($12,724)
Final FY 2010-11 Appropriation	$676,785	0.0	$272,677	$0	$0	$0	$404,108
FY11 Total Available Spending Authority	$676,785	0.0	$272,677	$0	$0	$0	$404,108
FY11 Expenditures	$676,785	0.0	$272,694	$0	$0	$0	$404,091
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	($17)	$0	$0	$0	$17
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$633,314	0.0	$316,657	$0	$0	$0	$316,657
Final FY 2011-12 Appropriation	$633,314	0.0	$316,657	$0	$0	$0	$316,657
FY12 Total Available Spending Authority	$633,314	0.0	$316,657	$0	$0	$0	$316,657
FY12 Expenditures	$633,314	0.0	$316,657	$0	$0	$0	$316,657
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$633,314	0.0	$316,657	$0	$0	$0	$316,657
FY 2012-13 Total Appropriation	**$633,314**	**0.0**	**$316,657**	**$0**	**$0**	**$0**	**$316,657**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$633,314	0.0	$316,657	$0	$0	$0	$316,657
FY 2013-14 Base Request	**$633,314**	**0.0**	**$316,657**	**$0**	**$0**	**$0**	**$316,657**
FY 2013-14 Total Request	**$633,314**	**0.0**	**$316,657**	**$0**	**$0**	**$0**	**$316,657**
Medicaid Modernization Act of 2003 State Contribution Payment							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$70,700,172	0.0	$70,700,172	$0	$0	$0	$0
Long Bill Add-ons, SB 11-209, FY11	$1,286,372	0.0	$1,286,372	$0	$0	$0	$0
Supplemental Appropriation, SB 11-139, FY11	$0	0.0	($13,671,043)	$0	$0	$0	$13,671,043
Final FY 2010-11 Appropriation	$71,986,544	0.0	$58,315,501	$0	$0	$0	$13,671,043
FY11 Total Available Spending Authority	$71,986,544	0.0	$58,315,501	$0	$0	$0	$13,671,043
FY11 Expenditures	$72,377,768	0.0	$58,711,725	$0	$0	$0	$13,666,043
FY 2010-11 Reversion \ (Overexpenditure)	($391,224)	0.0	($396,224)	$0	$0	$0	$5,000

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(5) Other Medical Services

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$91,156,720	0.0	$66,146,615	$0	$0	$0	$25,010,105
Supplemental Appropriation, HB 12-1184, FY12	$0	0.0	($5,633,177)	$0	$0	$0	$5,633,177
Long Bill Add-ons, HB 12-1335, FY12	$2,356,099	0.0	$2,356,099	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$93,512,819	0.0	$62,869,537	$0	$0	$0	$30,643,282
FY12 Total Available Spending Authority	$93,512,819	0.0	$62,869,537	$0	$0	$0	$30,643,282
FY12 Expenditures	$93,582,494	0.0	$62,939,212	$0	$0	$0	$30,643,282
FY 2011-12 Reversion \ (Overexpenditure)	($69,675)	0.0	($69,675)	$0	$0	$0	$0
Pursuant to Executive Order, FY 2011-12 expenditures include transfers to the Disaster Emergency Fund.							
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$90,656,176	0.0	$50,609,286	$0	$0	$0	$40,046,890
FY 2012-13 Total Appropriation	**$90,656,176**	**0.0**	**$50,609,286**	**$0**	**$0**	**$0**	**$40,046,890**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$90,656,176	0.0	$50,609,286	$0	$0	$0	$40,046,890
Annualization of FY 2012-13 R#11: "CHIPRA Bonus Payment True-up"	$0	0.0	($2,983,119)	$0	$0	$0	$2,983,119
Technical Correction for Annualization of FY 2011-12 BA#11: "Cash Fund Insolvency True-up"	$6,018,686	0.0	$0	$0	$0	$0	$6,018,686
FY 2013-14 Base Request	**$96,674,862**	**0.0**	**$47,626,167**	**$0**	**$0**	**$0**	**$49,048,695**
R#4: "Medicare Modernization Act of 2003 State Contribution Payment"	$14,603,355	0.0	$14,603,355	$0	$0	$0	$0
FY 2013-14 Total Request	**$111,278,217**	**0.0**	**$62,229,522**	**$0**	**$0**	**$0**	**$49,048,695**
Public School Health Services Contract Administration							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$799,700	0.0	$0	$0	$0	$0	$799,700
Final FY 2010-11 Appropriation	$799,700	0.0	$0	$0	$0	$0	$799,700
FY11 Total Available Spending Authority	$799,700	0.0	$0	$0	$0	$0	$799,700
FY11 Expenditures	$799,699	0.0	$0	$0	$0	$0	$799,699
FY 2010-11 Reversion \ (Overexpenditure)	$1	0.0	$0	$0	$0	$0	$1

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14							Schedule 3
(5) Other Medical Services							
Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$1,138,549	0.0	$0	$0	$0	$0	$1,138,549
Final FY 2011-12 Appropriation	$1,138,549	0.0	$0	$0	$0	$0	$1,138,549
FY12 Total Available Spending Authority	$1,138,549	0.0	$0	$0	$0	$0	$1,138,549
FY12 Expenditures	$824,064	0.0	$0	$0	$0	$0	$824,064
FY 2011-12 Reversion \ (Overexpenditure)	$314,485	0.0	$0	$0	$0	$0	$314,485
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$1,138,549	0.0	$0	$0	$0	$0	$1,138,549
FY 2012-13 Total Appropriation	**$1,138,549**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$1,138,549**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$1,138,549	0.0	$0	$0	$0	$0	$1,138,549
FY 2013-14 Base Request	**$1,138,549**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$1,138,549**
FY 2013-14 Total Request	**$1,138,549**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$1,138,549**
Public School Health Services							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$29,537,394	0.0	$0	$0	$15,391,007	$0	$14,146,387
Final FY 2010-11 Appropriation	$29,537,394	0.0	$0	$0	$15,391,007	$0	$14,146,387
FY11 Total Available Spending Authority	$29,537,394	0.0	$0	$0	$15,391,007	$0	$14,146,387
FY11 Expenditures	$24,659,097	0.0	$0	$0	$11,302,888	$0	$13,356,209
FY 2010-11 Reversion \ (Overexpenditure)	$4,878,297	0.0	$0	$0	$4,088,119	$0	$790,178
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$30,446,344	0.0	$0	$0	$16,010,155	$0	$14,436,189
Final FY 2011-12 Appropriation	$30,446,344	0.0	$0	$0	$16,010,155	$0	$14,436,189
FY12 Year-End Transfers	$0	0.0	$0	$0	$0	$0	$0
FY12 1331 Emergency Funding for the Public School Health Services Program	$15,486,243	0.0	$0	$0	$4,766,682	$0	$10,719,561
FY12 Roll-forward	$0	0.0	$0	$0	$0	$0	$0
FY12 Allocated Pots	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$45,932,587	0.0	$0	$0	$20,776,837	$0	$25,155,750
FY12 Expenditures	$44,781,920	0.0	($2,091,950)	$0	$22,390,960	$0	$24,482,910
FY 2011-12 Reversion \ (Overexpenditure)	$1,150,667	0.0	$2,091,950	$0	($1,614,123)	$0	$672,840

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(5) Other Medical Services

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$30,446,344	0.0	$0	$0	$16,010,155	$0	$14,436,189
FY 2012-13 Total Appropriation	**$30,446,344**	**0.0**	**$0**	**$0**	**$16,010,155**	**$0**	**$14,436,189**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$30,446,344	0.0	$0	$0	$16,010,155	$0	$14,436,189
FY 2013-14 Base Request	**$30,446,344**	**0.0**	**$0**	**$0**	**$16,010,155**	**$0**	**$14,436,189**
FY 2013-14 Total Request	**$30,446,344**	**0.0**	**$0**	**$0**	**$16,010,155**	**$0**	**$14,436,189**
(5) Other Medical Services, Total							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$122,603,094	0.0	$72,331,577	$0	$30,474,490	$2,235,000	$17,562,027
Long Bill Add-ons, SB 11-209, FY11	($2,797,111)	0.0	$1,366,223	$0	($1,848,483)	($2,235,000)	($79,851)
Supplemental Appropriation, SB 11-139, FY11	$0	0.0	($13,671,043)	$0	$0	$0	$13,671,043
Final FY 2010-11 Appropriation	$119,805,983	0.0	$60,026,757	$0	$28,626,007	$0	$31,153,219
FY11 Total Available Spending Authority	$119,805,983	0.0	$60,026,757	$0	$28,626,007	$0	$31,153,219
FY11 Expenditures	$110,290,101	0.0	$60,423,086	$0	$19,509,080	$0	$30,357,935
FY 2010-11 Reversion \ (Overexpenditure)	$9,515,882	0.0	($396,329)	$0	$9,116,927	$0	$795,284
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$139,828,218	0.0	$68,074,667	$0	$29,240,655	$0	$42,512,896
SB 11-210, Phase Out Supplemental OAP Health Fund, FY12	($2,230,500)	0.0	$0	$0	($2,230,500)	$0	$0
Supplemental Appropriation, HB 12-1184, FY12	$350,000	0.0	($5,458,177)	$0	$0	$0	$5,808,177
Long Bill Add-ons, HB 12-1335, FY12	$2,356,099	0.0	$2,356,099	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$140,303,817	0.0	$64,972,589	$0	$27,010,155	$0	$48,321,073
FY12 1331 Emergency Funding for the Public School Health Services Program	$15,486,243	0.0	$0	$0	$4,766,682	$0	$10,719,561
FY12 Total Available Spending Authority	$155,790,060	0.0	$64,972,589	$0	$31,776,837	$0	$59,040,634
FY12 Expenditures	$152,542,868	0.0	$62,950,314	$0	$31,539,245	$0	$58,053,309
FY 2011-12 Reversion \ (Overexpenditure)	$3,247,192	0.0	$2,022,275	$0	$237,592	$0	$987,325
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$138,847,174	0.0	$55,112,338	$0	$26,010,155	$0	$57,724,681
FY 2012-13 Total Appropriation	**$138,847,174**	**0.0**	**$55,112,338**	**$0**	**$26,010,155**	**$0**	**$57,724,681**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(5) Other Medical Services

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$138,847,174	0.0	$55,112,338	$0	$26,010,155	$0	$57,724,681
Annualization of FY 2012-13 R#11: "CHIPRA Bonus Payment True-up"	$0	0.0	($2,983,119)	$0	$0	$0	$2,983,119
Technical Correction for Annualization of FY 2011-12 BA#11: "Cash Fund Insolvency True-up"	$6,018,686	0.0	$0	$0	$0	$0	$6,018,686
FY 2013-14 Base Request	**$144,865,860**	**0.0**	**$52,129,219**	**$0**	**$26,010,155**	**$0**	**$66,726,486**
R#4: "Medicare Modernization Act of 2003 State Contribution Payment"	$14,603,355	0.0	$14,603,355	$0	$0	$0	$0
FY 2013-14 Total Request	**$159,469,215**	**0.0**	**$66,732,574**	**$0**	**$26,010,155**	**$0**	**$66,726,486**

(5) Other Medical Services	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Total Appropriation	**$138,847,174**	**0.0**	**$55,112,338**	**$0**	**$26,010,155**	**$0**	**$57,724,681**
FY 2013-14 Base Request	**$144,865,860**	**0.0**	**$52,129,219**	**$0**	**$26,010,155**	**$0**	**$66,726,486**
FY 2013-14 Total Request	**$159,469,215**	**0.0**	**$66,732,574**	**$0**	**$26,010,155**	**$0**	**$66,726,486**
Percentage Change FY 2012-13 to FY 2013-14	**14.85%**	**0.00%**	**21.08%**	**0.00%**	**0.00%**	**0.00%**	**15.59%**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(A) Executive Director's Office - Medicaid Funding, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$12,080,342	0.0	$5,414,766	$0	$0	$388	$6,665,188
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$98,932	$0	$0	$0	($98,932)
Supplemental Appropriation, SB 11-139, FY11	($9,275)	0.0	($4,246)	$0	$0	$0	($5,029)
Final FY 2010-11 Appropriation	$12,071,067	0.0	$5,509,452	$0	$0	$388	$6,561,227
FY11 Allocated Pots	($7,353,017)	0.0	($3,676,508)	$0	$0	$0	($3,676,509)
FY11 Total Available Spending Authority	$4,718,050	0.0	$1,832,944	$0	$0	$388	$2,884,718
FY11 Expenditures	$4,717,412	0.0	$1,956,417	$0	$0	$0	$2,760,995
FY 2010-11 Reversion \ (Overexpenditure)	$638	0.0	($123,473)	$0	$0	$388	$123,723
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$13,363,338	0.0	$6,681,669	$0	$0	$0	$6,681,669
SB 11-076, PERA Contribution Rates, FY12	($18,819)	0.0	($9,410)	$0	$0	$0	($9,409)
Final FY 2011-12 Appropriation	$13,344,519	0.0	$6,672,259	$0	$0	$0	$6,672,260
FY12 Allocated Pots	($7,438,675)	0.0	($3,719,336)	$0	$0	$0	($3,719,339)
FY12 Total Available Spending Authority	$5,905,844	0.0	$2,952,923	$0	$0	$0	$2,952,921
FY12 Expenditures	$4,169,886	0.0	$2,084,943	$0	$0	$0	$2,084,943
FY 2011-12 Reversion \ (Overexpenditure)	$1,735,958	0.0	$867,980	$0	$0	$0	$867,978
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$15,173,536	0.0	$7,586,768	$0	$0	$0	$7,586,768
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY13	$62,776	0.0	$31,388	$0	$0	$0	$31,388
HB 12-1339, Colorado Benefits Management System Project, FY13	$39,762	0.0	$19,881	$0	$0	$0	$19,881
FY 2012-13 Total Appropriation	**$15,276,074**	**0.0**	**$7,638,037**	**$0**	**$0**	**$0**	**$7,638,037**

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$15,276,074	0.0	$7,638,037	$0	$0	$0	$7,638,037
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY14	($62,776)	0.0	($31,388)	$0	$0	$0	($31,388)
HB 12-1339, Colorado Benefits Management System Project, FY14	$34,381	0.0	$17,191	$0	$0	$0	$17,190
FY14 Common Policy Adjustment	$1,751,988	0.0	$876,332	$0	$0	$0	$875,656
FY 2013-14 Base Request	**$16,999,667**	**0.0**	**$8,500,172**	**$0**	**$0**	**$0**	**$8,499,495**
NP-R#10: "DHS - DPA - Employee Engagement Survey Adjustment"	$7,736	0.0	$3,868	$0	$0	$0	$3,868
FY 2013-14 Total Request	**$17,007,403**	**0.0**	**$8,504,040**	**$0**	**$0**	**$0**	**$8,503,363**
(B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$9,359,525	0.0	$4,641,210	$0	$19,152	$22,385	$4,676,778
HB 10-1146, State-funded Public Assistance Programs, FY11	$184,387	0.0	$91,434	$0	$818	$0	$92,135
HB 10-1384, Alignment of Eligibility for the Old Age Pension Program, FY11	$17,220	0.0	$8,539	$0	$76	$0	$8,605
Supplemental Appropriation, SB 11-139, FY11	$29,510	0.0	($259,967)	$0	$274,951	$176	$14,350
Final FY 2010-11 Appropriation	$9,590,642	0.0	$4,481,216	$0	$294,997	$22,561	$4,791,868
FY11 Total Available Spending Authority	$9,590,642	0.0	$4,481,216	$0	$294,997	$22,561	$4,791,868
FY11 Expenditures	$8,547,537	0.0	$4,242,887	$0	$19,715	$0	$4,284,935
FY 2010-11 Reversion \ (Overexpenditure)	$1,043,105	0.0	$238,329	$0	$275,282	$22,561	$506,933
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$8,983,839	0.0	$4,461,609	$0	$14,428	$19,399	$4,488,403
HB 12-1339, Colorado Benefits Management System Project, FY12	$3,654,755	0.0	$1,820,992	$0	$8,521	$0	$1,825,242
Supplemental Appropriation, HB 12-1184, FY12	$1,165,046	0.0	($149,482)	$0	$732,537	($650)	$582,641
Final FY 2011-12 Appropriation	$13,803,640	0.0	$6,133,119	$0	$755,486	$18,749	$6,896,286
FY12 Total Available Spending Authority	$13,803,640	0.0	$6,133,119	$0	$755,486	$18,749	$6,896,286
FY12 Expenditures	$9,447,008	0.0	$4,147,409	$0	$550,920	$25,562	$4,723,117

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Reversion \ (Overexpenditure)	$4,356,632	0.0	$1,985,710	$0	$204,566	($6,813)	$2,173,169
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$9,040,363	0.0	$4,489,039	$0	$14,481	$20,577	$4,516,266
HB 12-1339, Colorado Benefits Management System Project, FY13	$7,591,074	0.0	$3,287,514	$0	$10,708	$0	$4,292,852
FY 2012-13 Total Appropriation	**$16,631,437**	**0.0**	**$7,776,553**	**$0**	**$25,189**	**$20,577**	**$8,809,118**
FY13 Roll-forward	$3,406,043	0.0	$1,697,240	$0	$7,837	$0	$1,700,966
FY 2012-13 Total Available Spending Authority	**$20,037,480**	**0.0**	**$9,473,793**	**$0**	**$33,026**	**$20,577**	**$10,510,084**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$16,631,437	0.0	$7,776,553	$0	$25,189	$20,577	$8,809,118
HB 12-1339, Colorado Benefits Management System Project, FY14	($7,026,961)	0.0	($3,007,252)	$0	($8,314)	$0	($4,011,395)
SB 10-061, Medicaid Hospice Room and Board Charges, FY14	($151,453)	0.0	($75,103)	$0	($310)	($362)	($75,678)
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	($25,728)	0.0	($12,777)	$0	($41)	($56)	($12,854)
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	($25,728)	0.0	($12,777)	$0	($41)	($56)	($12,854)
Annualization of FY 2012-13 R#13: "CBMS Electronic Document Management System"	($431,611)	0.0	($214,546)	$0	($429)	($1,294)	($215,342)
FY 2013-14 Base Request	**$8,969,956**	**0.0**	**$4,454,098**	**$0**	**$16,054**	**$18,809**	**$4,480,995**
FY 2013-14 Total Request	**$8,969,956**	**0.0**	**$4,454,098**	**$0**	**$16,054**	**$18,809**	**$4,480,995**
Current Roll-forward reporting requirements result in overstated reversions of $3,406,043 TF in FY 2011-12 and overstated spending authority of $3,406,043 TF in FY 2012-13.							
(B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System - HCPF Only							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$0	0.0	$0	$0	$0	$0	$0
Final FY 2010-11 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY11 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
Supplemental Appropriation, HB 12-1184, FY12	$812,400	0.0	$107,460	$0	$298,740	$0	$406,200
Final FY 2011-12 Appropriation	$812,400	0.0	$107,460	$0	$298,740	$0	$406,200
FY12 Total Available Spending Authority	$812,400	0.0	$107,460	$0	$298,740	$0	$406,200
FY12 Expenditures	$812,400	0.0	$107,460	$0	$298,740	$0	$406,200
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$611,520	0.0	$0	$0	$305,760	$0	$305,760
FY 2012-13 Total Appropriation	**$611,520**	**0.0**	**$0**	**$0**	**$305,760**	**$0**	**$305,760**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$611,520	0.0	$0	$0	$305,760	$0	$305,760
FY 2013-14 Base Request	**$611,520**	**0.0**	**$0**	**$0**	**$305,760**	**$0**	**$305,760**
FY 2013-14 Total Request	**$611,520**	**0.0**	**$0**	**$0**	**$305,760**	**$0**	**$305,760**
(B) Office of Information Technology Services - Medicaid Funding, CBMS SAS-70 Audit							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$56,069	0.0	$27,804	$0	$115	$134	$28,016
Final FY 2010-11 Appropriation	$56,069	0.0	$27,804	$0	$115	$134	$28,016
Restricted Funds from FY 2009-10	($1,410)	0.0	($1,410)	$0	$0	$0	$0
FY11 Total Available Spending Authority	$54,659	0.0	$26,394	$0	$115	$134	$28,016
FY11 Expenditures	$50,545	0.0	$25,114	$0	$65	$132	$25,234
FY 2010-11 Reversion \ (Overexpenditure)	$4,114	0.0	$1,280	$0	$50	$2	$2,782
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$55,204	0.0	$27,416	$0	$89	$119	$27,580
Final FY 2011-12 Appropriation	$55,204	0.0	$27,416	$0	$89	$119	$27,580
FY12 Total Available Spending Authority	$55,204	0.0	$27,416	$0	$89	$119	$27,580
FY12 Expenditures	$50,850	0.0	$25,294	$0	$53	$112	$25,391
FY 2011-12 Reversion \ (Overexpenditure)	$4,354	0.0	$2,122	$0	$36	$7	$2,189

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$55,204	0.0	$27,416	$0	$89	$119	$27,580
FY 2012-13 Total Appropriation	**$55,204**	**0.0**	**$27,416**	**$0**	**$89**	**$119**	**$27,580**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$55,204	0.0	$27,416	$0	$89	$119	$27,580
FY 2013-14 Base Request	**$55,204**	**0.0**	**$27,416**	**$0**	**$89**	**$119**	**$27,580**
FY 2013-14 Total Request	**$55,204**	**0.0**	**$27,416**	**$0**	**$89**	**$119**	**$27,580**
(B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System Client Services Improvement Project							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$1,242,581	0.0	$616,172	$0	$2,543	$2,972	$620,894
Final FY 2010-11 Appropriation	$1,242,581	0.0	$616,172	$0	$2,543	$2,972	$620,894
FY11 Total Available Spending Authority	$1,242,581	0.0	$616,172	$0	$2,543	$2,972	$620,894
FY11 Expenditures	$795,719	0.0	$396,274	$0	$456	$2,972	$396,017
FY 2010-11 Reversion \ (Overexpenditure)	$446,862	0.0	$219,898	$0	$2,087	$0	$224,877
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3
(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(B) Office of Information Technology Services - Medicaid Funding, Other Office of Information Technology Services Line Items							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$540,940	0.0	$216,220	$0	$0	$0	$324,720
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$8,810	$0	$0	$0	($8,810)
Final FY 2010-11 Appropriation	$540,940	0.0	$225,030	$0	$0	$0	$315,910
FY11 Total Available Spending Authority	$540,940	0.0	$225,030	$0	$0	$0	$315,910
FY11 Expenditures	$540,941	0.0	$220,082	$0	$0	$0	$320,859
FY 2010-11 Reversion \ (Overexpenditure)	($1)	0.0	$4,948	$0	$0	$0	($4,949)
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$556,271	0.0	$278,136	$0	$0	$0	$278,135
Final FY 2011-12 Appropriation	$556,271	0.0	$278,136	$0	$0	$0	$278,135
FY12 Total Available Spending Authority	$556,271	0.0	$278,136	$0	$0	$0	$278,135
FY12 Expenditures	$555,484	0.0	$277,742	$0	$0	$0	$277,742
FY 2011-12 Reversion \ (Overexpenditure)	$787	0.0	$394	$0	$0	$0	$393
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$500,820	0.0	$250,410	$0	$0	$0	$250,410
FY 2012-13 Total Appropriation	**$500,820**	**0.0**	**$250,410**	**$0**	**$0**	**$0**	**$250,410**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$500,820	0.0	$250,410	$0	$0	$0	$250,410
FY14 Common Policy Adjustment	($17,421)	0.0	($8,711)	$0	$0	$0	($8,710)
FY 2013-14 Base Request	**$483,399**	**0.0**	**$241,699**	**$0**	**$0**	**$0**	**$241,700**
NP-R#8: "DHS - OIT - Enterprise Asset Management"	$1,532	0.0	$766	$0	$0	$0	$766
FY 2013-14 Total Request	**$484,931**	**0.0**	**$242,465**	**$0**	**$0**	**$0**	**$242,466**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(B) Office of Information Technology Services - Medicaid Funding, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$11,199,115	0.0	$5,501,406	$0	$21,810	$25,491	$5,650,408
HB 10-1146, State-funded Public Assistance Programs, FY11	$184,387	0.0	$91,434	$0	$818	$0	$92,135
HB 10-1384, Alignment of Eligibility for the Old Age Pension Program, FY11	$17,220	0.0	$8,539	$0	$76	$0	$8,605
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$8,810	$0	$0	$0	($8,810)
Supplemental Appropriation, SB 11-139, FY11	$29,510	0.0	($259,967)	$0	$274,951	$176	$14,350
Final FY 2010-11 Appropriation	$11,430,232	0.0	$5,350,222	$0	$297,655	$25,667	$5,756,688
Restricted Funds from FY 2009-10	($1,410)	0.0	($1,410)	$0	$0	$0	$0
FY11 Total Available Spending Authority	$11,428,822	0.0	$5,348,812	$0	$297,655	$25,667	$5,756,688
FY11 Expenditures	$9,934,742	0.0	$4,884,357	$0	$20,236	$3,104	$5,027,045
FY 2010-11 Reversion \ (Overexpenditure)	$1,494,080	0.0	$464,455	$0	$277,419	$22,563	$729,643
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$9,595,314	0.0	$4,767,161	$0	$14,517	$19,518	$4,794,118
HB 12-1339, Colorado Benefits Management System Project, FY12	$3,654,755	0.0	$1,820,992	$0	$8,521	$0	$1,825,242
Supplemental Appropriation, HB 12-1184, FY12	$1,977,446	0.0	($42,022)	$0	$1,031,277	($650)	$988,841
Final FY 2011-12 Appropriation	$15,227,515	0.0	$6,546,131	$0	$1,054,315	$18,868	$7,608,201
FY12 Total Available Spending Authority	$15,227,515	0.0	$6,546,131	$0	$1,054,315	$18,868	$7,608,201
FY12 Expenditures	$10,865,742	0.0	$4,557,905	$0	$849,713	$25,674	$5,432,450
FY 2011-12 Reversion \ (Overexpenditure)	$4,361,773	0.0	$1,988,226	$0	$204,602	($6,806)	$2,175,751
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$10,207,907	0.0	$4,766,865	$0	$320,330	$20,696	$5,100,016
HB 12-1339, Colorado Benefits Management System Project, FY13	$7,591,074	0.0	$3,287,514	$0	$10,708	$0	$4,292,852
FY 2012-13 Total Appropriation	**$17,798,981**	**0.0**	**$8,054,379**	**$0**	**$331,038**	**$20,696**	**$9,392,868**
FY13 Roll-forward	$3,406,043	0.0	$1,697,240	$0	$7,837	$0	$1,700,966
FY 2012-13 Total Available Spending Authority	**$21,205,024**	**0.0**	**$9,751,619**	**$0**	**$338,875**	**$20,696**	**$11,093,834**

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$17,798,981	0.0	$8,054,379	$0	$331,038	$20,696	$9,392,868
HB 12-1339, Colorado Benefits Management System Project, FY14	($7,026,961)	0.0	($3,007,252)	$0	($8,314)	$0	($4,011,395)
SB 10-061, Medicaid Hospice Room and Board Charges, FY14	($151,453)	0.0	($75,103)	$0	($310)	($362)	($75,678)
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	($25,728)	0.0	($12,777)	$0	($41)	($56)	($12,854)
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	($25,728)	0.0	($12,777)	$0	($41)	($56)	($12,854)
Annualization of FY 2012-13 R#13: "CBMS Electronic Document Management System"	($431,611)	0.0	($214,546)	$0	($429)	($1,294)	($215,342)
FY14 Common Policy Adjustment	($17,421)	0.0	($8,711)	$0	$0	$0	($8,710)
FY 2013-14 Base Request	**$10,120,079**	**0.0**	**$4,723,213**	**$0**	**$321,903**	**$18,928**	**$5,056,035**
NP-R#8: "DHS - OIT - Enterprise Asset Management"	$1,532	0.0	$766	$0	$0	$0	$766
FY 2013-14 Total Request	**$10,121,611**	**0.0**	**$4,723,979**	**$0**	**$321,903**	**$18,928**	**$5,056,801**
(C) Office of Operations - Medicaid Funding, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$5,109,630	0.0	$1,962,609	$0	$0	$0	$3,147,021
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$96,174	$0	$0	$0	($96,174)
Supplemental Appropriation, SB 11-139, FY11	($26,753)	0.0	($10,779)	$0	$0	$0	($15,974)
Final FY 2010-11 Appropriation	$5,082,877	0.0	$2,048,004	$0	$0	$0	$3,034,873
FY11 Allocated Pots	$466,072	0.0	$233,036	$0	$0	$0	$233,036
FY11 Total Available Spending Authority	$5,548,949	0.0	$2,281,040	$0	$0	$0	$3,267,909
FY11 Expenditures	$5,039,839	0.0	$2,092,419	$0	$0	$0	$2,947,420
FY 2010-11 Reversion \ (Overexpenditure)	$509,110	0.0	$188,621	$0	$0	$0	$320,489
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$5,159,398	0.0	$2,579,699	$0	$0	$0	$2,579,699
SB 11-076, PERA Contribution Rates, FY12	($66,044)	0.0	($33,022)	$0	$0	$0	($33,022)
Supplemental Appropriation, HB 12-1184, FY12	($365,765)	0.0	($182,882)	$0	$0	$0	($182,883)
Final FY 2011-12 Appropriation	$4,727,589	0.0	$2,363,795	$0	$0	$0	$2,363,794
FY12 Allocated Pots	$569,145	0.0	$284,572	$0	$0	$0	$284,573
FY12 Total Available Spending Authority	$5,296,734	0.0	$2,648,367	$0	$0	$0	$2,648,367
FY12 Expenditures	$4,651,955	0.0	$2,325,978	$0	$0	$0	$2,325,977
FY 2011-12 Reversion \ (Overexpenditure)	$644,779	0.0	$322,389	$0	$0	$0	$322,390

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$4,814,610	0.0	$2,407,305	$0	$0	$0	$2,407,305
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY13	$9,915	0.0	$4,958	$0	$0	$0	$4,957
FY 2012-13 Total Appropriation	**$4,824,525**	**0.0**	**$2,412,263**	**$0**	**$0**	**$0**	**$2,412,262**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$4,824,525	0.0	$2,412,263	$0	$0	$0	$2,412,262
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY14	($9,915)	0.0	($4,958)	$0	$0	$0	($4,957)
FY14 Common Policy Adjustment	$3,393	0.0	$1,697	$0	$0	$0	$1,696
FY 2013-14 Base Request	**$4,818,003**	**0.0**	**$2,409,002**	**$0**	**$0**	**$0**	**$2,409,001**
NP-R#9: "DHS - DPA - Capitol Complex Building Upgrade, Repair, and Replacement"	$1,460	0.0	$730	$0	$0	$0	$730
FY 2013-14 Total Request	**$4,819,463**	**0.0**	**$2,409,732**	**$0**	**$0**	**$0**	**$2,409,731**
(D) Division of Child Welfare - Medicaid Funding, Administration							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$133,906	0.0	$66,953	$0	$0	$0	$66,953
Supplemental Appropriation, SB 11-139, FY11	($1,279)	0.0	($639)	$0	$0	$0	($640)
Final FY 2010-11 Appropriation	$132,627	0.0	$66,314	$0	$0	$0	$66,313
FY11 Allocated Pots	$15,442	0.0	$7,721	$0	$0	$0	$7,721
FY11 Total Available Spending Authority	$148,069	0.0	$74,035	$0	$0	$0	$74,034
FY11 Expenditures	$148,069	0.0	$74,036	$0	$0	$0	$74,033
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	($1)	$0	$0	$0	$1

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$133,659	0.0	$66,830	$0	$0	$0	$66,829
SB 11-076, PERA Contribution Rates, FY12	($2,721)	0.0	($1,361)	$0	$0	$0	($1,360)
Final FY 2011-12 Appropriation	$130,938	0.0	$65,469	$0	$0	$0	$65,469
FY12 Allocated Pots	$18,767	0.0	$9,383	$0	$0	$0	$9,384
FY12 Total Available Spending Authority	$149,705	0.0	$74,852	$0	$0	$0	$74,853
FY12 Expenditures	$149,705	0.0	$74,853	$0	$0	$0	$74,852
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	($1)	$0	$0	$0	$1
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$133,070	0.0	$66,535	$0	$0	$0	$66,535
FY 2012-13 Total Appropriation	**$133,070**	**0.0**	**$66,535**	**$0**	**$0**	**$0**	**$66,535**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$133,070	0.0	$66,535	$0	$0	$0	$66,535
FY 2013-14 Base Request	**$133,070**	**0.0**	**$66,535**	**$0**	**$0**	**$0**	**$66,535**
FY 2013-14 Total Request	**$133,070**	**0.0**	**$66,535**	**$0**	**$0**	**$0**	**$66,535**
(D) Division of Child Welfare - Medicaid Funding, Child Welfare Services							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$14,218,063	0.0	$5,461,158	$0	$0	$0	$8,756,905
HB 10-1338, Probation Eligible Two Prior Felony, FY11	$75,209	0.0	$28,887	$0	$0	$0	$46,322
Long Bill Add-ons, SB 11-209, FY11	$225,912	0.0	$355,805	$0	$0	$0	($129,893)
Final FY 2010-11 Appropriation	$14,519,184	0.0	$5,845,850	$0	$0	$0	$8,673,334
FY11 Year-End Transfers	($2,342,896)	0.0	($943,250)	$0	$0	$0	($1,399,646)
FY11 Total Available Spending Authority	$12,176,288	0.0	$4,902,600	$0	$0	$0	$7,273,688
FY11 Expenditures	$12,176,287	0.0	$4,890,172	$0	$0	$0	$7,286,115
FY 2010-11 Reversion \ (Overexpenditure)	$1	0.0	$12,428	$0	$0	$0	($12,427)

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$14,328,538	0.0	$7,164,269	$0	$0	$0	$7,164,269
Final FY 2011-12 Appropriation	$14,328,538	0.0	$7,164,269	$0	$0	$0	$7,164,269
FY12 Year-End Transfers	($3,393,058)	0.0	($1,696,529)	$0	$0	$0	($1,696,529)
FY12 Total Available Spending Authority	$10,935,480	0.0	$5,467,740	$0	$0	$0	$5,467,740
FY12 Expenditures	$10,935,479	0.0	$5,467,740	$0	$0	$0	$5,467,739
FY 2011-12 Reversion \ (Overexpenditure)	$1	0.0	$0	$0	$0	$0	$1
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$14,293,272	0.0	$7,146,636	$0	$0	$0	$7,146,636
FY 2012-13 Total Appropriation	**$14,293,272**	**0.0**	**$7,146,636**	**$0**	**$0**	**$0**	**$7,146,636**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$14,293,272	0.0	$7,146,636	$0	$0	$0	$7,146,636
FY 2013-14 Base Request	**$14,293,272**	**0.0**	**$7,146,636**	**$0**	**$0**	**$0**	**$7,146,636**
NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$214,399	0.0	$107,200	$0	$0	$0	$107,199
FY 2013-14 Total Request	**$14,507,671**	**0.0**	**$7,253,836**	**$0**	**$0**	**$0**	**$7,253,835**
(D) Division of Child Welfare - Medicaid Funding, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$14,351,969	0.0	$5,528,111	$0	$0	$0	$8,823,858
HB 10-1338, Probation Eligible Two Prior Felony, FY11	$75,209	0.0	$28,887	$0	$0	$0	$46,322
Long Bill Add-ons, SB 11-209, FY11	$225,912	0.0	$355,805	$0	$0	$0	($129,893)
Supplemental Appropriation, SB 11-139, FY11	($1,279)	0.0	($639)	$0	$0	$0	($640)
Final FY 2010-11 Appropriation	$14,651,811	0.0	$5,912,164	$0	$0	$0	$8,739,647
FY11 Year-End Transfers	($2,342,896)	0.0	($943,250)	$0	$0	$0	($1,399,646)
FY11 Allocated Pots	$15,442	0.0	$7,721	$0	$0	$0	$7,721
FY11 Total Available Spending Authority	$12,324,357	0.0	$4,976,635	$0	$0	$0	$7,347,722
FY11 Expenditures	$12,324,356	0.0	$4,964,208	$0	$0	$0	$7,360,148
FY 2010-11 Reversion \ (Overexpenditure)	$1	0.0	$12,427	$0	$0	$0	($12,426)

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$14,462,197	0.0	$7,231,099	$0	$0	$0	$7,231,098
SB 11-076, PERA Contribution Rates, FY12	($2,721)	0.0	($1,361)	$0	$0	$0	($1,360)
Final FY 2011-12 Appropriation	$14,459,476	0.0	$7,229,738	$0	$0	$0	$7,229,738
FY12 Year-End Transfers	($3,393,058)	0.0	($1,696,529)	$0	$0	$0	($1,696,529)
FY12 Allocated Pots	$18,767	0.0	$9,383	$0	$0	$0	$9,384
FY12 Total Available Spending Authority	$11,085,185	0.0	$5,542,592	$0	$0	$0	$5,542,593
FY12 Expenditures	$11,085,184	0.0	$5,542,593	$0	$0	$0	$5,542,591
FY 2011-12 Reversion \ (Overexpenditure)	$1	0.0	($1)	$0	$0	$0	$2
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$14,426,342	0.0	$7,213,171	$0	$0	$0	$7,213,171
FY 2012-13 Total Appropriation	**$14,426,342**	**0.0**	**$7,213,171**	**$0**	**$0**	**$0**	**$7,213,171**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$14,426,342	0.0	$7,213,171	$0	$0	$0	$7,213,171
FY 2013-14 Base Request	**$14,426,342**	**0.0**	**$7,213,171**	**$0**	**$0**	**$0**	**$7,213,171**
NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$214,399	0.0	$107,200	$0	$0	$0	$107,199
FY 2013-14 Total Request	**$14,640,741**	**0.0**	**$7,320,371**	**$0**	**$0**	**$0**	**$7,320,370**
(E) Office of Self Sufficiency - Medicaid Funding, Systematic Alien Verification for Eligibility, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$34,766	0.0	$17,383	$0	$0	$0	$17,383
Supplemental Appropriation, SB 11-139, FY11	($326)	0.0	($163)	$0	$0	$0	($163)
Final FY 2010-11 Appropriation	$34,440	0.0	$17,220	$0	$0	$0	$17,220
FY11 Allocated Pots	$2,653	0.0	$1,327	$0	$0	$0	$1,326
FY11 Total Available Spending Authority	$37,093	0.0	$18,547	$0	$0	$0	$18,546
FY11 Expenditures	$37,051	0.0	$1,636	$0	$0	$0	$35,415
FY 2010-11 Reversion \ (Overexpenditure)	$42	0.0	$16,911	$0	$0	$0	($16,869)

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$33,951	0.0	$16,976	$0	$0	$0	$16,975
SB 11-076, PERA Contribution Rates, FY12	($740)	0.0	($370)	$0	$0	$0	($370)
Final FY 2011-12 Appropriation	$33,211	0.0	$16,606	$0	$0	$0	$16,605
FY12 Year-End Transfers	$16,580	0.0	$0	$0	$0	$0	$16,580
FY12 Allocated Pots	$3,125	0.0	$1,562	$0	$0	$0	$1,563
FY12 Total Available Spending Authority	$52,916	0.0	$18,168	$0	$0	$0	$34,748
FY12 Expenditures	$36,336	0.0	$1,589	$0	$0	$0	$34,747
FY 2011-12 Reversion \ (Overexpenditure)	$16,580	0.0	$16,579	$0	$0	$0	$1
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$33,951	0.0	$16,976	$0	$0	$0	$16,975
FY 2012-13 Total Appropriation	**$33,951**	**0.0**	**$16,976**	**$0**	**$0**	**$0**	**$16,975**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$33,951	0.0	$16,976	$0	$0	$0	$16,975
FY 2013-14 Base Request	**$33,951**	**0.0**	**$16,976**	**$0**	**$0**	**$0**	**$16,975**
FY 2013-14 Total Request	**$33,951**	**0.0**	**$16,976**	**$0**	**$0**	**$0**	**$16,975**
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding, Administration							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$336,828	0.0	$168,414	$0	$0	$0	$168,414
Supplemental Appropriation, SB 11-139, FY11	($3,260)	0.0	($1,630)	$0	$0	$0	($1,630)
Final FY 2010-11 Appropriation	$333,568	0.0	$166,784	$0	$0	$0	$166,784
FY11 Allocated Pots	$51,509	0.0	$25,755	$0	$0	$0	$25,754
FY11 Total Available Spending Authority	$385,077	0.0	$192,539	$0	$0	$0	$192,538
FY11 Expenditures	$335,266	0.0	$167,633	$0	$0	$0	$167,633
FY 2010-11 Reversion \ (Overexpenditure)	$49,811	0.0	$24,906	$0	$0	$0	$24,905

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$392,848	0.0	$196,424	$0	$0	$0	$196,424
SB 11-076, PERA Contribution Rates, FY12	($7,666)	0.0	($3,833)	$0	$0	$0	($3,833)
Final FY 2011-12 Appropriation	$385,182	0.0	$192,591	$0	$0	$0	$192,591
FY12 Allocated Pots	$61,697	0.0	$30,848	$0	$0	$0	$30,849
FY12 Total Available Spending Authority	$446,879	0.0	$223,439	$0	$0	$0	$223,440
FY12 Expenditures	$348,942	0.0	$174,471	$0	$0	$0	$174,471
FY 2011-12 Reversion \ (Overexpenditure)	$97,937	0.0	$48,968	$0	$0	$0	$48,969
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$388,784	0.0	$194,392	$0	$0	$0	$194,392
FY 2012-13 Total Appropriation	**$388,784**	**0.0**	**$194,392**	**$0**	**$0**	**$0**	**$194,392**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$388,784	0.0	$194,392	$0	$0	$0	$194,392
FY 2013-14 Base Request	**$388,784**	**0.0**	**$194,392**	**$0**	**$0**	**$0**	**$194,392**
FY 2013-14 Total Request	**$388,784**	**0.0**	**$194,392**	**$0**	**$0**	**$0**	**$194,392**
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding, Residential Treatment for Youth (H.B. 99-1116)							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$116,840	0.0	$44,878	$0	$0	$0	$71,962
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$2,199	$0	$0	$0	($2,199)
Final FY 2010-11 Appropriation	$116,840	0.0	$47,077	$0	$0	$0	$69,763
FY11 Year-End Transfers	$37,446	0.0	$15,087	$0	$0	$0	$22,359
FY11 Total Available Spending Authority	$154,286	0.0	$62,164	$0	$0	$0	$92,122
FY11 Expenditures	$147,846	0.0	$62,164	$0	$0	$0	$85,682
FY 2010-11 Reversion \ (Overexpenditure)	$6,440	0.0	$0	$0	$0	$0	$6,440

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$116,840	0.0	$58,420	$0	$0	$0	$58,420
Final FY 2011-12 Appropriation	$116,840	0.0	$58,420	$0	$0	$0	$58,420
FY12 Year-End Transfers	$84,704	0.0	$42,352	$0	$0	$0	$42,352
FY12 Total Available Spending Authority	$201,544	0.0	$100,772	$0	$0	$0	$100,772
FY12 Expenditures	$201,542	0.0	$100,771	$0	$0	$0	$100,771
FY 2011-12 Reversion \ (Overexpenditure)	$2	0.0	$1	$0	$0	$0	$1
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$116,840	0.0	$58,420	$0	$0	$0	$58,420
FY 2012-13 Total Appropriation	**$116,840**	**0.0**	**$58,420**	**$0**	**$0**	**$0**	**$58,420**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$116,840	0.0	$58,420	$0	$0	$0	$58,420
FY 2013-14 Base Request	**$116,840**	**0.0**	**$58,420**	**$0**	**$0**	**$0**	**$58,420**
NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$1,753	0.0	$877	$0	$0	$0	$876
FY 2013-14 Total Request	**$118,593**	**0.0**	**$59,297**	**$0**	**$0**	**$0**	**$59,296**
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding, Mental Health Institutes							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$2,916,208	0.0	$1,120,115	$0	$0	$0	$1,796,093
Long Bill Add-ons, SB 11-209, FY11	$348,250	0.0	$188,652	$0	$0	$0	$159,598
Supplemental Appropriation, SB 11-139, FY11	$1,297,893	0.0	$522,920	$0	$0	$0	$774,973
Final FY 2010-11 Appropriation	$4,562,351	0.0	$1,831,687	$0	$0	$0	$2,730,664
FY11 Year-End Transfers	$1,362,222	0.0	$510,833	$0	$0	$0	$851,389
FY11 Total Available Spending Authority	$5,924,573	0.0	$2,342,520	$0	$0	$0	$3,582,053
FY11 Expenditures	$4,622,208	0.0	$1,868,406	$0	$0	$0	$2,753,802
FY 2010-11 Reversion \ (Overexpenditure)	$1,302,365	0.0	$474,114	$0	$0	$0	$828,251

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$4,176,550	0.0	$2,088,275	$0	$0	$0	$2,088,275
SB 11-076, PERA Contribution Rates, FY12	($46,631)	0.0	($23,316)	$0	$0	$0	($23,315)
Supplemental Appropriation, HB 12-1184, FY12	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
Final FY 2011-12 Appropriation	$5,255,785	0.0	$2,627,892	$0	$0	$0	$2,627,893
FY12 Year-End Transfers	$1,130,000	0.0	$565,000	$0	$0	$0	$565,000
FY12 Total Available Spending Authority	$6,385,785	0.0	$3,192,892	$0	$0	$0	$3,192,893
FY12 Expenditures	$4,755,640	0.0	$2,377,820	$0	$0	$0	$2,377,820
FY 2011-12 Reversion \ (Overexpenditure)	$1,630,145	0.0	$815,072	$0	$0	$0	$815,073
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$5,322,778	0.0	$2,661,389	$0	$0	$0	$2,661,389
FY 2012-13 Total Appropriation	**$5,322,778**	**0.0**	**$2,661,389**	**$0**	**$0**	**$0**	**$2,661,389**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$5,322,778	0.0	$2,661,389	$0	$0	$0	$2,661,389
FY 2013-14 Base Request	**$5,322,778**	**0.0**	**$2,661,389**	**$0**	**$0**	**$0**	**$2,661,389**
FY 2013-14 Total Request	**$5,322,778**	**0.0**	**$2,661,389**	**$0**	**$0**	**$0**	**$2,661,389**
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding, Administration							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$54,088	0.0	$27,044	$0	$0	$0	$27,044
Supplemental Appropriation, SB 11-139, FY11	($531)	0.0	($266)	$0	$0	$0	($265)
Final FY 2010-11 Appropriation	$53,557	0.0	$26,778	$0	$0	$0	$26,779
FY11 Total Available Spending Authority	$53,557	0.0	$26,778	$0	$0	$0	$26,779
FY11 Expenditures	$53,557	0.0	$26,778	$0	$0	$0	$26,779
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$0	0.0	$0	$0	$0	$0	$0
Final FY 2011-12 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY12 Total Available Spending Authority	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Total Appropriation	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$0	0.0	$0	$0	$0	$0	$0
FY 2013-14 Base Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 Total Request	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding, Alcohol and Drug Abuse Division, High Risk Pregnant Women Program							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$1,999,146	0.0	$767,872	$0	$0	$0	$1,231,274
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$37,628	$0	$0	$0	($37,628)
Final FY 2010-11 Appropriation	$1,999,146	0.0	$805,500	$0	$0	$0	$1,193,646
FY11 Total Available Spending Authority	$1,999,146	0.0	$805,500	$0	$0	$0	$1,193,646
FY11 Expenditures	$1,191,166	0.0	$489,860	$0	$0	$0	$701,306
FY 2010-11 Reversion \ (Overexpenditure)	$807,980	0.0	$315,640	$0	$0	$0	$492,340
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$1,999,146	0.0	$999,573	$0	$0	$0	$999,573
Final FY 2011-12 Appropriation	$1,999,146	0.0	$999,573	$0	$0	$0	$999,573
FY12 Total Available Spending Authority	$1,999,146	0.0	$999,573	$0	$0	$0	$999,573
FY12 Expenditures	$1,126,310	0.0	$563,155	$0	$0	$0	$563,155
FY 2011-12 Reversion \ (Overexpenditure)	$872,836	0.0	$436,418	$0	$0	$0	$436,418

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$1,999,146	0.0	$999,573	$0	$0	$0	$999,573
FY 2012-13 Total Appropriation	**$1,999,146**	**0.0**	**$999,573**	**$0**	**$0**	**$0**	**$999,573**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$1,999,146	0.0	$999,573	$0	$0	$0	$999,573
FY 2013-14 Base Request	**$1,999,146**	**0.0**	**$999,573**	**$0**	**$0**	**$0**	**$999,573**
NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$29,987	0.0	$14,994	$0	$0	$0	$14,993
FY 2013-14 Total Request	**$2,029,133**	**0.0**	**$1,014,567**	**$0**	**$0**	**$0**	**$1,014,566**
(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$5,423,110	0.0	$2,128,323	$0	$0	$0	$3,294,787
Long Bill Add-ons, SB 11-209, FY11	$348,250	0.0	$228,479	$0	$0	$0	$119,771
Supplemental Appropriation, SB 11-139, FY11	$1,294,102	0.0	$521,024	$0	$0	$0	$773,078
Final FY 2010-11 Appropriation	$7,065,462	0.0	$2,877,826	$0	$0	$0	$4,187,636
FY11 Year-End Transfers	$1,399,668	0.0	$525,920	$0	$0	$0	$873,748
FY11 Allocated Pots	$51,509	0.0	$25,755	$0	$0	$0	$25,754
FY11 Total Available Spending Authority	$8,516,639	0.0	$3,429,501	$0	$0	$0	$5,087,138
FY11 Expenditures	$6,350,043	0.0	$2,614,841	$0	$0	$0	$3,735,202
FY 2010-11 Reversion \ (Overexpenditure)	$2,166,596	0.0	$814,660	$0	$0	$0	$1,351,936
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$6,685,384	0.0	$3,342,692	$0	$0	$0	$3,342,692
SB 11-076, PERA Contribution Rates, FY12	($54,297)	0.0	($27,149)	$0	$0	$0	($27,148)
Supplemental Appropriation, HB 12-1184, FY12	$1,125,866	0.0	$562,933	$0	$0	$0	$562,933
Final FY 2011-12 Appropriation	$7,756,953	0.0	$3,878,476	$0	$0	$0	$3,878,477
FY12 Year-End Transfers	$1,214,704	0.0	$607,352	$0	$0	$0	$607,352
FY12 Allocated Pots	$61,697	0.0	$30,848	$0	$0	$0	$30,849
FY12 Total Available Spending Authority	$9,033,354	0.0	$4,516,676	$0	$0	$0	$4,516,678
FY12 Expenditures	$6,432,434	0.0	$3,216,217	$0	$0	$0	$3,216,217
FY 2011-12 Reversion \ (Overexpenditure)	$2,600,920	0.0	$1,300,459	$0	$0	$0	$1,300,461

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$7,827,548	0.0	$3,913,774	$0	$0	$0	$3,913,774
FY 2012-13 Total Appropriation	**$7,827,548**	**0.0**	**$3,913,774**	**$0**	**$0**	**$0**	**$3,913,774**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$7,827,548	0.0	$3,913,774	$0	$0	$0	$3,913,774
FY 2013-14 Base Request	**$7,827,548**	**0.0**	**$3,913,774**	**$0**	**$0**	**$0**	**$3,913,774**
NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$31,740	0.0	$15,871	$0	$0	$0	$15,869
FY 2013-14 Total Request	**$7,859,288**	**0.0**	**$3,929,645**	**$0**	**$0**	**$0**	**$3,929,643**
(G) Services for People with Disabilities - Medicaid Funding, Community Services for People with Developmental Disabilities, Administration							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$2,947,709	0.0	$1,473,855	$0	$0	$0	$1,473,854
Supplemental Appropriation, SB 11-139, FY11	($26,359)	0.0	($13,180)	$0	$0	$0	($13,179)
Final FY 2010-11 Appropriation	$2,921,350	0.0	$1,460,675	$0	$0	$0	$1,460,675
FY11 Allocated Pots	$248,323	0.0	$124,162	$0	$0	$0	$124,161
FY11 Total Available Spending Authority	$3,169,673	0.0	$1,584,837	$0	$0	$0	$1,584,836
FY11 Expenditures	$2,982,916	0.0	$1,491,458	$0	$0	$0	$1,491,458
FY 2010-11 Reversion \ (Overexpenditure)	$186,757	0.0	$93,379	$0	$0	$0	$93,378
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$2,923,329	0.0	$1,461,665	$0	$0	$0	$1,461,664
SB 11-076, PERA Contribution Rates, FY12	($50,650)	0.0	($25,325)	$0	$0	$0	($25,325)
Final FY 2011-12 Appropriation	$2,872,679	0.0	$1,436,340	$0	$0	$0	$1,436,339
FY12 Allocated Pots	$179,453	0.0	$89,726	$0	$0	$0	$89,727
FY12 Total Available Spending Authority	$3,052,132	0.0	$1,526,066	$0	$0	$0	$1,526,066
FY12 Expenditures	$2,885,448	0.0	$1,442,724	$0	$0	$0	$1,442,724
FY 2011-12 Reversion \ (Overexpenditure)	$166,684	0.0	$83,342	$0	$0	$0	$83,342

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$2,897,037	0.0	$1,448,519	$0	$0	$0	$1,448,518
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY13	$3,308	0.0	$1,654	$0	$0	$0	$1,654
FY 2012-13 Total Appropriation	**$2,900,345**	**0.0**	**$1,450,173**	**$0**	**$0**	**$0**	**$1,450,172**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$2,900,345	0.0	$1,450,173	$0	$0	$0	$1,450,172
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY14	($3,308)	0.0	($1,654)	$0	$0	$0	($1,654)
FY 2013-14 Base Request	**$2,897,037**	**0.0**	**$1,448,519**	**$0**	**$0**	**$0**	**$1,448,518**
FY 2013-14 Total Request	**$2,897,037**	**0.0**	**$1,448,519**	**$0**	**$0**	**$0**	**$1,448,518**
(G) Services for People with Disabilities - Medicaid Funding, Community Services for People with Developmental Disabilities, Program Costs							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$305,993,911	0.0	$117,481,180	$0	$427,007	$0	$188,085,724
Long Bill Add-ons, SB 11-209, FY11	$40,215,272	0.0	$21,782,600	$0	$20,613	$0	$18,412,059
Final FY 2010-11 Appropriation	$346,209,183	0.0	$139,263,780	$0	$447,620	$0	$206,497,783
FY11 Total Available Spending Authority	$346,209,183	0.0	$139,263,780	$0	$447,620	$0	$206,497,783
FY11 Expenditures	$340,614,514	0.0	$136,790,848	$0	$447,620	$0	$203,376,046
FY 2010-11 Reversion \ (Overexpenditure)	$5,594,669	0.0	$2,472,932	$0	$0	$0	$3,121,737
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$328,231,550	0.0	$164,115,774	$0	$1	$0	$164,115,775
Final FY 2011-12 Appropriation	$328,231,550	0.0	$164,115,774	$0	$1	$0	$164,115,775
FY12 Year-End Transfers	$1,623,550	0.0	$811,775	$0	$0	$0	$811,775
FY12 Total Available Spending Authority	$329,855,100	0.0	$164,927,549	$0	$1	$0	$164,927,550
FY12 Expenditures	$329,836,283	0.0	$164,927,548	$0	$1	$0	$164,908,734
FY 2011-12 Reversion \ (Overexpenditure)	$18,817	0.0	$1	$0	$0	$0	$18,816

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$340,502,802	0.0	$170,251,400	$0	$1	$0	$170,251,401
FY 2012-13 Total Appropriation	**$340,502,802**	**0.0**	**$170,251,400**	**$0**	**$1**	**$0**	**$170,251,401**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$340,502,802	0.0	$170,251,400	$0	$1	$0	$170,251,401
Annualization of FY 2012-13 NP-R#1: "DHS - New Funding – Developmental Disabilities Services"	$4,071,470	0.0	$2,035,735	$0	$0	$0	$2,035,735
FY 2013-14 Base Request	**$344,574,272**	**0.0**	**$172,287,135**	**$0**	**$1**	**$0**	**$172,287,136**
NP-R#1: "DHS - Developmental Disabiliities Services for New Resources"	$13,055,339	0.0	$6,527,670	$0	$0	$0	$6,527,669
NP-R#2: "DHS - Technical Changes for Developmental Disabilities Programs"	$301,732	0.0	$150,866	$0	$0	$0	$150,866
NP-R#3: "DHS - Early Intervention Services Caseload Growth and Associated Case Management"	$1,635,843	0.0	$817,922	$0	$0	$0	$817,921
NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$5,393,507	0.0	$2,696,754	$0	$0	$0	$2,696,753
FY 2013-14 Total Request	**$364,960,693**	**0.0**	**$182,480,347**	**$0**	**$1**	**$0**	**$182,480,345**
(G) Services for People with Disabilities - Medicaid Funding, Regional Centers							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$46,888,625	0.0	$16,142,266	$0	$0	$1,867,655	$28,878,704
Long Bill Add-ons, SB 11-209, FY11	$0	0.0	$881,507	$0	$0	$0	($881,507)
Supplemental Appropriation, SB 11-139, FY11	($84,657)	0.0	($34,109)	$0	$0	$0	($50,548)
Final FY 2010-11 Appropriation	$46,803,968	0.0	$16,989,664	$0	$0	$1,867,655	$27,946,649
FY11 Year-End Transfers	($35,700)	0.0	$0	$0	$0	$0	($35,700)
FY11 Allocated Pots	$6,563,786	0.0	$3,281,893	$0	$0	$0	$3,281,893
FY11 Total Available Spending Authority	$53,332,054	0.0	$20,271,557	$0	$0	$1,867,655	$31,192,842
FY11 Expenditures	$52,590,656	0.0	$19,225,052	$0	$0	$1,867,655	$31,497,949
FY 2010-11 Reversion \ (Overexpenditure)	$741,398	0.0	$1,046,505	$0	$0	$0	($305,107)

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$47,676,045	0.0	$21,970,368	$0	$0	$1,867,655	$23,838,022
SB 11-076, PERA Contribution Rates, FY12	($846,245)	0.0	($423,123)	$0	$0	$0	($423,122)
Supplemental Appropriation, HB 12-1184, FY12	($1,867,655)	0.0	$933,828	$0	$0	($1,867,655)	($933,828)
Final FY 2011-12 Appropriation	$44,962,145	0.0	$22,481,073	$0	$0	$0	$22,481,072
FY12 Year-End Transfers	($277,340)	0.0	($138,670)	$0	$0	$0	($138,670)
FY12 Allocated Pots	$6,601,053	0.0	$3,300,526	$0	$0	$0	$3,300,527
FY12 Total Available Spending Authority	$51,285,858	0.0	$25,642,929	$0	$0	$0	$25,642,929
FY12 Expenditures	$49,902,100	0.0	$25,641,215	$0	$0	$0	$24,260,885
FY 2011-12 Reversion \ (Overexpenditure)	$1,383,758	0.0	$1,714	$0	$0	$0	$1,382,044
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$47,801,815	0.0	$22,033,253	$0	$0	$1,867,655	$23,900,907
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY13	$181,222	0.0	$90,611	$0	$0	$0	$90,611
FY 2012-13 Total Appropriation	**$47,983,037**	**0.0**	**$22,123,864**	**$0**	**$0**	**$1,867,655**	**$23,991,518**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$47,983,037	0.0	$22,123,864	$0	$0	$1,867,655	$23,991,518
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY14	($181,222)	0.0	($90,611)	$0	$0	$0	($90,611)
FY 2013-14 Base Request	**$47,801,815**	**0.0**	**$22,033,253**	**$0**	**$0**	**$1,867,655**	**$23,900,907**
NP-R#2: "DHS - Technical Changes for Developmental Disabilities Programs"	($301,732)	0.0	($150,866)	$0	$0	$0	($150,866)
FY 2013-14 Total Request	**$47,500,083**	**0.0**	**$21,882,387**	**$0**	**$0**	**$1,867,655**	**$23,750,041**
(G) Services for People with Disabilities - Medicaid Funding, Regional Center Depreciation and Annual Adjustments							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$1,187,825	0.0	$593,913	$0	$0	$0	$593,912
Final FY 2010-11 Appropriation	$1,187,825	0.0	$593,913	$0	$0	$0	$593,912
FY11 Total Available Spending Authority	$1,187,825	0.0	$593,913	$0	$0	$0	$593,912
FY11 Expenditures	$1,187,825	0.0	$593,913	$0	$0	$0	$593,912
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$1,187,825	0.0	$593,913	$0	$0	$0	$593,912
Final FY 2011-12 Appropriation	$1,187,825	0.0	$593,913	$0	$0	$0	$593,912
FY12 Total Available Spending Authority	$1,187,825	0.0	$593,913	$0	$0	$0	$593,912
FY12 Expenditures	$1,187,825	0.0	$593,913	$0	$0	$0	$593,912
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$1,187,825	0.0	$593,913	$0	$0	$0	$593,912
FY 2012-13 Total Appropriation	**$1,187,825**	**0.0**	**$593,913**	**$0**	**$0**	**$0**	**$593,912**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$1,187,825	0.0	$593,913	$0	$0	$0	$593,912
FY 2013-14 Base Request	**$1,187,825**	**0.0**	**$593,913**	**$0**	**$0**	**$0**	**$593,912**
FY 2013-14 Total Request	**$1,187,825**	**0.0**	**$593,913**	**$0**	**$0**	**$0**	**$593,912**
(G) Services for People with Disabilities - Medicaid Funding, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$357,018,070	0.0	$135,691,214	$0	$427,007	$1,867,655	$219,032,194
Long Bill Add-ons, SB 11-209, FY11	$40,215,272	0.0	$22,664,107	$0	$20,613	$0	$17,530,552
Supplemental Appropriation, SB 11-139, FY11	($111,016)	0.0	($47,289)	$0	$0	$0	($63,727)
Final FY 2010-11 Appropriation	$397,122,326	0.0	$158,308,032	$0	$447,620	$1,867,655	$236,499,019
FY11 Year-End Transfers	($35,700)	0.0	$0	$0	$0	$0	($35,700)
FY11 Allocated Pots	$6,812,109	0.0	$3,406,055	$0	$0	$0	$3,406,054
FY11 Total Available Spending Authority	$403,898,735	0.0	$161,714,087	$0	$447,620	$1,867,655	$239,869,373
FY11 Expenditures	$397,375,911	0.0	$158,101,271	$0	$447,620	$1,867,655	$236,959,365
FY 2010-11 Reversion \ (Overexpenditure)	$6,522,824	0.0	$3,612,816	$0	$0	$0	$2,910,008

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$380,018,749	0.0	$188,141,720	$0	$1	$1,867,655	$190,009,373
SB 11-076, PERA Contribution Rates, FY12	($896,895)	0.0	($448,448)	$0	$0	$0	($448,447)
Supplemental Appropriation, HB 12-1184, FY12	($1,867,655)	0.0	$933,828	$0	$0	($1,867,655)	($933,828)
Final FY 2011-12 Appropriation	$377,254,199	0.0	$188,627,100	$0	$1	$0	$188,627,098
FY12 Year-End Transfers	$1,346,210	0.0	$673,105	$0	$0	$0	$673,105
FY12 Allocated Pots	$6,780,506	0.0	$3,390,252	$0	$0	$0	$3,390,254
FY12 Total Available Spending Authority	$385,380,915	0.0	$192,690,457	$0	$1	$0	$192,690,457
FY12 Expenditures	$383,811,656	0.0	$192,605,400	$0	$1	$0	$191,206,255
FY 2011-12 Reversion \ (Overexpenditure)	$1,569,259	0.0	$85,057	$0	$0	$0	$1,484,202
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$392,389,479	0.0	$194,327,085	$0	$1	$1,867,655	$196,194,738
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY13	$184,530	0.0	$92,265	$0	$0	$0	$92,265
FY 2012-13 Total Appropriation	**$392,574,009**	**0.0**	**$194,419,350**	**$0**	**$1**	**$1,867,655**	**$196,287,003**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$392,574,009	0.0	$194,419,350	$0	$1	$1,867,655	$196,287,003
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY14	($184,530)	0.0	($92,265)	$0	$0	$0	($92,265)
Annualization of FY 2012-13 NP-R#1: "DHS - New Funding – Developmental Disabilities Services"	$4,071,470	0.0	$2,035,735	$0	$0	$0	$2,035,735
FY 2013-14 Base Request	**$396,460,949**	**0.0**	**$196,362,820**	**$0**	**$1**	**$1,867,655**	**$198,230,473**
NP-R#1: "DHS - Developmental Disabiliities Services for New Resources"	$13,055,339	0.0	$6,527,670	$0	$0	$0	$6,527,669
NP-R#2: "DHS - Technical Changes for Developmental Disabilities Programs"	$0	0.0	$0	$0	$0	$0	$0
NP-R#3: "DHS - Early Intervention Services Caseload Growth and Associated Case Management"	$1,635,843	0.0	$817,922	$0	$0	$0	$817,921
NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$5,393,507	0.0	$2,696,754	$0	$0	$0	$2,696,753
FY 2013-14 Total Request	**$416,545,638**	**0.0**	**$206,405,166**	**$0**	**$1**	**$1,867,655**	**$208,272,816**

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(H) Adult Assistance Programs, Community Services for the Elderly - Medicaid Funding, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$1,800	0.0	$900	$0	$0	$0	$900
Final FY 2010-11 Appropriation	$1,800	0.0	$900	$0	$0	$0	$900
FY11 Total Available Spending Authority	$1,800	0.0	$900	$0	$0	$0	$900
FY11 Expenditures	$1,800	0.0	$900	$0	$0	$0	$900
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$1,800	0.0	$900	$0	$0	$0	$900
Final FY 2011-12 Appropriation	$1,800	0.0	$900	$0	$0	$0	$900
FY12 Total Available Spending Authority	$1,800	0.0	$900	$0	$0	$0	$900
FY12 Expenditures	$1,800	0.0	$900	$0	$0	$0	$900
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$1,800	0.0	$900	$0	$0	$0	$900
FY 2012-13 Total Appropriation	**$1,800**	**0.0**	**$900**	**$0**	**$0**	**$0**	**$900**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$1,800	0.0	$900	$0	$0	$0	$900
FY 2013-14 Base Request	**$1,800**	**0.0**	**$900**	**$0**	**$0**	**$0**	**$900**
FY 2013-14 Total Request	**$1,800**	**0.0**	**$900**	**$0**	**$0**	**$0**	**$900**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(I) Division of Youth Corrections - Medicaid Funding, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$2,686,201	0.0	$1,042,855	$0	$0	$0	$1,643,346
Long Bill Add-ons, SB 11-209, FY11	($204,688)	0.0	($36,132)	$0	$0	$0	($168,556)
Supplemental Appropriation, SB 11-139, FY11	($459)	0.0	($186)	$0	$0	$0	($273)
Final FY 2010-11 Appropriation	$2,481,054	0.0	$1,006,537	$0	$0	$0	$1,474,517
FY11 Year-End Transfers	$115,956	0.0	$47,043	$0	$0	$0	$68,913
FY11 Allocated Pots	$5,234	0.0	$2,617	$0	$0	$0	$2,617
FY11 Total Available Spending Authority	$2,602,244	0.0	$1,056,197	$0	$0	$0	$1,546,047
FY11 Expenditures	$2,602,242	0.0	$1,051,611	$0	$0	$0	$1,550,631
FY 2010-11 Reversion \ (Overexpenditure)	$2	0.0	$4,586	$0	$0	$0	($4,584)
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$1,286,981	0.0	$643,491	$0	$0	$0	$643,490
SB 11-076, PERA Contribution Rates, FY12	($1,030)	0.0	($515)	$0	$0	$0	($515)
Supplemental Appropriation, HB 12-1184, FY12	$221,672	0.0	$110,836	$0	$0	$0	$110,836
Long Bill Add-ons, HB 12-1335, FY12	$28,438	0.0	$14,219	$0	$0	$0	$14,219
Final FY 2011-12 Appropriation	$1,536,061	0.0	$768,031	$0	$0	$0	$768,030
FY12 Year-End Transfers	($34,788)	0.0	($17,394)	$0	$0	$0	($17,394)
FY12 Allocated Pots	$5,435	0.0	$2,717	$0	$0	$0	$2,718
FY12 Total Available Spending Authority	$1,506,708	0.0	$753,354	$0	$0	$0	$753,354
FY12 Expenditures	$1,506,706	0.0	$753,353	$0	$0	$0	$753,353
FY 2011-12 Reversion \ (Overexpenditure)	$2	0.0	$1	$0	$0	$0	$1
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$1,632,783	0.0	$816,392	$0	$0	$0	$816,391
FY 2012-13 Total Appropriation	**$1,632,783**	**0.0**	**$816,392**	**$0**	**$0**	**$0**	**$816,391**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$1,632,783	0.0	$816,392	$0	$0	$0	$816,391
FY 2013-14 Base Request	**$1,632,783**	**0.0**	**$816,392**	**$0**	**$0**	**$0**	**$816,391**
NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$23,806	0.0	$11,903	$0	$0	$0	$11,903
FY 2013-14 Total Request	**$1,656,589**	**0.0**	**$828,295**	**$0**	**$0**	**$0**	**$828,294**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 — Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(J) Other, Federal Medicaid Indirect Cost Reimbursement for Department of Human Services Programs, Final							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$500,000	0.0	$0	$0	$0	$0	$500,000
Final FY 2010-11 Appropriation	$500,000	0.0	$0	$0	$0	$0	$500,000
FY11 Total Available Spending Authority	$500,000	0.0	$0	$0	$0	$0	$500,000
FY11 Expenditures	$500,000	0.0	$0	$0	$0	$0	$500,000
FY 2010-11 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$500,000	0.0	$0	$0	$0	$0	$500,000
Final FY 2011-12 Appropriation	$500,000	0.0	$0	$0	$0	$0	$500,000
FY12 Total Available Spending Authority	$500,000	0.0	$0	$0	$0	$0	$500,000
FY12 Expenditures	$500,000	0.0	$0	$0	$0	$0	$500,000
FY 2011-12 Reversion \ (Overexpenditure)	$0	0.0	$0	$0	$0	$0	$0
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$500,000	0.0	$0	$0	$0	$0	$500,000
FY 2012-13 Total Appropriation	**$500,000**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$500,000**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$500,000	0.0	$0	$0	$0	$0	$500,000
FY 2013-14 Base Request	**$500,000**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$500,000**
FY 2013-14 Total Request	**$500,000**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$500,000**

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
(6) Department of Human Services Medicaid-Funded Programs, Total							
FY 2010-11 Actual							
FY 2010-11 Long Bill Appropriation,HB 10-1376	$408,405,003	0.0	$157,287,567	$0	$448,817	$1,893,534	$248,775,085
HB 10-1146, State-funded Public Assistance Programs, FY11	$184,387	0.0	$91,434	$0	$818	$0	$92,135
HB 10-1338, Probation Eligible Two Prior Felony, FY11	$75,209	0.0	$28,887	$0	$0	$0	$46,322
HB 10-1384, Alignment of Eligibility for the Old Age Pension Program, FY11	$17,220	0.0	$8,539	$0	$76	$0	$8,605
Long Bill Add-ons, SB 11-209, FY11	$40,584,746	0.0	$23,416,175	$0	$20,613	$0	$17,147,958
Supplemental Appropriation, SB 11-139, FY11	$1,174,504	0.0	$197,755	$0	$274,951	$176	$701,622
Final FY 2010-11 Appropriation	$450,441,069	0.0	$181,030,357	$0	$745,275	$1,893,710	$266,771,727
FY11 Year-End Transfers	($862,972)	0.0	($370,287)	$0	$0	$0	($492,685)
FY11 Allocated Pots	$2	0.0	$3	$0	$0	$0	($1)
Restricted Funds from FY 2009-10	($1,410)	0.0	($1,410)	$0	$0	$0	$0
FY11 Total Available Spending Authority	$449,576,689	0.0	$180,658,663	$0	$745,275	$1,893,710	$266,279,041
FY11 Expenditures	$438,883,396	0.0	$175,667,660	$0	$467,856	$1,870,759	$260,877,121
FY 2010-11 Reversion \ (Overexpenditure)	$10,693,293	0.0	$4,991,003	$0	$277,419	$22,951	$5,401,920
FY 2011-12 Actual							
FY 2011-12 Long Bill Appropriation,SB 11-209	$431,107,112	0.0	$213,405,407	$0	$14,518	$1,887,173	$215,800,014
HB 12-1339, Colorado Benefits Management System Project, FY12	$3,654,755	0.0	$1,820,992	$0	$8,521	$0	$1,825,242
SB 11-076, PERA Contribution Rates, FY12	($1,040,546)	0.0	($520,275)	$0	$0	$0	($520,271)
Supplemental Appropriation, HB 12-1184, FY12	$1,091,564	0.0	$1,382,693	$0	$1,031,277	($1,868,305)	$545,899
Long Bill Add-ons, HB 12-1335, FY12	$28,438	0.0	$14,219	$0	$0	$0	$14,219
Final FY 2011-12 Appropriation	$434,841,323	0.0	$216,103,036	$0	$1,054,316	$18,868	$217,665,103
FY12 Year-End Transfers	($850,352)	0.0	($433,466)	$0	$0	$0	($416,886)
FY12 Allocated Pots	$0	0.0	($2)	$0	$0	$0	$2
FY12 Total Available Spending Authority	$433,990,971	0.0	$215,669,568	$0	$1,054,316	$18,868	$217,248,219
FY12 Expenditures	$423,061,699	0.0	$211,088,878	$0	$849,714	$25,674	$211,097,433
FY 2011-12 Reversion \ (Overexpenditure)	$10,929,272	0.0	$4,580,690	$0	$204,602	($6,806)	$6,150,786

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2012-13 Appropriation							
FY 2012-13 Long Bill Appropriation, HB 12-1335	$447,007,956	0.0	$221,049,236	$0	$320,331	$1,888,351	$223,750,038
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY13	$257,221	0.0	$128,611	$0	$0	$0	$128,610
HB 12-1339, Colorado Benefits Management System Project, FY13	$7,630,836	0.0	$3,307,395	$0	$10,708	$0	$4,312,733
FY 2012-13 Total Appropriation	**$454,896,013**	**0.0**	**$224,485,242**	**$0**	**$331,039**	**$1,888,351**	**$228,191,381**
FY13 Roll-forward	$3,406,043	0.0	$1,697,240	$0	$7,837	$0	$1,700,966
FY 2012-13 Total Available Spending Authority	**$458,302,056**	**0.0**	**$226,182,482**	**$0**	**$338,876**	**$1,888,351**	**$229,892,347**
FY 2013-14 Request							
Final FY 2012-13 Appropriation	$454,896,013	0.0	$224,485,242	$0	$331,039	$1,888,351	$228,191,381
HB 12-1246, Reverse Payday Shift State Employees Paid Biweekly, FY14	($257,221)	0.0	($128,611)	$0	$0	$0	($128,610)
HB 12-1339, Colorado Benefits Management System Project, FY14	($6,992,580)	0.0	($2,990,061)	$0	($8,314)	$0	($3,994,205)
SB 10-061, Medicaid Hospice Room and Board Charges, FY14	($151,453)	0.0	($75,103)	$0	($310)	($362)	($75,678)
SB 11-008, Aligning Children's Medicaid Eligibility, FY14	($25,728)	0.0	($12,777)	$0	($41)	($56)	($12,854)
SB 11-250, Pregnant Women Medicaid Eligibility, FY14	($25,728)	0.0	($12,777)	$0	($41)	($56)	($12,854)
Annualization of FY 2012-13 R#13: "CBMS Electronic Document Management System"	($431,611)	0.0	($214,546)	$0	($429)	($1,294)	($215,342)
Annualization of FY 2012-13 NP-R#1: "DHS - New Funding – Developmental Disabilities Services"	$4,071,470	0.0	$2,035,735	$0	$0	$0	$2,035,735
FY14 Common Policy Adjustment	$1,737,960	0.0	$869,318	$0	$0	$0	$868,642

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14 Schedule 3

(6) Department of Human Services Medicaid-Funded Programs

Long Bill Line Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2013-14 Base Request	**$452,821,122**	**0.0**	**$223,956,420**	**$0**	**$321,904**	**$1,886,583**	**$226,656,215**
NP-R#1: "DHS - Developmental Disabiliities Services for New Resources"	$13,055,339	0.0	$6,527,670	$0	$0	$0	$6,527,669
NP-R#2: "DHS - Technical Changes for Developmental Disabilities Programs"	$0	0.0	$0	$0	$0	$0	$0
NP-R#3: "DHS - Early Intervention Services Caseload Growth and Associated Case Management"	$1,635,843	0.0	$817,922	$0	$0	$0	$817,921
NP-R#7: "DHS - 1.5% Community Provider Rate Increase"	$5,663,452	0.0	$2,831,728	$0	$0	$0	$2,831,724
NP-R#8: "DHS - OIT - Enterprise Asset Management"	$1,532	0.0	$766	$0	$0	$0	$766
NP-R#9: "DHS - DPA - Capitol Complex Building Upgrade, Repair, and Replacement"	$1,460	0.0	$730	$0	$0	$0	$730
NP-R#10: "DHS - DPA - Employee Engagement Survey Adjustment"	$7,736	0.0	$3,868	$0	$0	$0	$3,868
FY 2013-14 Total Request	**$473,186,484**	**0.0**	**$234,139,104**	**$0**	**$321,904**	**$1,886,583**	**$236,838,893**

(6) Department of Human Services Medicaid-Funded Programs							
FY 2011-12 Total Appropriation	**$454,896,013**	**0.0**	**$224,485,242**	**$0**	**$331,039**	**$1,888,351**	**$228,191,381**
FY 2012-13 Base Request	**$452,821,122**	**0.0**	**$223,956,420**	**$0**	**$321,904**	**$1,886,583**	**$226,656,215**
FY 2012-13 Total Request	**$473,186,484**	**0.0**	**$234,139,104**	**$0**	**$321,904**	**$1,886,583**	**$236,838,893**
Percentage Change FY 2011-12 to FY 2012-13	**4.02%**	**0.00%**	**4.30%**	**0.00%**	**-2.76%**	**-0.09%**	**3.79%**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING — FY 2013-14

Position and Object Code Detail

Personal Services		FY 2010-11 Actual		FY 2011-12 Actual		FY 2012-13 Estimate		FY 2013-14 Request	
Position Code	Position Type	Expenditures	FTE	Expenditures	FTE	Expenditures	FTE	Expenditures	FTE
H8A1XX	ACCOUNTANT I	$103,514	2.4	$132,902	3.0	$128,181	3.2	$138,629	3.2
H8A2XX	ACCOUNTANT II	$442,943	8.1	$437,354	8.2	$435,607	8.8	$464,111	8.8
H8A3XX	ACCOUNTANT III	$229,780	3.3	$210,527	3.0	$209,956	3.2	$220,505	3.2
H8A4XX	ACCOUNTANT IV	$96,504	1.0	$96,504	1.0	$96,034	1.1	$164,203	1.9
H8B3XX	ACCOUNTING TECHNICIAN III	$29,844	0.8	$31,388	0.8	$30,817	0.9	$33,657	0.9
I1A3XX	ACTUARY III	$72,990	1.0	$75,864	1.0	$75,360	1.1	$78,809	1.1
G3A3XX	ADMIN ASSISTANT II	$100,199	2.7	$31,741	0.9	$28,902	0.9	$31,945	0.9
G3A4XX	ADMIN ASSISTANT III	$193,515	5.2	$184,164	5.0	$184,114	5.3	$201,257	5.3
H2A3XX	APP PROGRAMMER II	$63,948	1.0	$5,329	0.1	$3,867	0.1	$4,172	0.1
H8D3XX	AUDITOR II	$56,471	1.1	$126,978	2.5	$126,407	2.7	$135,232	2.7
H8D4XX	AUDITOR III	$22,591	0.4	$56,796	1.0	$55,654	1.1	$59,102	1.1
H8D5XX	AUDITOR IV	$139,831	1.8	$138,096	2.0	$137,525	2.1	$144,423	2.1
H8D6XX	AUDITOR V	$50,006	0.6	$81,492	1.0	$80,686	1.1	$84,134	1.1
H8E3XX	BUDGET & POLICY ANLST III	$268,779	3.8	$98,946	1.4	$96,645	1.5	$158,938	2.3
H8E4XX	BUDGET & POLICY ANLST IV	$353,088	4.2	$340,110	4.0	$336,465	4.3	$350,361	4.3
H8E1XX	BUDGET ANALYST I	$316,844	6.7	$304,325	6.4	$301,957	6.8	$323,968	6.8
H8E2XX	BUDGET ANALYST II	$72,170	1.3	$230,036	4.1	$228,894	4.4	$243,196	4.4
H8C2XX	CONTROLLER II	$200,556	2.0	$200,556	2.0	$197,095	2.1	$203,993	2.1
G2C2TX	CUST SUPPORT COORD I	$158,416	3.9	$247,648	6.0	$247,077	6.4	$267,973	6.4
G2C3XX	CUST SUPPORT COORD II	$46,296	1.0	$46,296	1.0	$45,154	1.1	$48,602	1.1
G2C1IX	CUST SUPPORT INTERN	$162,146	4.5	$73,562	2.0	$73,259	2.1	$80,157	2.1
H6G1IX	GENERAL PROFESSIONAL I	$21,665	0.6	$19,781	0.5	$10,020	0.6	$11,846	0.6
H6G2TX	GENERAL PROFESSIONAL II	$599,751	13.3	$744,792	17.0	$718,552	18.1	$793,886	18.4
H6G3XX	GENERAL PROFESSIONAL III	$1,732,251	34.7	$2,296,077	45.8	$2,275,053	48.9	$2,433,497	48.9
H6G4XX	GENERAL PROFESSIONAL IV	$4,628,411	73.4	$4,899,713	77.9	$5,676,450	94.3	$6,408,332	101.1
H6G5XX	GENERAL PROFESSIONAL V	$1,442,802	19.3	$1,428,237	19.0	$1,502,986	21.3	$1,653,998	22.3
H6G6XX	GENERAL PROFESSIONAL VI	$1,239,432	15.1	$1,445,995	17.8	$1,435,798	19.0	$1,497,370	19.0
H6G7XX	GENERAL PROFESSIONAL VII	$0	0.0	$2,115	0.0	$2,098	0.0	$2,200	0.0
H2I4XX	IT PROFESSIONAL II	$114,144	2.0	$95,120	1.7	$94,162	1.8	$99,944	1.8
H2I5XX	IT PROFESSIONAL III	$86,436	1.0	$86,436	1.0	$85,865	1.1	$89,314	1.1

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING FY 2013-14
Position and Object Code Detail

Personal Services		FY 2010-11 Actual		FY 2011-12 Actual		FY 2012-13 Estimate		FY 2013-14 Request	
Position Code	Position Type	Expenditures	FTE	Expenditures	FTE	Expenditures	FTE	Expenditures	FTE
H6G8XX	MANAGEMENT	$1,434,798	12.2	$1,470,518	12.9	$1,463,143	13.7	$1,579,047	14.5
G3A5XX	OFFICE MANAGER I	$83,583	1.8	$40,248	0.9	$39,744	0.9	$42,787	0.9
C8E1XX	PHARMACY I	$0	0.0	$28,945	0.3	$28,744	0.4	$98,796	1.2
C8E2XX	PHARMACY II	$96,756	1.0	$96,756	1.0	$96,185	1.1	$99,634	1.1
C8E3XX	PHARMACY III	$0	0.0	$5,650	0.1	$5,616	0.1	$5,819	0.1
H4R1XX	PROGRAM ASSISTANT I	$300,613	7.8	$332,816	8.3	$328,078	8.8	$356,683	8.8
H4R2XX	PROGRAM ASSISTANT II	$28,000	0.6	$36,139	0.9	$35,652	0.9	$38,593	0.9
C1K2XX	PUB HLTH MED ADMIN II	$117,122	0.7	$161,141	1.0	$160,587	1.0	$163,934	1.0
H8G2XX	RATE/FINANCIAL ANLYST I	$51,195	1.1	$78,461	1.7	$77,503	1.8	$83,285	1.8
H8G3XX	RATE/FINANCIAL ANLYST II	$187,383	2.9	$204,740	3.3	$284,729	4.8	$351,899	5.5
H8G4XX	RATE/FINANCIAL ANLYST III	$168,820	2.3	$82,296	1.0	$81,725	1.1	$85,174	1.1
H8G1IX	RATE/FINANCIAL ANLYST INT	$35,325	0.8	$27,102	0.6	$26,732	0.7	$28,964	0.7
H8G5XX	RATE/FINANCIAL ANLYST IV	$123,814	1.6	$146,821	1.9	$145,729	2.0	$152,322	2.0
I1B1TX	STATISTICAL ANALYST I	$337,096	7.1	$295,479	6.2	$291,935	6.6	$313,338	6.6
I1B2XX	STATISTICAL ANALYST II	$286,421	5.0	$430,521	7.6	$426,186	8.1	$452,357	8.1
I1B3XX	STATISTICAL ANALYST III	$126,641	2.0	$108,672	1.7	$107,681	1.9	$113,666	1.9
I1B4XX	STATISTICAL ANALYST IV	$371,044	4.7	$359,923	4.6	$357,268	4.9	$373,295	4.9
H4M4XX	TECHNICIAN IV	$0	0.0	$12,915	0.4	$12,680	0.4	$14,100	0.4
P1A1XX	TEMPORARY AIDE	$76,065	1.8	$35,912	0.7	$35,525	0.7	$37,858	0.7
166000	EXECUTIVE DIRECTOR	$150,165	1.0	$150,000	1.0	$149,429	1.0	$152,878	1.0
Total Full and Part-time Employee Expenditures		**$17,020,164**	**270.6**	**$18,273,934**	**293.4**	**$19,075,509**	**326.2**	**$20,972,185**	**338.2**
PERA Contributions		$1,255,703	N/A	$1,391,675	N/A	$1,961,564	N/A	$2,156,602	N/A
Medicare		$261,419	N/A	$259,287	N/A	$270,660	N/A	$297,572	N/A
Overtime Wages		$150	N/A	$0	N/A	$0	N/A	$0	N/A
Shift Differential Wages		$0	N/A	$0	N/A	$0	N/A	$0	N/A
State Temporary Employees		$571,761	N/A	$602,978	N/A	$857,189	N/A	$710,239	N/A
Sick and Annual Leave Payouts		$135,501	N/A	$48,069	N/A	$79,000	N/A	$79,000	N/A
Contract Services		$100,176	N/A	$537,296	N/A	$350,000	N/A	$275,000	N/A
Furlough Wages		$0	N/A	$0	N/A	$0	N/A	$0	N/A
Other Expenditures (specify as necessary)		$0	N/A	($80,398)	N/A	$0	N/A	$0	N/A

Personal Services		**FY 2010-11 Actual**		**FY 2011-12 Actual**		**FY 2012-13 Estimate**		**FY 2013-14 Request**	
Position Code	Position Type	Expenditures	FTE	Expenditures	FTE	Expenditures	FTE	Expenditures	FTE
Total Temporary, Contract, and Other Expenditures		**$2,324,710**	**0.0**	**$2,758,907**	**0.0**	**$3,518,413**	**0.0**	**$3,518,413**	**0.0**
Pots Expenditures (excluding Salary Survey and Performance-based Pay already included above)		$2,100,293	N/A	$2,593,707	N/A				
Roll Forwards		$0	N/A	$0	N/A	$0	N/A		
Total Expenditures for Line Item		**$21,445,167**	**270.6**	**$23,626,548**	**293.4**	**$22,593,922**	**326.2**	**$24,490,598**	**338.2**
Total Spending Authority for Line Item		**$22,810,525**	**294.8**	**$24,275,937**	**312.5**	**$22,593,922**	**326.2**	**$24,490,598**	**338.2**
Amount Under/(Over) Expended		**$1,365,358**	**24.2**	**$649,389**	**19.1**	**$0**	**0.0**	**$0**	**0.0**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14 Position and Object Code Detail

Operating Expenses

Object Code	Object Code Description	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Estimate	FY 2013-14 Request
1350	EMPLOYEE NON-CASH INCENTIVES	$0	$10,000	$0	$0
1920	PERSONAL SVCS - PROFESSIONAL	$221,843	$174,332	$200,000	$200,000
2180	GROUNDS MAINTENANCE	$0	$7	$3	$0
2210	OTHER MAINTENANCE/REPAIR SVCS	$200	$0	$0	$0
2220	BLDG MAINTENANCE/REPAIR SVCS	$1,145	$190	$668	$668
2230	EQUIP MAINTENANCE/REPAIR SVCS	$3,963	$3,933	$3,930	$3,930
2231	IT HARDWARE MAINT/REPAIR SVCS	$2,167	$0	$1,000	$0
2232	IT SOFTWARE MNTC/UPGRADE SVCS	$0	$1,665	$2,000	$500
2251	RENTAL/LEASE MOTOR POOL VEH	$6,647	$9,869	$10,000	$10,000
2258	PARKING FEES	$1,713	$1,571	$1,570	$1,570
2259	PARKING FEE REIMBURSEMENT	$0	$915	$500	$500
2266	RENTAL OF IT SOFTWARE - PC	$8,000	$0	$0	$0
2510	IN-STATE TRAVEL	$8,818	$17,803	$25,000	$20,000
2511	IN-STATE COMMON CARRIER FARES	$1,867	$1,232	$1,500	$1,500
2512	IN-STATE PERS TRAVEL PER DIEM	$4,445	$9,180	$10,000	$10,000
2513	IN-STATE PERS VEHICLE REIMBSMT	$9,530	$13,855	$15,000	$15,000
2514	STATE-OWNED AIRCRAFT	$3,003	$7,037	$8,000	$8,000
2515	STATE-OWNED VEHICLE CHARGE	$0	$321	$320	$320
2520	IN-STATE TRAVEL/NON-EMPLOYEE	$283	$1,589	$1,589	$1,589
2522	IS/NON-EMPL - PERS PER DIEM	$2,572	$285	$1,429	$1,429
2523	IS/NON-EMPL - PERS VEH REIMB	$3,684	$1,324	$2,500	$2,500
2530	OUT-OF-STATE TRAVEL	$5,152	$12,828	$15,000	$15,000
2531	OS COMMON CARRIER FARES	$4,806	$12,629	$15,000	$15,000
2532	OS PERSONAL TRAVEL PER DIEM	$4,084	$8,014	$10,000	$10,000
2533	OS PERS VEHICLE REIMBURSEMENT	$0	$1	$0	$0
2540	OUT-OF-STATE TRAVEL/NON-EMPL	$0	$1,046	$2,000	$2,000
2541	OS/NON-EMPL - COMMON CARRIER	$0	$2,510	$3,000	$3,000
2542	OS/NON-EMPL - PERS PER DIEM	$0	$480	$800	$800
2610	ADVERTISING	$4,500	$0	$2,000	$2,000
2612	OTHER MARKETING EXPENSES	$0	$229	$50	$50
2630	COMM SVCS FROM DIV OF TELECOM	$259,550	$282,828	$300,000	$300,000
2631	COMM SVCS FROM OUTSIDE SOURCES	$22,600	$34,551	$35,000	$35,000
2680	PRINTING/REPRODUCTION SERVICES	$80,940	$96,378	$100,000	$100,000
2681	PHOTOCOPY REIMBURSEMENT	$0	$31	$30	$30

Operating Expenses

Object Code	Object Code Description	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Estimate	FY 2013-14 Request
2810	FREIGHT	$1,482	$1,232	$1,400	$1,400
2820	OTHER PURCHASED SERVICES	$1,207	$1,441	$1,500	$1,500
2831	STORAGE-PUR SERV	$7,702	$1,079	$1,500	$1,500
3110	OTHER SUPPLIES & MATERIALS	$16,701	$11,989	$16,000	$11,858
3116	NONCAP IT - PURCHASED PC SW	$38,942	$62,075	$65,000	$55,000
3117	EDUCATIONAL SUPPLIES	$601	$0	$300	$300
3118	FOOD AND FOOD SERV SUPPLIES	$0	$750	$500	$500
3120	BOOKS/PERIODICALS/SUBSCRIPTION	$26,954	$28,165	$30,000	$30,000
3121	OFFICE SUPPLIES	$66,285	$72,253	$80,000	$80,000
3122	PHOTOGRAPHIC SUPPLIES	$1,318	$2,850	$3,000	$3,000
3123	POSTAGE	$71,559	$91,203	$95,500	$95,500
3124	PRINTING/COPY SUPPLIES	$0	$137	$100	$100
3126	REPAIR & MAINTENANCE SUPPLIES	$0	$704	$400	$400
3128	NONCAPITALIZED EQUIPMENT	$23,521	$43,309	$47,000	$46,905
3132	NONCAP OFFICE FURN/OFFICE SYST	$67,363	$99,526	$125,000	$125,000
3140	NONCAPITALIZED IT - PC'S	$143,118	$155,800	$160,000	$160,000
3141	NONCAPITALIZED IT - SERVERS	$0	$4,496	$0	$0
3143	NONCAPITALIZED IT - OTHER	$50,260	$26,922	$33,700	$33,700
3216	NONCAPITALIZED IT - LEASED SOFTWARE	$4,542	$10,818	$13,000	$15,000
3950	GASOLINE	$15	$0	$0	$0
4100	OTHER OPERATING EXPENSES	$35,744	$34,609	$38,000	$40,000
4111	PRIZES AND AWARDS	$225	$530	$500	$500
4140	DUES AND MEMBERSHIPS	$20,890	$21,729	$22,000	$22,000
4151	INTEREST - LATE PAYMENTS	$18	$0	$15	$15
4170	MISCELLANEOUS FEES AND FINES	$77	$19	$50	$50
4180	OFFICIAL FUNCTIONS	$28,886	$44,911	$45,000	$45,000
4200	PURCHASE DISCOUNTS	$0	$5,000	$0	$0
4220	REGISTRATION FEES	$64,378	$68,652	$72,000	$72,000
4221	OTHER EDUCATIONAL - W2 RPT	$0	$256	$0	$0
6213	IT PC SW - DIRECT PURCHASE	$0	$6,494	$3,000	$3,000
6214	IT OTHER - DIRECT PURCHASE	$12,666	$0	$3,000	$3,000
Total Expenditures Denoted in Object Codes		**$1,345,966**	**$1,503,581**	**$1,625,353**	**$1,607,614**
Transfers		$0	$0	$0	$0
Roll Forwards		$0	$0	$0	$0
Total Expenditures for Line Item		**$1,345,966**	**$1,503,581**	**$1,625,353**	**$1,607,614**
Total Spending Authority for Line Item		**$1,626,785**	**$1,585,757**	**$1,625,353**	**$1,607,614**

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

FY 2013-14
Position and Object Code Detail

Operating Expenses

Object Code	Object Code Description	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Estimate	FY 2013-14 Request
Amount Under/(Over) Expended		**$280,819**	**$82,176**	**$0**	**$0**

Colorado Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Schedule 5: Line Item to Statute

(1) Executive Director's Office: (A) General Administration

Line Item Name	Line Item Description	Statutory Citation
Personal Services	Funds all salaries and wages to full-time, part-time, or temporary employees including professional services contracts, the State's contribution to the public employees retirement fund and the State's share of federal Medicare tax paid for state employees hired after April 1986.	24-50-101 et. seq., C.R.S. (2012) State Personnel System Act
Health, Life, and Dental	Covers the cost of the State's share of the employee's health, life and dental insurance.	24-50-609, C.R.S. (2012); 24-50-611, C.R.S. (2012) State Contributions and Employer Payments and 24-50-104 (1) (a) (II), C.R.S. (2012) Job evaluation and compensation, total compensation philosophy
Short-term Disability	Funds insurance coverage available for all employees and paid by the State based on payroll that provides partial payment of an employee's salary if that individual becomes disabled and cannot perform his or her work duties.	24-51-701, C.R.S. (2012) Short-term Disability and Disability Retirement and 24-50-104 (1) (a) (II), C.R.S. (2012) Job evaluation and compensation, total compensation philosophy
SB 04-257 Amortization Equalization Disbursement	This line item reflects an increase to the effective PERA contribution rates beginning January 1, 2006 to bring the Department into compliance with 24-51-411 C.R.S. (2012).	24-51-411, C.R.S. (2012) Amortization equalization disbursement - repeal
SB 06-235 Supplemental Amortization Equalization Disbursement	This line item reflects an increase to the effective PERA contribution rates funded though the Salary Survey and Senior Executive Service appropriation beginning January 1, 2008 to bring the Department into compliance with 24-51-411 C.R.S. (2012).	24-51-411, C.R.S. (2012) Amortization equalization disbursement - repeal
Salary Survey and Senior Executive Service	The Salary Survey and Senior Executive Services appropriation reflects the amounts appropriated to the Department to cover the cost of salary increases based on the job and wage classification survey performed annually by the Department of Personnel and Administration.	24-50-104 (1) (a) (I) and (II), C.R.S. (2012) Job evaluation and compensation, total compensation philosophy

Line Item Name	Line Item Description	Statutory Citation
Merit Pay	This line item reflects the annual amount appropriated for periodic salary increases for State employees based on demonstrated ability for satisfactory quality and quantity of performance. Each employee undergoes an annual performance evaluation, which is used to determine potential merit-based salary increases each fiscal year. Each State department must abide by parameters established by the Department of Personnel and Administration.	24-50-104, C.R.S. (2012) Job evaluation and compensation - state employee reserve fund - created - definitions.

(1) Executive Director's Office: (A) General Administration (cont.)

Line Item Name	Line Item Description	Statutory Citation
Workers' Compensation	Funds insurance coverage paid by the State for employee work-related accidents and providing compensation to employees or their survivors if the employee is injured or killed on the job.	8-40-101, C.R.S. (2012) through 8-47-209, C.R.S. (2012) and 24-30-1510.7, C.R.S. (2012) Workers' Compensation for State Employees
Operating Expenses	This line item includes supplies, materials, phone service, printing, postage, equipment and travel necessary for the general operation and administration of the Department.	NA
Legal Services	This line item represents the cost of purchasing legal services from the Department of Law at an hourly rate set by the Governor's Office of State Planning and Budgeting.	N/A
Administrative Law Judge Services	This line item is for the purchase of administrative law judge and paralegal services from the Division of Administrative Hearings in the Department of Personnel and Administration, and the appropriation for each affected State department is allocated as a Statewide Common Policy. The State appropriates these funds based upon actual utilization in prior years.	24-30-1002, C.R.S. (2012) and 24-30-1003, C.R.S. (2012) and 25.5-1-107 (1), C.R.S. (2012)
Purchases of Services from Computer Center	Funding for computer systems services provided to the Department by the General Government Computer Center.	24-37.5-604, C.R.S. (2012) and 25.5-4-204, C.R.S. (2012)
Multiuse Network Payments	This line was created for FY 2010-11 due to the establishment of the Governor's Office of Information Technology and subsequent consolidation of Department Information Technology personnel into that organization. These payments are to cover the cost of managing the statewide multiuse network.	24-37.5-104 et seq., C.R.S. (2012)
Management and Administration of OIT	This line item funds the OIT's "back-office" expenses associated with the centralization of the management of State agencies information technology resources in OIT.	24-37.5-102 et seq., C.R.S. (2012)
COFRS Modernization	It funds the first two phases of a five-phase project to replace the statewide accounting system used by the Office of the State Controller to record all state revenues and expenditures.	HB 12- 1335

Line Item Name	Line Item Description	Statutory Citation
Payment to Risk Management and Property Funds	This is a statewide allocation appropriated to pay for two programs in the Department of Personnel and Administration: The State Liability Program and the State Property Program. The allocation is based on the value of the agency's property holdings and an actuarially developed formula based on cash flow needs of each department.	24-30-1510, C.R.S. (2012) and 24-30-1510.5, C.R.S. (2012)
Leased Space	This line item is to provide office space for required staff.	25.5-1-104, C.R.S. (2012)
Capitol Complex Leased Space	This line item includes the amount allocated to the Department based on the Department's square foot usage in the Capitol Complex.	25.5-1-104, C.R.S. (2012) and 24-30-1303, C.R.S. (2012)

(1) Executive Director's Office: (A) General Administration (cont.)

Line Item Name	Line Item Description	Statutory Citation
General Professional Services and Special Projects	Includes any special projects or temporary projects that the Joint Budget Committee or General Assembly funds each year as well as other on-going professional contracts that the Department has that were previously funded in the Department's personal services line item. Also includes funding from the Nursing Home Penalty Cash Fund to provide grants to nursing facilities to promote culture change.	25-1-107.5, C.R.S. (2012) Nursing Home Penalty Cash Fund

(1) Executive Director's Office: (B) Transfers to Other Departments

Line Item Name	Line Item Description	Statutory Citation
Transfer to Department of Public Health and Environment Facility for Survey and Certification	Provides funding for survey and certification by the Department of Public Health and Environment of nursing facilities, hospices, home health agencies, and home and community based services agencies in accordance with applicable rules and regulations.	25-1.5-103 (1), C.R.S. (2012)
Transfer to Department of Public Safety for Life Safety Code Inspections for Health Facilities	Provide Medicaid funding to the Department of Public Safety for continuation of the Life Safety Code Inspections for nursing facilities.	24-33.5-1201 (5), C.R.S. (2012)
Transfer to Department of Public Health and Environment Facility for Nurse Home Visitor Program	Partially funds a program operated via an Interagency Agreement with the Department of Public Health and Environment. This program is funded by tobacco master settlement funds, and was created as a result of SB 00-071. The program offers home visits by trained nurses to first-time mothers eligible for Medicaid with incomes at or below 200 percent of the federal poverty level and services are offered through the second birthday of the child.	25-31-101 et seq., C.R.S. (2012) Colorado Nurse Home Visitor Program

Line Item Name	Line Item Description	Statutory Citation
Transfer to Department of Public Health and Environment for Enhanced Prenatal Care Training and Technical Assistance	Funds a program operated via an Interagency Agreement with the Department of Public Health and Environment to train health care providers in coordinating and evaluating services for at-risk pregnant women with the goal of reducing low-weight births.	N/A
Transfer to Department of Regulatory Agencies for Nurse Aide Certification	Provides funding for the Department of Regulatory Agencies for the Medicaid portion of the federal requirement (OBRA-87) to certify nurse aides working in Medicaid facilities.	12-38.1-101 et seq., C.R.S. (2012)
Transfer to Department of Regulatory Agencies for Reviews	Provides funding for the Department of Regulatory Agencies to perform sunset reviews of the Department's programs.	24-34-104, C.R.S. (2012)
Transfer to Department of Education for Public School Health Services Administration	Provides funding for the administrative expenses of the Department of Education for the Public School Health Services Program created in SB 97-101.	25.5-5-318 (8) (b), C.R.S. (2012)

(1) Executive Director's Office: (C) Information Technology Contracts and Projects

Information Technology Contracts	Includes funding for the Medicaid Management Information System contract which provides funding for the contract for the operation of the Medicaid Management Information System used to pay Medicaid provider claims and provide management information to assist the Department in the operation of the Medicaid program. Also includes funding for HIPAA Web Portal maintenance which provides funding for the costs for continued operations and maintenance of the Web Portal for access to information by medical providers and program managers within the Department. Required by federal regulations.	25.5-4-204, C.R.S. (2012) Automated medical assistance administration 25.5-4-105, C.R.S. (2012) Federal Requirements under Title XIX

Line Item Name	Line Item Description	Statutory Citation
MMIS Reprocurement Contracts	The State must competitively bid the role of the fiscal agent for the operation of the MMIS once every eight years.	25.5-4-204, C.R.S. (2012) Automated medical assistance administration
MMIS Reprocurement Contracted Staff	The State must competitively bid the role of the fiscal agent for the operation of the MMIS once every eight years.	25.5-4-204, C.R.S. (2012) Automated medical assistance administration
Fraud Detection Software Contract	Includes funding for fraud detection software that utilizes neural network and learning technology to detect fraud, abuse or waste in the Medicaid program. This funding also supports such functions as compliance monitoring, provider referrals, and utilization review.	25.5-4-301, C.R.S. (2012) Recoveries - overpayments - penalties - interest - adjustments - liens - review or audit procedures - repeal.
Centralized Eligibility Vendor Contract Project	Provides funding for an eligibility modernization vendor. The vendor will conduct eligibility activities for the Children's Basic Health Plan as well as new populations pursuant to HB 09-1293 including the Medicaid buy-in for persons with disabilities and adults without dependent children.	25.5-4-102, C.R.S. (2012); and 25.5-4-402.3 (b) (G), C.R.S. (2012).

(1) Executive Director's Office: (D) Eligibility Determinations and Client Services

Line Item Name	Line Item Description	Statutory Citation
Medical Identification Cards	Provides funds to produce and mail Medical Identification Cards to eligible Medicaid recipients and Old Age Pension State Medical Program clients.	25.5-4-102, C.R.S. (2012)
Contracts for Special Eligibility Determinations	Includes funding for Disability Determination Services which provides funding to conduct federally mandated disability determinations for individuals waiting for eligibility determinations of Supplemental Security Income or, if not financially eligible for Supplemental Security Income, those who are potentially eligible for Medicaid due to a disability. Also includes funding for Nursing Facility Preadmission Screeing and Resident Review (PASRR) assessment which provides funding for screenings and reviews mandated by federal law in OBRA-87 to determine appropriateness of nursing home placements for individuals with major mental illnesses or developmental disabilities. Also funds training for community mental health centers to ensure the screenings and reviews are properly conducted. Also includes funding for outstationing activities at hospitals in order for hospitals to process applications for the Medicaid program. This funding was created as a result of the passage of HB 09-1293, "Health Care Affordability Act".	25.5-4-105, C.R.S. (2012) Federal Requirements under Title XIX 25.5-6-104, C.R.S. (2012) Long-term care placements - comprehensive and uniform client assessment instrument - long-term care access study - legislative declaration 25.5-4-205, C.R.S. (2012) Verification of Eligibility 25.5-4-402.3 (3) (a), C.R.S. (2012) Hospital Provider Fee
County Administration	Provides funding to county departments of social/human services for determining eligibility for the Department's programs.	25.5-1-120 through 122, C.R.S. (2012)

Line Item Name	Line Item Description	Statutory Citation
Hospital Provider Fee County Administration	Provides hospital provider fee funding to county departments of social/human services for determining eligibility for the Department's hospital provider dee funded programs.	25.5-1-120 through 122, C.R.S. (2012) 25.5-4-402.3 (3) (a), C.R.S. (2012) Hospital Provider Fee
Administrative Case Management	Provides funding to county departments of social/human services for case management related to the protection and care for children.	25.5-1-120 through 122, C.R.S. (2012)
Customer Outreach	Includes funding for outreach and case management services for the Early and Periodic Screening, Diagnosis, and Treatment program required by federal regulations and performed via contracts and agreements with counties, local governments and other entities. Also includes funding for contracting with an enrollment broker for managed care enrollment and disenrollment functions for Medicaid clients in managed care organizations.	25.5-5-102 (1) (g), C.R.S. (2012) Basic services for the categorically needy - mandated services 25.5-5-406 (1) (a) (II), C.R.S. (2012) Required features of the managed care system

(1) Executive Director's Office: (E) Utilization and Quality Review Contracts

Line Item Name	Line Item Description	Statutory Citation
Professional Services Contracts	Includes funding for Acute Care Utilization Review which provides funding for performing prior authorization and post payment reviews for certain services to determine medical necessity and appropriateness for those services. Also includes funding for Long-term Care Utilization Review, which provides funding for performing reviews for long term care services to determine medical necessity and appropriateness for those services. In addition, the utilization review contractor performs pre-admission screening and periodic continued stay reviews for Medicaid clients seeking admittance to nursing facilities and home and community based services waiver programs. Some of the reviews for long-term care programs are required by federal regulations. Also includes funding for the External Quality Review contract which assists the Department in establishing quality measurements for services provided to Medicaid clients and administering a quality measurement system. Included in the contract scope are medical quality improvement studies, consumer surveys, data analysis and quality and utilization indicators. Also includes funding for Drug Utilization Review. Federal Regulations mandate the drug utilization review function. The purpose of the program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate and medically necessary, and not likely to result in adverse medical effects. Drug Utilization Review programs consist of prospective and retrospective drug use reviews, the application of explicit predetermined standards and an educational program. Also includes funding for the Mental Health External Quality Review contract which assists the Department in establishing quality measurements for services provided to Medicaid mental health clients and administering a quality measurement system. Contracting with an External Quality Review Organization is required under federal regulation for Medicaid programs with a health maintenance organization component.	25.5-5-405, C.R.S. (2012) Quality Measurements; 25.5-4-301(2), C.R.S. (2012) Recoveries - overpayments - penalties - interest - adjustments 25.5-5-506, C.R.S. (2012) Prescribed drugs - utilization review 42 CFR 456.703 (2009) Drug Use Review Program 25.5-5-411, C.R.S. (2012) Medicaid community mental health services - administration - rules.

(1) Executive Director's Office: (F) Provider Audits and Services

Line Item Name	Line Item Description	Statutory Citation
Professional Audit Contracts	Includes funding for contracting with an independent accounting firm to perform audits of nursing facility cost reports for rate setting. Also includes funding for contracting with an independent accounting firm for audit of cost and rate data for Medicaid hospitals, federally qualified health centers and rural health clinics. The audited cost reports are the basis for setting annual facility rates to cover the reasonable and necessary costs of an efficiently run facility per federal and State mandate. Also includes funding to support annual financial audits of Single Entry Point agencies. Also includes funding for the Payment Error Rate Measurement Project, with funding appropriated in FY 2010-11 (no funding is requested in FY 2011-12 due to the review cycle). This project is to improve the accuracy of Medicaid payments by conducting a statistical sampling of billing claims for the Medicaid and Children's Basic Health Plan programs to ensure that proper reimbursement payments are made. In addition, this line item includes funding for a Colorado Indigent Care Program (CICP) auditor and a Disproportionate Share Hospital (DSH) payments auditor.	25.5-6-201 and 25.5-6-202, C.R.S. (2012) Nursing facility reimbursement; 25.5-6-204, C.R.S. (2012) Providers - reimbursement - fees - nursing facility; 25.5-4-401 (1) (a), C.R.S. (2012) Provider reimbursement rules; 25.5-4-402, C.R.S. (2012) Hospital reimbursement; 25.5-5-408 (1) (d), C.R.S. (2012) Federally Qualified Health Centers 25.5-6-106, C.R.S. (2012) Single entry point system and 25.5-6-107, C.R.S. (2012) Financing of single entry point system 25.5-4-105, C.R.S. (2012) Federal Requirements under Title XIX 25.5-4-402.3 (3) (a), C.R.S. (2012) Hospital Provider Fee

(1) Executive Director's Office: (G) Recoveries and Recoupment Contract Costs

Line Item Name	Line Item Description	Statutory Citation
Estate Recovery	Provides funding for a contractor operated program to recover funds from estates of Medicaid clients over age 55, who reside in nursing facilities or are the recipients of long term care. The Department contracts with a private sector entity that pursues the recoveries on a contingency fee basis.	25.5-4-301, C.R.S. (2012) Recoveries - overpayments - penalties - interest - adjustments

(2) Medical Services Premiums

Line Item Name	Line Item Description	Statutory Citation
Services for Supplemental Security Income Adults 65 and Older (SSI 65+)	Provides funding for authorized medical services provided to Medicaid eligible clients.	25.5-5-101 (1), C.R.S. (2012) Mandatory provisions - eligible groups
Services for Supplemental Security Income Adults (SSI 60 - 64)	Provides funding for authorized medical services provided to Medicaid eligible clients.	25.5-5-101 (1), C.R.S. (2012) Mandatory provisions - eligible groups

Line Item Name	Line Item Description	Statutory Citation
Services for Qualified Medicare Beneficiaries (QMBs) and Special Low-Income Medicare Beneficiaries (SLIMBs)	Provides funding for authorized medical services provided to Medicaid eligible clients.	25.5-5-101 (1), C.R.S. (2012) Mandatory provisions - eligible groups; 25.5-5-103 (1), C.R.S. (2012) Mandated programs with special state provisions

Line Item Name	Line Item Description	Statutory Citation
Services for Supplemental Security Income Disabled Individuals	Provides funding for authorized medical services provided to Medicaid eligible clients.	25.5-5-101 (1), C.R.S. (2012) Mandatory provisions - eligible groups
Services for Categorically Eligible Low-Income Adults	Provides funding for authorized medical services provided to Medicaid eligible clients.	25.5-5-101 (1), C.R.S. (2012) Mandatory provisions - eligible groups
Services for Baby Care Program Adults	Provides funding for authorized medical services provided to Medicaid eligible clients.	25.5-5-201 (1), C.R.S. (2012) Optional provisions - optional groups
Services for Breast and Cervical Cancer Treatment Clients	Provides funding for authorized medical services provided to Medicaid eligible clients.	25.5-5-201 (1), C.R.S. (2012) Optional provisions - optional groups
Services for Expansion Health Care Low-Income Adult Clients	Provides funding for authorized medical services provided to Medicaid eligible clients.	25.5-5-101 (1), C.R.S. (2012) Mandatory provisions - eligible groups; 25.5-5-103 (1), C.R.S. (2012) Mandated programs with special state provisions
Services for Eligible Children	Provides funding for authorized medical services provided to Medicaid eligible clients.	25.5-5-101 (1), C.R.S. (2012) Mandatory provisions - eligible groups; 25.5-5-201 (1), C.R.S. (2012) Optional provisions - optional groups

(2) Medical Services Premiums (cont.)

Line Item Name	Line Item Description	Statutory Citation
Services for Foster Children	Provides funding for authorized medical services provided to Medicaid eligible clients.	25.5-5-101 (1), C.R.S. (2012) Mandatory provisions - eligible groups; 25.5-5-201 (1), C.R.S. (2012) Optional provisions - optional groups
Services for Non-Citizens	Provides funding for authorized medical services provided to Medicaid eligible clients.	25.5-5-103 (1), C.R.S. (2012) Mandated programs with special state provisions

(3) Medicaid Mental Health Community Programs

Line Item Name	Line Item Description	Statutory Citation
Mental Health Capitation Payments	Capitation payment to mental health managed care organizations for providing services to individuals with mental illness through community-based mental health programs.	25.5-5-411, C.R.S. (2012)

Line Item Name	Line Item Description	Statutory Citation
Medicaid Mental Health Fee for Service Payments	Provides Medicaid reimbursement to non-Mental Health Center providers (including hospitals, psychiatrists, psychologists, etc.) which are treating clients for mental health related issues.	25.5-5-411, C.R.S. (2012)

(4) Indigent Care Program

Line Item Name	Line Item Description	Statutory Citation
Safety Net Provider Payments	Provides partial reimbursement to hospital and clinic providers for medical services rendered to the State's non-Medicaid, uninsured or underinsured low-income residents. Individuals have income with assets at or below 250% of the federally poverty level and are not eligible for Medicaid.	25.5-3-108 (1) - (5), C.R.S. (2012) 25.5-3-104, C.R.S. (2012) Program for the medically indigent established
Colorado Health Care Services Fund	Fund that distributes money to Denver Health, Certified Health Care Providers, and Private Primary Care Clinics that provide indigent adults with primary care to prevent emergency hospitalization.	25.5-3-112, C.R.S. (2012) Health Care Services Fund
The Children's Hospital, Clinic Based Indigent Care	Provides funding to offset a portion of Colorado Indigent Care Program clinic-based provider's uncompensated costs to provide medical care to indigent persons. These clinics are located primarily outside the Denver metro area.	25.5-3-104, C.R.S. (2012)
Health Care Services Fund Programs	Provides funding for clinics operated by licensed or certified health care facilities (hospitals) and federally qualifying health centers.	25.5-3-112 (2) (a), C.R.S. (2012) and 25.5-3-112 (2) (b) (I), C.R.S. (2012)
Pediatric Speciality Hospital	Provides funding to offset a portion of a Medicaid clinic-based provider's uncompensated costs to provide medical care to indigent children.	24-22-117 (1) (c) (I) (B), C.R.S. (2012)
HB 05-1262 Appropriation from General Fund to Pediatric Speciality Hospital Fund	Augments hospital reimbursement rates for regional pediatric trauma centers.	24-22-117 (1) (c) (I) (B), C.R.S. (2012)
HB 05-1262 Appropriation from Tobacco Tax Cash Fund to the General Fund	Provides revenue from the Tobacco Tax Cash Fund to the State's General Fund for health-related purposes.	24-22-117 (1) (c), C.R.S. (2012)
Primary Care Fund Program	Provides funding to health care providers that provide services to Colorado's low-income uninsured or underinsured citizens.	24-22-117 (2) (b) (I), C.R.S. (2012)
Primary Care Grant Program Special Distribution	The Primary Care Grant Program Special Distribution fund was created during the 2010 legislative session with the intent of minimizing losses to clinics who receive money from the Primary Care Fund.	25.5-3-112 (4) (a), C.R.S. (2012)

Line Item Name	Line Item Description	Statutory Citation
HB 97-1304 Children's Basic Health Plan Trust	Contains the State's share of the costs of operating and providing medical, prenatal, and dental services to enrollees in the Children's Basic Health Plan.	25.5-8-105, C.R.S. (2012). Children's Basic Health Plan Trust created
Children's Basic Health Plan Administration	Funds the costs of contracts to provide for the administration of the Children's Basic Health Plan.	25.5-8-111, C.R.S. (2012) Contracts for administration of Children's Basic Health Plan and 25.5-8-107 (4), C.R.S. (2011)
Children's Basic Health Plan Medical and Dental Costs	Funds the costs of authorized medical services to eligible low-income children and pregnant women enrolled in the Children's Basic Health Plan.	25.5-8-107 (1) (a) (I), C.R.S. (2012) Schedule of services for Children's Basic Health Plan - medical; 25.5-8-109, C.R.S. (2012)
Children's Basic Health Plan Premium Costs	Funds the costs of authorized medical services to eligible low-income children and pregnant women and dental services to eligible low-income children enrolled in the Children's Basic Health Plan.	25.5-8-107 (1) (a) (I), C.R.S. (2012) Schedule of services for Children's Basic Health Plan - medical; 25.5-8-109, C.R.S. (2012)
Children's Basic Health Plan Dental Benefit Costs	Funds the costs of authorized dental services to eligible low-income children enrolled in the Children's Basic Health Plan.	25.5-8-107 (1) (a) (II), C.R.S. (2012) Schedule of services for Children's Basic Health Plan - dental; 25.5-8-109, C.R.S. (2012)

(5) Other Medical Services

Line Item Name	Line Item Description	Statutory Citation
Services for Old Age Pension State Medical Program Clients	A program providing medical care to clients eligible for the State Old Age Pension Program.	State Constitution, Title XXIV, Section 7 Old Age Pension Health and Medical Fund, 25.5-2-101, C.R.S. (2012) Old Age Pension Health and Medical Care Fund - Supplemental Old Age Pension Health and Medical Care Fund
Transfer of Tobacco Tax Cash Fund into the Supplemental Old Age Pension State Medical Fund	Provides additional funding for services for Old Age Pension State Medical Program clients which provides medical care to clients eligible for the State Old Age Pension Program.	State Constitution, Title XXIV, Section 7 Old Age Pension Health and Medical Fund, 24-22-117 (1) (c), C.R.S. (2012) Old Age Pension Health and Medical Care Fund - Supplemental Old Age Pension Health and Medical Care Fund
Commission on Family Medicine Residency Training Programs	Provides Medicaid funding for the Colorado Family Medicine Residency Training Program operated by the Department of Higher Education/University of Colorado Health Sciences Center.	25-1-902 (1), C.R.S. (2012) and 25-1-903 (1) (C), C.R.S. (2012) Duties of family medicine commission

Line Item Name	Line Item Description	Statutory Citation
State University Teaching Hospitals - Denver Health and Hospital Authority	This line item provides funding for Graduate Medical Education through Denver Health and Hospital Authority. Reimbursement is provided through fee-for-service payments and lump sum payments when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education.	25.5-1-101 et seq., C.R.S. (2012)
State University Teaching Hospitals - University of Colorado Hospital Authority	This line item provides funding for Graduate Medical Education through University of Colorado Hospital Authority. Reimbursement is provided through fee-for-service payments and lump sum payments when clients enrolled in managed care organizations are seen by students involved in Graduate Medical Education.	25.5-1-101 et seq., C.R.S. (2012)
Medicare Modernization Act of 2003 State Contribution Payment	Funding is for a percentage of prescription drug costs associated with dual eligible clients. These drug expenditures are now part of the federal Medicare program.	25.5-4-105, C.R.S. (2012) Federal Requirements under Title XIX
Public School Health Services Contract Administration	The line item contains all administrative funding for the program excluding the transfer of funds to the Department of Education	25.5-5-318 (8) (b), C.R.S. (2012)
Public School Health Services	Reimbursement for services provided under contracts with public school districts, boards of cooperative services and state K-12 educational institutions to Medicaid eligible children in school-based health clinics.	25.5-5-318, C.R.S. (2012) Contracts with school districts for health services to Medicaid eligible students

(6) Department of Human Services Medicaid Funded Programs

Line Item Name	Line Item Description	Statutory Citation
All Line Items	See Department of Human Services Schedule 5 for Description.	See Department of Human Services Schedule 5 for Statutory Citation

Colorado Department of Health Care Policy and Financing								
FY 2013-14 Budget Request								
Schedule 6: Special Bills Summary								
Bill Number	**Short Bill Title**	**Line Items**	**FTE**	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**
FY 2012-13								
HB 12-1340	Nursing Facility Per Diem Reduction							
		(2) Medical Services Premiums	0.0	($9,024,676)	($4,512,338)	$0	$0	$0
		Total HB 12-1340	**0.0**	**($9,024,676)**	**($4,512,338)**	**$0**	**$0**	**$0**
HB 12-1281	Medicaid Payment Reform Pilot Program							
		(1) Executive Director's Office						
		(A) General Administration						
		Personal Services	0.8	$47,538	$23,769	$0	$0	$0
		Operating Expenses	0.0	$5,541	$2,771	$0	$0	$0
		General Professional Services and Special Projects	0.0	$160,000	$80,000	$0	$0	$0
		Total HB 12-1281	**0.8**	**$213,079**	**$106,540**	**$0**	**$0**	**$0**
HB 12-1246	Bi-Weekly Pay Date Shift							
		(1) Executive Director's Office						
		(A) General Administration						
		Personal Services	0.0	$28,498	$28,498	$0	$0	$0
		(6) Department of Human Services Medicaid-Funded						
		(A) Executive Director's Office - Medicaid Funding	0.0	$62,776	$31,388	$0	$0	$0
		(C) Information Technology Contracts and Projects						
		(C) Office of Operations - Medicaid Funding	0.0	$9,915	$4,958	$0	$0	$0
		(G) Recoveries and Recoupment Contract Costs						
		Regional Centers	0.0	$184,530	$92,265	$0	$0	$0
		Total HB 12-1246	**0.0**	**$285,719**	**$157,109**	**$0**	**$0**	**$0**
SB 12-159	Evaluation Children With Autism Medicaid Waiver							
		(2) Medical Services Premiums	0.0	$6,925	$0	$0	$3,463	$0
		Total SB 12-159	**0.0**	**$6,925**	**$0**	**$0**	**$3,463**	**$0**
SB 12-060	Medicaid Recipient Fraud							
		(1) Executive Director's Office						
		(A) General Administration						
		Personal Services	0.1	$5,216	$2,608	$0	$0	$0
		(2) Medical Services Premiums	0.0	($54,156)	($2,608)	$0	($24,470)	$0
		Total SB 12-060	**0.1**	**($48,940)**	**$0**	**$0**	**($24,470)**	**$0**
SB 11-250	Pregnant Women Medicaid Eligibility	(1) Executive Director's Office						
		(C) Information Technology Contracts and Projects						
		Information Technology Contracts	0.0	$6,930	$1,681	$0	$73	$0
		(2) Medical Services Premiums	0.0	$7,346,456	$2,571,260	$0	$0	$0
		(3) Medicaid Mental Health Community Programs						
		Mental Health Capitation Payments	0.0	$180,133	$63,047	$0	$0	$0
SB 11-250	Pregnant Women Medicaid	(4) Indigent Care Program						

Colorado Department of Health Care Policy and Financing								
FY 2013-14 Budget Request								
Schedule 6: Special Bills Summary								
Bill Number	**Short Bill Title**	**Line Items**	**FTE**	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**
	Eligibility	Children's Basic Health Plan Administration	0.0	$1,000	$0	$0	$350	$0
		Children's Basic Health Plan Medical and Dental	0.0	($9,387,101)	($3,285,485)	$0	$0	$0
		(6) Department of Human Services Medicaid-Funded						
		(B) Office of Information Technology Services - Medicaid Funding						
		Colorado Benefits Management System	0.0	$25,728	$12,777	$0	$41	$56
		Total SB 11-250	**0.0**	**($1,826,854)**	**($636,720)**	**$0**	**$464**	**$56**
SB 11-008	Aligning Children's Medicaid Eligibility							
		(1) Executive Director's Office						
		(C) Information Technology Contracts and Projects						
		Information Technology Contracts	0.0	$6,930	$1,733	$0	$0	$0
		(D) Eligibility Determinations and Client Services						
		County Administration	0.0	$241,325	$72,398	$0	$48,265	$0
		Customer Outreach	0.0	$39,715	$19,858	$0	$0	$0
		(2) Medical Services Premiums	0.0	$8,298,832	$2,904,591	$0	$0	$0
		(3) Medicaid Mental Health Community Programs						
		Mental Health Capitation Payments	0.0	$1,009,781	$353,423	$0	$0	$0
		(4) Indigent Care Program						
		Children's Basic Health Plan Administration	0.0	$1,000	$0	$0	$350	$0
		Children's Basic Health Plan Medical and Dental	0.0	($11,929,097)	$0	$0	($4,175,184)	$0
		(6) Department of Human Services Medicaid-Funded						
		(B) Office of Information Technology Services - Medicaid Funding						
		Colorado Benefits Management System	0.0	$25,728	$12,777	$0	$41	$56
		Total SB 11-008	**0.0**	**($2,305,786)**	**$3,364,780**	**$0**	**($4,126,528)**	**$56**
FY 2012-13 Department Total			**0.9**	**($12,700,533)**	**($1,520,629)**	**$0**	**($4,147,071)**	**$112**
FY 2011-12								
HB 12-1202	Quitline Matching Funds							
		(2) Medical Services Premiums	0.0	$577,316	$0	$0	$288,658	$0
		Total HB 12-1202	**0.0**	**$577,316**	**$0**	**$0**	**$288,658**	**$0**
HB 12-1339	CBMS Modernization and Improvement							
		(6) Department of Human Services Medicaid-Funded						
		(B) Office of Information Technology Services -						
		Colorado Benefits Management System	0.0	$3,654,755	$1,820,992	$0	$8,521	$0
		Total HB 12-1339	**0.0**	**$3,654,755**	**$1,820,992**	**$0**	**$8,521**	**$0**

Bill Number	Short Bill Title	Line Items	FTE	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
HB 11-1242	Medicaid Provider Integration Of Service							
		(A) General Administration						
		General Professional Services and Special Projects	0.0	$113,500	$0	$0	$56,750	$0
		Total HB 11-1242	**0.0**	**$113,500**	**$0**	**$0**	**$56,750**	**$0**
SB 11-076	Pera Contribution Rates	(1) Executive Director's Office						
		(A) General Administration						
		Personal Services	0.0	($508,843)	($166,362)	$0	($56,118)	$0
		(B) Transfers to Other Departments						
		Transfer to Department of Public Health and Environment Facility for Survey and Certification	0.0	($79,170)	($27,710)	$0	$0	$0
		Transfer to Department of Education for Public School Health Services Administration	0.0	($1,685)	$0	$0	$0	$0
		(6) Department of Human Services Medicaid-Funded Programs						
		(A) Executive Director's Office - Medicaid Funding	0.0	($18,819)	($9,410)	$0	$0	$0
		(C) Office of Operations - Medicaid Funding	0.0	($66,044)	($33,022)	$0	$0	$0
		(D) Division of Child Welfare - Medicaid Funding						
		Administration	0.0	($2,721)	($1,361)	$0	$0	$0
		(E) Office of Self Sufficiency - Medicaid Funding, Systematic Alien Verification for Eligibility	0.0	($740)	($370)	$0	$0	$0
		(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding						
		Administration	0.0	($7,666)	($3,833)	$0	$0	$0
		Mental Health Institutes	0.0	($46,631)	($23,316)	$0	$0	$0
		(G) Services for People with Disabilities - Medicaid Funding						
		Community Services for People with Developmental Disabilities, Administration	0.0	($50,650)	($25,325)	$0	$0	$0
		Regional Centers	0.0	($846,245)	($423,123)	$0	$0	$0
		(I) Division of Youth Corrections - Medicaid Funding	0.0	($1,030)	($515)	$0	$0	$0
		Total SB 11-076	**0.0**	**($1,630,244)**	**($714,347)**	**$0**	**($56,118)**	**$0**
SB 11-125	Nursing Home Fees & Order Of Payments	(1) Executive Director's Office						
		(A) General Administration						
		General Professional Services and Special Projects	0.0	$60,000	$30,000	$0	$0	$0
		(2) Medical Services Premiums	0.0	$30,994,411	$0	$0	$15,497,206	$0
		Total SB 11-125	**0.0**	**$31,054,411**	**$30,000**	**$0**	**$15,497,206**	**$0**

Colorado Department of Health Care Policy and Financing

FY 2013-14 Budget Request

Schedule 6: Special Bills Summary

Bill Number	Short Bill Title	Line Items	FTE	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
SB 11-177	Repeal Sunset Teen Pregnancy & Dropout Program	(1) Executive Director's Office						
		(A) General Administration						
		Personal Services	1.0	$47,817	$23,909	$0	$0	$0
		Operating Expenses	0.0	$5,653	$2,826	$0	$0	$0
		(2) Medical Services Premiums	0.0	$144,165	($26,735)	$0	$19,763	$0
		Total SB 11-177	**1.0**	**$197,635**	**$0**	**$0**	**$19,763**	**$0**
SB 11-210	Phase Out Supplemental OAP Health Fund	(2) Medical Services Premiums	0.0	$0	($2,230,500)	$0	$2,230,500	$0
		(5) Other Medical Services						
		Transfer of Tobacco Tax Cash Fund into the Supplemental Old Age Pension State Medical Fund	0.0	($2,230,500)	$0	$0	($2,230,500)	$0
		Total SB 11-210	**0.0**	**($2,230,500)**	**($2,230,500)**	**$0**	**$0**	**$0**
SB 11-211	Tobacco Revenues Offset Medical Services	(2) Medical Services Premiums	0.0	$0	($33,000,000)	$0	$29,713,649	$3,286,351
		Total SB 11-211	**0.0**	**$0**	**($33,000,000)**	**$0**	**$29,713,649**	**$3,286,351**
SB 11-212	Use Provider Fee Offset GF Medicaid	(2) Medical Services Premiums	0.0	$0	($50,000,000)	$0	$50,000,000	$0
		Total SB 11-212	**0.0**	**$0**	**($50,000,000)**	**$0**	**$50,000,000**	**$0**
SB 11-215	2011 Nursing Facility Rate Reduction	(2) Medical Services Premiums	0.0	($8,865,830)	($4,432,915)	$0	$0	$0
		Total SB 11-215	**0.0**	**($8,865,830)**	**($4,432,915)**	**$0**	**$0**	**$0**
SB 11-216	Children's Basic Health Plan General Fund Appropriation	(1) Executive Director's Office						
		(A) General Administration						
		Personal Services	(0.2)	($23,494)	$0	$0	($23,494)	$0
		Short-term Disability	0.0	($18)	$0	$0	($18)	$0
		S.B. 04-257 Amortization Equalization Disbursement	0.0	($543)	$0	$0	($543)	$0
		S.B. 06-235 Supplemental Amortization Equalization Disbursement	0.0	($308)	$0	$0	($308)	$0
		(4) Indigent Care Program						
		Pediatric Specialty Hospital	0.0	($1,485,944)	$0	$0	($296,872)	($446,100)
		Appropriation from General Fund to Pediatric Specialty Hospital Fund	0.0	($446,100)	$0	($446,100)	$0	$0
		Comprehensive Primary and Preventive Care Grants Program	0.0	($2,706,995)	$0	$0	($2,706,995)	$0
		Children's Basic Health Plan Medical and Dental Costs	0.0	$0	($3,449,967)	$446,100	$3,003,867	$0
		Total SB 11-216	**(0.2)**	**($4,663,402)**	**($3,449,967)**	**$0**	**($24,363)**	**($446,100)**

Colorado Department of Health Care Policy and Financing								
FY 2013-14 Budget Request								
Schedule 6: Special Bills Summary								
Bill Number	**Short Bill Title**	**Line Items**	**FTE**	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**
SB 11-219	2011 Transfers For Health Care Services	(2) Medical Services Premiums	0.0	$0	($15,775,670)	$0	$15,775,670	$0
		(4) Indigent Care Program						
		Health Care Services Fund Programs	0.0	$23,510,000	$0	$0	$11,755,000	$0
		Primary Care Fund Program	0.0	($28,253,000)	$0	$0	($28,253,000)	$0
		Primary Care Grant Program Special Distribution	0.0	$2,135,830	$0	$0	$2,135,830	$0
		Total SB 11-219	**0.0**	**($2,607,170)**	**($15,775,670)**	**$0**	**$1,413,500**	**$0**
FY 2011-12 Department Total			**0.8**	**$15,600,471**	**($107,752,407)**	**$0**	**$96,917,566**	**$2,840,251**
FY 2010-11								
HB 10-1005	Home Health Care	(2) Medical Services Premiums	0.0	$123,270	$0	$0	$47,348	$0
		Total HB 10-1005	**0.0**	**$123,270**	**$0**	**$0**	**$47,348**	**$0**
HB 10-1027	Medicaid Hospice Life Expectancy	(1) Executive Director's Office						
		(A) General Administration						
		General Professional Services and Special Projects	0.0	$25,000	$0	$0	$12,500	$0
		Total HB 10-1027	**0.0**	**$25,000**	**$0**	**$0**	**$12,500**	**$0**
HB 10-1033	Screening Brief Intervention Referral	(2) Medical Services Premiums	0.0	$870,155	$334,227	$0	$0	$0
		Total HB 10-1033	**0.0**	**$870,155**	**$334,227**	**$0**	**$0**	**$0**
HB 10-1053	Medicaid Community Long-term Care Saving	(1) Executive Director's Office						
		(A) General Administration						
		General Professional Services and Special Projects	0.0	$75,000	$0	$0	$37,500	$0
		Total HB 10-1053	**0.0**	**$75,000**	**$0**	**$0**	**$37,500**	**$0**
HB 10-1146	State-funded Public Assistance Programs	(2) Medical Services Premiums	0.0	($704,421)	($869,842)	$0	$0	$0
		(6) Department of Human Services Medicaid-Funded Programs						
		(B) Offices of Information Technology Services Medicaid Funding						
		Colorado Benefits Management System	0.0	$184,387	$91,434	$0	$818	$0
		Total HB 10-1146	**0.0**	**($520,034)**	**($778,408)**	**$0**	**$818**	**$0**
HB 10-1338	Probation Eligible Two Prior Felony	(6) Department of Human Services Medicaid-Funded Programs						
		(D) Division of Child Welfare - Medicaid Funding						
		Child Welfare Services	0.0	$75,209	$28,887	$0	$0	$0
		Total HB 10-1338	**0.0**	**$75,209**	**$28,887**	**$0**	**$0**	**$0**

Colorado Department of Health Care Policy and Financing

FY 2013-14 Budget Request

Schedule 6: Special Bills Summary

Bill Number	Short Bill Title	Line Items	FTE	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
HB 10-1378	Transfers for Health Care Services	(2) Medical Services Premiums	0.0	$0	($12,800,000)		$12,800,000	$0
		(4) Indigent Care Program						
		Health Care Services Fund Programs	0.0	$29,635,145	$0	$0	$11,940,000	$0
		Primary Care Fund Program	0.0	($28,300,000)	$0	$0	($28,300,000)	$0
		Primary Care Grant Program Special Distribution	0.0	$3,560,000	$0	$0	$3,560,000	$0
		Total HB 10-1378	**0.0**	**$4,895,145**	**($12,800,000)**	**$0**	**$0**	**$0**
HB 10-1379	2010 Nursing Facility Rate Reduction	(2) Medical Services Premiums	0.0	($6,234,689)	($8,211,333)	$0	$5,806,343	$0
		Total HB 10-1379	**0.0**	**($6,234,689)**	**($8,211,333)**	**$0**	**$5,806,343**	**$0**
HB 10-1380	Use Supplemental OAP Health Fund for Medicaid	(2) Medical Services Premiums	0.0	$0	($4,850,000)	$0	$4,850,000	$0
		Total HB 10-1380	**0.0**	**$0**	**($4,850,000)**	**$0**	**$4,850,000**	**$0**
HB 10-1381	Tobacco Revenues Offset Medical Services	(2) Medical Services Premiums	0.0	$0	($25,691,418)	$0	$21,200,983	$4,490,435
		Total HB 10-1381	**0.0**	**$0**	**($25,691,418)**	**$0**	**$21,200,983**	**$4,490,435**
HB 10-1382	Repeal Delay of Public Medical Assistance Program Payments	(2) Medical Services Premiums	0.0	($43,121,235)	($14,679,904)	$0	($2,023,356)	($17,380)
		(4) Indigent Care Program						
		H.B. 97-1304 Children's Basic Health Plan Trust	0.0	$2,554,602	$2,554,602	$0	$0	$0
		Total HB 10-1382	**0.0**	**($40,566,633)**	**($12,125,302)**	**$0**	**($2,023,356)**	**($17,380)**
HB 10-1384	Alignment of Eligibility for the Old Age Pension Program	(6) Department of Human Services Medicaid-Funded Programs						
		(B) Offices of Information Technology Services Medicaid Funding						
		Colorado Benefits Management System	0.0	$17,220	$8,539	$0	$76	$0
		Total HB 10-1384	**0.0**	**$17,220**	**$8,539**	**$0**	**$76**	**$0**
SB 10-061	Medicaid Hospice Room and Board Charges	(1) Executive Director's Office						
		(A) General Administration						
		General Professional Services and Special Projects	0.0	$102,570	$0	$0	$51,285	$0
		Total SB 10-061	**0.0**	**$102,570**	**$0**	**$0**	**$51,285**	**$0**
SB 10-167	Medicaid Efficiency & False Claims	(1) Executive Director's Office						
		(A) General Administration						
		Personal Services	7.0	$447,118	$223,559	$0	$0	$0
		Operating Expenses	0.0	$39,340	$19,670	$0	$0	$0
		(C) Information Technology Contracts						
		Information Technology Contracts	0.0	$641,903	$160,476	$0	$0	$0

Colorado Department of Health Care Policy and Financing

FY 2013-14 Budget Request

Schedule 6: Special Bills Summary

Bill Number	Short Bill Title	Line Items	FTE	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds
SB 10-167	Medicaid Efficiency & False Claims	(D) Eligibility Determinations and Client Services						
		County Administration	0.0	$200,000	$100,000	$0	$0	$0
		(2) Medical Services Premiums	0.0	($2,390,570)	($918,218)	$0	$0	$0
		Total SB 10-167	**7.0**	**($1,062,209)**	**($414,513)**	**$0**	**$0**	**$0**
SB 10-169	Provider Fee Enhanced Match	(2) Medical Services Premiums	0.0	$0	($46,329,388)	$0	$46,329,388	$0
		Total SB 10-169	**0.0**	**$0**	**($46,329,388)**	**$0**	**$46,329,388**	**$0**
FY 2010-11 Department Total			**7.0**	**($42,224,996)**	**($110,828,709)**	**$0**	**$76,300,385**	**$4,473,055**

Federal Funds
($4,512,338)
($4,512,338)
$23,769
$2,770
$80,000
$106,539
$0
$31,388
$4,957
$92,265
$128,610
$3,462
$3,462
$2,608
($27,078)
($24,470)
$5,176
$4,775,196
$117,086

	Federal Funds
	$650
	($6,101,616)
	$12,854
	($1,190,654)
	$5,197
	$120,662
	$19,857
	$5,394,241
	$656,358
	$650
	($7,753,913)
	$12,854
	($1,544,094)
	($7,032,945)
	$288,658
	$288,658
	$1,825,242
	$1,825,242

Federal Funds
$56,750
$56,750
($286,363)
($51,460)
($1,685)
($9,409)
($33,022)
($1,360)
($370)
($3,833)
($23,315)
($25,325)
($423,122)
($515)
($859,779)
$30,000
$15,497,205
$15,527,205

Federal Funds
$23,908
$2,827
$151,137
$177,872
$0
$0
$0
$0
$0
$0
$0
($4,432,915)
($4,432,915)
$0
$0
$0
$0
($742,972)
$0
$0
$0
($742,972)

Federal Funds
$0
$11,755,000
$0
$0
$11,755,000
$23,595,061
$75,922
$75,922
$12,500
$12,500
$535,928
$535,928
$37,500
$37,500
$165,421
$92,135
$257,556
$46,322
$46,322

Federal Funds
$0
$17,695,145
$0
$0
$17,695,145
($3,829,699)
($3,829,699)
$0
$0
$0
$0
($26,400,595)
$0
($26,400,595)
$8,605
$8,605
$51,285
$51,285
$223,559
$19,670
$481,427

Federal Funds
$100,000
($1,472,352)
($647,696)
$0
$0
($12,169,727)

Colorado Department of Health Care Policy and Financing							
FY 2013-14 Budget Request							
Schedule 7: Supplemental Bills Summary							
Bill Number	**Line Items**	**FTE**	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**
FY 2011-12							
HB 12-1335	**(1) Executive Director's Office**						
Add-ons	**(A) General Administration**						
	Personal Services	(0.5)	($31,693)	($15,847)	$0	$0	$0
	Operating Expenses	0.0	($475)	($238)	$0	$0	$0
	Total	**(0.5)**	**($32,168)**	**($16,085)**	**$0**	**$0**	**$0**
	(2) Medical Services Premiums	0.0	$101,141,841	($47,259,656)	$89,352,237	$5,412,542	$57,769
	Total	**0.0**	**$101,141,841**	**($47,259,656)**	**$89,352,237**	**$5,412,542**	**$57,769**
	(3) Medicaid Mental Health Community Programs						
	Mental Health Capitation Payments	0.0	$2,653,058	$5,986,391	$0	($4,738,434)	$11,502
	Total	**0.0**	**$2,653,058**	**$5,986,391**	**$0**	**($4,738,434)**	**$11,502**
	(4) Indigent Care Program						
	Safety Net Provider Payments	0.0	($4,555,560)	$0	$0	($2,277,780)	$0
	Children's Basic Health Plan Medical and Dental Costs	0.0	($29,603,573)	$0	$0	($10,052,683)	$0
	Total	**0.0**	**($34,159,133)**	**$0**	**$0**	**($12,330,463)**	**$0**
	(5) Other Medical Services						
	Medicaid Modernization Act of 2003 State Contribution Payment	0.0	$2,356,099	$2,356,099	$0	$0	$0
	Total	**0.0**	**$2,356,099**	**$2,356,099**	**$0**	**$0**	**$0**
	(6) Department of Human Services Medicaid-Funded Programs						
	(I) Division of Youth Corrections - Medicaid Funding	0.0	$28,438	$14,219	$0	$0	$0
	Total	**0.0**	**$28,438**	**$14,219**	**$0**	**$0**	**$0**
Total HB 12-1335 Add-ons		**(0.5)**	**$71,988,135**	**($38,919,032)**	**$89,352,237**	**($11,656,355)**	**$69,271**
HB 12-1184	**(1) Executive Director's Office**						
	(A) General Administration						
	Administrative Law Judge Services	0.0	$26,297	$13,148	$0	$0	$0
	General Professional Services and Special Projects	0.0	($120,000)	$0	$0	($60,000)	$0
	(B) Transfers to Other Departments						
	Transfer to Department of Public Health and Environment Facility for Survey and Certification	0.0	$217,047	$0	$0	$0	$0
	(C) Information Technology Contracts and Projects						
	Centralized Eligibility Vendor Contract Project	0.0	$2,230,940	$0	$0	$1,246,853	$0
	(D) Eligibility Determinations and Client Services						
	Medical Identification Cards	0.0	$9,240	$0	$0	$4,620	$0
	County Administration	0.0	($2,361,502)	$0	$0	($1,180,751)	$0
	Hospital Provider Fee County Administration	0.0	$2,361,502	$0	$0	$1,180,751	$0
	Customer Outreach	0.0	$90,506	$0	$0	$45,253	$0
	(E) Utilization and Quality Review Contracts						
	Professional Services Contracts	0.0	$493,612	$62,500	$0	$53,795	$0
	Total	**0.0**	**$2,947,642**	**$75,648**	**$0**	**$1,290,521**	**$0**
HB 12-1184	**(2) Medical Services Premiums**	0.0	$2,220,236	($18,323,616)	$0	$18,322,469	$0
	Total	**0.0**	**$2,220,236**	**($18,323,616)**	**$0**	**$18,322,469**	**$0**
	(4) Indigent Care Program						

Colorado Department of Health Care Policy and Financing							
FY 2013-14 Budget Request							
Schedule 7: Supplemental Bills Summary							
Bill Number	**Line Items**	**FTE**	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**
	Safety Net Provider Payments	0.0	($15,896,240)	$0	$0	($7,948,120)	$0
	Children's Basic Health Plan Medical and Dental Costs	0.0	$1,385,723	($138,601)	$0	$713,695	$0
	Total	**0.0**	**($14,510,517)**	**($138,601)**	**$0**	**($7,234,425)**	**$0**
	(5) Other Medical Services						
	Commission on Family Medicine Residency Training Programs	0.0	$350,000	$175,000	$0	$0	$0
	Medicaid Modernization Act of 2003 State Contribution Payment	0.0	$0	($5,633,177)	$0	$0	$0
	Total	**0.0**	**$350,000**	**($5,458,177)**	**$0**	**$0**	**$0**
	(6) Department of Human Services Medicaid-Funded Programs						
	(B) Office of Information Technology Services - Medicaid Funding						
	Colorado Benefits Management System	0.0	$1,165,046	($149,482)	$0	$732,537	($650)
	Colorado Benefits Management System, HPCF Only	0.0	$812,400	$107,460	$0	$298,740	$0
	(C) Office of Operations - Medicaid Funding	0.0	($365,765)	($182,882)	$0	$0	$0
	(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding						
	Mental Health Institutes	0.0	$1,125,866	$562,933	$0	$0	$0
	(G) Services for People with Disabilities - Medicaid Funding						
	Regional Centers	0.0	($1,867,655)	$933,828	$0	$0	($1,867,655)
	(I) Division of Youth Corrections - Medicaid Funding	0.0	$221,672	$110,836	$0	$0	$0
	Total	**0.0**	**$1,091,564**	**$1,382,693**	**$0**	**$1,031,277**	**($1,868,305)**
Total HB 12-1184		**0.0**	**($7,901,075)**	**($22,462,053)**	**$0**	**$13,409,842**	**($1,868,305)**
HB 12-1184	**(2) Medical Services Premiums**	0.0	$0	$0	$0	$0	$0
Add-ons	**Total**	**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total HB 12-1184 Add-ons		**0.0**	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2010-11							
HB 12-1335							
Add-ons	**(2) Medical Services Premiums**	0.0	$0	$3,976,005	($3,976,005)	$0	$0
	Total	**0.0**	**$0**	**$3,976,005**	**($3,976,005)**	**$0**	**$0**
Total HB 12-1335 Add-ons		**0.0**	**0.0**	**$3,976,005**	**($3,976,005)**	**0.0**	**0.0**
SB 11-209	**(1) Executive Director's Office**						
Add-ons	**(B) Transfers to Other Departments**						
	Transfer to Department of Public Health and Environment for Nurse Home Visitor Program	0.0	$0	$0	$0	$0	$56,588
	Total		**$0**	**$0**	**$0**	**$0**	**$56,588**
SB 11-209	**(2) Medical Services Premiums**	0.0	$237,436,847	($54,936,910)	$117,900,000	$97,223,834	($180,916)
Add-ons	**Total**		**$237,436,847**	**($54,936,910)**	**$117,900,000**	**$97,223,834**	**($180,916)**
	(3) Medicaid Mental Health Community Programs						
	Medicaid Mental Health Capitation Payments	0.0	$504,513	$6,216,220	$0	$2,096,032	$954
	Medicaid Mental Health Fee for Service Payments	0.0	$503,380	$257,478	$0	$0	$0
	Total	**0.0**	**$1,007,893**	**$6,473,698**	**$0**	**$2,096,032**	**$954**

Colorado Department of Health Care Policy and Financing							
FY 2013-14 Budget Request							
Schedule 7: Supplemental Bills Summary							
Bill Number	**Line Items**	**FTE**	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**
	(4) Indigent Care Program						
	Safety Net Provider Payments	0.0	$12,119,174	$0	$0	$6,499,834	$0
	The Children's Hospital, Clinic Based Indigent Care	0.0	$0	$115,051	$0	$0	$0
	Pediatric Specialty Hospital	0.0	$0	$278,653	$0	$0	$0
	H.B. 97-1304 Children's Basic Health Plan Trust	0.0	$4,604,711	$4,604,711	$0	$0	$0
	Children's Basic Health Plan Medical and Dental Costs	0.0	($1,182,054)	$0	$0	($413,718)	$0
	Total		**$15,541,831**	**$4,998,415**	**$0**	**$6,086,116**	**$0**
	(5) Other Medical Services						
	Services for Old Age Pension State Medical Program Clients	0.0	($4,083,483)	$0	$0	($1,848,483)	($2,235,000)
	Commission on Family Medicine Residency Training Programs	0.0	$0	$32,690	$0	$0	$0
	State University Teaching Hospitals - Denver Health and Hospital Authority	0.0	$0	$34,437	$0	$0	$0
	State University Teaching Hospitals - University of Colorado Hospital Authority	0.0	$0	$12,724	$0	$0	$0
	Medicare Modernization Act of 2003 State Contribution Payment	0.0	$1,286,372	$1,286,372	$0	$0	$0
	Total		**($2,797,111)**	**$1,366,223**	**$0**	**($1,848,483)**	**($2,235,000)**
	(6) Department of Human Services Medicaid Funded Programs						
	(A) Executive Director's Office - Medicaid Funding	0.0	$0	$98,932	$0	$0	$0
	(B) Office of Information Technology Services - Medicaid Funding						
	Other Office of Information Technology Services Line Items	0.0	$0	$8,810	$0	$0	$0
	(C) Office of Operations - Medicaid Funding	0.0	$0	$96,174	$0	$0	$0
	(D) Division of Child Welfare - Medicaid Funding						
	Child Welfare Services	0.0	$225,912	$355,805	$0	$0	$0
	(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding						
	Residential Treatment for Youth (HB 99-1116)	0.0	$0	$2,199	$0	$0	$0
	Mental Health Institutes	0.0	$348,250	$188,652	$0	$0	$0
	Alcohol and Drug Abuse Division, High Risk Pregnant Women Program	0.0	$0	$37,628	$0	$0	$0
SB 11-209	**(G) Services for People with Disabilities - Medicaid Funding**						
Add-ons	Community Services for People with Developmental Disabilities, Program Costs	0.0	$40,215,272	$21,782,600	$0	$20,613	$0
	Regional Centers	0.0	$0	$881,507	$0	$0	$0
	(I) Division of Youth Corrections - Medicaid Funding	0.0	($204,688)	($36,132)	$0	$0	$0
	Total		**$40,584,746**	**$23,416,175**	**$0**	**$20,613**	**$0**
Total SB 11-209 Add ons		**0.0**	**$291,774,206**	**($12,208,701)**	**$0**	**$20,613**	**($4,354,916)**
SB 11-139	**(1) Executive Director's Office**						

Colorado Department of Health Care Policy and Financing							
FY 2013-14 Budget Request							
Schedule 7: Supplemental Bills Summary							
Bill Number	**Line Items**	**FTE**	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**
	(A) General Administration						
	Personal Services	0.0	($80,422)	($76,146)	$0	$0	($4,276)
	(B) Transfers to Other Departments						
	Transfer to Department of Public Health and Environment Facility for Survey and Certification	0.0	($36,092)	($12,632)	$0	$0	$0
	Transfer to Department of Public Health and Environment for Enhanced Pernatal Care Training and Technical Assistance	0.0	($779)	($390)	$0	$0	$0
	(C) Information Technology Contracts and Projects						
	Information Technology Contracts	0.0	($211,316)	($96,766)	$0	$0	$0
	Total		**($328,609)**	**($185,934)**	**$0**	**$0**	**($4,276)**
	(2) Medical Services Premiums	0.0	$0	($51,000,000)	$0	$51,000,000	$0
	Total		**$0**	**($51,000,000)**	**$0**	**$51,000,000**	**$0**
	(4) Indigent Care Program						
	H.B. 97-1304 Children's Basic Health Plan Trust	0.0	$1,500,000	$0	$0	$1,500,000	$0
	Children's Basic Health Plan Medical and Dental Costs	0.0	($13,258,756)	$0	$0	($4,967,398)	$0
	Children's Basic Health Plan Dental Benefit Costs	0.0	($13,878,070)	$0	$0	($4,857,325)	$0
	Total		**($25,636,826)**	**$0**	**$0**	**($8,324,723)**	**$0**
	(5) Other Medical Services						
	Medicare Modernization Act of 2003 State Contribution Payment	0.0	$0	($13,671,043)	$0	$0	$0
	Total		**$0**	**($13,671,043)**	**$0**	**$0**	**$0**
	(6) Department of Human Services Medicaid Funded Programs						
	(A) Executive Director's Office - Medicaid Funding	0.0	($9,275)	($4,246)	$0	$0	$0
	(B) Office of Information Technology Services - Medicaid Funding						
	Colorado Benefits Management System	0.0	$29,510	($259,967)	$0	$274,951	$176
	(C) Office of Operations - Medicaid Funding	0.0	($26,753)	($10,779)	$0	$0	$0
	(D) Division of Child Welfare - Medicaid Funding						
	Administration	0.0	($1,279)	($639)	$0	$0	$0
	(E) Office of Self Sufficiency - Medicaid Funding						
SB 11-139	Systematic Alien Verification for Eligibility	0.0	($326)	($163)	$0	$0	$0
	(F) Mental Health and Alcohol and Drug Abuse Services - Medicaid Funding						
	Administration	0.0	($3,260)	($1,630)	$0	$0	$0
	Mental Health Institutes	0.0	$1,297,893	$522,920	$0	$0	$0
	Alcohol and Drug Abuse Division, Administration	0.0	($531)	($266)	$0	$0	$0
	(G) Services for People with Disabilities - Medicaid Funding						
	Community Services for People with Developmental Disabilities, Administration	0.0	($26,359)	($13,180)	$0	$0	$0
	Regional Centers	0.0	($84,657)	($34,109)	$0	$0	$0
	(I) Division of Youth Corrections - Medicaid Funding		($459)	($186)	$0	$0	$0

Colorado Department of Health Care Policy and Financing							
FY 2013-14 Budget Request							
Schedule 7: Supplemental Bills Summary							
Bill Number	**Line Items**	**FTE**	**Total Funds**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**
	Total		**$1,174,504**	**$197,755**	**$0**	**$274,951**	**$176**
Total SB 11-139		**0.0**	**($24,790,931)**	**($64,659,222)**	**$0**	**$42,950,228**	**($4,100)**

Federal Funds
($15,846)
($237)
($16,083)
$53,578,949
$53,578,949
$1,393,599
$1,393,599
($2,277,780)
($19,550,890)
($21,828,670)
$0
$0
$14,219
$14,219
$33,142,014
$13,149
($60,000)
$217,047
$984,087
$4,620
($1,180,751)
$1,180,751
$45,253
$377,317
$1,581,473
$2,221,383
$2,221,383

Federal Funds
($7,948,120)
$810,629
($7,137,491)
$175,000
$5,633,177
$5,808,177
$582,641
$406,200
($182,883)
$562,933
($933,828)
$110,836
$545,899
$3,019,441
$0
$0
$0
$0
$0
0.0
($56,588)
($56,588)
$77,430,839
$77,430,839
($7,808,693)
$245,902
($7,562,791)

Federal Funds
$5,619,340
($115,051)
($278,653)
$0
($768,336)
$4,457,300
$0
($32,690)
($34,437)
($12,724)
$0
($79,851)
($98,932)
($8,810)
($96,174)
($129,893)
($2,199)
$159,598
($37,628)
$18,412,059
($881,507)
($168,556)
$17,147,958
$35,560,017

Federal Funds
$0
($23,460)
($389)
($114,550)
($138,399)
$0
$0
$0
($8,291,358)
($9,020,745)
($17,312,103)
$13,671,043
$13,671,043
($5,029)
$14,350
($15,974)
($640)
($163)
($1,630)
$774,973
($265)
($13,179)
($50,548)
($273)

Federal Funds
$701,622
($3,077,837)

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 11G - "Children's Basic Health Plan Trust"
25.5-8-105, C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$599,735***	***$7,745,026***	***$5,811,404***	***$4,121,716***	***$4,013,450***
Changes in Cash Assets	$50,208,167	$60,007,920	$30,070,550	$30,163,652	$29,918,771
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($43,062,876)	($61,941,542)	($31,760,238)	($30,271,919)	($30,147,851)
TOTAL CHANGES TO FUND BALANCE	**$7,145,291**	**($1,933,622)**	**($1,689,688)**	**($108,266)**	**($229,080)**
Assets Total	***$50,208,167***	***$60,007,920***	***$30,070,550***	***$30,163,652***	***$29,918,771***
Cash (B)	$50,208,167	$60,007,920	$30,070,550	$30,163,652	$29,918,771
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$43,062,876***	***$61,941,542***	***$31,760,238***	***$30,271,919***	***$30,147,851***
Cash Liabilities (C)	$43,062,876	$61,941,542	$31,760,238	$30,271,919	$30,147,851
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$7,745,026***	***$5,811,404***	***$4,121,716***	***$4,013,450***	***$3,784,370***
Net Cash Assets - (B-C)	***$7,145,291***	***($1,933,622)***	***($1,689,688)***	***($108,266)***	***($229,080)***
Change from Prior Year Fund Balance (D-A)	***$7,145,291***	***($1,933,622)***	***($1,689,688)***	***($108,266)***	***($229,080)***
Cash Flow Summary					
Revenue Total	$50,208,167	$60,007,920	$30,070,550	$30,163,652	$29,918,771
Fees	$428,326	$620,097	$1,235,770	$1,588,055	$1,822,615
Cash	$49,781,534	$59,365,603	$28,818,107	$28,564,121	$28,084,680
Interest	($1,693)	$22,220	$16,673	$11,476	$11,476

Expenses Total	$43,062,876	$61,941,542	$31,760,238	$30,271,919	$30,147,851
Cash Expenditures	$43,062,876	$61,941,542	$33,890,549	$17,499,556	$17,499,556
Change Requests (If Applicable)					
FY 2013-14 R#3: "Children's Basic Health Plan Medical and Dental Costs"	$0	$0	($2,130,311)	$12,649,321	$12,404,440
FY 2013-14 R#5: "Medicaid Management Information System Reprocurement"	$0	$0	$0	$123,042	$243,855
Net Cash Flow	$7,145,291	($1,933,622)	($1,689,688)	($108,266)	($229,080)

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(A) General Administration, Personal Services	$210,342	$134,232	$255,242	$268,403	$268,403
(A) General Administration, Operating Expenses	$768	$768	$768	$768	$768
(A) General Administration, Legal Services	$4,062	$6,933	$7,074	$7,074	$7,074
(A) General Administration, COFRS Modernization	$0	$0	$14,368	$14,368	$14,368
(C) Information Technology Contracts and Projects, Information Technology Contracts	$235,162	$246,755	$246,828	$246,755	$246,755
(F) Provider Audits and Services, Professional Audit Contracts	$58,096	$0	$0	$102,988	$102,988
Division Subtotal	**$508,430**	**$388,688**	**$524,280**	**$640,356**	**$640,356**
FY 2013-14 R#5: "Medicaid Management Information System Reprocurement"	N/A	N/A	$0	$123,042	$243,855
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	N/A	N/A	$0	$0	$0
FY 2013-14 R#10: "Leased Space Rent Increase and True-up"	N/A	N/A	$0	$0	$0
Division Subtotal with Decision Items	**$508,430**	**$388,688**	**$524,280**	**$763,398**	**$884,211**
(4) Indigent Care Program					
Safety Net Provider Payments	$0	$0	$0	$0	$0
Children's Basic Health Plan Administration	$1,902,277	$1,934,256	$2,295,791	$2,010,221	$2,010,221
Children's Basic Health Plan Medical and Dental Costs	$33,513,031	$25,718,442	$31,053,239	$14,840,875	$14,840,875
Division Subtotal	**$35,415,308**	**$27,652,698**	**$33,349,030**	**$16,851,096**	**$16,851,096**
FY 2013-14 R#3: "Children's Basic Health Plan Medical and Dental Costs"	N/A	N/A	($2,130,311)	$12,649,321	$12,404,440
Division Subtotal with Decision Items	**$35,415,308**	**$27,652,698**	**$31,218,719**	**$29,500,417**	**$29,255,536**

(6) Department of Human Services Medicaid Funded Programs					
(B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	$19,715	$11,770	$17,150	$8,015	$8,015
(B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System, CBMS SAS-70 Audit	$65	$53	$89	$89	$89
(B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System Client Services Improvement Project	$456	$0	$0	$0	$0
Division Subtotal	**$20,236**	**$11,823**	**$17,239**	**$8,104**	**$8,104**
Division Subtotal with Decision Items	**$20,236**	**$11,823**	**$17,239**	**$8,104**	**$8,104**
Transfer to General Fund	$0	$0	$0	$0	$0
TOTAL	**$35,943,973**	**$28,053,208**	**$33,890,549**	**$17,499,556**	**$17,499,556**
TOTAL with Decision Items	**$35,943,973**	**$28,053,208**	**$31,760,238**	**$30,271,919**	**$30,147,851**
Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$66,073	$60,053	$169,385	$211,300	$230,539
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$1,277,929	$958,882	$680,083	$662,219	$624,421
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	The purpose of the fund is to pay for the administration and purchase of insurance and health care services for clients of the Children's Basic Health Plan established by HB 97-1304 and HB 98-1325.
Fee Sources	Starting in FY 1999-00, premiums are collected from families of enrollees who enter the program. Amounts are $25 for families with one child enrolled and $35 for families with two or more children enrolled. Fees collected from parents are assumed to be used first before other funding sources are used.
Non-Fee Sources	Tobacco Litigation Settlement monies, General Fund appropriations, Tobacco Tax appropriations, donations, and interest earned on the fund balance.
Long Bill Groups Supported by Fund	(1) Executive Director's Office, (4) Indigent Care Program, (6) Department of Human Services Medicaid Funded Programs

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 14B - "Comprehensive Primary and Preventive Care Fund"
25.5-3-207 (1) and 24-75-11.4.5 (1.5)(a)(III), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$165,134***	***$187,655***	***$246,552***	***$0***	***$0***
Changes in Cash Assets	$2,846,539	$58,897	$0	$0	$0
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($2,824,017)	$0	$0	$0	$0
TOTAL CHANGES TO FUND BALANCE	**$22,521**	**$58,897**	**$0**	**$0**	**$0**
Assets Total	***$2,846,539***	***$58,897***	***$0***	***$0***	***$0***
Cash (B)	$2,846,539	$58,897	$0	$0	$0
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$2,824,017***	***$0***	***($246,552)***	***$0***	***$0***
Cash Liabilities (C)	$2,824,017	$0	($246,552)	$0	$0
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$187,655***	***$246,552***	***$0***	***$0***	***$0***
Net Cash Assets - (B-C)	***$22,521***	***$58,897***	***$0***	***$0***	***$0***
Change from Prior Year Fund Balance (D-A)	***$22,521***	***$58,897***	***$0***	***$0***	***$0***
Cash Flow Summary					
Revenue Total	$2,846,539	$58,897	$0	$0	$0
Fees	$0	$0	$0	$0	$0
Cash	$2,824,017	$52,848	$0	$0	$0
Interest	$22,522	$6,049	$0	$0	$0

Expenses Total	$2,824,017	$0	$0	$0	$0
Cash Expenditures	$2,824,017	$0	$0	$0	$0
Change Requests (If Applicable)					
Net Cash Flow	$22,521	$58,897	$0	$0	$0

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Transfer to General Fund	$2,824,017	$0	($246,552)	$0	$0
TOTAL	**$2,824,017**	**$0**	**($246,552)**	**$0**	**$0**
TOTAL with Decision Items	**$2,824,017**	**$0**	**($246,552)**	**$0**	**$0**
Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$465,963	$0	$0	$0	$0
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	The purpose of this fund is to pay for service and capital construction grants awarded through the Comprehensive Primary and Preventive Care Grants Program created in 25.5-3-204, C.R.S., as well as expenditures incurred by the Department in the administration of the program. SB 11-216 permanently eliminated this grant program effective in FY 2011-12.
Fee Sources	There are no fees.
Non-Fee Sources	Monies for the fund are appropriated annually by the General Assembly from the Tobacco Litigation Settlement Trust Fund. Interest earned on the balance of the fund is credited to the fund. Any gifts, grants, or donations may be credited to the fund.
Long Bill Groups Supported by Fund	(1) Executive Director's Office; (4) Indigent Care Program

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 15B - "Medicaid Buy-in Cash Fund"
25.5-6-1404 (3) (b), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$0***	***$0***	***$280***	***$280***	***$280***
Changes in Cash Assets	$0	$11,797	$3,275,210	$7,992,980	$12,142,700
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	$0	($11,517)	($3,275,210)	($7,992,980)	($12,142,700)
TOTAL CHANGES TO FUND BALANCE	**$0**	**$280**	**$0**	**$0**	**$0**
Assets Total	***$0***	***$11,797***	***$3,275,210***	***$7,992,980***	***$12,142,700***
Cash (B)	$0	$11,797	$3,275,210	$7,992,980	$12,142,700
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$0***	***$11,517***	***$3,275,210***	***$7,992,980***	***$12,142,700***
Cash Liabilities (C)	$0	$11,517	$3,275,210	$7,992,980	$12,142,700
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$0***	***$280***	***$280***	***$280***	***$280***
Net Cash Assets - (B-C)	***$0***	***$280***	***$0***	***$0***	***$0***
Change from Prior Year Fund Balance (D-A)	***$0***	***$280***	***$0***	***$0***	***$0***
Cash Flow Summary					
Revenue Total	$0	$11,797	$3,275,210	$7,992,980	$12,142,700
Fees	$0	$11,797	$3,275,210	$7,992,980	$12,142,700
Cash	$0	$0	$0	$0	$0
Interest	$0	$0	$0	$0	$0

Expenses Total	$0	$11,517	$3,275,210	$7,992,980	$12,142,700
Cash Expenditures	$0	$11,517	$4,531,955	$4,531,955	$4,531,955
Change Requests (If Applicable)					
FY 2013-14 R#1: "Medical Services Premiums"	$0	$0	($1,256,745)	$3,461,025	$7,610,745
Net Cash Flow	$0	$280	$0	$0	$0

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(2) Medical Services Premiums					
Medical Services Premiums	$0	$0	$4,531,955	$4,531,955	$4,531,955
Division Subtotal	**$0**	**$0**	**$4,531,955**	**$4,531,955**	**$4,531,955**
FY 2013-14 R#1: "Medical Services Premiums"	N/A	N/A	($1,256,745)	$3,461,025	$7,610,745
Division Subtotal with Decision Items	**$0**	**$0**	**$3,275,210**	**$7,992,980**	**$12,142,700**
Transfer to General Fund	$0	$0	$0	$0	$0
TOTAL	**$0**	**$0**	**$4,531,955**	**$4,531,955**	**$4,531,955**
TOTAL with Decision Items	**$0**	**$0**	**$3,275,210**	**$7,992,980**	**$12,142,700**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$280	$280	$280	$280
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$0	$1,900	$747,773	$747,773	$747,773
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	Created through the passage of HB 08-1072, the purpose of the fund is to pay for implementation and administration of the Medicaid Buy-In Program for the Disabled.
Fee Sources	Premiums will be paid by clients eligible for and participating in the program based on a sliding-fee scale.
Non-Fee Sources	The Department is authorized to solicit and accept federal grants to cover the costs of an actuarial study. If an individual is eligible for Medicaid under 25.5-6-1404 (1), C.R.S., and the individual's employer would pay for all or a portion of the individual's private insurance, the Department may accept contributions from the individual's employer to offset part of the cost of providing services under the program.
Long Bill Groups Supported by Fund	(2) Medical Services Premiums.

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 15D - "Breast and Cervical Cancer Prevention and Treatment Fund"
25.5-5-308 (8)(a), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$9,036,534***	***$6,553,278***	***$4,451,871***	***$3,613,141***	***$2,654,383***
Changes in Cash Assets	$419,906	$413,305	$461,974	$452,805	$442,324
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($2,903,163)	($2,514,712)	($1,300,704)	($1,411,563)	($1,425,563)
TOTAL CHANGES TO FUND BALANCE	**($2,483,256)**	**($2,101,407)**	**($838,730)**	**($958,757)**	**($983,238)**
Assets Total	***$419,906***	***$413,305***	***$461,974***	***$452,805***	***$442,324***
Cash (B)	$419,906	$413,305	$461,974	$452,805	$442,324
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$2,903,163***	***$2,514,712***	***$1,300,704***	***$1,411,563***	***$1,425,563***
Cash Liabilities (C)	$2,903,163	$2,514,712	$1,300,704	$1,411,563	$1,425,563
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$6,553,278***	***$4,451,871***	***$3,613,141***	***$2,654,383***	***$1,671,145***
Net Cash Assets - (B-C)	***($2,483,256)***	***($2,101,407)***	***($838,730)***	***($958,757)***	***($983,238)***
Change from Prior Year Fund Balance (D-A)	***($2,483,256)***	***($2,101,407)***	***($838,730)***	***($958,757)***	***($983,238)***
Cash Flow Summary					
Revenue Total	$419,906	$413,305	$461,974	$452,805	$442,324
Fees	$309,475	$331,275	$331,275	$331,275	$331,275
Cash	$0	$0	$0	$0	$0
Interest	$110,431	$82,030	$130,699	$121,530	$111,049

Expenses Total	$2,903,163	$2,514,712	$715,162	$1,063,313	$1,126,275
Cash Expenditures	$2,903,163	$2,514,712	$1,300,704	$1,411,563	$1,425,563
Change Requests (If Applicable)	$0	$0	($292,771)	($174,125)	($149,644)
FY 2013-14 R#1: "Medical Services Premiums"	$0	$0	($289,825)	($193,419)	($168,938)
FY 2013-14 R#2: "Medicaid Mental Health Community Programs"	$0	$0	($2,946)	($78)	($78)
FY 2013-14 R#13: "1.5% Provider Rate Increase"	$0	$0	$0	$19,372	$19,372
Net Cash Flow	($2,483,256)	($2,101,407)	($253,188)	($610,507)	($683,950)

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(A) General Administration, Personal Services	$23,041	$24,631	$24,268	$25,484	$25,650
(A) General Administration, Operating Expenses			$166	$166	$166
(A) General Administration, COFRS Modernization			$1,439	$1,439	$1,439
Division Subtotal	**$23,041**	**$24,631**	**$25,707**	**$27,089**	**$27,089**
Division Subtotal with Decision Items	**$23,041**	**$24,631**	**$25,707**	**$27,089**	**$27,089**
(2) Medical Services Premiums					
Medical Services Premiums	$2,844,464	$2,434,755	$1,484,910	$1,484,910	$1,484,910
Division Subtotal	**$2,844,464**	**$2,434,755**	**$1,484,910**	**$1,484,910**	**$1,484,910**
FY 2013-14 R#1: "Medical Services Premiums"	N/A	N/A	($289,825)	($193,419)	($168,938)
FY 2013-14 R#13: "1.5% Provider Rate Increase"	N/A	N/A	$0	$19,372	$19,372
Division Subtotal with Decision Items	**$2,844,464**	**$2,434,755**	**$1,195,085**	**$1,310,863**	**$1,335,344**
(3) Medicaid Mental Health					
Mental Health Capitation Payments	$35,658	$55,326	$34,189	$34,189	$34,189
Division Subtotal	**$35,658**	**$55,326**	**$34,189**	**$34,189**	**$34,189**
FY 2013-14 R#2: "Medicaid Mental Health Community Programs"	N/A	N/A	($2,946)	($78)	($78)
Division Subtotal with Decision Items	**$35,658**	**$55,326**	**$31,243**	**$34,111**	**$34,111**
Revenue transfer to Coordinated Care for People with Disabilities, Fund 19Z	$153,211	$71,642	$48,669	$39,500	$29,019
TOTAL	**$3,056,373**	**$2,586,355**	**$1,593,475**	**$1,585,688**	**$1,575,207**
TOTAL with Decision Items	**$3,056,373**	**$2,586,355**	**$1,300,704**	**$1,411,563**	**$1,425,563**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$4,829,830	$3,568,291	$2,590,931	$1,941,963	$1,251,590
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$479,022	$414,928	$214,616	$232,908	$235,218
Excess Uncommitted Fee Reserve Balance	**$4,350,808**	**$3,153,363**	**$2,376,315**	**$1,709,055**	**$1,016,372**
Compliance Plan (narrative)	Sections 25.5-5-308(8)(c)(III)(A) and (B), C.R.S., direct the Department to accumulate funds, including				

Cash Fund Narrative Information	
Purpose/Background of Fund	**Main Fund:** Created with the passage of SB 01S2-012, the purpose of the fund is to provide for the prevention and treatment of breast and cervical cancer for women for whom it is not otherwise available for reasons of cost. This fund was scheduled to expire after FY 2007-08 but use of the fund was extended through FY 2013-14 through HB 08-1373. **Eligibility Expansion Account:** The purpose of the Account balance plus amounts pledged or promised as gifts, grants, or donations may only be appropriated when the Department determines that such amount is sufficient to sustain the projected number of newly eligible individuals described at 25.5-5-308 (2)(a)(I)(B), C.R.S.
Fee Sources	**Main Fund:** There are no fees.
Non-Fee Sources	**Main Fund:** Per SB 01S2-012, monies for this fund are appropriated annually by the General Assembly from interest accrued by the Tobacco Litigation Settlement Trust Fund. However, per SB 03-019, due to this fund being subject to the "annual financial and compliance audit of the 'Colorado Medical Assistance Act'...this program shall not be considered a Tobacco Settlement Program." Therefore, this program does not have a statutory specified limit or allocation amount. Any gifts, grants, or donations also may be credited to the fund. Section 25.5-5-308 (10), C.R.S. states that the section authorizing the fund shall be repealed on July 1, 2014. **Eligibility Expansion Account:** Gifts, grants, or donation and any moneys appropriated by the General Assembly.
Long Bill Groups Supported by Fund	(1) Executive Director's Office; (2) Medical Services Premiums; (3) Medicaid Mental Health Community Programs

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 15J - "Native American Substance Abuse Treatment Cash Fund"
25.5-5-315 (1), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$741***	***$741***	***$741***	***$741***	***$741***
Changes in Cash Assets	$0	$0	$0	$0	$0
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	$0	$0	$0	$0	$0
TOTAL CHANGES TO FUND BALANCE	**$0**	**$0**	**$0**	**$0**	**$0**
Assets Total	***$0***	***$0***	***$0***	***$0***	***$0***
Cash (B)	$0	$0	$0	$0	$0
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$0***	***$0***	***$0***	***$0***	***$0***
Cash Liabilities (C)	$0	$0	$0	$0	$0
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$741***	***$741***	***$741***	***$741***	***$741***
Net Cash Assets - (B-C)	***$0***	***$0***	***$0***	***$0***	***$0***
Change from Prior Year Fund Balance (D-A)	***$0***	***$0***	***$0***	***$0***	***$0***
Cash Flow Summary					
Revenue Total	$0	$0	$0	$0	$0
Fees	$0	$0	$0	$0	$0
Cash	$0	$0	$0	$0	$0
Interest	$0	$0	$0	$0	$0

Expenses Total	$0	$0	$0	$0	$0
Cash Expenditures	$0	$0	$0	$0	$0
Change Requests (If Applicable)					
Net Cash Flow	$0	$0	$0	$0	$0

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
TOTAL	**$0**	**$0**	**$0**	**$0**	**$0**
TOTAL with Decision Items	**$0**	**$0**	**$0**	**$0**	**$0**
Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$0	$0	$0	$0	$0
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	Created through the passage of HB 02-1263, the purpose of the fund is to provide for the administrative costs associated with preparing and submitting the request for federal approval to provide substance abuse treatment services to Native Americans in Colorado. The fund was discontinued but later recreated by SB 04-028.
Fee Sources	There are no fees.
Non-Fee Sources	Funding was appropriated by the General Assembly from one-time donations and any interest earned.
Long Bill Groups Supported by Fund	None.

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 15K - "Supplemental Old Age Pension Health and Medical Care Fund"
25.5-2-101 (3), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$4,612,087***	***$2,739,534***	***$0***	***$0***	***$0***
Changes in Cash Assets	$5,033,639	$2,850,000	$0	$0	$0
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($6,906,192)	($5,589,534)	$0	$0	$0
TOTAL CHANGES TO FUND BALANCE	**($1,872,553)**	**($2,739,534)**	**$0**	**$0**	**$0**
Assets Total	***$5,033,639***	***$2,850,000***	***$0***	***$0***	***$0***
Cash (B)	$5,033,639	$2,850,000	$0	$0	$0
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$6,906,192***	***$5,589,534***	***$0***	***$0***	***$0***
Cash Liabilities (C)	$6,906,192	$5,589,534	$0	$0	$0
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$2,739,534***	***$0***	***$0***	***$0***	***$0***
Net Cash Assets - (B-C)	***($1,872,553)***	***($2,739,534)***	***$0***	***$0***	***$0***
Change from Prior Year Fund Balance (D-A)	***($1,872,553)***	***($2,739,534)***	***$0***	***$0***	***$0***
Cash Flow Summary					
Revenue Total	$5,033,639	$2,850,000	$0	$0	$0
Fees	$0	$0	$0	$0	$0
Cash	$5,033,639	$2,850,000	$0	$0	$0
Interest	$0	$0	$0	$0	$0

Expenses Total	$6,906,192	$5,589,534	$0	$0	$0
Cash Expenditures	$6,906,192	$5,589,534	$0	$0	$0
Change Requests (If Applicable)					
Net Cash Flow	($1,872,553)	($2,739,534)	$0	$0	$0

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(2) Medical Services Premiums					
Medical Services Premiums	$4,850,000	$3,000,000	$0	$0	$0
Division Subtotal	**$4,850,000**	**$3,000,000**	**$0**	**$0**	**$0**
Division Subtotal with Decision Items	**$4,850,000**	**$3,000,000**	**$0**	**$0**	**$0**
(5) Other Medical Services					
Services for Old Age Pension State Medical Program Clients	$56,192	$0	$0	$0	$0
Division Subtotal	**$56,192**	**$0**	**$0**	**$0**	**$0**
Division Subtotal with Decision Items	**$56,192**	**$0**	**$0**	**$0**	**$0**
Transfer to General Fund	$2,000,000	$2,589,534	$0	$0	$0
TOTAL	**$6,906,192**	**$5,589,534**	**$0**	**$0**	**$0**
TOTAL with Decision Items	**$6,906,192**	**$5,589,534**	**$0**	**$0**	**$0**
Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$1,139,522	$922,273	$0	$0	$0
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	The purpose of the fund is to provide funding to increase hospital reimbursements under Medicaid and the Colorado Indigent Care Program, establish hospital quality incentive payments, increase eligibility for parents of Medicaid eligible children to 100% of the federal poverty level, increase eligibility for children and pregnant women in the Children's Basic Health Plan to 250% of the federal poverty level, provide eligibility for adults without Medicaid dependent children up to 100% of the federal poverty level, establish the Medicaid Buy-In Program for Individuals with Disabilities for individuals with family income up to 450% of the federal poverty level, and to provide 12-month guaranteed eligibility to children in Medicaid.
Fee Sources	Provider fees collected from hospitals pursuant to section 25.5-4-402.3 (3), C.R.S. beginning July 1, 2009. Fee level is set annually by the Medical Services Board, as recommended by the Hospital Provider Fee Oversight and Advisory Board. The amount of the fee is to be set so that the amount collected shall approximate the projected expenditures for that year per 25.5-4-402.3 (3), C.R.S.
Non-Fee Sources	Monies in the Fund shall be subject to federal matching as authorized by federal law and subject to annual appropriation by the General Assembly. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the Fund.
Long Bill Groups Supported by Fund	(1) Executive Director's Office; (2) Medical Services Premiums; (3) Medicaid Mental Health Community Services; (4) Indigent Care Program; (6) Department of Human Services Medicaid Funded Program.

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 17R - "Pediatric Hospice Care Fund"
25.5-5-305 (6), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$984***	***$988***	***$983***	***$983***	***$983***
Changes in Cash Assets	$4	$0	$0	$0	$0
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	$0	($5)	$0	$0	$0
TOTAL CHANGES TO FUND BALANCE	**$4**	**($5)**	**$0**	**$0**	**$0**
Assets Total	***$4***	***$0***	***$0***	***$0***	***$0***
Cash (B)	$4	$0	$0	$0	$0
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$0***	***$5***	***$0***	***$0***	***$0***
Cash Liabilities (C)	$0	$5	$0	$0	$0
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$988***	***$983***	***$983***	***$983***	***$983***
Net Cash Assets - (B-C)	***$4***	***($5)***	***$0***	***$0***	***$0***
Change from Prior Year Fund Balance (D-A)	***$4***	***($5)***	***$0***	***$0***	***$0***
Cash Flow Summary					
Revenue Total	$4	$0	$0	$0	$0
Fees	$0	$0	$0	$0	$0
Cash	$0	$0	$0	$0	$0
Interest	$4	$0	$0	$0	$0

Expenses Total	$0	$5	$0	$0	$0
Cash Expenditures	$0	$5	$0	$0	$0
Change Requests (If Applicable)					
Net Cash Flow	$4	($5)	$0	$0	$0

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Transfer to General Fund	$0	$0	$0	$0	$0
TOTAL	**$0**	**$0**	**$0**	**$0**	**$0**
TOTAL with Decision Items	**$0**	**$0**	**$0**	**$0**	**$0**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$0	$1	$0	$0	$0
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	The purpose of the fund was to provide for the administration costs in FY 2004-05 associated with preparing and submitting the request for federal approval for the provision of pediatric hospice care. The request was in the form of an 1115 waiver. The fund was established with the passage of SB 04-206.
Fee Sources	There are no fees.
Non-Fee Sources	The Department was authorized to seek and accept gifts, grants, or donations from private or public sources. Interest income may be earned on the monies deposited in the fund.
Long Bill Groups Supported by Fund	None.

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 18A - "Colorado Autism Treatment Fund"
25.5-6-805, C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$1,585,692***	***$2,054,447***	***$2,574,382***	***$3,047,468***	***$3,487,652***
Changes in Cash Assets	$1,044,713	$1,037,856	$1,047,437	$1,056,154	$1,064,265
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($575,958)	($517,921)	($574,351)	($615,970)	($607,077)
TOTAL CHANGES TO FUND BALANCE	**$468,756**	**$519,935**	**$473,086**	**$440,184**	**$457,188**
Assets Total	***$1,044,713***	***$1,037,856***	***$1,047,437***	***$1,056,154***	***$1,064,265***
Cash (B)	$1,044,713	$1,037,856	$1,047,437	$1,056,154	$1,064,265
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$575,958***	***$517,921***	***$574,351***	***$615,970***	***$607,077***
Cash Liabilities (C)	$575,958	$517,921	$574,351	$615,970	$607,077
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$2,054,447***	***$2,574,382***	***$3,047,468***	***$3,487,652***	***$3,944,840***
Net Cash Assets - (B-C)	***$468,756***	***$519,935***	***$473,086***	***$440,184***	***$457,188***
Change from Prior Year Fund Balance (D-A)	***$468,756***	***$519,935***	***$473,086***	***$440,184***	***$457,188***
Cash Flow Summary					
Revenue Total	$1,044,713	$1,037,856	$1,047,437	$1,056,154	$1,064,265
Fees	$0	$0	$0	$0	$0
Cash	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Interest	$44,713	$37,856	$47,437	$56,154	$64,265

Expenses Total	$575,958	$517,921	$574,351	$615,970	$607,077
Cash Expenditures	$575,958	$517,921	$926,206	$958,932	$958,932
Change Requests (If Applicable)					
FY 2013-14 R#1: "Medical Services Premiums"	$0	$0	($351,855)	($342,962)	($351,855)
Net Cash Flow	$468,756	$519,935	$473,086	$440,184	$457,188

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(A) General Administration, Personal Services	$17,502	$0	$32,958	$34,684	$34,684
(A) General Administration, Operating Expenses	$2,405	$0	$2,405	$2,405	$2,405
(A) General Administration, COFRS Modernization	$0	$0	$1,870	$1,870	$1,870
(A) General Administration, General Professional Services and Special Projects	$0	$0	$0	$31,000	$31,000
(C) Information Technology Contracts and Projects, Information Technology Contracts	$1,885	$1,727	$1,885	$1,885	$1,885
(D) Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations	$5,000	$5,000	$5,000	$5,000	$5,000
Division Subtotal	**$26,792**	**$6,727**	**$44,118**	**$76,844**	**$76,844**
Division Subtotal with Decision Items	**$26,792**	**$6,727**	**$44,118**	**$76,844**	**$76,844**
(2) Medical Services Premiums					
Medical Services Premiums	$549,166	$511,193	$882,088	$882,088	$882,088
Division Subtotal	**$549,166**	**$511,193**	**$882,088**	**$882,088**	**$882,088**
FY 2013-14 R#1: "Medical Services Premiums"	N/A	N/A	($351,855)	($342,962)	($351,855)
Division Subtotal with Decision Items	**$549,166**	**$511,193**	**$530,233**	**$539,126**	**$530,233**
Transfer to General Fund	$0	$0	$0	$0	$0
TOTAL	**$575,958**	**$517,921**	**$926,206**	**$958,932**	**$958,932**
TOTAL with Decision Items	**$575,958**	**$517,921**	**$574,351**	**$615,970**	**$607,077**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$95,033	$85,457	$152,824	$158,224	$158,224
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	The purpose of the fund is to provide services for eligible autistic children enrolled in the Home and Community Based Services Program. The fund was created by SB 04-177.
Fee Sources	There are no fees.
Non-Fee Sources	Monies in the fund are comprised of Tobacco Settlement monies allocated to the fund. The monies in the fund are subject to annual appropriation by the General Assembly for the purposes described in legislation.
Long Bill Groups Supported by Fund	(1) Executive Director's Office; (2) Medical Services Premiums

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 18K - "Health Care Expansion Fund"
24-22-117 (2)(a)(I), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$79,234,953***	***$100,000***	***$99,998***	***$99,996***	***$232,486***
Changes in Cash Assets	$68,545,212	$68,409,177	$67,829,559	$66,901,281	$65,988,061
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($147,680,164)	($68,409,179)	($67,829,561)	($66,768,791)	($65,855,803)
TOTAL CHANGES TO FUND BALANCE	**($79,134,953)**	**($2)**	**($2)**	**$132,490**	**$132,258**
Assets Total	***$68,545,212***	***$68,409,177***	***$67,829,559***	***$66,901,281***	***$65,988,061***
Cash (B)	$68,545,212	$68,409,177	$67,829,559	$66,901,281	$65,988,061
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$147,680,164***	***$68,409,179***	***$67,829,561***	***$66,768,791***	***$65,855,803***
Cash Liabilities (C)	$147,680,164	$68,409,179	$67,829,561	$66,768,791	$65,855,803
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$100,000***	***$99,998***	***$99,996***	***$232,486***	***$364,744***
Net Cash Assets - (B-C)	***($79,134,953)***	***($2)***	***($2)***	***$132,490***	***$132,258***
Change from Prior Year Fund Balance (D-A)	***($79,134,953)***	***($2)***	***($2)***	***$132,490***	***$132,258***
Cash Flow Summary					
Revenue Total	$68,545,212	$68,409,177	$67,829,559	$66,901,281	$65,988,061
Fees	$0	$0	$0	$0	$0
Cash	$66,964,928	$68,266,089	$67,695,245	$66,768,789	$65,855,801
Interest	$1,580,284	$143,089	$134,314	$132,492	$132,260

Expenses Total	$147,680,164	$68,409,179	$67,829,561	$66,768,791	$65,855,803
Cash Expenditures	$147,680,164	$68,409,179	$67,872,149	$67,872,149	$67,872,149
Change Requests (If Applicable)					
FY 2013-14 R#1: "Medical Services Premiums"	$0	$0	($42,588)	($1,103,358)	($2,016,346)
Net Cash Flow	($79,134,953)	($2)	($2)	$132,490	$132,258

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(A) General Administration, Personal Services	$120,998	$0	$0	$0	$0
(A) General Administration, Operating Expenses	$4,430	$0	$0	$0	$0
(A) General Administration, Leased Space	$5,500	$0	$0	$0	$0
(C) Information Technology Contracts and Projects, Information Technology Contracts	$284,377	$0	$0	$0	$0
(D) Eligibility Determinations and Client Services, Medical Identification Cards	$10,759	$0	$0	$0	$0
(D) Eligibility Determinations and Client Services, County Administration	$406,240	$0	$0	$0	$0
(D) Eligibility Determinations and Client Services, Customer Outreach	$33,514	$0	$0	$0	$0
(E) Utilization and Quality Review Contracts, Professional Services Contracts	$55,981	$0	$0	$0	$0
Division Subtotal	**$921,799**	**$0**	**$0**	**$0**	**$0**
Division Subtotal with Decision Items	**$921,799**	**$0**	**$0**	**$0**	**$0**
(2) Medical Services Premiums					
Medical Services Premiums	$113,220,519	$68,266,089	$67,872,147	$67,872,147	$67,872,147
Division Subtotal	**$113,220,519**	**$68,266,089**	**$67,872,147**	**$67,872,147**	**$67,872,147**
FY 2013-14 R#1: "Medical Services Premiums"	N/A	N/A	($42,588)	($1,103,358)	($2,016,346)
Division Subtotal with Decision Items	**$113,220,519**	**$68,266,089**	**$67,829,559**	**$66,768,789**	**$65,855,801**
(3) Medicaid Mental Health					
Mental Health Capitation Payments	$5,680,612	$0	$0	$0	$0
Division Subtotal	**$5,680,612**	**$0**	**$0**	**$0**	**$0**
Division Subtotal with Decision Items	**$5,680,612**	**$0**	**$0**	**$0**	**$0**

(4) Indigent Care Program					
Children's Basic Health Plan Administration	$198,392	$0	$0	$0	$0
Children's Basic Health Plan Medical and Dental Costs	$24,009,652	$0	$1	$1	$1
Division Subtotal	**$24,208,044**	**$0**	**$1**	**$1**	**$1**
FY 2013-14 R#3: "Children's Basic Health Plan Medical and Dental Costs"	N/A	N/A	$0	$0	$0
Division Subtotal with Decision Items	**$24,208,044**	**$0**	**$1**	**$1**	**$1**
(6) Department of Human Services Medicaid Funded Programs					
(G) Services for People with Disabilities - Medicaid Funding, Community Services for People with Developmental Disabilities, Program Costs	$568,907	$1	$1	$1	$1
Division Subtotal	**$568,907**	**$1**	**$1**	**$1**	**$1**
Division Subtotal with Decision Items	**$568,907**	**$1**	**$1**	**$1**	**$1**
Transfer to General Fund	$1,580,284	$0	$0	$0	$0
TOTAL	**$146,180,164**	**$68,266,090**	**$67,872,149**	**$67,872,149**	**$67,872,149**
TOTAL with Decision Items	**$146,180,164**	**$68,266,090**	**$67,829,561**	**$66,768,791**	**$65,855,803**
Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$24,367,227	$11,287,515	$11,198,905	$11,198,905	$11,198,905
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	The purpose of the fund is to provide funding to expand eligibility in the Children's Basic Health Plan for children and pregnant women from 185% to 200% of federal poverty level, fund enrollment in the Children's Basic Health Plan above the FY 2003-04 level, to remove the asset test under the Medical Assistance Program for children and families, to expand the number of children that can be enrolled in the Children's Home and Community Based Service Program and the Children's Extensive Support Program, to increase eligibility in the Medical Assistance Program to at least 60% of the federal poverty level for a parent of a child who is eligible for the Medical Assistance Program or the Children's Basic Health Plan. Additionally, the fund provides funding to reinstate presumptive eligibility to pregnant women under Medicaid, fund Medicaid for certain legal immigrants, and expand Medicaid benefits to Foster Care children through age 20.
Fee Sources	There are no fees.
Non-Fee Sources	The State Treasurer and State Controller transfer money into the fund from Tobacco Tax revenues received with an allocation based on statutory percentages stated in 24-22-117 (2)(a)(I), C.R.S.
Long Bill Groups Supported by Fund	(1) Executive Director's Office; (2) Medical Services Premiums; (3) Medicaid Mental Health Community Services; (4) Indigent Care Program; (6) Department of Human Services Medicaid Funded Program.

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 18L - "Primary Care Fund"
24-22-117 (2)(b)(I), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$8***	***$8***	***$8***	***$99,947***	***$199,887***
Changes in Cash Assets	$27,786,036	$28,296,802	$28,126,091	$28,129,060	$28,129,060
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($27,786,036)	($28,296,802)	($28,026,152)	($28,029,120)	($28,029,120)
TOTAL CHANGES TO FUND BALANCE	**$0**	**$0**	**$99,939**	**$99,939**	**$99,939**
Assets Total	***$27,786,036***	***$28,296,802***	***$28,126,091***	***$28,129,060***	***$28,129,060***
Cash (B)	$27,786,036	$28,296,802	$28,126,091	$28,129,060	$28,129,060
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$27,786,036***	***$28,296,802***	***$28,026,152***	***$28,029,120***	***$28,029,120***
Cash Liabilities (C)	$27,786,036	$28,296,802	$28,026,152	$28,029,120	$28,029,120
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$8***	***$8***	***$99,947***	***$199,887***	***$299,826***
Net Cash Assets - (B-C)	***$0***	***$0***	***$99,939***	***$99,939***	***$99,939***
Change from Prior Year Fund Balance (D-A)	***$0***	***$0***	***$99,939***	***$99,939***	***$99,939***
Cash Flow Summary					
Revenue Total	$27,786,036	$28,296,802	$28,126,091	$28,129,060	$28,129,060
Fees	$0	$0	$0	$0	$0
Cash	$27,659,427	$28,196,863	$28,026,152	$28,029,120	$28,029,120
Interest	$126,609	$99,939	$99,939	$99,939	$99,939

Expenses Total	$27,786,036	$28,296,802	$28,026,152	$28,029,120	$28,029,120
Cash Expenditures	$27,786,036	$28,296,802	$28,026,152	$28,029,120	$28,029,120
Change Requests (If Applicable)					
Net Cash Flow	$0	$0	$99,939	$99,939	$99,939

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(A) General Administration, Personal Services	$2,486	$0	$57,523	$60,491	$60,491
(A) General Administration, Operating Expenses	$52	$0	$629	$629	$629
Division Subtotal	**$2,539**	**$0**	**$58,152**	**$61,120**	**$61,120**
Division Subtotal with Decision Items	**$2,539**	**$0**	**$58,152**	**$61,120**	**$61,120**
(2) Medical Services Premiums					
Medical Services Premiums	$12,187,035	$14,306,033	$0	$0	$0
Division Subtotal	**$12,187,035**	**$14,306,033**	**$0**	**$0**	**$0**
Division Subtotal with Decision Items	**$12,187,035**	**$14,306,033**	**$0**	**$0**	**$0**
(4) Indigent Care Program					
Health Care Services Fund Programs	$11,909,853	$0	$0	$0	$0
Primary Care Grant Program Special Distribution	$3,560,000	$0	$0	$0	$0
Primary Care Fund Program	$0	$0	$27,968,000	$27,968,000	$27,968,000
Division Subtotal	**$15,469,853**	**$0**	**$27,968,000**	**$27,968,000**	**$27,968,000**
Division Subtotal with Decision Items	**$15,469,853**	**$0**	**$27,968,000**	**$27,968,000**	**$27,968,000**
Transfer to General Fund	$126,609	$0	$0	$0	$0
TOTAL	**$27,786,036**	**$14,306,033**	**$28,026,152**	**$28,029,120**	**$28,029,120**
TOTAL with Decision Items	**$27,786,036**	**$14,306,033**	**$28,026,152**	**$28,029,120**	**$28,029,120**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$4,584,696	$4,668,972	$4,624,315	$4,624,805	$4,624,805
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	The purpose of the fund is to provide financing for comprehensive primary care provided by eligible providers beginning in FY 2005-06. This financing arrangement was created with the passage of HB 05-1262. This funding partially compensates federally qualified health centers, school based health centers, certified rural health clinics, and other such entities that provide uncompensated care to indigent and uninsured clients.
Fee Sources	There are no fees.
Non-Fee Sources	Funding contingent on the amount of tobacco tax revenue collected, as annually appropriated by the General Assembly.
Long Bill Groups Supported by Fund	(1) Executive Director's Office; (2) Medical Services Premiums; (4) Indigent Care Program

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 18P - "Pediatric Specialty Hospital Fund"
24-22-117 (2)(e) and 24-75-1104.5 (1.5)(a)(X), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$2,155***	***$2,750***	***$0***	***$0***	***$0***
Changes in Cash Assets	$744,323	$32	$0	$0	$0
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($743,728)	($2,782)	$0	$0	$0
TOTAL CHANGES TO FUND BALANCE	**$595**	**($2,750)**	**$0**	**$0**	**$0**
Assets Total	***$744,323***	***$32***	***$0***	***$0***	***$0***
Cash (B)	$744,323	$32	$0	$0	$0
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$743,728***	***$2,782***	***$0***	***$0***	***$0***
Cash Liabilities (C)	$743,728	$2,782	$0	$0	$0
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$2,750***	***$0***	***$0***	***$0***	***$0***
Net Cash Assets - (B-C)	***$595***	***($2,750)***	***$0***	***$0***	***$0***
Change from Prior Year Fund Balance (D-A)	***$595***	***($2,750)***	***$0***	***$0***	***$0***
Cash Flow Summary					
Revenue Total	$744,323	$32	$0	$0	$0
Fees	$0	$0	$0	$0	$0
Cash	$743,728	$0	$0	$0	$0
Interest	$595	$32	$0	$0	$0

Expenses Total	$743,728	$2,782	$0	$0	$0
Cash Expenditures	$743,728	$2,782	$0	$0	$0
Change Requests (If Applicable)					
Net Cash Flow	$595	($2,750)	$0	$0	$0

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(4) Indigent Care Program					
Pediatric Specialty Hospital	$307,000	$0	$0	$0	$0
Division Subtotal	**$307,000**	**$0**	**$0**	**$0**	**$0**
Division Subtotal with Decision Items	**$307,000**	**$0**	**$0**	**$0**	**$0**
Transfer to General Fund	$0	$0	$0	$0	$0
TOTAL	**$307,000**	**$0**	**$0**	**$0**	**$0**
TOTAL with Decision Items	**$307,000**	**$0**	**$0**	**$0**	**$0**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$122,715	$459	$0	$0	$0
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	Main Fund: The purpose of this fund is to augment hospital reimbursement rates for regional pediatric trauma centers as defined in 25-3.5-703, C.R.S. in FY 2011-12. SB 11-216 permanently eliminated this Fund effective in FY 2011-12. Supplemental Tobacco Litigation Settlement Account: Per 24-22-117 (2)(e)(II), C.R.S., this money will be used to offset the Medicaid shortfall for The Children's Hospital to augment hospital reimbursement rates. SB 11-216 permanently eliminated this Fund effective in FY 2011-12.
Fee Sources	Main Fund: There are no fees.
Non-Fee Sources	Main Fund: The Department is authorized to seek and accept gifts, grants, or donations from private or public sources. Interest from the deposit of moneys in the fund may be earned. SB 11-216 permanently eliminated this Fund effective in FY 2011-12. Supplemental Tobacco Litigation Settlement Account: Monies are appropriated annually by the General Assembly from the Supplemental Tobacco Litigation Settlement Fund. SB 11-216 permanently eliminated this Fund effective in FY 2011-12.
Long Bill Groups Supported by Fund	Main Fund: (4) Indigent Care Program.

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 19V - "Colorado Health Care Services Fund"
25.5-3-112 (1)(a), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$54,730***	***$55,798***	***$56,545***	***$1,505***	***$1,525***
Changes in Cash Assets	$1,068	$11,755,747	$757	$20	$20
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	$0	($11,755,000)	($55,797)	$0	$0
TOTAL CHANGES TO FUND BALANCE	**$1,068**	**$747**	**($55,040)**	**$20**	**$20**
Assets Total	***$1,068***	***$11,755,747***	***$757***	***$20***	***$20***
Cash (B)	$1,068	$11,755,747	$757	$20	$20
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$0***	***$11,755,000***	***$55,797***	***$0***	***$0***
Cash Liabilities (C)	$0	$11,755,000	$55,797	$0	$0
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$55,798***	***$56,545***	***$1,505***	***$1,525***	***$1,546***
Net Cash Assets - (B-C)	***$1,068***	***$747***	***($55,040)***	***$20***	***$20***
Change from Prior Year Fund Balance (D-A)	***$1,068***	***$747***	***($55,040)***	***$20***	***$20***
Cash Flow Summary					
Revenue Total	$1,068	$11,755,747	$757	$20	$20
Fees	$0	$0	$0	$0	$0
Cash	$0	$11,755,000	$0	$0	$0
Interest	$1,068	$747	$757	$20	$20

Expenses Total	$0	$11,755,000	$55,797	$0	$0
Cash Expenditures	$0	$11,755,000	$55,797	$0	$0
Change Requests (If Applicable)					
Net Cash Flow	$1,068	$747	($55,040)	$20	$20

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(A) General Administration, COFRS Modernization	$0	$0	$55,797	$0	$0
Division Subtotal	**$0**	**$0**	**$55,797**	**$0**	**$0**
Division Subtotal with Decision Items	**$0**	**$0**	**$55,797**	**$0**	**$0**
Transfer to General Fund	$0	$0	$0	$0	$0
TOTAL	**$0**	**$0**	**$55,797**	**$0**	**$0**
TOTAL with Decision Items	**$0**	**$0**	**$55,797**	**$0**	**$0**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$0	$1,939,575	$9,207	$0	$0
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	Created through passage of SB 06-044 in FY 2005-06, the purpose of the fund is to provide for the otherwise uncompensated costs and to provide better care for uninsured Coloradans by directing additional resources to be targeted to primary care services in the State. The Fund expired July 1, 2010.
Fee Sources	There are no fees.
Non-Fee Sources	Funding was appropriated by the General Assembly from one-time donations, and any interest earned.
Long Bill Groups Supported by Fund	(1) Executive Director's Office; (4) Indigent Care Program

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 19Z - "Coordinated Care for People with Disabilities Fund"
25.5-6-111 (4), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$1,148,374***	***$1,226,733***	***$1,176,988***	***$992,380***	***$796,865***
Changes in Cash Assets	$176,638	$88,401	$48,669	$39,500	$29,019
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($98,279)	($138,146)	($233,277)	($235,015)	($235,015)
TOTAL CHANGES TO FUND BALANCE	**$78,359**	**($49,745)**	**($184,608)**	**($195,515)**	**($205,996)**
Assets Total	***$176,638***	***$88,401***	***$48,669***	***$39,500***	***$29,019***
Cash (B)	$176,638	$88,401	$48,669	$39,500	$29,019
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$98,279***	***$138,146***	***$233,277***	***$235,015***	***$235,015***
Cash Liabilities (C)	$98,279	$138,146	$233,277	$235,015	$235,015
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$1,226,733***	***$1,176,988***	***$992,380***	***$796,865***	***$590,870***
Net Cash Assets - (B-C)	***$78,359***	***($49,745)***	***($184,608)***	***($195,515)***	***($205,996)***
Change from Prior Year Fund Balance (D-A)	***$78,359***	***($49,745)***	***($184,608)***	***($195,515)***	***($205,996)***
Cash Flow Summary					
Revenue Total	$176,638	$88,401	$48,669	$39,500	$29,019
Fees	$0	$0	$0	$0	$0
Cash	$0	$0	$0	$0	$0
Interest	$176,638	$88,401	$48,669	$39,500	$29,019

Expenses Total	$98,279	$138,146	$233,277	$235,015	$235,015
Cash Expenditures	$98,279	$138,146	$298,977	$300,715	$300,715
Change Requests (If Applicable)					
FY 2013-14 R#1: "Medical Services Premiums"	$0	$0	($65,700)	($65,700)	($65,700)
Net Cash Flow	$78,359	($49,745)	($184,608)	($195,515)	($205,996)

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(A) General Administration, Personal Services	$0	$0	$30,335	$32,073	$32,073
(A) General Administration, Operating Expenses	$0	$0	$442	$442	$442
Division Subtotal	**$0**	**$0**	**$30,777**	**$32,515**	**$32,515**
Division Subtotal with Decision Items	**$0**	**$0**	**$30,777**	**$32,515**	**$32,515**
(2) Medical Services Premiums					
Medical Services Premiums	$0	$0	$268,200	$268,200	$268,200
Division Subtotal	**$0**	**$0**	**$268,200**	**$268,200**	**$268,200**
FY 2013-14 R#1: "Medical Services Premiums"	N/A	N/A	($65,700)	($65,700)	($65,700)
Division Subtotal with Decision Items	**$0**	**$0**	**$202,500**	**$202,500**	**$202,500**
Transfer to General Fund	$0	$0	$0	$0	$0
TOTAL	**$0**	**$0**	**$298,977**	**$300,715**	**$300,715**
TOTAL with Decision Items	**$0**	**$0**	**$233,277**	**$235,015**	**$235,015**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$16,216	$22,794	$49,331	$49,618	$49,618
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	Created through passage of SB 06-128, the purpose of the fund is to improve the quality of care received by Medicaid recipients with disabilities. The statute directs that a non-profit organization submit a proposal to the Department for a pilot program to meet the purposes of the fund. The program should be client-centered, comprehensive, and integrated with the goals of reducing emergency room visits, hospitalizations, and secondary disabilities. Per 25.5-6-111 (7)(a), C.R.S., the program ends effective July 1 of the fifth year following implementation of the pilot program.
Fee Sources	There are no fees.
Non-Fee Sources	Funding is transferred from interest earned in the Breast and Cervical Cancer Prevention and Treatment Fund. The Breast and Cervical Cancer Prevention and Treatment Fund is to be repealed on July 1, 2014.
Long Bill Groups Supported by Fund	(1) Executive Director's Office; (2) Medical Services Premiums

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 22V - "Local Government Provider Fee Cash Fund"
29-28-103 (2) (d), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$0***	***$0***	***$0***	***$0***	***$0***
Changes in Cash Assets	$0	$0	$0	$0	$0
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	$0	$0	$0	$0	$0
TOTAL CHANGES TO FUND BALANCE	**$0**	**$0**	**$0**	**$0**	**$0**
Assets Total	***$0***	***$0***	***$0***	***$0***	***$0***
Cash (B)	$0	$0	$0	$0	$0
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$0***	***$0***	***$0***	***$0***	***$0***
Cash Liabilities (C)	$0	$0	$0	$0	$0
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$0***	***$0***	***$0***	***$0***	***$0***
Net Cash Assets - (B-C)	***$0***	***$0***	***$0***	***$0***	***$0***
Change from Prior Year Fund Balance (D-A)	***$0***	***$0***	***$0***	***$0***	***$0***
Cash Flow Summary					
Revenue Total	$0	$0	$0	$0	$0
Fees	$0	$0	$0	$0	$0
Cash	$0	$0	$0	$0	$0
Interest	$0	$0	$0	$0	$0

Expenses Total	$0	$0	$0	$0	$0
Cash Expenditures	$0	$0	$0	$0	$0
Change Requests (If Applicable)					
Net Cash Flow	$0	$0	$0	$0	$0

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(2) Medical Services Premiums					
Medical Services Premiums	$0	$0	$0	$0	$0
Division Subtotal	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 R#1: "Medical Services Premiums"	N/A	N/A	$0	$0	$0
FY 2013-14 R#7: "Substance Use Disorder Benefit"	N/A	N/A	$0	$0	$0
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	N/A	N/A	$0	$0	$0
	N/A	N/A	$0	$0	$0
Division Subtotal with Decision Items	**$0**	**$0**	**$0**	**$0**	**$0**
(4) Indigent Care Program					
Safety Net Provider Payments	$0	$0	$0	$0	$0
Health Care Services Fund Programs	$0	$0	$0	$0	$0
Primary Care Grant Program Special Distribution	$0	$0	$0	$0	$0
Pediatric Specialty Hospital	$0	$0	$0	$0	$0
Children's Basic Health Plan Administration	$0	$0	$0	$0	$0
Children's Basic Health Plan Medical and Dental Costs	$0	$0	$0	$0	$0
Division Subtotal	**$0**	**$0**	**$0**	**$0**	**$0**
FY 2013-14 R#3: "Children's Basic Health Plan Medical and Dental Costs"	N/A	N/A	$0	$0	$0
Division Subtotal with Decision Items	**$0**	**$0**	**$0**	**$0**	**$0**
Transfer to General Fund	$0	$0	$0	$0	$0
TOTAL	**$0**	**$0**	**$0**	**$0**	**$0**
TOTAL with Decision Items	**$0**	**$0**	**$0**	**$0**	**$0**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$0	$0	$0	$0	$0
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	Created through the passage of SB 08-214, the purpose of the fund is to sustain or increase reimbursements to providers serving Medicaid clients and low-income populations. The fund will be used to deposit provider fees from participating local governments for which the Department will request federal matching funds for redistribution to providers.
Fee Sources	The fees are to be received by the Department either from participating local governments that collect a provider fee on health services, or directly from qualified providers within the boundaries of participating local governments.
Non-Fee Sources	Any moneys in the fund not expended for the purpose of this section shall be invested by the State Treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.
Long Bill Groups Supported by Fund	(2) Medical Services Premiums; (4) Indigent Care Program

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 22X - "Medicaid Nursing Facility Cash Fund"
25.5-6-203 (2) (a), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$7,762,422***	***$3,445,286***	***$1,258,802***	***$1,283,450***	***$1,308,582***
Changes in Cash Assets	$26,485,391	$41,343,257	$42,092,898	$43,312,350	$43,312,843
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($30,802,527)	($43,529,741)	($42,068,250)	($43,287,218)	($43,287,218)
TOTAL CHANGES TO FUND BALANCE	**($4,317,136)**	**($2,186,484)**	**$24,648**	**$25,132**	**$25,625**
Assets Total	***$26,485,391***	***$41,343,257***	***$42,092,898***	***$43,312,350***	***$43,312,843***
Cash (B)	$26,485,391	$41,343,257	$42,092,898	$43,312,350	$43,312,843
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$30,802,527***	***$43,529,741***	***$42,068,250***	***$43,287,218***	***$43,287,218***
Cash Liabilities (C)	$30,802,527	$43,529,741	$42,068,250	$43,287,218	$43,287,218
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$3,445,286***	***$1,258,802***	***$1,283,450***	***$1,308,582***	***$1,334,208***
Net Cash Assets - (B-C)	***($4,317,136)***	***($2,186,484)***	***$24,648***	***$25,132***	***$25,625***
Change from Prior Year Fund Balance (D-A)	***($4,317,136)***	***($2,186,484)***	***$24,648***	***$25,132***	***$25,625***
Cash Flow Summary					
Revenue Total	$26,485,391	$41,343,257	$42,092,898	$43,312,350	$43,312,843
Fees	$26,320,554	$41,275,796	$42,068,250	$43,287,218	$43,287,218
Cash	$41	$0	$0	$1	$2
Interest	$164,795	$67,461	$24,648	$25,131	$25,623

Expenses Total	$30,802,527	$43,529,741	$42,068,250	$43,287,218	$43,287,218
Cash Expenditures	$30,802,527	$43,529,741	$43,528,399	$43,531,647	$43,531,647
Change Requests (If Applicable)					
FY 2013-14 R#1: "Medical Services Premiums"	$0	$0	($1,460,149)	($244,429)	($244,429)
Net Cash Flow	($4,317,136)	($2,186,484)	$24,648	$25,132	$25,625

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(A) General Administration, Personal Services	$63,766	$54,608	$56,756	$60,004	$60,004
(A) General Administration, Operating Expenses	$2,288	$1,845	$2,718	$2,718	$2,718
(A) General Administration, General Professional Services and Special Projects	$45,318	$67,125	$75,000	$75,000	$75,000
(F) Provider Audits and Services, Professional Audit Contracts	$0	$12,420	$12,420	$12,420	$12,420
Division Subtotal	**$111,372**	**$135,998**	**$146,894**	**$150,142**	**$150,142**
Division Subtotal with Decision Items	**$111,372**	**$135,998**	**$146,894**	**$150,142**	**$150,142**
(2) Medical Services Premiums					
Medical Services Premiums	$30,691,155	$43,393,743	$43,381,505	$43,381,505	$43,381,505
Division Subtotal	**$30,691,155**	**$43,393,743**	**$43,381,505**	**$43,381,505**	**$43,381,505**
FY 2013-14 R#1: "Medical Services Premiums"	N/A	N/A	($1,460,149)	($244,429)	($244,429)
Division Subtotal with Decision Items	**$30,691,155**	**$43,393,743**	**$41,921,356**	**$43,137,076**	**$43,137,076**
(4) Indigent Care Program					
Division Subtotal	**$0**	**$0**	**$0**	**$0**	**$0**
Division Subtotal with Decision Items	**$0**	**$0**	**$0**	**$0**	**$0**
Transfer to General Fund	$0	$0	$0	$0	$0
TOTAL	**$30,802,527**	**$43,529,741**	**$43,528,399**	**$43,531,647**	**$43,531,647**
TOTAL with Decision Items	**$30,802,527**	**$43,529,741**	**$42,068,250**	**$43,287,218**	**$43,287,218**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$3,423,844	$1,256,748	$1,282,699	$1,307,823	$1,333,418
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$5,082,417	$7,182,407	$7,182,186	$7,182,722	$7,182,722
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	Created through the passage of SB 08-214, the purpose of the fund is to sustain or increase reimbursements to providers serving Medicaid clients and low-income populations. The fund will be used to deposit provider fees from participating local governments for which the Department will request federal matching funds for redistribution to providers.
Fee Sources	The fees are to be received by the Department either from participating local governments that collect a provider fee on health services, or directly from qualified providers within the boundaries of participating local governments.
Non-Fee Sources	Any moneys in the fund not expended for the purpose of this section shall be invested by the State Treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.
Long Bill Groups Supported by Fund	(2) Medical Services Premiums; (4) Indigent Care Program

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 23G - "Department of Health Care Policy and Financing Cash Fund"
25.1-1-109, C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$51,042***	***$91,270***	***$74,090***	***$70,257***	***$66,424***
Changes in Cash Assets	$68,500	$20,000	$0	$0	$0
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($28,272)	($37,180)	($3,833)	($3,833)	($3,833)
TOTAL CHANGES TO FUND BALANCE	**$40,228**	**($17,180)**	**($3,833)**	**($3,833)**	**($3,833)**
Assets Total	***$68,500***	***$20,000***	***$0***	***$0***	***$0***
Cash (B)	$68,500	$20,000	$0	$0	$0
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$28,272***	***$37,180***	***$3,833***	***$3,833***	***$3,833***
Cash Liabilities (C)	$28,272	$37,180	$3,833	$3,833	$3,833
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$91,270***	***$74,090***	***$70,257***	***$66,424***	***$62,591***
Net Cash Assets - (B-C)	***$40,228***	***($17,180)***	***($3,833)***	***($3,833)***	***($3,833)***
Change from Prior Year Fund Balance (D-A)	***$40,228***	***($17,180)***	***($3,833)***	***($3,833)***	***($3,833)***
Cash Flow Summary					
Revenue Total	$68,500	$20,000	$0	$0	$0
Fees	$0	$0	$0	$0	$0
Cash	$68,500	$20,000	$0	$0	$0
Interest	$0	$0	$0	$0	$0

Expenses Total	$28,272	$37,180	$3,833	$3,833	$3,833
Cash Expenditures	$28,272	$37,180	$3,833	$3,833	$3,833
Change Requests (If Applicable)					
Net Cash Flow	$40,228	($17,180)	($3,833)	($3,833)	($3,833)

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(A) General Administration, Operating Expenses	$0	$0	$3,833	$3,833	$3,833
Division Subtotal	**$0**	**$0**	**$3,833**	**$3,833**	**$3,833**
Division Subtotal with Decision Items	**$0**	**$0**	**$3,833**	**$3,833**	**$3,833**
Transfer to General Fund	$0	$0	$0	$0	$0
TOTAL	**$0**	**$0**	**$3,833**	**$3,833**	**$3,833**
TOTAL with Decision Items	**$0**	**$0**	**$3,833**	**$3,833**	**$3,833**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$4,665	$6,135	$632	$632	$632
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
	Main Fund: Created through the passage of HB 94-1193, the purpose of the fund is to collect fees or otherwise by the Department. Moneys from the fund shall be appropriated by the General Assembly for the direct and indirect costs of the Department's duties as provided by law. **Hospice Care Account:** Created through the passage of SB 10-061, the purpose of which is to fund the Department's costs associated with preparing and submitting a federal waiver to pay for room and board for a person receiving hospice care in a class I nursing facility or in a licensed hospice inpatient facility.
Fee Sources	Not applicable.
Non-Fee Sources	**Main Fund:** The Department may receive any gifts, grants, or donations to be deposited into the fund and appropriations approved by the General Assembly. **Hospice Care Account:** The Department may receive any gifts, grants, or donations to be deposited into the fund and appropriations approved by the General Assembly.
Long Bill Groups Supported by Fund	(1) Executive Director's Office

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 24A - "Hospital Provider Fee Cash Fund"
25.5-4- 402.3 (4), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$5,714,436***	***$22,198,436***	***$24,545,430***	***$3,721,242***	***$3,721,242***
Changes in Cash Assets	$442,553,052	$586,536,447	$661,895,430	$642,832,617	$602,826,782
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($426,069,052)	($584,189,452)	($682,719,618)	($642,832,617)	($602,826,782)
TOTAL CHANGES TO FUND BALANCE	**$16,484,000**	**$2,346,995**	**($20,824,188)**	**$0**	**$0**
Assets Total	***$442,553,052***	***$586,536,447***	***$661,895,430***	***$642,832,617***	***$602,826,782***
Cash (B)	$442,553,052	$586,536,447	$661,895,430	$642,832,617	$602,826,782
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$426,069,052***	***$584,189,452***	***$682,719,618***	***$642,832,617***	***$602,826,782***
Cash Liabilities (C)	$426,069,052	$584,189,452	$682,719,618	$642,832,617	$602,826,782
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$22,198,436***	***$24,545,430***	***$3,721,242***	***$3,721,242***	***$3,721,242***
Net Cash Assets - (B-C)	***$16,484,000***	***$2,346,995***	***($20,824,188)***	***$0***	***$0***
Change from Prior Year Fund Balance (D-A)	***$16,484,000***	***$2,346,995***	***($20,824,188)***	***$0***	***$0***
Cash Flow Summary					
Revenue Total	$442,553,052	$586,536,447	$661,895,430	$642,832,617	$602,826,782
Fees	$441,057,840	$585,719,586	$660,973,618	$641,937,353	$601,987,234
Cash	$0	$0	$0	$0	$0
Interest	$1,495,212	$816,861	$921,812	$895,264	$839,548

Expenses Total	$426,069,052	$584,189,452	$682,719,618	$642,832,617	$602,826,782
Cash Expenditures	$426,069,052	$584,189,452	$668,300,872	$646,231,913	$646,231,913
Change Requests (If Applicable)					
FY 2013-14 R#1: "Medical Services Premiums"	$0	$0	$10,196,721	($11,197,226)	($49,167,738)
FY 2013-14 R#2: "Medicaid Mental Health Community Programs"	$0	$0	$1,179,360	($1,313,190)	($5,075,416)
FY 2013-14 R#3: "Children's Basic Health Plan Medical and Dental Costs"	$0	$0	$3,042,665	$7,085,735	$8,776,002
FY 2013-14 R#5: "Medicaid Management Information System Reprocurement"	$0	$0	$0	$164,792	$363,403
FY 2013-14 R#7: "Substance Use Disorder Benefit"	$0	$0	$0	$42,035	$97,407
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	$0	$0	$0	$849,795	$874,500
FY 2013-14 R#10: "Leased Space Rent Increase and True-up"	$0	$0	$0	($46,344)	($44,901)
FY 2013-14 R#13: "1.5% Provider Rate Increase"	$0	$0	$0	$1,015,107	$771,612
Net Cash Flow	$16,484,000	$2,346,995	($20,824,188)	$0	$0

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(A) General Administration, Personal Services	$1,080,269	$1,479,096	$1,825,260	$1,914,400	$1,914,400
(A) General Administration, Operating Expenses	$36,803	$68,343	$41,608	$41,608	$41,608
(A) General Administration, Legal Services	$27,998	$55,738	$97,047	$97,047	$97,047
(A) General Administration, Administrative Law Judge Services	$14,305	$24,698	$43,364	$43,364	$43,364
(A) General Administration, COFRS Modernization	$0	$0	$99,716	$99,716	$99,716
(A) General Administration, Leased Space	$97,790	$116,224	$151,164	$151,164	$151,164
(A) General Administration, General Professional Services and Special Projects	$187,118	$191,321	$277,500	$277,500	$277,500
(C) Information Technology Contracts and Projects, Information Technology Contracts	$227,415	$1,086,116	$1,317,953	$1,412,213	$1,412,213
(C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	$0	$1,263,293	$2,534,204	$3,059,783	$3,059,783
(D) Eligibility Determinations and Client Services, Medical Identification Cards	$0	$4,132	$4,620	$4,620	$4,620
(D) Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations	$0	$656,117	$2,801,268	$2,801,268	$2,801,268
(D) Eligibility Determinations and Client Services, County Administration	$880,251	$0	$0	$0	$0

(D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration	$0	$969,772	$1,290,536	$1,290,536	$1,290,536
(D) Eligibility Determinations and Client Services, Customer Outreach	$40,252	$101,362	$86,861	$86,861	$86,861
(E) Utilization and Quality Review Contracts, Professional Services Contracts	$15,524	$57,620	$114,332	$114,332	$114,332
(F) Provider Audits and Services, Professional Audit Contracts	$0	$0	$250,000	$250,000	$250,000
Division Subtotal	**$2,607,725**	**$6,073,833**	**$10,935,433**	**$11,644,412**	**$11,644,412**
FY 2013-14 R#5: "Medicaid Management Information System Reprocurement"	N/A	N/A	$0	$164,792	$363,403
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	N/A	N/A	$0	$562,215	$152,205
FY 2013-14 R#10: "Leased Space Rent Increase and True-up"	N/A	N/A	$0	($46,344)	($44,901)
Division Subtotal with Decision Items	**$2,607,725**	**$6,073,833**	**$10,935,433**	**$12,325,075**	**$12,115,119**
(2) Medical Services Premiums					
Medical Services Premiums	$283,925,525	$418,255,138	$482,144,867	$457,094,420	$457,094,420
Division Subtotal	**$283,925,525**	**$418,255,138**	**$441,444,867**	**$441,394,420**	**$441,394,420**
FY 2013-14 R#1: "Medical Services Premiums"	N/A	N/A	$10,196,721	($11,197,226)	($49,167,738)
FY 2013-14 R#7: "Substance Use Disorder Benefit"	N/A	N/A	$0	($282)	($33,883)
FY 2013-14 R#8: "Medicaid Dental Benefit for Adults"	N/A	N/A	$0	$287,580	$722,295
FY 2013-14 R#13: "1.5% Provider Rate Increase"	N/A	N/A	$0	$1,015,107	$771,612
Division Subtotal with Decision Items	**$283,925,525**	**$418,255,138**	**$451,641,588**	**$431,499,599**	**$393,686,706**
(3) Medicaid Mental Health					
Mental Health Capitation Payments	$3,843,622	$5,736,622	$13,614,743	$13,614,743	$13,614,743
Medicaid Mental Health Fee for Service Payments	$0	$0	$0	$0	$0
Division Subtotal	**$3,843,622**	**$5,736,622**	**$13,614,743**	**$13,614,743**	**$13,614,743**
FY 2013-14 R#2: "Medicaid Mental Health Community Programs"	N/A	N/A	$1,179,360	($1,313,190)	($5,075,416)
FY 2013-14 R#7: "Substance Use Disorder Benefit"	N/A	N/A	$0	$42,317	$131,290
Division Subtotal with Decision Items	**$3,843,622**	**$5,736,622**	**$14,794,103**	**$12,343,870**	**$8,670,617**

(4) Indigent Care Program					
Safety Net Provider Payments	$130,867,920	$144,316,724	$150,345,292	$152,617,801	$152,617,801
Children's Basic Health Plan Administration	$6,974	$7,690	$9,361	$9,361	$9,361
Children's Basic Health Plan Medical and Dental Costs	$4,817,287	$8,967,953	$10,945,416	$10,945,416	$10,945,416
Division Subtotal	**$135,692,180**	**$153,292,367**	**$161,300,069**	**$163,572,578**	**$163,572,578**
FY 2013-14 R#3: "Children's Basic Health Plan Medical and Dental Costs"	N/A	N/A	$3,042,665	$7,085,735	$8,776,002
Division Subtotal with Decision Items	**$135,692,180**	**$153,292,367**	**$164,342,734**	**$170,658,313**	**$172,348,580**
(6) Department of Human Services Medicaid Funded Programs					
(B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System	$0	$532,752	$0	$0	$0
(B) Office of Information Technology Services - Medicaid Funding, Colorado Benefits Management System, HCPF only	$0	$298,740	$305,760	$305,760	$305,760
Division Subtotal	**$0**	**$831,492**	**$305,760**	**$305,760**	**$305,760**
Division Subtotal with Decision Items	**$0**	**$831,492**	**$305,760**	**$305,760**	**$305,760**
Transfer to General Fund	$0	$65,700,000	$40,700,000	$15,700,000	$15,700,000
TOTAL	**$426,069,052**	**$649,889,452**	**$668,300,872**	**$646,231,913**	**$646,231,913**
TOTAL with Decision Items	**$426,069,052**	**$649,889,452**	**$682,719,618**	**$642,832,617**	**$602,826,782**
Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$22,123,436	$24,511,246	$3,716,060	$3,716,060	$3,716,060
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$70,301,394	$96,391,260	$110,269,644	$106,628,266	$106,628,266
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	The purpose of the fund is to provide funding to increase hospital reimbursements under Medicaid and the Colorado Indigent Care Program, establish hospital quality incentive payments, increase eligibility for parents of Medicaid eligible children to 100% of the federal poverty level, increase eligibility for children and pregnant women in the Children's Basic Health Plan to 250% of the federal poverty level, provide eligibility for adults without Medicaid dependent children up to 100% of the federal poverty level, establish the Medicaid Buy-In Program for Individuals with Disabilities for individuals with family income up to 450% of the federal poverty level, and to provide 12-month guaranteed eligibility to children in Medicaid.
Fee Sources	Provider fees collected from hospitals pursuant to section 25.5-4-402.3 (3), C.R.S. beginning July 1, 2009. Fee level is set annually by the Medical Services Board, as recommended by the Hospital Provider Fee Oversight and Advisory Board. The amount of the fee is to be set so that the amount collected shall approximate the projected expenditures for that year per 25.5-4-402.3 (3), C.R.S.
Non-Fee Sources	Monies in the Fund shall be subject to federal matching as authorized by federal law and subject to annual appropriation by the General Assembly. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the Fund.
Long Bill Groups Supported by Fund	(1) Executive Director's Office; (2) Medical Services Premiums; (3) Medicaid Mental Health Community Services; (4) Indigent Care Program; (6) Department of Human Services Medicaid Funded Program.

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 25J - "Home Health Telemedicine Cash Fund"
25.5-5-321 (2) (c), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$0***	***$0***	***$60,637***	***$20,302***	***$20,302***
Changes in Cash Assets	$0	$61,635	$0	$0	$0
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	$0	($998)	($40,335)	$0	$0
TOTAL CHANGES TO FUND BALANCE	**$0**	**$60,637**	**($40,335)**	**$0**	**$0**
Assets Total	***$0***	***$61,635***	***$0***	***$0***	***$0***
Cash (B)	$0	$61,635	$0	$0	$0
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$0***	***$998***	***$40,335***	***$0***	***$0***
Cash Liabilities (C)	$0	$998	$40,335	$0	$0
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$0***	***$60,637***	***$20,302***	***$20,302***	***$20,302***
Net Cash Assets - (B-C)	***$0***	***$60,637***	***($40,335)***	***$0***	***$0***
Change from Prior Year Fund Balance (D-A)	***$0***	***$60,637***	***($40,335)***	***$0***	***$0***
Cash Flow Summary					
Revenue Total	$0	$61,635	$0	$0	$0
Fees	$0	$0	$0	$0	$0
Cash	$0	$61,635	$0	$0	$0
Interest	$0	$0	$0	$0	$0

Expenses Total	$0	$998	$40,335	$0	$0
Cash Expenditures	$0	$998	$40,335	$40,335	$40,335
Change Requests (If Applicable)					
FY 2013-14 R#1: "Medical Services Premiums"	$0	$0	$0	($40,335)	($40,335)
Net Cash Flow	$0	$60,637	($40,335)	$0	$0

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(2) Medical Services Premiums					
Medical Services Premiums	$0	$0	$40,335	$40,335	$40,335
Division Subtotal	**$0**	**$0**	**$40,335**	**$40,335**	**$40,335**
FY 2013-14 R#1: "Medical Services Premiums"	N/A	N/A	$0	($40,335)	($40,335)
Division Subtotal with Decision Items	**$0**	**$0**	**$40,335**	**$0**	**$0**
Transfer to General Fund	$0	$0	$0	$0	$0
TOTAL	**$0**	**$0**	**$40,335**	**$40,335**	**$40,335**
TOTAL with Decision Items	**$0**	**$0**	**$40,335**	**$0**	**$0**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$0	$165	$6,655	$6,655	$6,655
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	N/A				

Cash Fund Narrative Information	
Purpose/Background of Fund	Created through the passage of HB 10-1005, the purpose of the fund is to pay for reimbursement of home health telemedicine services in FY 2010-11 and FY 2011-12. After two years or if the moneys in the cash fund are depleted, the Department is authorized to seek funding through the normal budgetary process to fund home health telemedicine services.
Fee Sources	Not applicable.
Non-Fee Sources	The Department may receive any gifts, grants, or donations to be deposited into the fund and appropriations approved by the General Assembly.
Long Bill Groups Supported by Fund	(2) Medical Services Premiums

Schedule 9: Cash Funds Reports
Department of Health Care Policy and Financing
FY 2013-14 Budget Request
Fund 284 - "Nursing Home Penalty Cash Fund"
25.5-6-205 (3)(a), C.R.S. (2012)

	Actual	Actual	Appropriated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Year Beginning Fund Balance (A)	***$1,900,275***	***$2,069,743***	***$2,225,680***	***$2,353,352***	***$2,481,024***
Changes in Cash Assets	$247,497	$212,672	$212,672	$212,672	$212,672
Changes in Non-Cash Assets	$0	$0	$0	$0	$0
Changes in Long-Term Assets	$0	$0	$0	$0	$0
Changes in Total Liabilities	($78,028)	($56,736)	($85,000)	($85,000)	($85,000)
TOTAL CHANGES TO FUND BALANCE	**$169,468**	**$155,937**	**$127,672**	**$127,672**	**$127,672**
Assets Total	***$247,497***	***$212,672***	***$212,672***	***$212,672***	***$212,672***
Cash (B)	$247,497	$212,672	$212,672	$212,672	$212,672
Other Assets(Detail as necessary)	$0	$0	$0	$0	$0
Receivables	$0	$0	$0	$0	$0
Liabilities Total	***$78,028***	***$56,736***	***$85,000***	***$85,000***	***$85,000***
Cash Liabilities (C)	$78,028	$56,736	$85,000	$85,000	$85,000
Long Term Liabilities	$0	$0	$0	$0	$0
Ending Fund Balance (D)	***$2,069,743***	***$2,225,680***	***$2,353,352***	***$2,481,024***	***$2,608,696***
Net Cash Assets - (B-C)	***$169,468***	***$155,937***	***$127,672***	***$127,672***	***$127,672***
Change from Prior Year Fund Balance (D-A)	***$169,468***	***$155,937***	***$127,672***	***$127,672***	***$127,672***
Cash Flow Summary					
Revenue Total	$247,497	$212,672	$212,672	$212,672	$212,672
Fees	$0	$0	$0	$0	$0
Cash	$247,497	$212,672	$212,672	$212,672	$212,672
Interest	$0	$0	$0	$0	$0

Expenses Total	$78,028	$56,736	$85,000	$85,000	$85,000
Cash Expenditures	$78,028	$56,736	$85,000	$85,000	$85,000
Change Requests (If Applicable)	$0	$0	$0	$0	$0
Net Cash Flow	$169,468	$155,937	$127,672	$127,672	$127,672

Fund Expenditures Line Item Detail	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
(1) Executive Director's Office					
(A) General Administration, General Professional Services	$78,028	$56,472	$85,000	$85,000	$85,000
Division Subtotal	$78,028	$56,472	$85,000	$85,000	$85,000
TOTAL	**$78,028**	**$56,472**	**$85,000**	**$85,000**	**$85,000**
TOTAL with Decision Items	**$78,028**	**$56,472**	**$85,000**	**$85,000**	**$85,000**

Cash Fund Reserve Balance	Actual	Actual	Estimated	Requested	Projected
	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15
Uncommitted Fee Reserve Balance (total reserve balance minus exempt assets and previously appropriated funds; calculated based on % of revenue from fees)	$0	$0	$0	$0	$0
Target/Alternative Fee Reserve Balance (amount set in statute or 16.5% of total expenses)	$12,875	$9,361	$14,025	$14,025	$14,025
Excess Uncommitted Fee Reserve Balance	**$0**	**$0**	**$0**	**$0**	**$0**
Compliance Plan (narrative)	NA				

Cash Fund Narrative Information	
Purpose/Background of Fund	The purpose of the fund is to protect the assets and well-being of residents in nursing facilities in case a facility is found to be in violation of federal regulations. The fund was created through the passage of SB 89-005. Penalties assessed against nursing facilities are to be deposited in the fund.
Fee Sources	There are no fees.
Non-Fee Sources	Civil penalties imposed upon and collected from nursing facilities for violations of federal regulations based on surveys by the Department of Public Health and Environment. Penalty amounts are based on facility survey history and the severity of the deficiencies and are determined by either the Centers for Medicare and Medicaid Services or the Department. In addition, interest is earned on the balance of the fund.
Long Bill Groups Supported by Fund	(1) Executive Director's Office

Department of Health Care Policy and Financing

Final Update to FY 2012-13 Strategic Plan
Report on FY 2011-12 Performance Measures
FY 2013-14 Budget Request

November 1, 2012

TABLE OF CONTENTS

OBJECTIVE 1: INCREASE THE NUMBER OF INSURED COLORADANS 3
Percent of Eligible Children Who Are Enrolled in Medicaid 3
Percent of Eligible Children Who Are Enrolled in CHP+ 3
Percent of Eligible Parents Who Are Enrolled in Medicaid 3
Determine Annual Benchmarks to Measure Enrollment of Newly Eligible Populations Under HB 09-1293 Expansions 6
OBJECTIVE 2: IMPROVE HEALTH OUTCOMES 7
Percent of Medicaid Children with Dental Caries Experience 7
Percent of Medicaid Children Who Receive a Dental Service 8
Percent of CHP+ Children Who Receive a Dental Service 9
Initiate Development of a Data Strategy for Long-Term Integration of Clinical and Claims Data 10
Number of Annual Depression Screenings for Adolescents (Age 11-20) on Medicaid/CHP+ Combined 11
OBJECTIVE 3: INCREASE ACCESS TO HEALTH CARE 12
Percent of Adult Medicaid Clients Who Have a Medical Home or Focal Point of Care 12
Percent of Medicaid Children Who Have a Medical Home or Focal Point of Care 13
Number of Providers Participating in Medicaid 14
Determine Appropriate Benchmarks to Measure Increases in Provider Participation to Serve Future Expansion Populations 15
OBJECTIVE 4: CONTAIN HEALTH CARE COSTS 16
Complete Phase I of the Accountable Care Collaborative 16
Implement Payment Reform via the Benefits Collaborative, National Correct Coding Initiative, and Behavioral Health Organization Rate Reform 17
Percent of Hospital Readmissions Within 30 Days of Discharge Among Medicaid Clients (Excluding Dual-Eligibiles) 19
Initiate Development of a Data Strategy for Long-Term Containment of Health Care Costs 20
Percent Reduction of Medical Services Premiums Expenditures for Nursing Facilities 22
OBJECTIVE 5: IMPROVE THE LONG-TERM CARE SERVICE DELIVERY SYSTEM 23
Develop a Five-Year Strategy to Increase the Number of Dual-Eligible Long-Term Care Clients Who Have a Health Home 23
Develop a Five-Year Strategy to Improve Long-Term Care Population Outcomes 23
Develop a Roadmap for Waiver Consolidation 24
Percent of Dual-Eligibles Enrolled in the Accountable Care Collaborative for a Focal Point of Care 25

OBJECTIVE 1: INCREASE THE NUMBER OF INSURED COLORADANS

The Department aims to increase the number of insured Coloradans by increasing enrollment of individuals eligible for its Medicaid and Children's Basic Health Plan (CHP+) programs. Widening eligibility guidelines from the Colorado Health Care Affordability Act coincides with the federal Affordable Care Act and has allowed the Department to proactively prepare for these newly optional eligibility increases. With each fiscal year, the Department's goal is to have a higher percentage of the eligible population enrolled, which will improve health outcomes for an increasing number of Colorado's population.

Performance Measure 1A[1]:
Percent of Eligible Children Who Are Enrolled in Medicaid

Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	85%	87%	87%	~~89%~~	N/A	~~91%~~	N/A	~~93%~~	N/A	~~95%~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to minimal Department control and infrequency of data.*

Performance Measure 1B[1]:
Percent of Eligible Children Who Are Enrolled in CHP+

Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	62%	64%	63%	~~67%~~	N/A	~~70%~~	N/A	~~73%~~	N/A	~~75%~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to minimal Department control and infrequency of data.*

Performance Measure 1C[1]:
Percent of Eligible Parents Who Are Enrolled in Medicaid

Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	76%	76%	75%	~~79%~~	N/A	~~81%~~	N/A	~~83%~~	N/A	~~85%~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to minimal Department control and infrequency of data.*

Strategy:

The Department plans to discontinue all three of these measures effective FY 2012-13 for the following reasons:

- These enrollment measures were based on objectives from the Health Resources and Services Administration-State Health Access Program (HRSA-SHAP) grant, and, since this federal funding has been discontinued, the Department no longer has resources for an outreach team to perform enrollment functions.
- Due to the two-year lag required to report data, the relevance of these measures is relatively low. These estimates are calculated from data provided by the Colorado Health Institute based on analysis of data regarding health insurance status from the American Community Survey. Due to the lag in data available from the American Community Survey, the Department uses data from the most recent year available as a proxy for the evaluation of the performance measures. This, however, may understate the number of individuals with access to health insurance in the measurement year, as the survey cannot account for increases in enrollment in Medicaid or CHP+ during the year.
- The Department has minimal control over clients entering and exiting its programs, and once the individual mandate to have health insurance is effective in 2014, targeted efforts to enroll eligible individuals will no longer be relevant.
- Using HRSA-SHAP grant funding, the Department initiated a multi-pronged approach to achieve these benchmarks in FY 2011-12. The multi-pronged approach included:
  - improvements to the Colorado Benefits Management System (CBMS), eligibility system processing speed through CITRIX upgrades, and moving the entire system to a web-based format;
  - heightened awareness of the timeliness, processing standards, and corrective action plan benchmarks through communication and outreach. This was conducted through individual eligibility site visits, Director’s letters, regular community meetings, and trainings. Additionally, eligibility sites were provided with monthly reports outlining processing times;
  - reviews of conflicting policies and clarification offered to eligibility sites;
  - research and identification of the top reasons applications are pending, and communicating this to eligibility sites that work the cases, as well as working with the CBMS vendor if the pending applications are related to system issues;
  - focused technical assistance to eligibility sites not meeting percentage goals through weekly progress reports on the timeliness percentages so the Department can contact each site below the processing requirement to offer technical assistance and support;
  - the development of additional reports on pending cases or cases identified within exceptions reports needing prioritized and worked by individual eligibility sites to assist in their workload management;
  - providing, through grant funding, additional processing assistance through the Integrated Document Solutions as the Overflow Unit to process family Medicaid and CHP+ applications and redeterminations for eligibility sites that requested assistance. The Department also funded staffing hours for county eligibility staff to perform overtime to assist with processing time frames;
  - the introduction of business process improvements strategies through the Colorado Eligibility Process Improvement Collaborative (CEPIC). County departments implemented new processing strategies that encompassed business process

improvements, staggered work hours to alleviate some of the system activity during peak hours, and overtime for eligibility technicians to decrease the backlog. Further, the Department trained eligibility sites on business process improvements and LEAN to provide ongoing support to those sites as they initiated changes;
  - research and data fixes to clean up administratively incorrect data or issues with interfaces that adversely impacted the processing time performance statistics; and
  - implementing the web-based PEAK online application, which was reported to have assisted with decreasing the eligibility sites' average processing of cases due to the upload process.

Several program automations and system changes were implemented to decrease workload and increase efficiency. These program changes included:

- administrative renewal, which eliminates the need for worker intervention on many redeterminations and aligns redetermination dates across multiple programs in order to eliminate multiple redetermination dates on one case;
- automation of the ex-parte process;
- implementing the Income and Eligibility Verification System interface that verifies client income for clients through the Colorado Department of Labor and Employment. This initiative allows clients to self-declare their verifiable work income for Medicaid and CHP+, which decreases paperwork delays in processing complete applications and redeterminations;
- implementing the Social Security Administration interface that verifies citizenship and identity for U.S. citizens. This initiative allows clients to self-declare their U.S. citizenship status for Medicaid and CHP+, which decreases paperwork delays in processing complete applications and redeterminations; and
- completing a case assignment system fix, which assigned Family Medicaid and CHP+ applications to the user or user's office/county taking the application and added an authorization trigger to prevent these applications from remaining in a pending status. This change also created two new detail reports to assist the eligibility sites with their new applications and redeterminations.

Evaluation of Prior-Year Performance:

The Department met the 87% benchmark for eligible children enrolled in Medicaid for FY 2011-12 with an additional 32,223 Medicaid children enrolled. The Department came close to meeting the 64% benchmark for eligible children enrolled in CHP+ and the 76% benchmark for eligible parents enrolled in Medicaid. An additional 6,999 CHP+ children were enrolled in CHP+ (for an estimated 63% of all eligible children) and an additional 20,404 Medicaid parents were enrolled in Medicaid (for an estimated 75% of eligible parents) in FY 2011-12.

These estimates are calculated from data provided by the Colorado Health Institute based on analysis of data regarding health insurance status in 2009 from the American Community Survey. Due to the lag in data available from the American Community Survey, the Department uses data from the most recent year available as a proxy for the evaluation of the performance measures.

This, however, may understate the number of individuals with access to health insurance in the measurement year, as the survey cannot account for increases in enrollment in Medicaid or CHP+ during the year.

Performance Measure 1D: Determine Annual Benchmarks to Measure Enrollment of Newly Eligible Populations Under HB 09-1293 Expansions											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:

Benchmarks for the population expansions under the Colorado Health Care Affordability Act (HB 09-1293) are established through the Department's Budget Request to the General Assembly. Based on that forecast, the Hospital Provider Fee is adjusted so revenue is sufficient to cover the costs of the expansions. For the Adults without Dependent Children expansion, an enrollment limit of 10,000 was established and approved through the Medical Services Board and the Department's Section 1115 Demonstration Waiver with the Centers for Medicare and Medicaid Services. The Department's Eligibility Division has established a monthly process to review the enrollment levels, authorize new enrollments up to the enrollment limit from an established waitlist, and created limits within the Colorado Benefits Management System to prevent enrollment from exceeding the established limit.

Evaluation of Prior-Year Performance:

In accordance with its Section 1115 Demonstration Waiver for the Adults without Dependent Children expansion, the Department implemented the program with an enrollment limit of 10,000 in May 2012. The Hospital Provider Fee model included sufficient revenue and the Department's budget had sufficient spending authority to support the costs of all HB 09-1293 expansion populations implemented to date.

At this time, the Department cannot accurately measure the percent of eligible individuals who are enrolled pursuant to HB 09-1293 due to the timeliness of necessary data from the American Community Survey.

OBJECTIVE 2: IMPROVE HEALTH OUTCOMES

The Department intends to improve health outcomes for clients in the Medicaid and CHP+ programs. This effort will include reducing the percentage of children with dental caries, which is the disease that causes tooth decay and can lead to cavities in teeth and has been shown to be linked to other physical health issues. This effort also includes increasing the number of depression screenings in adolescents and reducing the obesity weight among both adults and children. As a measure to maintain cost-effective care, the Department plans to link an increasing percentage of Medicaid provider payments to value-based outcomes. These efforts should collectively improve health outcomes for Coloradans while combating cost increases.

Performance Measure 2A[1]: Percent of Medicaid Children with Dental Caries Experience											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	57%	55%	55%	~~<55%~~	N/A	~~<55%~~	N/A	~~<55%~~	N/A	~~<55%~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to infrequency of data.*

Strategy:
To increase the number of Medicaid children who have access to dental care and receive dental services, the Department is developing an Oral Health Care Action Plan with guidance from the Centers for Medicare and Medicaid Services and the Colorado Oral Health stakeholder community. The Action Plan will implement four Medicaid oral health care goals, including one to decrease the number of Medicaid children with dental caries experience by ten percentage points in a four-year period. The Department expects to complete and implement parts of the Action Plan starting January l, 2013.

The Department continues to work with external partners, particularly the Cavity Free at Three (CF3) initiative, to reduce early childhood caries. The CF3 initiative is a grant-funded, statewide consortium of dentists, physicians, public health professionals, foundations, and child-health advocates working to improve oral health outcomes for children in Colorado by educating health professionals about the consequences of early-childhood caries and their role in preventing this disease. The vision is that all children in Colorado, regardless of where they live or their health insurance status, have access to preventive oral care and a dental home starting at age one.

This performance measure will be discontinued effective FY 2012-13 due to infrequency of data, as described in the “Evaluation of Prior Year Performance” section below.

Evaluation of Prior-Year Performance:

The Department is using the nationally recognized Basic Screening Survey (BSS) as a proxy for the percentage of Medicaid children in the third grade with cavities. The BSS is conducted by the Colorado Department of Public Health and Environment and its Oral Health Unit contractors. The survey is conducted every three to five years, represents a single point in time, and is funded by the Centers for Disease Control and Prevention and the Maternal and Child Health Bureau. The most recent survey was conducted in 2011 and showed a 55% caries experience for predominately low-income Colorado children in the third grade. The Department met its goal of a 2% decrease in caries as determined by this survey. The previous survey was completed in 2009 and showed a 57% caries experience for predominately low-income children in the third grade. Unlike medical treatment, diagnosis codes do not exist for dental treatment, necessitating the use of oral examinations rather than claims data to report on this performance measure.

Performance Measure 2B: Percent of Medicaid Children Who Receive a Dental Service											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	49%	51%	52%	53%	TBD	55%	TBD	57%	TBD	59%	TBD

Strategy:

To increase the number of Medicaid children who have access to dental care and receive dental services, the Department is developing an Oral Health Care Action Plan with guidance from the Centers for Medicare and Medicaid Services and the Colorado Oral Health stakeholder community. The Action Plan will implement four Medicaid oral health care goals, including one to increase the number of Medicaid children receiving oral health care services by 10 percentage points in a four-year period. The Department expects to complete and implement parts the Action Plan starting January l, 2013. The Department has also agreed to an external, comprehensive dental benefit review funded by Caring for Colorado. The Department anticipates the reviewer will look at the benefit in its entirety to determine best practices and/or benefit design to maximize Departmental and national strategic goals of increasing access to evidenced-based, preventive services for clients.

Evaluation of Prior-Year Performance:

In federal fiscal year 2010-11, approximately 52% of Medicaid children received a dental service. These estimates are calculated from data provided to the federal Centers for Medicare and Medicaid Services (CMS) and represent the number of children who have been continuously enrolled in Medicaid for at least 90 days and received any dental service between October 1, 2010, and September 30, 2011.

The Department has observed a steady increase of approximately 2.5% per year over the past four years in Medicaid children receiving a dental service. The Department has observed a commensurate increase in dental provider enrollment and outreach, which

increased needed access for clients. In addition, medical providers have been educated to screen and refer children for necessary dental services. Dental staff at the Department will continue to work on internal and external statewide initiatives for continued outreach to both dental providers and clients.

Due to the one-year lag in data available from the federal report the Department uses to evaluate this performance measure ("EPSDT CMS 416 report"), the Department uses data from the most recent year available as a proxy for the number of children receiving dental services in the measurement year. This methodology may, however, understate the actual result, as older data cannot account for progress made during the actual measurement year.

Performance Measure 2C: Percent of CHP+ Children Who Receive a Dental Service											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	44%	46%	41%	45%	TBD	47%	TBD	49%	TBD	51%	TBD

Strategy:

To increase the number of Children's Basic Health Plan (CHP+) children who have access to dental care and receive dental services, the Department is developing an Oral Health Care Action Plan in concert with the CHP+ Oral Health Care Contractor and with guidance from the Centers for Medicare and Medicaid Services (CMS) and the Colorado Oral Health stakeholder community. The Action Plan will implement four CHP+ oral health care goals, including one to increase the number of CHP+ children receiving oral health care services by 10 percentage points over a four-year period. The Department expects to complete and implement parts of the Action Plan beginning 2013. In addition, the Department spent the past year drafting a Request for Proposals (RFP) for a new CHP+ Oral Health Care Contract effective July 1, 2013. The goals, strategies, and tactics of the Action Plan are incorporated in this RFP.

Evaluation of Prior-Year Performance:

In federal fiscal year 2010-11, approximately 41% of CHP+ children received a dental service. These estimates are calculated from data provided by the CHP+ Oral Health contractor based on the federal Centers for Medicare and Medicaid Services (CMS) methodology for the Medicaid EPSDT CMS 416 report discussed above and represent the number of children who have been continuously enrolled in CHP+ for at least 90 days and received any dental service between October 1, 2010, and September 30, 2011.

While there was a decrease in CHP+ oral health care utilization from FY 2010-11 to FY 2011-12, the Department believes this is largely due to a change in the methodology used to calculate this measure. Through FY 2010-11, the methodology measured utilization relative to the average CHP+ annual caseload rather than the number of children continuously enrolled in CHP+ for at least

90 days. This change in methodology is consistent with a recent CMS requirement that state CHIP programs adopt the standardized Medicaid methodology for calculating oral health care benefit utilization.

Due to the one-year lag in the data used by the Department to evaluate this performance measure (consistent with the EPSDT CMS 416 report), the Department uses data from the most recent year available as a proxy for the number of children receiving dental services in the measurement year. This methodology may, however, understate the actual result, as older data cannot account for progress made during the actual measurement year.

Performance Measure 2D: Initiate Development of a Data Strategy for Long-Term Integration of Clinical and Claims Data											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:

The Department is working with its partner agencies and the Governor's Office of Information Technology (OIT) to implement a Comprehensive State Health Information Management Strategy (C-SHIMS). As the State Medicaid Agency, the Department has a strong and ongoing interest in ensuring efficient and effective collection, management, availability, use, and governance of health information across state health programs, agencies, and non-governmental partners. The overall goal is for the Department to take a lead role in encouraging the adoption and efficient and effective use of Health Information Technology (HIT) by state agencies and the Colorado health care community by providing leadership and funding when possible. The Department assumes the level of financial and technical support needed to achieve this joint goal will be available from the Centers for Medicare and Medicaid Services (CMS).

As a comprehensive health information management strategy, C-SHIMS is expected to be a blueprint to drive strategic thinking and collaboration that will evolve over time with the needs and demands of a transforming health system. C-SHIMS builds upon the Colorado Information Marketplace being championed and implemented by the State Chief Information Officer and Secretary of Technology, and it is built upon a framework of "Capture, Link, Serve and Provide." These principal components of C-SHIMS are essential if health information is to be utilized to achieve outcome, service, programmatic, budgetary, reporting, and other related goals across state agencies and the broader Colorado health community.

Through the Health Information Technology for Economic and Clinical Health (HITECH) Act, CMS can provide enhanced federal funding of 90% to modernize and update the State's HIT infrastructure. This funding can be used for the design, development, and implementation (DDI) of statewide databases that will directly benefit the State's health information exchange or the State Medicaid agency. HITECH funds are meant to support time-limited activities and do not provide funding for maintenance. The Department

intends to update its State Medicaid HIT Plans (SMHP) and HITECH Implementation Advanced Planning Document (IAPD, approved on October 18, 2011) to obtain enhanced federal funding for projects described in this document.

In addition, the Department may also request enhanced federal funding through an IAPD for the reprocurement of the Department's Medicaid Management Information System (MMIS), as HIT is vital to the Department's claims payment processes, efficient program administration, reporting, analytics, and monitoring of quality of care. The Department expects to submit an IAPD to CMS during FY 2012-13 with an effective date of July 1, 2013. The reprocured MMIS is expected to be operational by July 2016.

Evaluation of Prior-Year Performance:
The development of a data strategy for integration of clinical and claims data was initiated via kickoff of the procurement process for the Colorado Medicaid Management Innovation and Transformation (COMMIT) project. Included in the COMMIT project is the Department's data warehouse and analytical capabilities. C-SHIMS outlines a strategic approach to integrate data from a variety of sources into the Department's data warehouse, including clinical and quality data to provide sophisticated analytics to create client risk scores, performance monitoring and benchmarking, evaluating utilization variances, and creating provider profiles. The Department developed a written strategy, which was finalized on August 1, 2012.

Performance Measure 2E[1]: Number of Annual Depression Screenings for Adolescents (Age 11-20) on Medicaid/CHP+ Combined											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual[2]	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1,500	TBD	~~3,000~~	N/A	~~N/A~~	N/A	~~N/A~~	N/A	~~N/A~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to reporting lag time and low correlation between depression screenings and treatment.*
[2]*FY 2011-12 data not available until January 2013.*

Strategy:
The Department's strategy for increasing the number of adolescent depression screenings is to communicate the availability of this benefit and online depression tool kit. Communications are targeted to fee-for-service primary care providers through the "At A Glance" and "Provider Bulletin" newsletters and other provider sources such as the Colorado Children's Healthcare Access Program.

Evaluation of Prior-Year Performance:
Not applicable. New measure effective FY 2012-13.

OBJECTIVE 3: INCREASE ACCESS TO HEALTH CARE

Enrolling eligible clients is only effective in improving health outcomes if these individuals have access to high quality health care. As one of its goals, the Department intends to increase the percentage of Medicaid clients, both adults and children, who have a medical home or focal point of care. By having a medical home or focal point of care, these clients will receive the health care services they need in a timely manner, effectively preventing more expensive emergency treatment that comes as a result of neglected health conditions.

Performance Measure 3A[1]: Percent of Adult Medicaid Clients Who Have a Medical Home or Focal Point of Care											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual[2]	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	38%	42%	38.4%	~~52%~~	N/A	~~70%~~	N/A	~~75%~~	N/A	~~80%~~	N/A

[1]*Measure to be replaced effective FY 2012-13 by "Number of Medicaid clients enrolled in the Accountable Care Collaborative."*
[2] *Preliminary result based on 1st half of FY 2011-12. Final result pending data run-out from claims on 2nd half of FY 2011-12 (available January 2013).*

Strategy:
The Department's strategy for this measure in FY 2011-12 was to implement Phase I of the Accountable Care Collaborative (ACC). The goal in the first year of the ACC program was to enroll up to 123,000 Medicaid members, providing them with a focal point of care. Each Regional Care Collaborative Organization (RCCO) in the ACC launched enrollment in designated focus communities in which a contracted provider network of Primary Care Medical Providers (PCMPs) was established, as well as an informal network of specialists, ancillary providers, and community resources. Whenever possible, ACC enrollees were linked to a PCMP based on claims history. RCCOs also used a variety of additional strategies to reach members with no clear pattern of claims history and link them to a PCMP. To assist in this process, a subgroup of the ACC Program Improvement Advisory Committee was formed in February 2012 to develop recommendations for optimizing the linking process. Recommendations that have been, or are being, implemented include: adding the State Seal to Health Colorado letters and envelopes to draw attention to them; developing a statewide provider directory to show new members a wide range of provider options across the state; developing a set of federally approved marketing guidelines to support outreach to ACC members not yet linked with a PCMP; and developing a plan for rechecking the claims history of unlinked ACC Members every six months to link them with a PCMP.

Evaluation of Prior-Year Performance:
The Department implemented Phase I of the Accountable Care Collaborative. New members were enrolled in May 2011, and the program met its initial enrollment benchmark of 123,000 clients for FY 2011-12. Although ACC members may choose to opt out of the program, opt out rates have been consistently very low (approximately 5%) over the fiscal year. The Department and the RCCOs

have worked on ways to identify and contact hard-to-reach populations (e.g., the new Adults without Dependent Children) and ways to address the four main program goals: improved client health, improved client and provider experience, reducing overall cost of care, and providing detailed and actionable data to support program strategies.

Performance Measure 3B[1]: Percent of Medicaid Children Who Have a Medical Home or Focal Point of Care											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	78%	80%	79%	~~86%~~	N/A	~~92%~~	N/A	~~97%~~	N/A	~~100%~~	N/A

[1]*Measure to be replaced effective FY 2012-13 by "Number of Medicaid clients enrolled in the Accountable Care Collaborative."*

Strategy:
To meet the goals of SB 07-130, the Department, the Colorado Department of Public Health and Environment, providers, advocates, and other community stakeholders are participating in the Colorado Medical Home Initiative (CMHI) so that every child enrolled in Medicaid and CHP+ receive access to health care in a medical home. In FY 2011-12 the Department changed its methodology to include federally qualified health centers (FQHC) and school-based health centers, as well as the new Accountable Care Collaborative providers as medical homes in this program. The program included a Triple Aim for Families: increase quality and accessibility of services; increase capacities for families to change their own trajectories; and transform systems and services.

Evaluation of Prior-Year Performance:
In FY 2011-12, the distinct count of children who could be attributed to a medical home was 263,679; this number excludes 43,438 children who had two or more visits to a federally qualified health center or rural health clinic (FQHC/RHC). The total number of Medicaid children is 334,633, which is the average number of Foster Care and Eligible Children in FY 2011-12. If the 43,438 children with two or more visits to a FQHC/RHC had been factored in, the percent of Medicaid children who had a medical home in FY 2011-12 would be 92%. For a comparable result to the pre-Accountable Care Collaborative methodology used in prior years for this performance measure, FQHC/RHC visits were excluded from the calculation. This results in 79% of children being attributed to a medical home, almost meeting the 80% benchmark.

Performance Measure 3C: Number of Providers Participating in Medicaid											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	24,669	25,902	26,283	27,597	TBD	5% increase from FY 2012-13 Actual	TBD	5% increase from FY 2013-14 Actual	TBD	5% increase from FY 2014-15 Actual	TBD

Strategy:
In FY 2011-12, the Department implemented provisions of the Health Resources and Services Administration-State Health Access Program (HRSA-SHAP) grant to create a Provider Relations team, consisting of two full-time staff, for the purpose of retaining existing Medicaid providers, assisting prospective providers in the enrollment process, and initiating a provider-recruitment strategy. In coming years, the Department's Regional Care Collaborative Organizations will encourage providers to join the Accountable Care Collaborative and become a Medicaid provider. The Clinical Services Office will also network with providers and provider organizations to recruit new providers.

Evaluation of Prior-Year Performance:
By the end of FY 2010-11, there were 24,669 Medicaid providers in Colorado. This represents a correction to the number of FY 2010-11 providers originally reported (27,336) in the Department's FY 2012-13 Budget Request. The corrected number reflects "active" providers with at least one claim per calendar year. As a result, the benchmark for FY 2011-12 has been adjusted to reflect a 5% increase over the FY 2010-11 actual number. The Department exceeded the corrected FY 2011-12 benchmark with a total of 26,283 Medicaid providers. This represents a 6.5% increase over the 24,669 Medicaid providers in FY 2010-11.

Performance Measure 3D: Determine Appropriate Benchmarks to Measure Increases in Provider Participation to Serve Future Expansion Populations											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:
The Department estimates a 5% annual increase in provider participation over the next five years will be sufficient to meet the needs of Medicaid clients. This is based on conclusions and methodology of the Colorado Health Institute (CHI) December 2011 report "A Half Million Newly Insured: An Analysis of Primary Care Workforce Needs After Health Care Reform," and supported by Oregon's ongoing Health Study, which cites an initial increase in participant medical utilization. The Department has adapted these findings to its Medicaid-specific populations and incorporated the need to add specialty care providers.

Evaluation of Prior Year Performance:
The Department determined a 5% annual increase in provider participation over the next five years will be sufficient to serve expansion populations under HB 09-1293 and future needs of Medicaid clients.

OBJECTIVE 4: CONTAIN HEALTH CARE COSTS

Increasing caseload is understood to carry an additional financial burden to the State, which is particularly concerning during an economic downturn. The Department has identified a number of areas where it can contain health care costs while still providing health care services to its Medicaid and CHP+ clients. These cost-containment opportunities are made possible by an assortment of efforts to consolidate and streamline the delivery process, thus maximizing a number of potential efficiencies. The Department aims to assure delivery of appropriate, high-quality health care and expand and preserve health care services in the most cost-effective manner possible, as well as design programs that result in improved health status for clients served and improve health outcomes.

Performance Measure 4A: Complete Phase I of the Accountable Care Collaborative											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:
By completing Phase I of the Accountable Care Collaborative (ACC), the Department built a solid framework for coordinated care to achieve improved health outcomes, client experience, and lower per-capita costs. The ACC works to improve health outcomes through a coordinated, client-centered system and controls costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources. The three key performance indicators for FY 2011-12 were: 1) reduction in emergency department utilization, 2) reduction in hospital readmissions within 30 days, and 3) reduction in utilization of high-cost imaging (e.g., computerized tomography scans and magnetic resonance imaging). As the ACC program continues to evolve, the Department is developing ways to use data to identify regional and provider-based cost variations and inform additional cost-containment strategies.

Evaluation of Prior-Year Performance:
Phase I of the ACC was completed on June 30, 2012, and the ACC program moved into Expansion Phase in July 2012. As of September 2012, the ACC has approximately 135,000 enrollees, including the new Adults without Dependent Children population. The Department expects to increase enrollment by approximately 30,000 per month beginning October 2012.

Performance Measure 4B: Implement Payment Reform via the Benefits Collaborative, National Correct Coding Initiative, and Behavioral Health Organization Rate Reform											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:

The Benefits Collaborative serves as the Department's formal policy-development process. The Benefits Collaborative is a transparent, stakeholder-driven process for: ensuring benefit coverage policies are based on the best-available clinical evidence and guided by best practices; outlining the appropriate amount, scope, and duration of Medicaid benefits; and promoting the health and functioning of Medicaid clients. The collaborative is intended to provide guidelines for determining coverage criteria for Colorado Medicaid's covered benefits, promoting appropriate utilization and access to care, and minimizing variations in care. The development of the policies were centered around three main goals: 1) defining clinical criteria, 2) reducing inappropriate utilization, and 3) promoting proper billing practices.

The Department will implement National Correct Coding Initiative (NCCI) in accordance with the federal Affordable Care Act (ACA). The NCCI editing methodologies will be implemented in order to prevent coding errors and potential fraud, waste, and abuse. Medicare and most insurance companies already follow NCCI rules, and this will bring the NCCI rules to Medicaid. SB 10-167 allocated funding to the Department for such implementation and future operations. The Department began the development of this project in FY 2010-11 and, in FY 2011-12, finalized the system and policy requirements. Starting February 1, 2013, the Department's NCCI Implementation Project will begin the editing of claims in the Department's Medicaid Management Information System (MMIS). After necessary system changes and approval by the Medical Services Board, claims submitted by providers shall be edited according to the six NCCI methodologies:

- NCCI procedure to procedure edits for practitioner and Ambulatory Surgical Centers (ASC) services
- NCCI procedure to procedure edits for outpatient hospital services
- NCCI procedure to procedure edits for Durable Medical Equipment claims
- Medically Unlikely Edits (MUEs) for practitioner and ASC services
- MUEs for outpatient hospital services
- MUEs for supplier claims for Durable Medical Equipment

In implementing Behavioral Health Organization (BHO) rate reform, the Mental Health Rates group uses the annual case rate based on the Chronic Illness and Disability Payment System (CDPS), a risk-adjustment model that groups diagnoses according to chronic and disabling disease to measure service efficiency by BHOs. With the service mix data, Rates also analyzes the impact of the

prevention/early intervention services on the efficiency change from year to year and among BHOs. When there is any efficiency gain available, the Department will share a portion of the gain for incentives for the prevention/early intervention services.

Evaluation of Prior-Year Performance:

The Department is implementing payment reform through the Benefits Collaborative, NCCI, and BHO rate reform. With respect to the Benefits Collaborative, the Department has worked closely with the Colorado Radiological Society to ensure the radiology benefit coverage standards are based upon generally accepted standards of practice and the American College of Radiology's Appropriateness Criteria. Three of these Benefit Coverage Standards entered the public comment period in August 2012. The Department's stakeholders have capitalized on the opportunity to provide cost-effective ways for Colorado Medicaid to render services. In addition, and as a result of stakeholder feedback, the Department plans to offer tablet computers as a lower-cost option for Medicaid clients requiring Augmentative and Alternative Communication Devices (AACDs). Effective June 1, 2012, the Medical Services Board approved a rule to allow the Department to incorporate by reference any Benefit Coverage Standard developed through the Benefits Collaborative process. The inclusion of the Benefit Coverage Standards into rule will assist in the Department's client appeals defense.

In implementing NCCI, the Department meets weekly to further progress. The estimated implementation date is February 2013. The Department will adjust rates associated with certain procedure codes that have been out-of-balance and would conflict with NCCI coding guidelines. The Department is reaching out to affected providers and is updating rules, billing manuals, and provider bulletins.

The Department has also begun implementing BHO rate reform as described above. When there is any efficiency gain available, the Department will share a portion of the gain for incentives for the prevention/early intervention services.

Performance Measure 4C: Percent of Hospital Readmissions Within 30 Days of Discharge Among Medicaid Clients (Excluding Dual-Eligibiles)											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual[1]	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	9.95%	9.55%	TBD	9.65%	TBD	9.36%	TBD	9.08%	TBD	8.80%	TBD

[1] *FY 2011-12 data not available until January 2013 (requires six months paid date run-out).*

Strategy:

There were many activities initiated to affect the 30 day hospital readmission rate during FY 2011-12:

- The readmission rate is now a key performance indicator for each Regional Care Collaborative Organization.
- A policy to deny payment for any readmission that occurred within 48 hours of a discharge was implemented July 1, 2011.
- A questionnaire was sent to all hospitals about their current efforts to decrease 30-day hospital readmissions. The intent of this questionnaire was to increase awareness of the importance of decreasing readmissions.
- A work group of Department staff was initiated to focus on activities that could be done to lower readmissions.
- A collaborative effort between the Center for Improving Value in Health Care, Colorado Hospital Association, Colorado Regional Health Information Organization, and the Department began investigating the need for a statewide initiative focused on reducing readmissions.

Evaluation of Prior-Year Performance:

In FY 2010-11, the percent of hospital readmissions within 30 days of discharge among Medicaid clients (excluding dual-eligibles) was 9.95%. This represents a correction to the 9.4% hospital readmission rate originally reported in the Department’s FY 2012-13 Budget Request. As a result, the benchmark for FY 2011-12 was adjusted to 9.55% to reflect the targeted four-tenths of one percentage point decrease from the actual rate in FY 2010-11. The actual rate is based on an analysis of claims data six months after the close of the reporting period to allow for the completion of provider billing cycles. When compared to a 16-state Medicaid average of 8.3%, Colorado’s readmission rate is nearly 1.7% higher than the other states. The Department will be able to gauge the success of the strategies employed in FY 2011-12 in February 2013.

Performance Measure 4D: Initiate Development of a Data Strategy for Long-Term Containment of Health Care Costs											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:

A major component of the Department's data strategy in FY 2011-12 was to complete implementation of the Accountable Care Collaborative and, in particular, the Statewide Data and Analytics contractor (SDAC). The SDAC is responsible for providing secure electronic access to clinically actionable data to the Regional Care Collaborative Organizations (RCCOs) and Primary Care Medical Providers (PCMPs) to help them meet the goals of the Accountable Care Collaborative (ACC) – to improve client health and reduce costs. The SDAC helps providers by allowing PCMPs to better coordinate Medicaid clients' care by: providing secure access to diagnoses, prescriptions, and other health information; providing reports to PCMPs and RCCOs to help eliminate avoidable and duplicative procedures; and analyzing claims to identify potentially preventable health events (e.g., ER visits and hospital readmissions). The SDAC is contributing to the development of a data strategy for long-term containment of health care costs by:

- building and implementing the ACC data repository;
- creating reports using advanced health care analytics;
- hosting and maintaining a Web Portal;
- fostering accountability and ongoing improvement among RCCOs and providers; and
- identifying data-driven opportunities to improve care and outcomes.

Evaluation of Prior-Year Performance:

The SDAC completed development of the SDAC data warehouse, including the establishment of a regular, weekly data feed from the Department. This data feed contains all physical health and pharmaceutical administrative data captured by the Department's Medicaid Management Information System (MMIS). The data warehouse contains data from January 2008 forward. The SDAC also incorporated behavioral health data from calendar years 2008 to 2010. The SDAC transforms the data warehouse into actionable information. First, the data is run through a series of algorithms that create comparable groups of clients based on diagnoses and co-morbid health conditions, then this information is displayed in the SDAC web portal. The web portal became operational in January 2012.

RCCOs and PCMPs have access to the Web Portal dashboard. The dashboard contains information on RCCO and PCMP performance for the ACC Key Performance Indicators (KPIs). The KPIs include: 30-day all-cause readmissions, ER visits, and high-cost imaging services. By tracking these metrics on a risk-adjusted basis, the Department is able to compare the RCCOs and PCMPs

to each other. RCCOs and PCMPs are using the dashboard Web Portal to help guide their care management priorities. For instance, a RCCO may notice that they are performing poorly on the ER visits KPI metric. They are able to "drill down" into the metric and determine the specific patients who have the highest number of ER visits.

The SDAC hosted a monthly operations meeting for RCCOs and Department staff during FY 2011-12 to demonstrate how the Web Portal can be used to enhance care management practices in a manner that focuses on optimizing practice resources. This monthly meeting facilitated the dissemination of best practices across RCCOs. RCCOs were able to provide feedback to the SDAC that led to the creation of several monthly care-management reports. The development of the Patient Profiler tool began during a monthly SDAC operations meeting. This tool displays a patient history by service category, listing the inpatient hospital stays, ER visits, drugs, and primary/specialty care visits a patient has had in the past year. Both RCCO and PCMP representatives reviewed this tool positively in terms of its impact on care management practices.

During the past year, the SDAC has been discussing how to best incorporate behavioral health data and hospital data on an ongoing basis. The behavioral health information in the State's MMIS is not actionable due to a large number of edits that influence what behavioral health claims are actually paid and how they are priced. The Department sent the SDAC three years of behavioral health claims data and is currently building a system to send this information on an ongoing basis. The SDAC and Department have also been in close contact with the Colorado Regional Health Information Organization on linking admission, discharge, and transfer hospital data into the SDAC in a real-time basis. Incorporating this data set would be an asset for providers. Providers are not currently notified when their patients are admitted to the hospital. As a result, it is difficult to coordinate care with the hospital or to arrange for appropriate care transitions upon discharge. Delivering this information to providers in a timely fashion would be a significant step forward in terms of actionable data for providers. The Department and the SDAC are currently aiming for implementation in March 2013.

Performance Measure 4E[1]: Percent Reduction of Medical Services Premiums Expenditures for Nursing Facilities											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	Total Expenditures for Class I Nursing Facilities: $521,244,769	0.7% (Reduction of $3,648,713 from prior FY expenditure)	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[1]Measure discontinued effective FY 2012-13 due to dependency of nursing facility expenditures on external factors such as growth of aging populations and federal and state rules and regulations.

Strategy:
One of the Department's strategies for containing Medical Services Premiums expenditures for nursing facilities is to minimize the aggregate census of Class I Nursing Facilities by applying the Minimum Data Set (MDS) 3.0 Section Q assessment process. The MDS Section Q assessment is part of the federally mandated process that assesses nursing facility residents' health conditions, treatment, abilities, and plans for discharge. It is designed to explore nursing facility residents' desire for living in the community through an individualized, person-centered evaluation. Once community placement is expressed by nursing facility residents, community transitions measures are applied using Community Transition Services in the HCBS-EBD waiver and Colorado Choice Transitions program processes. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition.

It is not possible, however, to set targeted expenditure reductions for nursing facilities due to dependency on external factors such as growth of aging populations and federal and State rules and regulations for nursing facility reimbursement.

Evaluation of Prior-Year Performance:
Not applicable. New measure effective FY 2012-13.

OBJECTIVE 5: IMPROVE THE LONG-TERM CARE SERVICE DELIVERY SYSTEM

As the population ages and costs increase, long-term care continues to serve as a difficult category in the arena of public health care. Long-term care services are expensive; however, the Department believes there are efficiencies that can yet be attained, thus minimizing and perhaps containing cost increases while continuing to deliver the same level of care. Transitioning clients from facility-based care to community-based care and consolidating waiver programs are efficiency opportunities the Department plans to immediately pursue.

Performance Measure 5A: Develop a Five-Year Strategy to Increase the Number of Dual-Eligible Long-Term Care Clients Who Have a Health Home											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:

The Department's strategy to increase the number of dual-eligible clients who have a health home is to enroll them in the Accountable Care Collaborative (ACC) in 2013. All dual-eligible clients who are not already receiving care in a coordinated setting will be enrolled in the ACC. In the next year, it is likely the Department will pursue a health homes project through section 2703 of the Affordable Care Act (ACA), which may include some dual-eligible clients.

Evaluation of Prior-Year Performance:

The Department has a strategy in place and is in negotiations with the Centers for Medicare and Medicaid Services to finalize a contract and Memorandum of Understanding to implement the Demonstration to Integrate Care for Dual-Eligible Clients. The Department anticipates completing these negotiations in early 2013 and enrolling dual-eligible clients into the ACC later in 2013.

Performance Measure 5B: Develop a Five-Year Strategy to Improve Long-Term Care Population Outcomes											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Yera FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:
To improve outcomes for the long-term care (LTC) population, the Department will develop a strategic plan with input from Long-Term Supports and Services (LTSS) stakeholders. The key sections for developing the plan include the Quality Health Improvement Unit, the Quality Assurance/Audit Unit in the LTSS Division, and the LTC Reform Unit. The plan will identify key outcome measures to track and aggregate over time. A key criterion for selecting measures will be the capacity of the Department to collect data related to specific measures. In the first year of the plan, baseline data will be established for all measures, which key personnel will use to establish goals and develop intervention strategies. A few years from now, the Department may want to consider developing a home- and community-based services (HCBS) scorecard and Nursing Home scorecard as part of this process so clients can see which of the LTSS providers offers the best quality of care linked to the best client outcomes.

Evaluation of Prior-Year Performance:
A five-year strategy to improve long-term care population outcomes has not been completed. Governor Hickenlooper redirected the Department and the Department of Human Services to focus first on cooperating to improve efficiencies in the delivery of services to the developmentally disabled and inform the Joint Budget Committee and General Assembly in writing as efforts progressed. In addition, turnover of a position in the Department's Quality and Health Improvement Unit, as well as delay in filling a manager position in the LTSS Division, caused additional postponement of the development of a plan to improve health outcomes for the LTSS population.

Performance Measure 5C: Develop a Roadmap for Waiver Consolidation											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	1	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Strategy:
To establish a roadmap for waiver consolidation, the Department created a subcommittee of the Long-Term Care Advisory Committee (LTCAC) to work on a plan to consolidate waivers. The first subcommittee meeting was in August of 2012. The Department expects the roadmap will be established no later than March 2013 and will provide a detailed plan that lays out the key recommendations for consolidating the home- and community-based services (HCBS) waivers, key decisions, resource requirements, information technology system changes, stakeholder engagement process, suggested waiver amendments and renewals, and a timeline. The Department is currently working on procuring a contractor to provide technical assistance and develop the roadmap.

Evaluation of Prior-Year Performance:
The Department did not pursue waiver consolidation in FY 2011-12. It was essential to first establish the LTCAC then develop the strategic priorities in collaboration with the LTCAC. The LTCAC identified waiver consolidation as a priority in FY 2011-12.

Performance Measure 5D[1]: Percent of Dual-Eligibles Enrolled in the Accountable Care Collaborative for a Focal Point of Care											
Baseline Index FY 2010-11		Prior Year FY 2011-12		Current Year FY 2012-13		1-Year FY 2013-14		2-Year FY 2014-15		5-Year FY 2017-18	
Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
N/A	N/A	N/A	N/A	~~60%~~	N/A	~~70%~~	N/A	~~70%~~	N/A	~~70%~~	N/A

[1]*Measure discontinued effective FY 2012-13 due to dependency on federal funding.*

Strategy:
The Department's strategy for this measure is linked to federal funding via a Memorandum of Understanding (MOU) and contract with the Centers for Medicare and Medicaid Services for the Demonstration to Integrate Care for Dual Eligible Clients (demonstration project). Because of delays in development of the MOU and contract for the demonstration project, it will not be executed and implemented in January 2013 as originally anticipated; the expected implementation date is April 2013 or later. Upon implementation, the Department anticipates approximately 10,000 dual-eligible clients perm month will be enrolled in the demonstration project, resulting in a low percentage of dual-eligible clients being enrolled by the end of FY 2012-13 if the contract is awarded. There is no State budgetary impact because, if implemented, the demonstration project would be funded through a federal grant. This performance measure will be discontinued effective FY 2012-13 due to dependency on federal funding.

Evaluation of Prior Year Performance:
Not applicable. New measure effective FY 2012-13.

Colorado Health Care Affordability Act: Outlook FY 2009-10 to FY 2014-15	FY 2009-10 Actuals	FY 2010-11 Actuals	FY 2011-12 Actuals	FY 2012-13 Estimate	FY 2013-14 Request	FY 2014-15 Estimate [4]
A. Hospital Provider Fee Cash Fund Revenue						
Actual/Projected Revenue	$340,869,957	$441,057,840	$585,719,330	$660,973,618	$641,937,353	$601,987,234
Interest Earned	$900,117	$1,495,212	$816,861	$921,812	$895,264	$839,548
Other Income	$0	$0	$256	$0	$0	$0
Previous Year's Cash Fund Balance	N/A	$5,714,436	$22,198,436	$24,545,430	$3,721,241	$3,721,241
Hospital Provider Fee Cash Funds Available	**$341,770,074**	**$448,267,488**	**$608,734,883**	**$686,440,860**	**$646,553,858**	**$606,548,023**
B. Hospital Provider Fee Cash Fund Expenditures						
(1) Executive Director's Office - Total Prior to Bottom-Line Adjustments	**$1,321,599**	**$2,607,725**	**$6,073,833**	**$10,935,433**	**$11,644,412**	**$11,644,412**
(A) General Administration	$963,117	$1,444,283	$1,935,420	$2,535,659	$2,624,799	$2,624,799
(C) Information Technology Contracts and Projects	$127,872	$227,415	$2,349,409	$3,852,157	$4,471,996	$4,471,996
(D) Eligibility Determinations and Client Services	$225,111	$920,503	$1,731,383	$4,183,285	$4,183,285	$4,183,285
(E) Utilization and Quality Review Contracts	$5,500	$15,524	$57,620	$364,332	$364,332	$364,332
Bottom-Line Adjustments	$0	$0	$0	$0	$680,663	$470,707
(1) Executive Director's Office - Total After Bottom-Line Adjustments[1]	**$1,321,599**	**$2,607,725**	**$6,073,833**	**$10,935,433**	**$12,325,075**	**$12,115,119**
(2) Medical Service Premiums - Total Prior to Bottom-Line Adjustments	**$130,563,456**	**$222,581,532**	**$352,555,138**	**$451,641,588**	**$430,197,194**	**$392,226,682**
Expansion Populations	$1,212,199	$34,324,731	$48,544,623	$110,454,148	$82,481,221	$44,510,709
Supplemental Payments to Hospitals	$129,351,256	$188,256,800	$304,010,516	$341,187,440	$347,715,973	$347,715,973
Bottom-Line Adjustments	$0	$0	$0	$0	$1,302,405	$1,460,024
(2) Medical Services Premiums Request- Total After Bottom-Line Adjustments[1]	**$130,563,456**	**$222,581,532**	**$352,555,138**	**$451,641,588**	**$431,499,599**	**$393,686,706**
(3) Medicaid Mental Health Community Programs - Total Prior to Bottom-Line Adjustments	**$321,539**	**$3,843,622**	**$5,736,622**	**$14,819,227**	**$12,342,252**	**$8,588,140**
Expansion Populations	$321,539	$3,843,622	$5,736,622	$14,819,227	$12,342,252	$8,588,140
Bottom-Line Adjustments	$0	$0	$0	($25,124)	$1,618	$82,477
(3) Mental Health Request - Total After Bottom-Line Adjustments[1]	**$321,539**	**$3,843,622**	**$5,736,622**	**$14,794,103**	**$12,343,870**	**$8,670,617**
(4) Indigent Care Program - Total Prior to Bottom-Line Adjustments[2]	**$124,429,144**	**$135,692,180**	**$153,292,367**	**$164,342,735**	**$170,658,313**	**$172,348,580**
Children's Basic Health Plan Administration	$0	$6,974	$7,690	$9,361	$9,361	$9,361
Expansion Populations	$61,047	$4,817,287	$8,967,953	$13,988,082	$18,031,151	$19,721,418
Supplemental Payments to CICP Providers	$124,368,097	$130,867,920	$144,316,724	$150,345,292	$152,617,801	$152,617,801
Bottom-Line Adjustments	$0	$0	$0	$0	$0	$0
(4) Indigent Care Program- Total After Bottom-Line Adjustments[1]	**$124,429,144**	**$135,692,180**	**$153,292,367**	**$164,342,735**	**$170,658,313**	**$172,348,580**
(6) Department of Human Services Medicaid Funded Programs - Total Prior to Bottom-Line Adjustments	**$19,900**	**$0**	**$831,492**	**$305,760**	**$305,760**	**$305,760**
DHS: Colorado Benefits Management System	$19,900	$0	$831,492	$305,760	$305,760	$305,760
Bottom-Line Adjustments	$0	$0	$0	$0	$0	$0
(6) Department of Human Services Medicaid Funded Programs - Total After Bottom-Line Adjustments[1]	**$19,900**	**$0**	**$831,492**	**$305,760**	**$305,760**	**$305,760**
C. Other Expenditures	**$41,400,000**	**$61,343,993**	**$65,700,000**	**$40,700,000**	**$15,700,000**	**$15,700,000**
General Fund Relief	$41,400,000	$53,493,993	$50,000,000	$25,000,000	$0	$0
CICP General Fund	$0	$7,850,000	$15,700,000	$15,700,000	$15,700,000	$15,700,000
D. Provider Refunds	**$38,000,000**	**$0**	**$0**	**$0**	**$0**	**$0**
E. Base Total Fund Hospital Provider Fee Expenditures - Total Prior to Bottom-Line Adjustments	**$675,819,346**	**$902,424,375**	**$1,112,518,195**	**$1,340,802,404**	**$1,409,645,035**	**$1,464,606,106**
Total Bottom-Line Adjustments: Total Funds	**$0**	**$0**	**$0**	**($62,358)**	**$6,085,254**	**$6,449,448**
Final Total Fund Hospital Provider Fee Expenditures After Bottom-Line Adjustments	**$675,819,346**	**$902,424,375**	**$1,112,518,195**	**$1,340,740,046**	**$1,415,730,289**	**$1,471,055,554**
F. Base Hospital Provider Fee Expenditures - Total Prior to Bottom-Line Adjustments	**$336,055,638**	**$426,069,052**	**$584,189,452**	**$682,744,743**	**$640,847,931**	**$600,813,574**
Total Bottom-Line Adjustments: Hospital Provider Fee Cash Funds	**$0**	**$0**	**$0**	**($25,124)**	**$1,984,686**	**$2,013,208**
Final State Share After Bottom-Line Adjustments: Hospital Provider Fee Cash Funds	**$336,055,638**	**$426,069,052**	**$584,189,452**	**$682,719,619**	**$642,832,617**	**$602,826,782**
G. Cash Fund Reserve Balance [3]	**$5,714,436**	**$22,198,436**	**$24,545,430**	**$3,721,241**	**$3,721,241**	**$3,721,241**

Notes for Hospital Provider Fee Cash Fund: Outlook FY 2009-10 to FY 2014-15
[1] Long Bill Group totals for projected Hospital Provider Fee Cash Fund expenditures incorporate Change Requests. For more detail on the specific requests affecting Hospital Provider Fee Cash Fund expenditures, please refer to the Schedule 9 submitted with the Department's November 1, 2012, FY 2013-14 Budget Request.
[2] The Total Prior to Bottom-Line Adjustments for the Indigent Care Program Long Bill Group will not match that shown in the Indigent Care Program Expansions table of this report, as this summary includes the Children's Basic Health Plan Administration costs while the Expansion Populations table does not.
[3] The Department was granted authority by the Hospital Provider Fee Oversight and Advisory Board to create and maintain a reserve fund using unspent Hospital Provider Fee cash funds, although this policy is subject to annual reconsideration.
[4] Long Bill Group totals for FY 2014-15 will not match figures presented in the Schedule 9, which assumes constant expenditures after FY 2013-14. The population expenditures presented in this document are estimated separately throughout the forecast period.
[5] The sum of individual line items may not equal totals by Long Bill Group due to rounding.

Medical Services Premiums - Rate, Caseload, and Expenditure Forecast

		FY 2009-10 Actuals	FY 2010-11 Actuals	FY 2011-12 Actuals	FY 2012-13 Estimate	FY 2013-14 Request [4]	FY 2014-15 Estimate [4]
Medicaid Parents to 100% of the Federal Poverty Level [1]							
1	Per Capita Cost [1]	$748.73	$2,284.86	$2,653.31	$2,563.11	$2,627.50	$2,645.67
2	% Change Over Prior Year	N/A	205.17%	16.13%	-3.40%	2.51%	0.69%
3	Caseload [1]	3,238	27,166	35,461	42,531	47,351	49,210
4	% Change Over Prior Year	N/A	738.97%	30.53%	19.94%	11.33%	3.93%
5	**Total Fund Expenditures**	**$2,424,399**	**$68,649,463**	**$94,088,919**	**$109,011,510**	**$124,414,821**	**$130,193,207**
6	**Cash Fund Expenditures**	**$1,212,199**	**$34,324,731**	**$46,975,653**	**$54,505,756**	**$31,103,705**	**$0**
Buy-In Program for Individuals with Disabilities							
7	Per Capita Cost [2]	$0.00	$0.00	$8,330.90	$10,567.71	$10,909.60	$11,162.31
8	% Change Over Prior Year	N/A	N/A	N/A	26.85%	3.24%	2.32%
9	Per Client Premiums Contribution: Disabled Buy-In Cash Fund	$0.00	$0.00	$216.56	$1,500.33	$1,462.58	$1,451.26
10	Effective Per Capita Cost	$0.00	$0.00	$8,114.34	$9,067.38	$9,447.02	$9,711.05
11	Caseload [1]	0	0	52	2,183	5,465	8,367
12	% Change Over Prior Year	N/A	N/A	N/A	4098.08%	150.34%	53.10%
13	**Total Fund Expenditures**	**$0**	**$0**	**$433,207**	**$23,069,309**	**$59,620,971**	**$93,395,019**
14	**Cash Fund Expenditures - Hospital Provider Fee Cash Fund**	**$0**	**$0**	**$211,064**	**$10,778,485**	**$28,185,494**	**$44,510,709**
15	**Cash Fund Expenditures - Medicaid Buy-In Cash Fund [3]**	**$0**	**$0**	**$11,261**	**$3,275,210**	**$7,992,980**	**$12,142,700**
Adults without Dependent Children to 100% of the Federal Poverty Level							
16	Per Capita Cost [2]	$0.00	$0.00	$2,399.33	$9,033.98	$9,276.81	$9,530.37
17	% Change Over Prior Year	N/A	N/A	N/A	276.52%	2.69%	2.73%
18	Caseload [1]	0	0	1,134	10,000	10,000	10,000
19	% Change Over Prior Year	N/A	N/A	N/A	781.83%	0.00%	0.00%
20	**Total Fund Expenditures**	**$0**	**$0**	**$2,720,845**	**$90,339,815**	**$92,768,088**	**$95,303,701**
21	**Cash Fund Expenditures**	**$0**	**$0**	**$1,357,906**	**$45,169,907**	**$23,192,022**	**$0**
22	**Expansion Populations Total Funds Expenditures**	**$2,424,399**	**$68,649,463**	**$97,242,971**	**$222,420,634**	**$276,803,880**	**$318,891,927**
23	**Expansion Populations Hospital Provider Fee Cash Funds Expenditures**	**$1,212,199**	**$34,324,731**	**$48,544,623**	**$110,454,148**	**$82,481,221**	**$44,510,709**
24	**Supplemental Payments to Hospitals - Total Fund Expenditures**	**$312,468,739**	**$455,348,284**	**$608,021,031**	**$682,374,883**	**$695,431,946**	**$695,431,946**
25	**Supplemental Payments to Hospitals - Hospital Provider Fee Cash Fund Expenditures**	**$129,351,256**	**$188,256,800**	**$304,010,516**	**$341,187,440**	**$347,715,973**	**$347,715,973**
Total Fund Hospital Provider Fee Expenditures (Row 22 + Row 24)		**$314,893,138**	**$523,997,747**	**$705,264,002**	**$904,795,517**	**$972,235,826**	**$1,014,323,873**
State Share: Hospital Provider Fee Cash Funds (Row 23 + Row 25)		**$130,563,456**	**$222,581,532**	**$352,555,138**	**$451,641,588**	**$430,197,194**	**$392,226,682**

Notes for Medical Services Premiums - Rate, Caseload, and Expenditure Forecast

[1] Projected caseload and per capita expenditures for the Medicaid Parents to 100% FPL population are taken from Exhibit J of the Department's FY 2013-14 November 1, 2012 R-1. Caseload estimates for the Buy-In Program for Individuals with Disabilities are based on American Community Survey uninsured estimates analyzed by the Colorado Health Institute. The caseload estimates for the Adults without Dependent Children is annual average of the enrollment cap of 10,000 in the program.

[2] The description of how per capita costs were developed for the Buy-In Program for Individuals with Disabilities and Adults without Dependent Children can be found in the Medical Services Premiums Narrative submitted in the Department's November 1, 2012 Budget submission.

[3] The Medicaid Buy-In Cash Fund expenditures are based on the Medicaid Buy-In Program for Working Adults with Disabilities and Medicaid Buy-in program for Children with Disabilities premium schedules approved by the Medical Services Board. These expenditures are not eligible for a federal match.

[4] FY 2013-14 and FY 2014-15 fund splits assume that the 100% federal match provided under the Affordable Care Act beginning in CY 2014 will apply to the Medicaid Parents to 100% and Adults without Dependent Children populations, though the Department is awaiting federal guidance on this issue.

Medicaid Mental Health - Rate, Caseload, and Expenditure Forecast

		FY 2009-10 Actuals	FY 2010-11 Actuals	FY 2011-12 Actuals	FY 2012-13 Estimate	FY 2013-14 Request[2]	FY 2014-15 Estimate
Medicaid Parents to 100% of the Federal Poverty Level							
1	Per Capita Cost [1]	$233.86	$281.78	$287.26	$286.21	$296.90	$307.83
2	% Change Over Prior Year	N/A	20.49%	1.94%	-0.37%	3.74%	3.68%
3	Caseload[1]	3,238	27,166	35,461	42,531	47,351	49,210
4	% Change Over Prior Year	N/A	738.97%	30.53%	19.94%	11.33%	3.93%
5	**Total Fund Expenditures**	**$643,078**	**$7,687,244**	**$10,186,472**	**$12,172,798**	**$14,058,512**	**$15,148,314**
6	**Cash Fund Expenditures**	**$321,539**	**$3,843,622**	**$5,093,236**	**$6,086,399**	**$3,514,628**	**$0**
Buy-In Program for Individuals with Disabilities							
7	Per Capita Cost [1]	$0.00	$0.00	$1,763.06	$1,829.71	$1,940.64	$2,052.86
8	% Change Over Prior Year	N/A	N/A	N/A	3.78%	6.06%	5.78%
9	Caseload[1]	0	0	52	2,183	5,465	8,367
10	% Change Over Prior Year	N/A	N/A	N/A	4098.08%	150.34%	53.10%
11	**Total Fund Expenditures**	**$0**	**$0**	**$91,679**	**$3,994,257**	**$10,605,598**	**$17,176,280**
12	**Cash Fund Expenditures**	**$0**	**$0**	**$45,839**	**$1,997,128**	**$5,302,799**	**$8,588,140**
Adults without Dependent Children to 100% of the Federal Poverty Level							
13	Per Capita Cost[1]	$0.00	$0.00	$1,053.87	$1,347.14	$1,409.93	$1,475.33
14	% Change Over Prior Year	N/A	N/A	N/A	27.83%	4.66%	4.64%
15	Caseload[1]	0	0	1,134	10,000	10,000	10,000
16	% Change Over Prior Year	N/A	N/A	N/A	781.83%	0.00%	0.00%
17	**Total Fund Expenditures**	**$0**	**$0**	**$1,195,093**	**$13,471,400**	**$14,099,300**	**$14,753,300**
18	**Cash Fund Expenditures**	**$0**	**$0**	**$597,547**	**$6,735,700**	**$3,524,825**	**$0**
19	**Expansion Populations Total Funds Expenditures**	**$643,078**	**$7,687,244**	**$11,473,244**	**$29,638,455**	**$38,763,410**	**$47,077,894**
20	**Expansion Populations Hospital Provider Fee Cash Funds Expenditures**	**$321,539**	**$3,843,622**	**$5,736,622**	**$14,819,227**	**$12,342,252**	**$8,588,140**

Notes for Medicaid Mental Health - Rate, Caseload, and Expenditure Forecast

[1] Caseload projections are the same as those in the Medical Services Premiums exhibit. Projected per capita expenditures for the above populations are taken from the Department's FY 2013-14 November 1, 2012 R-2, Exhibit JJ.
[2] FY 2013-14 and FY 2014-15 fund splits assume that the 100% federal match provided under the Affordable Care Act beginning in CY 2014 will apply to the Medicaid Parents to 100% and Adults without Dependent Children populations, though the Department is awaiting federal guidance on this issue.

Indigent Care Program Expansions - Rate, Caseload, and Expenditure Forecast

		FY 2009-10 Actuals	FY 2010-11 Actuals	FY 2011-12 Actuals	FY 2012-13 Estimate	FY 2013-14 Request	FY 2014-15 Estimate
Children's Basic Health Plan Children's Medical and Dental Premiums from 205-250% of the Federal Poverty Level							
1	Per Capita Cost [1]	$986.38	$2,398.67	$1,894.36	$2,137.92	$2,381.93	$2,451.96
2	% Change Over Prior Year	N/A	143.18%	-21.02%	12.86%	11.41%	2.94%
3	Enrollment [1]	136	4,023	11,049	15,795	18,002	19,045
4	% Change Over Prior Year	N/A	2858.09%	174.65%	42.95%	13.97%	5.79%
5	**Total Fund Expenditures**	**$133,498**	**$9,628,000**	**$20,930,793**	**$33,768,446**	**$42,879,504**	**$46,697,544**
6	**Cash Fund Expenditures [2]**	**$46,724**	**$3,369,800**	**$7,325,778**	**$11,973,225**	**$15,263,046**	**$16,694,138**
Children's Basic Health Plan Prenatal Costs from 205-250% of the Federal Poverty Level							
7	Per Capita Cost [1]	$3,383.51	$15,199.81	$10,478.91	$10,944.36	$13,337.05	$13,729.16
8	% Change Over Prior Year	N/A	349.23%	-31.06%	4.44%	21.86%	2.94%
9	Enrollment [1]	11	272	448	526	593	630
10	% Change Over Prior Year	N/A	2372.73%	64.61%	17.48%	12.74%	6.24%
11	**Total Fund Expenditures**	**$37,219**	**$4,134,349**	**$4,691,931**	**$5,756,733**	**$7,908,871**	**$8,649,371**
12	**Cash Fund Expenditures [2]**	**$13,027**	**$1,447,022**	**$1,642,176**	**$2,014,857**	**$2,768,105**	**$3,027,280**
Children's Basic Health Plan Dental Costs from 205-250% of the Federal Poverty Level [3]							
13	Per Capita Cost	$27.23	N/A	N/A	N/A	N/A	N/A
14	% Change Over Prior Year	N/A	N/A	N/A	N/A	N/A	N/A
15	Enrollment	136	N/A	N/A	N/A	N/A	N/A
16	% Change Over Prior Year	N/A	N/A	N/A	N/A	N/A	N/A
17	**Total Fund Expenditures**	**$3,704**	N/A	N/A	N/A	N/A	N/A
18	**Cash Fund Expenditures**	**$1,296**	N/A	N/A	N/A	N/A	N/A
19	**Expansion Populations Total Fund Expenditures**	**$174,420**	**$13,762,349**	**$25,622,724**	**$39,525,179**	**$50,788,375**	**$55,346,915**
20	**Expansion Populations Cash Funds Expenditures**	**$61,047**	**$4,816,822**	**$8,967,953**	**$13,988,082**	**$18,031,151**	**$19,721,418**
21	**Safety Net Provider Payments: Supplemental Payments to Hospitals-Total Fund Expenditures**	**$248,736,194**	**$289,889,142**	**$288,633,447**	**$300,690,584**	**$305,235,601**	**$305,235,601**
22	**Safety Net Provider Payments: Supplemental Payments to Hospitals-Hospital Provider Fee Cash Fund Expenditures**	**$124,368,097**	**$130,867,920**	**$144,316,724**	**$150,345,292**	**$152,617,801**	**$152,617,801**
Total Fund Hospital Provider Fee Expenditures (Row 19 + Row 21)		**$248,910,614**	**$303,651,491**	**$314,256,171**	**$340,215,763**	**$356,023,976**	**$360,582,516**
State Share: Hospital Provider Fee Cash Funds (Row 20 + Row 22)		**$124,429,144**	**$135,684,742**	**$153,284,677**	**$164,333,374**	**$170,648,952**	**$172,339,219**

Notes for Children's Basic Health Plan Expansion - Rate, Caseload, and Expenditure Forecast

[1] Per capita costs and caseload figures for the Children's Basic Health Plan are taken from Exhibits C2 and C3 in the Department's November 1, 2012 FY 2013-14 R-3.

[2] Children's Basic Health Plan expenditures receive an enhanced federal match rate of 65%. Enrollment fees are included in the Cash Fund Expenditures shown, but are not eligible for a federal match. Please refer to Exhibits C2 and C3 in the Department's November 1, 2012 FY 2013-14 R-3 for more details on the cash fund splits.

[3] For FY 2010-11 forward, the Children's Basic Health Plan Medical and Dental Benefits costs were consolidated into one line item in the Department's budget.

Health Care Expansion Fund: Outlook FY 2008-09 to FY 2014-15

	FY 2008-09 Actuals	FY 2009-10 Actuals	FY 2010-11 Actuals	FY 2011-12 Actuals	FY 2012-13 Estimate	FY 2013-14 Estimate	FY2014-15 Estimate
A. Tobacco Tax Revenues							
Tax Revenue[1]	$159,334,567	$148,454,086	$145,575,930	$148,404,541	$147,163,575	$145,149,542	$143,164,785
B. Health Care Expansion Fund							
Transfer (46%)	$73,293,901	$68,288,879	$66,964,928	$68,266,089	$67,695,245	$66,768,789	$65,855,801
Interest Earned[2]	$4,589,248	$2,788,748	$1,580,284	$143,089	$134,314	$132,492	$132,260
Health Care Expansion Funds Available	$77,883,149	$71,077,627	$68,545,212	$68,409,177	$67,829,559	$66,901,281	$65,988,061
General Fund Transfers[3]	$0	($7,377,996)	($1,580,284)	($143,089)	$0	$0	$0
Net Health Care Expansion Funds Available to Support Program Expenses	**$77,883,149**	**$63,699,631**	**$66,964,928**	**$68,266,089**	**$67,829,559**	**$66,901,281**	**$65,988,061**
C. Health Care Expansion Fund Reserve Balance							
Previous Year's Reserve Fund Ending Balance	$130,653,130	$119,601,623	$79,234,953	$100,000	$99,998	$99,996	$232,486
Beginning Health Care Expansion Fund Reserve Balance	$135,721,615	$119,601,623	$79,234,953	$100,000	$99,998	$99,996	$232,486
Fund Required from the Reserve Balance in the Current Year	$16,119,995	$40,366,669	$79,134,953	$2	$2	($132,490)	($132,258)
Health Care Expansion Fund Year-End Reserve Balance	**$119,601,623**	**$79,234,953**	**$100,000**	**$99,998**	**$99,996**	**$232,486**	**$364,744**
D. Health Care Expansion Fund Expenditures							
(1) Executive Director's Office[4]	**$550,255**	**$964,806**	**$921,799**	**$0**	**$0**	**$0**	**$0**
(2) Medical Service Premiums	**$69,577,006**	**$65,813,605**	**$65,532,641**	**$68,266,089**	**$67,829,559**	**$66,768,789**	**$65,855,801**
(3) Medicaid Mental Health Community Programs	**$5,202,175**	**$6,047,643**	**$5,680,612**	**$0**	**$0**	**$0**	**$0**
(4) Indigent Care Program	**$18,093,822**	**$30,037,096**	**$25,708,044**	**$1**	**$1**	**$1**	**$1**
(6) Department of Human Services Medicaid Funded Programs	**$579,886**	**$541,738**	**$568,907**	**$1**	**$1**	**$1**	**$1**
General Fund Transfers[3]	**$0**	**$661,413**	**$47,687,878**	**$0**	**$0**	**$0**	**$0**
E. Total Health Care Expansion Fund Expenditures/Need[5]	**$94,003,144**	**$104,066,301**	**$146,099,880**	**$110,979,136**	**$117,226,208**	**$114,472,909**	**$111,871,301**
F. Total Health Care Expansion Fund Transfers	**$94,003,144**	**$104,066,301**	**$146,099,880**	**$68,266,091**	**$67,829,561**	**$66,768,791**	**$65,855,803**
G. Health Care Expansion Fund Populations Funding Shortfall	**$0**	**$0**	**$0**	**$42,613,047**	**$49,296,651**	**$47,471,632**	**$45,650,754**
H. Health Care Expansion Fund Reserve Balance - Increase / (Decrease)	**($16,119,995)**	**($40,366,669)**	**($79,134,953)**	**($42,713,047)**	**($49,396,649)**	**($47,571,628)**	**($45,883,240)**

Notes for Health Care Expansion Fund: Outlook FY 2008-09 to FY 2014-15

[1] Tobacco Tax revenue projections are taken from the June 2012 Amendment 35 Revenue Forecast published by Legislative Council.

[2] The interest rate used to project earnings for the fund is equal to the interest rate received in July 2012. Per SB 09-270, all interest earned on the balance of the Health Care Expansion Fund during FY 2008-09 through FY 2011-12 shall be transferred to the General Fund. The FY 2008-09 earned interest was not transferred to the General Fund until FY 2009-10.

[3] General Fund transfers for FY 2009-10 thru FY 2011-12 consists of the interest income earned, however FY 2009-10 also consists of an additional $1,293,900 which was transferred to the Medical Services Premiums line item, and a net amount of $3,956,761 due to audit adjustments. For FY 2010-11, the General Fund transfer also includes an amount of $47,687,878 to avoid payment delays.

[4] The Executive Director's Office appropriation was eliminated for FY 2011-12 forward pursuant to SB 11-209.

[5] For FY 2011-12 forward, the expenditures for Long Bill groups 2, 3, 4, and 6 are an estimate of what would be needed to support the expansion populations shown on Page R-2 of this Update.

[6] The impact of the enhanced Federal Medical Assistance Percentage (FMAP) provided under the American Recovery and Reinvestment Act of 2009 (ARRA) for FY 2008-09 through FY 2010-11 is incorporated into Long Bill Group totals on this page.

Health Care Expansion Fund Populations Expenditure History and Forecast

		FY 2008-09 Actual[7]	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Estimate	FY 2013-14 Estimate	FY 2014-15 Estimate
Expansion Adults to 60% FPL[1]								
1	Total Expansion Adults to 60% FPL Medical Services Premiums Expenditures	$34,055,796	$44,317,318	$60,314,804	$70,493,330	$77,128,585	$84,836,712	$87,541,334
2	**Total Expansion Adults to 60% FPL Expansion Fund Expenditures**	**$14,546,082**	**$17,022,282**	**$24,360,064**	**$35,246,665**	**$38,564,292**	**$42,418,356**	**$43,770,667**
3	% Change Over Prior Year	77.59%	30.13%	36.10%	16.88%	9.41%	9.99%	3.19%
4	Total Expansion Adults to 60% FPL Mental Health Expenditures	$3,111,446	$4,419,081	$5,636,127	$6,806,877	$8,189,899	$9,077,124	$9,670,172
5	**Total Expansion Adults to 60% FPL Expansion Fund Expenditures**	**$1,328,976**	**$1,697,424**	**$2,278,368**	**$3,403,438**	**$4,094,950**	**$4,538,562**	**$4,835,086**
6	% Change Over Prior Year	46.40%	42.03%	27.54%	20.77%	20.32%	10.83%	6.53%
Presumptive Eligibility[2]								
7	Total Presumptive Eligibility Expenditures	$3,461,490	$2,769,787	$3,494,317	$2,474,819	$2,293,491	$2,451,307	$2,611,433
8	**Total Presumptive Eligibility Expansion Fund Expenditures**	**$1,478,489**	**$1,063,875**	**$1,405,319**	**$1,237,410**	**$1,146,746**	**$1,225,654**	**$1,305,716**
9	% Change Over Prior Year	-42.15%	-19.98%	26.16%	-29.18%	-7.33%	6.88%	6.53%
HB 05-1086 Optional Legal Immigrants[3]								
10	Total Optional Legal Immigrants Medical Services Premiums Expenditures	$29,261,806	$31,549,557	$33,075,468	$33,894,110	$34,341,197	$34,811,490	$35,618,930
11	**Total Optional Legal Immigrants Expansion Fund Expenditures**	**$12,498,449**	**$12,118,185**	**$13,344,279**	**$16,947,055**	**$17,170,599**	**$17,405,745**	**$17,809,465**
12	% Change Over Prior Year	135.35%	7.82%	4.84%	2.48%	1.32%	1.37%	2.32%
13	Total Optional Legal Immigrants Mental Health Expenditures	$1,113,662	$1,301,623	$1,454,268	$1,616,105	$1,787,657	$1,954,720	$2,121,784
14	**Total Optional Legal Immigrants Expansion Fund Expenditures**	**$475,673**	**$499,953**	**$587,774**	**$808,053**	**$893,829**	**$977,360**	**$1,060,892**
15	% Change Over Prior Year		16.88%	11.73%	11.13%	10.62%	9.35%	8.55%
Asset Test Removal - Adults and Children[4]								
16	Total Asset Test Removal Medical Services Premiums Expenditures	$64,509,474	$66,400,818	$38,021,580	$28,856,493	$30,156,635	$32,317,569	$33,311,237
17	**Total Asset Test Removal Expansion Fund Expenditures**	**$27,553,609**	**$25,504,554**	**$15,225,763**	**$14,428,247**	**$15,078,318**	**$16,158,785**	**$16,655,619**
18	% Change Over Prior Year	12.66%	2.93%	-42.74%	-24.10%	4.51%	7.17%	3.07%
19	Total Asset Test Removal Mental Health Expenditures	$5,229,325	$5,950,880	$2,768,660	$2,087,291	$2,319,517	$2,657,580	$2,941,221
20	**Total Asset Test Removal Expansion Fund Expenditures**	**$2,233,575**	**$2,285,733**	**$1,106,433**	**$1,043,646**	**$1,159,759**	**$1,328,790**	**$1,470,611**
21	% Change Over Prior Year	7.33%	13.80%	-53.47%	-24.61%	11.13%	14.57%	10.67%
Children's Home- and Community-Based Services (CHCBS)[5]								
22	Total Children's Home- and Community-Based Services Medical Services Premiums Expenditures	$21,322,871	$20,552,304	$21,823,493	$21,794,736	$22,232,813	$23,282,201	$23,703,612
23	**Total Health Care Expansion Fund Expenditures**	**$9,107,531**	**$7,894,140**	**$8,784,174**	**$10,897,368**	**$11,116,407**	**$11,641,101**	**$11,851,806**
24	% Change Over Prior Year	36.37%	-3.61%	6.19%	-0.13%	2.01%	4.72%	1.81%
25	Total Children's Home- and Community-Based Services Mental Health Expenditures	$978,282	$992,182	$999,706	$961,297	$981,100	$1,040,554	$1,100,699
26	**Total Health Care Expansion Fund Expenditures**	**$417,849**	**$381,097**	**$402,637**	**$480,648**	**$490,550**	**$520,277**	**$550,350**
27	% Change Over Prior Year	70.74%	1.42%	0.76%	-3.84%	2.06%	6.06%	5.78%
Children's Extensive Support (CES)[5]								
28	Total Children's Extensive Support Medical Services Premiums Expenditures	$3,288,883	$3,329,475	$3,149,801	$3,171,621	$3,235,366	$3,388,073	$3,449,377
29	**Total Children's Extensive Support Expansion Fund Expenditures**	**$1,404,764**	**$1,278,851**	**$1,265,650**	**$1,585,811**	**$1,617,683**	**$1,694,037**	**$1,724,689**
30	% Change Over Prior Year	138.70%	1.23%	-5.40%	0.69%	2.01%	4.72%	1.81%
31	Total Children's Extensive Support Mental Health Expenditures	$114,920	$117,669	$109,070	$120,703	$123,189	$130,655	$138,207
32	**Total Children's Extensive Support Expansion Fund Expenditures**	**$49,085**	**$45,197**	**$43,915**	**$60,352**	**$61,595**	**$65,327**	**$69,103**
33	% Change Over Prior Year	35.09%	2.39%	-7.31%	10.67%	2.06%	6.06%	5.78%
34	Total Children's Extensive Support Developmental Disabilities Expenditures	$1,311,971	$1,410,409	$1,419,148	$1,450,454	$1,482,451	$1,515,154	$1,548,578
35	**Total Children's Extensive Support Expansion Fund Expenditures**	**$579,886**	**$541,738**	**$568,907**	**$725,227**	**$741,225**	**$757,577**	**$774,289**
36	% Change Over Prior Year	26.74%	7.50%	0.62%	2.21%	2.21%	2.21%	2.21%
Expansion Foster Care[6]								
37	Total Expansion Foster Care Medical Services Premiums Expenditures	$1,095,770	$2,425,715	$2,900,970	$3,548,405	$3,583,436	$3,594,910	$3,625,432
38	**Total Foster Care Expansion Fund Expenditures**	**$468,031**	**$931,717**	**$1,167,964**	**$1,774,203**	**$1,791,718**	**$1,797,455**	**$1,812,716**
39	% Change Over Prior Year	295.76%	121.37%	19.59%	22.32%	0.99%	0.32%	0.85%
40	Total Expansion Foster Care Mental Health Expenditures	$1,622,720	$2,963,392	$3,138,306	$3,032,416	$3,006,996	$2,963,412	$2,958,965
41	**Total Foster Care Expansion Fund Expenditures**	**$693,104**	**$1,138,239**	**$1,261,484**	**$1,516,208**	**$1,503,498**	**$1,481,706**	**$1,479,483**
42	% Change Over Prior Year	71.76%	82.62%	5.90%	-3.37%	-0.84%	-1.45%	-0.15%
Children's Basic Health Plan								
43	Total Children's Basic Health Plan Medical and Dental Expenditures	$49,698,138	$84,886,129	$70,099,006	$59,499,446	$62,271,541	$35,606,221	$19,145,169
44	**Total Children's Basic Health Plan Fund Expenditures**	**$17,394,348**	**$29,710,145**	**$25,509,652**	**$20,824,806**	**$21,795,039**	**$12,462,177**	**$6,700,809**
45	% Change Over Prior Year	20.07%	70.80%	-17.42%	-15.12%	4.66%	-42.82%	-46.23%

Total Health Care Expansion Fund Expenditures at Enhanced ARRA FMAP	**$90,229,452**	**$102,113,131**	**$97,312,384**	**$110,979,136**	**$117,226,208**	**$114,472,909**	**$111,871,301**

Notes for Expenditure History and Forecast

[1] Projected expenditures for the Expansion Adults to 60% FPL population are taken from the Department's November 1, 2012 FY 2013-14 R-1 and R-2.

[2] Expenditures for the Presumptive Eligibility population dropped significantly in FY 2011-12. For FY 2012-13 forward, expenditures are projected using an average of the first 24 months of monthly percentage changes for the population trended from the lower FY 2011-12 base level.

[3] The Optional Legal Immigrants population expenditure is forecast using an Ordinary Least Squares (OLS) regression model.

[4] Expenditures for the Asset Test Removal population dropped significantly in FY 2010-11 due to eligibility redeterminations which resulted in clients being reclassified out of asset test. For FY 2012-13 forward, the forecasts are based upon a methodology that estimates the amount of expenditures using a weighted average growth rate calculated using the caseload and per capita growth rates from the AFDC-Adults and Eligible Children populations included in the Department's November 1, 2012 FY 2013-14 R-1 and R-2. This is the same methodology used historically from a lower FY 2010-11 base level.

[5] Expenditure projections for the Children's Home- and Community-Based Services and Children's Extensive Support Waiver programs are based on the trends in the Disabled Individuals to 59 category from Exhibit C and Exhibit DD in the Department's November 1, 2012 FY 2012-13 R-1 and R-2, respectively, applied to the average per capita cost for these waiver clients.

[6] Foster Care Medical Services Premiums per capita costs are projected using the average of 24 months of year-over-year percentage changes since July of 2010 multiplied by the prior year. Foster Care Mental Health expenditures are projected using the same mental health per capita as the traditional Foster Care population from Exhibit DD in the Department's FY 2013-14 R-2. Foster Care caseload is projected using the same growth rates as the traditional Foster Care population.

[7] Total Medical Services Premiums and Mental Health expenditures from the Health Care Expansion Fund for individual populations as given on this page calculate the costs of expansion populations at the blended average FY 2008-09 FMAP of 57.29% and will not match the total on the Outlook Page, which is actual expenditure that accounts for the timing of expenditures over the year.

[8] Children's Basic Health Plan expenditures in this income range are expected to decrease beginning in January 2013 due to the implementation of SB 11-008 and SB 11-250, which increase Medicaid eligibility for children age 6 to 18 up to 133% FPL and pregnant women to 185% FPL, respectively.

FY 2013-14 Budget Request
Glossary and Acronyms

The Office of State Planning and Budgeting glossary can be found at http://www.colorado.gov/cs/Satellite/OSPB/GOVR/1218709346377

Acronym/Term	Description
1931 family	Section of the federal law (TANF) from which the Medicaid group eligibility is derived
300%ers	Persons whose income is up to three times the supplemental security income payment limit. This optional eligibility category is eligible for Medicaid by virtue of their need for long-term care services.
340B	340B is a federally administered program that allows covered entities to provide low priced outpatient prescription drugs to their patients.
AAA	Area Agency on Aging
AB	Aid to the Blind
ACA	Affordable Care Act- federal health care reform signed into law by President Obama on March 23, 2010. Also known as PPACA
ACC	Accountable Care Collaborative
ACF	Alternative Care Facility
ACS	Affiliated Computer Services, fiscal agent for Medicaid claims processing and reporting as of December 1999. Formerly known as Consultec. Now owned by Xerox State Healthcare.
ADA	Americans with Disabilities Act
ADLs	Activities of Daily Living
Adult Foster Care	This is not a Medicaid program or service; however, many adult foster care eligibles are also Medicaid eligible. This provides residential care with supervision for client medications, etc. It is funded through 95% General Fund and up to a 5% local match.
AED	Amortization Equalization Disbursement – increases the employer distribution to the PERA Trust Fund to authorize the unfunded liability beginning January 1, 2006.
AFC	Adult Foster Care
AFDC-A	Aid to Families with Dependent Children – Adults (a pre-welfare reform title, now replaced by Temporary Assistance to Needy Families - TANF)
AFDC-C	Aid to Families with Dependent Children – Children (a pre-welfare reform title, now replaced by Temporary Assistance to Needy Families - TANF)

Acronym/Term	Description
ALJ	Administrative Law Judge
Allowed Charge	The amount Medicare will consider for payment for a given service or supply
AMPS	Automated Medicaid Payment System - electronic claims system
Ancillary Services	Those services and supplies provided to patients on an as-needed basis
AND	Aid to the Needy Disabled
AND/AB	Combination of Aid to the Needy Disabled and Aid to the Blind. Individuals in these combined eligibility categories are aged 0 through 59 and meet SSI blindness and/or other disability criteria.
Annualization	An adjustment of partial year funding or the removal of one-time funding in an appropriation from the previous fiscal year to reflect appropriate funding for the full request year
ANSI	American National Standards Institute
AOA	Administration on Aging
AP	Assistance Payments
APCD	All-Payer Claims Database
APD	Advance Planning Document
ARRA	American Recovery and Reinvestment Act
ASC	Ambulatory Surgical Centers
ASO	Administrative Service Organization
AWP	Average Wholesale Price
BC-A	Baby Care Adults; a Medicaid eligibility category appropriated in the Long Bill
BCCP	Breast and Cervical Cancer Program; a Medicaid eligibility category appropriated in the Long Bill
BC-KC	Baby Care – Kids Care Program
BHO	Behavioral Health Organization; capitated contractual providers for Medicaid community mental health services, formerly Mental Health Assessment and Services Agencies (MHASAs)
BI	Brain Injury
BIDS System	Colorado procurement information system
BOA	Business Objects of America – an ad hoc reporting system used in Decision Support Systems
BRI	Base Reduction Item, a type of budgetary Change Request decreasing General Fund in an upcoming fiscal year.
BUS	Benefits Utilization System; a web-based system for long-term care eligibility assessments (the ULTC 100.2 form)

Acronym/Term	Description
CAH	Critical Access Hospitals
CAHPS	Consumer Assessment of Healthcare Providers and Systems - a health care customer satisfaction survey
CAPS	County Automated Payment System.
Carve-Out	A benefit or service that is not included under an otherwise global services agreement, such as the Medicaid mental health capitation program
CBHP	Children's Basic Health Plan
CBLTC	Community-Based Long-Term Care
CBMS	Colorado Benefits Management System
CCB	Community Centered Boards
CDSS	County Departments of Social Services
CCR	Code of Colorado Regulations
CDASS	Consumer Directed Attendant Support Services
CDCE	Consumer-Directed Care for the Elderly
CDF	Colorado Drug Formulary
CEDARS	Colorado Eligibility Disbursement and Reporting System
CELI-A	Categorically Eligible Low-income Adults; a Medicaid eligibility category appropriated in the Long Bill (previously AFDC-A)
CES	Children's Extensive Support (Home and Community-Based Services)
CF	Cash Funds.
CFE	Cash Funds Exempt. This represents cash funds transferred within the State, reported as Cash Funds Exempt to avoid double-counting funds, which would create a TABOR impact. This designation has been eliminated for FY 2008-09 and onwards and replaced with the designation Reappropriated Funds.
CFMC	Colorado Foundation for Medical Care, a Quality Improvement Organization
CFMS	County Financial Management System
CFR	Code of Federal Regulations
CGTS	Colorado Government Technology Service Division
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHCAA	The Colorado Health Care Affordability Act, also called the Hospital Provider Fee or HB 09-1293.
CHCBS	The Children's Home and Community-Based Services

Acronym/Term	Description
CHIPRA	Children's Health Insurance Program Reauthorization Act
CHP+	Child Health Plan *Plus*, also called Children's Basic Health Plan (CBHP)
CICP	Colorado Indigent Care Program
CIDS 2000	Client Information Data Subsystem for the 21st Century
CIVHC	The Center for Improving Value in Health Care
Class I Nursing Homes	Refers to general nursing facilities
Class II/IV Nursing Homes	Refers to nursing facilities for physically and developmentally disabled individuals
Class IV Nursing Homes	Regional centers for the developmentally disabled (operated by the Department of Human Services)
Clawback	A monthly payment made by the state to the federal Medicare program, roughly in the amount that the state would have spent on prescription drugs for dual eligible client in the absence of the MMA.
CMPN	Colorado Medicaid Provider Network
CMS	The Centers for Medicare and Medicaid Services, previously the federal Health Care Financing Administration (HCFA)
CNA	Certified Nurses Aide
CNS	County Nursing Service
CO-CHAMP	Colorado Comprehensive Health Access Modernization Program
CO/EBTS	Colorado Electronic Benefits Transfer Service
COFRS	Colorado Financial Reporting System
COHBE	Colorado Health Benefit Exchange
Coinsurance	The 20% of the allowed charge the beneficiary is responsible for paying on assigned Medicare beneficiaries
COLA	Cost of Living Adjustment
COLD	Computer Output to Laser Disk. One type of reporting system used by MMIS.
COLO R/X	Colorado Drug Formulary
Colorado Works	Colorado's Welfare Reform Program (the federal name is Temporary Assistance to Needy Families - TANF)
COmPASS	Colorado Community Personal Assistance Services and Supports federal grant
CORHIO	Colorado Regional Health Information Organization
COUP	Client Overutilization Program

Acronym/Term	Description
CPT	Current Procedural Terminology
CRICC	Colorado Regional Integrated Care Collaborative
CRS	Colorado Revised Statutes
C-SEAP	Colorado State Employee Assistance Program
CSHCN	Children with Special Health Care Needs
CSRA	Community Spouse Resource Assessment
CWEST	Child Welfare Eligibility and Services Tracking System
CW-FC	Child Welfare - Foster Care
CY	Calendar Year
DAC	Disabled Adult Child
DD	Developmentally Disabled
DDS	Disability Determination Services - agency that specializes in disability eligibility for both Social Security and Medicaid
DHMC	Denver Health Medical Center, formerly known as Denver General Hospital. Also known as Denver Health Medicaid Choice, the Denver County MCO
DHS	Colorado Department of Human Services
DI	Decision Item, a type of budgetary Change Request for additional General Fund in an upcoming fiscal year
Disabled	Supplemental Security Income Disabled Individuals; a Medicaid eligibility category appropriated in the Long Bill
DM	Disease Management
DME	Durable Medical Equipment
DMO	Disease Management Organization
DORA	Colorado Department of Regulatory Agencies
DPA	Colorado Department of Personnel and Administration
DPHE	Colorado Department of Public Health and Environment
DRA	The Deficit Reduction Act of 2005. A federal bill designed to slow the rate of spending growth for Medicare, Medicaid and Social Security.
DRG	Diagnosis Related Group, the basis for inpatient hospital reimbursement

Acronym/Term	Description
DSH	Disproportionate share hospital payments are for hospitals that serve a disproportionately large share of indigent clients.
DSS	Decision Support System
Dual eligible	A client eligible for both full Medicare and full Medicaid
DUR	Drug Utilization Review
EB	Enrollment Broker
EGUR	Evidence Guided Utilization Review
EHR	Electronic Health Records
EIS/DDS	Executive Information System/Decision Support System
Eligible	This refers to one full-time equivalent client for a defined period of time. Every person who is issued a Medicaid authorization card is called an "eligible." It does not refer to the number of clients who actually use a medical service.
Eligible Children	A Medicaid eligibility category appropriated in the Long Bill (previously AFDC-C/BC)
EP	Eligible Professionals
EOMB	Explanation of Medical Benefits
EPSDT	Early and Periodic Screening, Diagnosis and Treatment – Medicaid for clients up to age 21
EQRO	External Quality Review Organization
ESURS	Enterprise Surveillance Utilization Reporting System
FC	Foster Care
FFP	Federal Financial Participation – the percent of federal match
FFS	Fee-for-Service - non-capitated health care payment system
FFY	Federal Fiscal Year - October 1 through September 30
Figure Setting	A JBC meeting discussing a fiscal year budget request
Fiscal Agent	The contractor that processes claims for the Medicaid program, currently Xerox State Healthcare.
Fiscal Intermediary	An insurance company that manages Medicare claims and provides audit-reimbursement services for the Centers for Medicare and Medicaid Services to assure providers utilize program benefits appropriately.
Fiscal note	A report of the estimation of funds needed to finance a legislative bill.
FMAP	Federal Medical Assistance Percentage – the percent of federal match that the Centers for Medicare and Medicaid Services pays for Medicaid medical services.

Acronym/Term	Description
FPL	Federal Poverty Level – the federal poverty measure. Used with a percentage in determining eligibility, i.e. those with an income level below 185% of FPL may be eligible for certain Medicaid programs. Also called Federal Poverty Guidelines.
FQHC	Federally Qualified Health Center - health service facility for low income persons in a medically underserved area
FTE	Full-Time Equivalent employee
FY	Fiscal Year (State) - July 1 through June 30
GF	General Fund. The general fund is the state's primary operating fund. It is used to account for all financial resources except those required to be accounted for in another fund.
GFE	General Fund Exempt. Funding the State is allowed to retain above the Tax Payer Bill of Rights (TABOR) Revenue Limit as a result of the passage of Referendum C.
Goebel	Lawsuit initiated in 1981 on behalf of residents of northwest Denver with chronic mental illness claiming a denial of services
GSS	General Support Services, now the Department of Personnel and Administration
HB	House Bill (of Colorado General Assembly)
HB 09-1293	The Colorado Health Care Affordability Act, also called the Hospital Provider Fee
HCA	Home Care Allowance. Not a Medicaid program but part of the Maintenance of Effort agreement that allows Medicaid funding to continue to be received by Colorado.
HCBS	Home and Community-Based Services
HCBS-BI	Home and Community-Based Services – Brain Injury
HCBS-CES	Home and Community-Based Services - Children’s Extensive Support
HCBS-BI	Home- and Community-Based Services - Brain Injury
HCBS-Children’s	Home and community-based services waiver for children with physical disabilities
HCBS-CES	Home- and Community-Based Services - Children’s Extensive Services
HCBS-CHRP	Home- and Community-Based Services - Children’s Habilitation Residential Program
HCBS-CWA	Home- and Community-Based Services – Children with Autism
HCBS-DD	Home- and Community-Based Services - Developmental Disabilities
HCBS-EBD	Home- and Community-Based Services - Elderly, Blind, and Disabled
HCBS-MI	Home- and Community-Based Services - Mentally Ill
HCBS-PLWA	Home- and Community-Based Services - Persons Living with AIDS

Acronym/Term	Description
HCBS-PHW	Home- and Community-Based Services - Pediatric Hospice Waiver; also known as Children with Life Limiting Illness (CLLI)
HCBS-SCI	Home- and Community-Based Services – Spinal Cord Injury
HCBS-SLS	Home- and Community-Based Services - Supported Living Services (for persons with developmental disabilities)
HCPCS	Healthcare Common Procedure Coding System
HCPF	Colorado Department of Health Care Policy and Financing - Colorado's Single State Agency for Medicaid
Health Insurance Buy-In (HIBI)	Premium and coinsurance/deductible payments for private health insurance policies for Medicaid clients when it can be shown to be cost effective
HEDIS	Healthplan Employer Data and Information Set - a group of national measures used to compare health plans
HECF	Health, Environment, Children and Families – former name of a Senate Committee of the State Legislature
HEWI	Health, Environment, Welfare and Institutions – Committee of the State Legislature
HH	Home Health
HHA	Home Health Agency
HHS	Health and Human Services - federal agency
HIBI	Health Insurance Buy-In Program
HIE	Health Information Exchange
HIFA	Health Insurance Flexibility and Accountability federal waiver
HIPAA	Health Insurance Portability and Accountability Act of 1996 (HIPAA) – a federal Act that simplifies health care administration by standardizing medical data transactions, codes, and identifiers and provides additional protections to the privacy and security of personal health information.
HIT	Health Information Technology
HITECH	The Health Information Technology for Economic and Clinical Health Act of 2009
HMO	Health Maintenance Organization
Home Care Allowance	This is not a Medicaid program or service; however, most Home Care Allowance eligible are also Medicaid eligible. Services are for persons residing in their own homes and include personal care and supportive services. It is funded through 95% General Fund and up to a 5% local match

Acronym/Term	Description
Home Mod	Home Modification
Hospital Provider Fee	The Colorado Health Care Affordability Act, also called HB 09-1293
HRSA	Health Resources and Services Administration
IAPD	Implementation Advance Planning Document
IBNR	Incurred but not reported. Adjustments to future payments or claims based on the analysis of previous data patterns.
ICF	Intermediate Care Facility
ICFs/MR	Intermediate Care Facility - Mentally Retarded
IHSS	In-Home Support Services
IMAP	Information Management Annual Plan
IMC	Information Management Commission
Income trusts	Court approved trust used in Medicaid
Inpatient	Inpatient Hospital Care
IT	Information Technology
JBC	The Joint Budget Committee of the Colorado General Assembly
Lab/X-ray	Laboratory and Radiology Services
LAN	Local Area Network
LOS	Length of Stay
LPN	Licensed Practical Nurse
LTC	Long-Term Care
LTC-101	Long-Term Care Assessment Form
LTC-102	Monthly home- and community-based services non-diversion/termination report form
LTC-103	Home -and community-based services case plan form
LTC-104	Home- and community-based services case plan revision form
LTC-105	Home- and community-based services prior approval and cost containment form
LTC-106A	Client payment form for home- and community-based services - 300% non alternative care facility clients
LTC-106B	Client payment form for home- and community-based services - all alternative care facility clients
LTC-107	Home- and community-based services notice of service status/eligibility form
LTC-108	Home- and community-based services statement of services - claim form

Acronym/Term	Description
LTC-109	Home- and community-based services form for application of individual providers
LTC-110	Home- and community-based services form for monthly listing of new individual providers, re-certifications, de-certification
LTC-111	Home- and community-based services complaint information form
MA	Medical Assistance
MAC	Medicaid Administrative Claiming
MAC	Medicaid Authorization Card
MAC	Medical Advisory Council
MAC	Maximum Allowable Cost
MAGI	Modified Adjusted Gross Income
MCCS	Medicaid Coordinated Care System
MCO	Managed Care Organization
MCPI	Medical Consumer Price Index
MD	Medical Doctor
MDS	Minimum Data Set for resident assessment
MEDI-MEDI	Medicare-Medicaid Data Matching Project
Medicare	That portion of the Social Security Act which provides health care benefits to citizens over age 65 or under age 65 who are permanently disabled or suffering from chronic renal failure
Medicare Part A	That part of Medicare law providing for in-patient hospitalization, State nursing facility care, nursing facility benefits, and home health services to senior citizens
Medicare Part B	A supplement to Part A for physicians' services, outpatient hospital services, and other supplies. Waivers were granted in 1996 to enable use of resource utilization groupings for routine costs.
Medicare Part C	The Medicare Advantage, on managed care benefit
Medicare Part D	An optional prescription drug benefit for Medicare beneficiaries (not optional for dual eligibles) effective January 1, 2006
Mental Health	This refers to the mental health care provided through the community mental health services program
MEQC	Medicaid Eligibility Quality Control Unit
MHASA	See BHOs. Mental Health Assessment and Services Agency – Obsolete term referring to contractual providers for the mental health capitation program operated by the Department of Human Services.
MI	Medically Indigent

Acronym/Term	Description
MI	Mental Illness
MIA	Monthly Income Allowance
MMA	Medicare Modernization Act or the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003
MMIS	Medicaid Management Information System
MMMNA	Minimum Monthly Maintenance Needs Allowance
MOE	Maintenance of Effort Provisions
MORE	Maximizing Outreach, Retention, and Enrollment
MRI	Magnetic Resonance Imaging
MSR	Monthly Status Report required for ongoing cash assistance in the Temporary Assistance to Needy Families program
Needy Newborn	Babies born to mothers on Medicaid at the time of the baby's birth
NF	Nursing Facility
NFT	Nursing Facility Transitions federal grant
Non-citizens	Adults and/or children who have not established legal residence in the US and certain qualifications of legal immigrants who meet certain eligibility requirements; a Medicaid eligibility category appropriated in the Long Bill
Non-Prioritized Decision Items	A Change Request originating from one department but affecting the budget of a different department
NPI	National Provider Identifier – A standard under HIPAA that requires a single identification number for every health care provider.
OAB	The Hospital Provider Fee Oversight and Advisory Board
OAP-A (65+)	Supplemental Security Income Adults 65 and Older; a Medicaid eligibility category appropriated in the Long Bill (previously OAP-A SSI)
OAP-B (60-64)	Supplemental Security Income Adults 60 to 64; a Medicaid eligibility category appropriated in the Long Bill (previously OAP-B SSI)
OAP-SO	Old Age Pension - State Only health and medical benefits, can be Old Age Pension A or Old Age Pension B, but not necessarily disabled
OAP-SMP	Old Age Pension - State Medical Program; the current term for OAP-SO
OASDI	Old Age Survivors Disability Insurance

Acronym/Term	Description
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of Inspector General
OLTC	Options for Long Term Care
OMB	Office of Management and Budget (Federal)
OP	Outpatient
Option/Mandate	Certain Medicaid services are mandated by federal law as a condition of participating in the federal Medicaid program and certain others are optional for the states
OSA	Office of the State Auditor
OSPB	The Office of State Planning and Budgeting
OT	Occupational Therapy
OT/PT/ST	Occupational Therapy/Physical Therapy/Speech Therapy
Outpatient	Outpatient hospital services includes all hospital-based outpatient care ranging from emergency room to hospital based care
PACE	Programs of All Inclusive Care for the Elderly
PAPD	Planning Advance Planning Document
PAR	Prior Authorization Review
PARIS	The Public Assistance Reporting Information System
PASRR	Pre-Admission Screening and Annual Resident Reviews
PC	Personal Care
PCBH	Personal Care Boarding Home
PCCM	Primary Care Case Management
PCMP	Primary Care Medical Providers, also called Medical Homes
PCP	Primary Care Physician
PCPP	Primary Care Physician Program
PDL	Preferred Drug List. A utilization mechanism designed to control costs for drugs for clients who are using the Medical Assistance Program
PDN	Private Duty Nursing
PE	Presumptive Eligibility -Temporary eligibility for Medicaid and Child Health Plan *Plus* pregnant women, children or women enrolled in BCCP.
PEAK	Colorado Program Eligibility and Application Kit through CBMS for online eligibility applications

Acronym/Term	Description
PETI	Post Eligibility Treatment of Income
PERA	Public Employee Retirement Association
PERM	Payment Error Rate Measurement Program
PHP	Prepaid Health Plan
Pickle	Eligibility group named after the House sponsor of a 1977 amendment to the Social Security Act. Its intention is to reinstate Medicaid to former Supplemental Security Income recipients less cost of living adjustments.
PIHP	Prepaid Inpatient Health Plan
PIU	Program Integrity Unit
POC	Plan of Care
POTS	This is not an acronym. It is a term used for common policy allocations, appropriated to individual lines that in the next year show in Personal Services. Examples include Salary Survey; Health, Life, and Dental; Short Term Disability; and Performance-based Pay.
PPACA	The Patient Protection and Affordable Care Act - federal health care reform signed into law by President Obama on March 23, 2010. Also known as ACA.
PPS	Prospective Payment System
Prescription Drug	Includes payment for all drugs provided through Medicaid including those dispensed in nursing homes, but excluding those which are dispensed in the inpatient hospital setting
PRO	Peer Review Organization. The new CMS designation is QIO, Quality Improvement Organization
PRWORA	Personal Responsibility and Work Opportunity Act; a federal law also know as Welfare Reform on 1996
PT/ST	Physical Therapy/Speech Therapy
QA	Quality Assurance
QCIP	Quality of Care Incentive Program
QDWI	Qualified Disabled Working Individuals
QI-1	Medicare Qualified Individual 1
QI-2	Medicare Qualified Individual 2
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiary; a Medicaid eligibility category appropriated in the Long Bill
QMB – Dual	Qualified Medicare Beneficiary – who receives Medicaid and/or other insurance

Acronym/Term	Description
QMB - Only	Qualified Medicare Beneficiary – eligible for Medicare Part B premium, co-insurance and deductibles
RCCO	Regional Care Coordination Organizations
Reappropriated Funds (RF)	Funds originally appropriated to one department and subsequently transferred to another department. Replaces the designation of Cash Funds Exempt in FY 2009-10 onwards.
Rebate - Prescription Drugs	Medicaid prescription drug adjustment. Manufacturers rebate Medicaid drug expenses for certain items. The rebates are not accounted for in the Medicaid Management Information System and are handled manually through accounting transactions.
Referendum C	A voter-approved referendum suspending the Taxpayers' Bill of Rights (TABOR) and allowing the state to retain any budgetary surplus from June 30, 2006 to 2010.
Residential Program	The residential care provided for as part of the home and community based services for the developmentally disabled waiver.
ResQuIP	Resident Centered Quality Improvement Program
RFI	Request for Information
RFP	Request for Proposals
RHC	Rural Health Clinic
Ribicoff Children	Children age 6 to 19 born after September 30, 1983 – Eligibility category
RN	Registered Nurse
Roll-forward	Approval of a transfer of a fiscal year's unexpended funds to the subsequent fiscal year
RTC	Residential Treatment Center for children with behavioral problems
RUGs	Resource Utilization Groupings
SAVE	Systematic Alien Verification of Eligibility Program
SB	Senate Bill (of Colorado General Assembly)
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCRC	Systems Change for Real Choices federal grant
SDAC	The Statewide Data and Analytics Contractor
SED Sites	Satellite Eligibility Determination Sites
SEP	Single Entry Point
SFY	State Fiscal Year (see FY)
SHAP	State Health Access Program
SHEA	State Health Expenditure Account

Acronym/Term	Description
SIDMOD	State Identification Module
Single State Agency	Federal designation of one agency per state responsible for administration of Medicaid. The Department of Health Care Policy and Financing (HCPF) performs this function for Colorado.
SISC	Supplemental Security Income Status Code
SLMB or SLIMB	Special Low-Income Medicare Beneficiaries; a Medicaid eligibility category appropriated in the Long Bill
SMAC	State Maximum Allowable Cost
SMIB	Supplemental Medical Insurance Benefits
SMSA	Standard Metropolitan Statistical Area
SNAP	Supplemental Nutrition Assistance Program. Formerly called the Food Stamp Program. The federal Department of Agriculture provides funding for the program.
SNF	Skilled Nursing Facility
SPA	Single Purpose Application
SPA	State Plan Amendment
Spec	Specialty Physician
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSI Disabled	Supplemental Security Income Disabled Individuals, also referred to as “Disabled”
SSI Eligible	All who meet SSI guidelines are eligible for Medicaid
STARS	Services, Tracking, Analysis, and Reporting System; a historical system now replaced by BOA
SURS	Surveillance Utilization Review System
TABOR	The Taxpayers’ Bill of Rights
TANF	Temporary Assistance to Needy Families (changed from Aid to Families with Dependent Children in 1996; also referred to as Colorado Works)
TBI	Traumatic Brain Injury
TCN	Transaction Control Number; this is the unique number assigned by the Medicaid Management Information System to identify an individual claims
TCS	Transaction Code Sets ; the HIPAA standard that specifies formats and values that can be used during the electronic submission of data

Acronym/Term	Description
Telemedicine	Systems of electronic communication between patients and medical practitioners to coordinate patient care
TISI	Treatment of Institutionalized Spouse's Income
Title XIX	Social Security Act - Medicaid
Title XVIII	Social Security Act - Medicare
Title XXI	Social Security Act - Children's Health Insurance Plan
TM	Transitional Medicaid adults and adults with children leaving 1931 eligibility due to increased earned income who are guaranteed continuation of Medicaid under certain eligibility qualifications.
TPA	Third Party Administrator
TPL	Third Party Liability
TPR	Third Party Recovery
TRAILS	Children, Youth, and Families System, including Foster Care
TWWIIA	Ticket to Work, Work Incentives – federal provisions that permit states to create Medicaid buy-in programs
TWFC	Transfer Without Fair Consideration
UB04	Uniform billing 2004. Electronic form for submitting institutional claims.
ULTC-100	Uniform long-term care - client needs assessment tool form
ULTC-100.2	Uniform long-term care - client needs assessment tool form – updated. A web based system for long term care eligibility assessment used by Single Entry point Agencies and Community Center Boards
Under 21 Psych.	Private psychiatric hospital care for persons under age 21
Undocumented	See Non-citizens – eligible for emergency services only
UPEP	The Unified Provider Enrollment Process
UPL	Upper Payment Limit; a federal maximum payment used for federal financing
UR	Utilization Review
Vol. 8	Rules manual for Health Care Policy and Financing, also called the Code of Colorado Regulations Section 8
Waiver	A certain eligibility criteria that allows clients to apply for Medicaid who are not eligible under traditional Medicaid program categories or allows clients to receive services that are not part of the traditional Medicaid program.

Acronym/Term	Description
Wrap-Around Services	Medicaid services that are not covered by health maintenance organizations, but that are covered for Medicaid clients enrolled in health maintenance organizations by referral or direct access to fee-for-service Medicaid providers.
XSH	Xerox State Healthcare. The current vendor for managing MMIS.
YTD	Year-to-Date