Colorado Department of Health Care Policy and Financing

FY 2014-15 Performance Plan

November 1, 2013

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Table of Contents

INTRODUCTION

The Department of Health Care Policy and Financing is the federally designated Single State Agency to receive Medicaid (Title XIX) funding from the federal government for administration or supervision of the Medicaid program. As such, in order to receive federal financial participation, the Department is responsible for the provision of all health care services to persons who qualify as categorically needy under Title XIX of the Social Security Act. Most of the Department's programs are funded in part by the federal Centers for Medicare and Medicaid Services that provides roughly 50% of the Department's Medicaid budget and 65% of the funding for the Children's Basic Health Plan. The Department also provides health care policy leadership for the State's Executive Branch.

The Department oversees services and distributes administrative costs through interagency agreements with other departments. Because the Department is the Single State Agency designated to administer or supervise the administration of the Medicaid program, a number of statewide programs and services are financed through the Department's budget each fiscal year. Included in these programs and services are services for persons with developmental disabilities, mental health institutes, and nurse aide certifications.

The Department also receives Child Health Insurance Program (Title XXI) funding from the federal government for the Children's Basic Health Plan, marketed as Child Health Plan *Plus* or CHP+. CHP+ provides basic health insurance coverage for uninsured children and pregnant women of low-income families, and is a non-entitlement, non-Medicaid program that delivers coverage in accordance with the principles of private insurance. In addition to the Medicaid program and CHP+, the Department administers the following programs:

- The Old Age Pension State Medical Program provides limited medical care for individuals eligible for Old Age Pension grants.
- 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.
- The School Health Services Program provides reimbursement to qualified school districts that provide health services to children enrolled in Medicaid.
- The Primary Care Fund, which is funded by taxes on tobacco products, provides an allocation of moneys to health care providers that provide basic health care services in an outpatient setting to residents of Colorado who are considered medically indigent.

The statutory authority for the Department can be found at Title 25.5 of the Colorado Revised Statutes.

25.5-4-104, C.R.S. Program of medical assistance - single state agency

(1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

25.5-8-104, C.R.S. Children's basic health plan – rules

The medical services board is authorized to adopt rules to implement the children's basic health plan to provide health insurance coverage to eligible persons on a statewide basis pursuant to the provisions of this article. Any rules adopted by the children's basic health plan policy board in accordance with the requirements of the "State Administrative Procedure Act", article 4 of title 24, C.R.S., shall be enforceable and shall be valid until amended or repealed by the medical services board.

25.5-3-104, C.R.S. Program for the medically indigent established - eligibility – rules

(1) A program for the medically indigent is hereby established, to commence July 1, 1983, which shall be administered by the state department, to provide payment to providers for the provision of medical services to eligible persons who are medically indigent. The state board may promulgate rules as are necessary for the implementation of this part 1 in accordance with article 4 of title 24, C.R.S.

SMART Government Act

The State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act (House Bill 10-1119) established a performance-based budgeting system for Colorado. Section 2-7-201, et seq., C.R.S., requires departments to create performance plans outlining their goals, and describe how those goals will be evaluated through performance measures. Performance plans are to be readily available to legislators and the public, and contain the following components:

- A statement of the department's mission or vision;
- A description of the major functions of the department;
- Performance measures for the major functions of the department;
- Performance goals that correspond to the department's performance measures and that extend to at least three years into the future;
- A narrative description of the strategies necessary to meet the performance goals; and
- A summary of the department's most recent performance evaluation.

House Bills 11-1212 and 13-1299 amended the SMART Government Act requiring incorporation of continuous process improvement systems based on lean government principles. The Department has adopted process improvement as a strategic goal in its Performance Plan, and established a LEAN Community to drive innovative changes in work processes, deployment of staff, and organizational policy.

Strategic Management Process

In January 2012, the Department initiated a new Strategic Management Process which operates year-round to formulate, implement, and evaluate strategy. Strategy formulation activities in calendar year 2012 centered on development of a 5-year Strategy Map (see page 10) as the cornerstone of the Department's FY 2014-15 Performance Plan. In developing its Strategy Map, the Department recorded over 500 "touchpoints" or interactions with managers and staff who contributed to the development of goals, strategies and performance measures. External and internal assessments were completed to prioritize and distill themes from a Department analysis of strengths, weaknesses, opportunities and threats (SWOT). Distilled themes were mapped to six "lenses" commonly used across private, public, and non-profit sectors to evaluate business success: Customers; Communication; Technology; People; Process; and Financing. These lenses, paired with Department themes, formed the foundation for the Department's six strategic goals listed below, which are designed to ensure customer-focused performance management:

Goal I – Improve health outcomes, client experience and lower per capita costs **(Customer)**
Goal II – Sustain effective internal and external relationships **(Communications)**
Goal III – Provide exceptional service through technological innovation **(Technology)**
Goal IV – Build and sustain a culture where we recruit and retain talented employees **(People)**
Goal V – Enhance efficiency and effectiveness through process improvement **(Process)**
Goal VI – Ensure sound stewardship of financial resources **(Financing)**

The Department monitors progress toward performance measures through a continuous evaluation process. Details about strategy implementation and evaluation, with comparisons of actual results to benchmarks, are provided in the Strategic Policy Initiatives section of the Department's Performance Plan.

Department Performance Plan

Department Description

The Department Description contains the Department's mission and vision, organizational chart and major program descriptions. This section is designed to give the reader a basic understanding of the Department, its divisions, organizational structure, and major programs.

Strategy Map

Due to the cross-functional nature of teamwork within the Department, its FY 2014-15 Performance Plan follows the goal-based organization of its Strategy Map on page 10. The

Department's major functions are described in the Department Description, and are represented on the Strategy Map by strategies supporting each of the Department's six strategic goals. Goal I has an external customer focus, while Goals II through VI are designed to make the Department more efficient, customer-focused, and operationally effective.

Strategic Policy Initiatives

This section includes narratives about the Department's Strategic Policy Initiatives. Strategic Policy Initiatives are strategies for achieving key measures within Goal I to improve health outcomes, client experience and lower per capita costs. Logic model diagrams in this section link the Department's mission, vision and goals to strategies, objectives and performance measures. The tables in this section provide historical data for the preceding five years where available, and contain current-year and three-year benchmarks. Each table indicates whether a performance measure serves as an input, output or outcome, and the tables use arrows to show process flow.

5-YEAR STRATEGY MAP

VISION

The Coloradans we serve have integrated health care and enjoy physical, mental and social well-being.

MISSION

Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

GOALS

I. Improve health outcomes, client experience and lower per capita costs* (Customer)	II. Sustain effective internal and external relationships (Communications)	III. Provide exceptional service through technological innovation (Technology)	IV. Build and sustain a culture where we recruit and retain talented employees (People)	V. Enhance efficiency and effectiveness through process improvement (Process)	VI. Ensure sound stewardship of financial resources (Financing)

STRATEGIES

Logic Models & Implementation Plans

A. Integrated Delivery System	A. Internal Communications	A. Health Information Technology (HIT)	A. Workforce Development	A. Strategic Management Process (SMP)	A. Cost Containment Extpertise
B. Benefit / Program Design	B. External Communications	B. Collaboration & File Sharing	B. Employee Engagement	B. LEAN Community	B. Fraud, Waste & Abuse Prevention
C. Payment Methodology	C. Government Affairs		C. Human Resources Transformation	C. Tri-Agency & Interagency Collaboration	C. Grants Management
D. Eligibility & Enrollment			D. Revitalization		
E. Client Experience & Engagement					

5-Year Programmatic Performance Measures

1-Year Operational Performance Measures

**Adapted from the Institute for Healthcare Improvement's Triple Aim.*

STRATEGIC POLICY INITIATIVES

Strategy I.A.
Integrated Delivery System

Vision: The Coloradans we serve have integrated health care and enjoy physical, mental and social well-being

Mission: Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Goal: I. Improve health outcomes, client experience and lower per capita costs

Strategy I.A. Integrated Delivery System: Transform the health care delivery system from a traditional fee-for-service model to a regional, outcomes-focused, client/family-centered coordinated system of care.

Objectives

Accountable Care Collaborative	Access to Care	Integrated Care for Physical and Behavioral Health	Care Coordination

Performance Measures

1.A.1 Medicaid Clients Input	I.A.2 ACC Enrollees* Input/Output	I.A.3 ACC Enrollment Rate Outcome	1.A.4 ACC Enrollees w/ PCMP* Output
I.A.5 ACC Enrollees w/ PCMP Rate Outcome	1.A.6 Emergency Dept Visits per Thousand* Outcome	I.A.7 Hospital Readmission Rate* Outcome	I.A.8 Provider Applications Received Input
I.A.9 Provider Applications Activated Output	I.A.10 Medicaid Providers* Output		

*Shaded performance measures represent Strategic Policy Initiatives. Strategy descriptions and evaluations of prior year performance are included for these measures.

Strategic Policy Initiatives

- I.A.2-ACC Enrollees
- I.A.4-ACC Enrollees w PCMP
- I.A.6-Emergency Department Visits per Thousand
- I.A.7-Hospital Readmission Rate
- I.A.10-Medicaid Providers

I.A.2-ACC Enrollees and I.A.4-ACC Enrollees w PCMP

Strategy: The Accountable Care Collaborative (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. This is essential to improving clients' health and reducing costs. Medicaid clients in the ACC receive the regular Medicaid benefit package and belong to a Regional Care Collaborative Organization (RCCO). Medicaid clients also choose a Primary Care Medical Provider (PCMP). As a medical home, the PCMP coordinates and manages a client's health needs across specialties and along the continuum of care, which improves health outcomes through a coordinated, client-centered system and controls costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources.

Evaluation of Prior Year Performance (see table I.A.2 on page 15): Enrollment for FY 2012-13 exceeded expectations. All approved eligibility types are being enrolled each month; policy decisions about new enrollment populations are underway for FY 2013-14. Children's Medical Home providers were transitioned off of pay-for-performance reimbursement effective May 31, 2013 and are now enrolling in the ACC, along with their attributed members. In addition, the RCCOs have engaged in an aggressive provider contracting campaign to prepare for Medicaid expansion and other changes.

I.A.6-Emergency Department Visits per Thousand

Strategy: The Department's strategy for achieving the national Medicaid Health Maintenance Organization average of 744 Emergency Department visits per 1,000 clients is multi-pronged and includes the following activities:

- implementing this measure as a Key Performance Indicator (KPI) for the Accountable Care Collaborative (ACC) organizations;
- placing high Emergency Department utilizers into the Client Overutilization Program;
- evaluating results of Emergency Department visit reduction efforts in other states to determine what activities are the most effective;
- engaging hospitals and other providers in high-utilizing areas of the state to work with the Department in addressing client needs using less costly mechanisms of meeting their needs;
- investigating the possibility of expanding use of urgent care centers; and
- notifying providers when their clients use the Emergency Department for clients in the ACC program.

Evaluation of Prior Year Performance (see table I.A.6 on page 17): Emergency Department visits have increased since FY 2011-12. Preliminary data from December 2012 show 867 visits per 1,000 clients. Due to the six-month reporting lag time from the claims run-out period, FY 2012-13 data will be available in January 2014. The Department did not anticipate the recent trend among emergency departments and urgent care clinics to build capacity and advertise short wait times, and these efforts have impacted utilization. The Department has established an Accountable Care Collaborative Performance Improvement Advisory Committee, which continues to monitor this issue. The committee is working to resolve both clinical and administrative difficulties around efforts to decrease Emergency Department visits.

I.A.7-Hospital Readmission Rate

Strategy: For measuring the hospital readmission rate, "events" rather than "individuals" are counted for a period of 30 days using data from paid claims. The number of readmission events is divided by the number of all admission and readmission events, where "event" is an acute care inpatient admission or readmission to an acute inpatient hospital facility for adults or children. The Department is focused on several activities to impact the 30 day hospital readmission rate:

- 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 investigated the need for a statewide initiative focused on reducing readmissions. This resulted in a new performance measure for hospital quality incentive payments (HQIP) funded through the hospital provider fee.

Evaluation of Prior Year Performance (see table I.A.7 on page 17): FY 2011-12 actual 30 day all-cause hospital readmissions came in at 10.35%. This means that of all the hospital admissions that occurred during FY 2011-12, 10.35% resulted in a subsequent hospital admission. The Department set an ambitious goal of reducing hospital readmissions by 0.4 percentage points from the FY 2010-11 metric of 9.95% to 9.55%. Hospital readmissions often occur due to poor patient transition planning, including improper adherence to medication regimens. The Department sought to leverage the State's new Accountable Care Collaborative (ACC) program to address the hospital readmission problem.

The Accountable Care Collaborative was implemented at the beginning of FY 2011-12. However, the Regional Care Collaborative Organizations (RCCOs) that make up the ACC needed between six and nine months to become fully operational. The RCCOs have served as care management

entities since the inception of the ACC, but establishing such an organization involves significant start-up costs. As a result it was difficult for the RCCOs to begin their stated mission and achieve desired impacts until later in FY 2011-12.

An additional issue was operationalizing the Statewide Data and Analytics Contractor (SDAC) which provided crucial care management information to the RCCOs, including patient diagnoses and pharmaceutical data. The RCCOs use SDAC data to identify which patients need care transition assistance following a hospital stay. Though the SDAC was fully online and operational after only a six month start-up period, this meant the RCCOs were without access to critical patient information until early 2012.

New results for FY 2012-13 and beyond suggest that the RCCOs are making progress in the effort to reduce both 30-day all cause hospital readmissions and the subset of events known as potentially preventable readmissions. This is encouraging news. However, it may be the case that hospital readmission rates did not rise as much as the statistics indicate in FY 2011-12. The patient make-up of Colorado Medicaid changed substantially during FY 2011-12 as the adult without dependent children population became eligible. Because neither the benchmark nor the actual statistics were adjusted to reflect changes in case mix, demographics, or patient acuity, it is difficult to make a comparison between benchmarks and statistics calculated using dissimilar groups of people.

In general it is difficult to draw conclusions by comparing a single data point to a benchmark. This is because of inherent random fluctuations that permeate the utilization of healthcare services. The Department's best tool to combat these measurement issues is more frequent evaluations. With the SDAC in place today, hospital readmissions are tracked on a monthly basis. The healthcare data are expected to remain "noisy" in the future. However, more frequent evaluations provide for more data points, and with continued efforts to reduce readmission rates, progress with this performance measure is expected in the months and years to come.

I.A.10-Medicaid Providers

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. Since then, the Department's Regional Care Collaborative Organizations have been encouraging providers to join the Accountable Care Collaborative and become Medicaid providers. In addition, the Department's Clinical Services Office networks with providers and their professional organizations to continually recruit new providers.

Effective FY 2013-14, the Department modified its reporting methodology for counting the number of Medicaid providers. In prior years, only those providers with paid claims during the fiscal year were included. Because those who are enrolled as Medicaid providers yet saw no clients during the year still represent points of access for the Medicaid population, these providers are now included in the reporting methodology.

Evaluation of Prior Year Performance (see table I.A.10 on page 18): The Department saw a 9% increase in the number of enrolled Medicaid providers in FY 2012-13 from FY 2011-12. This is attributed to the efforts described above to recruit new providers, as well as to reimbursement rate increases. Section 1202 of the Affordable Care Act authorized a primary care rate bump that increased Medicaid rates to Medicare rates for two years effective January 1, 2013. Following this rate increase, the Department observed an increase in the number of providers and the number of clients they served. The flat growth in the number of providers between FY 2010-11 and FY 2011-12 was likely influenced by the FY 2011-12 budget reduction initiatives which reduced Medicaid provider rates.

Goal I. Customer	**Strategy I.A. Integrated Delivery System**		**Performance Measure I.A.1 Number of Medicaid Clients***					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Input	Medicaid Clients	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	356,711	N/A	412,854	N/A	465,881
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	513,653	N/A	568,576	672,741	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			851,108	--				
			*Medicaid Only Caseload (excludes dual-eligible clients). Source: Projections 2014-15 R-1 Exhibit B MMIS-DSS					
Goal I. Customer	**Strategy I.A. Integrated Delivery System**		**Performance Measure I.A.2 Number of Medicaid Clients Enrolled in the Accountable Care Collaborative***					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Output	ACC Enrollees	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	124,449	200,000	335,801	460,000	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			711,000	--				
			*Excludes dual-eligible clients					
Goal I. Customer	**Strategy I.A. Integrated Delivery System**		**Performance Measure I.A.3 Percent of Medicaid Clients Enrolled in the Accountable Care Collaborative***					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	ACC Enrollment Rate	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	24%	N/A	59%	68%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			84%	--				
			*Excludes dual-eligible clients					

Goal I. Customer	Strategy I.A. Integrated Delivery System		Performance Measure I.A.2 Number of Medicaid Clients Enrolled in the Accountable Care Collaborative*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Input	ACC Enrollees	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	124,449	200,000	335,801	460,000	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			711,000	--				

*Duplicated measure to show shift from output to input. Excludes dual-eligible clients

Goal I. Customer	Strategy I.A. Integrated Delivery System		Performance Measure I.A.4 Number of Accountable Care Collaborative Clients Assigned a Primary Care Medical Provider (PCMP)*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Output	ACC Enrollees w PCMP	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	254,946	368,000	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			639,900	--				

*Excludes dual-eligible clients

Goal I. Customer	Strategy I.A. Integrated Delivery System		Performance Measure I.A.5 Percent of Accountable Care Collaborative Clients Connected to a PCMP*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	ACC Enrollees w PCMP Rate	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	76%	80%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			90%	--				

*Excludes dual-eligible clients

Goal I. Customer	Strategy I.A. Integrated Delivery System		Performance Measure I.A.6 Number of Emergency Department Visits per 1,000 Medicaid Clients*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Emergency Dept Visits per Thousand	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	885	N/A	851
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	835	744	TBDJan14	744	--
			3 Year Goal FY 2015-16		*Benchmark of 744 based on Nov 2012 Nat'l Medicaid HMO Avg. Emergency Dept (ED) visits have gone up since FY 2011-12. As of Dec 2012, ED visits = 867/1,000 clients. Due to reporting lag time from the claims run-out period, FY 2012-13 data will be available in Jan 2014. No data available prior to FY 2009-10.			
			Benchmark	Actual				
			744	--				

Goal I. Customer	Strategy I.A. Integrated Delivery System		Performance Measure I.A.7 Percent of Hospital Readmissions Within 30 Days of Discharge Among Medicaid Clients*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Hospital Readmission Rate	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	10.29%	N/A	9.44%	N/A	9.95%
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			9.55%	10.35%	9.65%	TBDJan14	TBDJan14	--
			3 Year Goal FY 2015-16		*Due to reporting lag time from claims run-out period, FY 2012-13 data will be available in Jan 2014.			
			Benchmark	Actual				
			TBDJan14	--				

Goal I. Customer	Strategy I.A. Integrated Delivery System		Performance Measure I.A.8 Number of Provider Applications Received (Medicaid Fee-For-Service)					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Input	Provider Applications Received	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	4,219	4,641	--
			3 Year Goal FY 2015-16		*Growth rate projected for FY 2013-14 is 10% (sustained from FY 2012-13 due to impact of ACA and additional provider rate increases). Growth rate projected for FY 2015-16 is 5%.			
			Benchmark	Actual				
			4,873	--				

Goal I. Customer	Strategy I.A. Integrated Delivery System		Performance Measure I.A.9 Number of Provider Applications Activated (Medicaid Fee-For-Service)*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Output	Provider Applications Activated	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	3,668	3,945	--
			3 Year Goal FY 2015-16		*Of the total provider applications received, those not activated were either denied or pending additional information. Benchmarks = 85% of applications received.			
			Benchmark	Actual				
			4,142	--				

Goal I. Customer	Strategy I.A. Integrated Delivery System		Performance Measure I.A.10 Number of Providers Participating in Medicaid Fee-For-Service*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Output	Medicaid Providers	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	31,266	N/A	33,270	N/A	36,530
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	36,537	N/A	39,821	43,803	--
			3 Year Goal FY 2015-16		*Includes providers with active enrollment span even if no paid claims. Growth rate projected for FY 2013-14 is 10% (sustained from FY 2012-13 due to impact of ACA and additional provider rate increases). Growth rate projected for FY 2015-16 is 5%.			
			Benchmark	Actual				
			45,993	--				

Strategy I.B.
Benefit/Program Design

Vision: The Coloradans we serve have integrated health care and enjoy physical, mental and social well-being

Mission: Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Goal: I. Improve health outcomes, client experience and lower per capita costs

Strategy I.B. Benefit/Program Design: Design benefits and programs to improve health outcomes, client experience, and lower per capita costs.

Objectives

Benefits Collaborative-Defined Medical Services	Long-Term Services and Supports	Prenatal Care	Children's Health Outcomes

Performance Measures

I.B.1 New Benefit Coverage Standards* Output	I.B.2 Colorado Choice Transitions - Pipeline Input	I.B.3 Colorado Choice Transitions – Transitioned* Output	I.B.4 Long-term Care Clients Input
I.B.5 Long-term Care Clients - HCBS Output	I.B.6 Long-term Care Clients - HCBS Rate Outcome	I.B.7 Medicaid Children Under Age One Input	I.B.8 Well-Child Visits Under Age One* Output
I.B.9 Well-Child Visits Under Age One Rate Outcome	I.B.10 Medicaid Baby Deliveries Input	I.B.11 Medicaid Baby Deliveries with Prenatal Output	I.B.12 Medicaid Clients Receiving Timely Prenatal* Outcome
I.B.13 Medicaid Clients Receiving Postpartum Care* Outcome			

*Shaded performance measures represent Strategic Policy Initiatives. Strategy descriptions and evaluations of prior year performance are included for these measures.

Strategic Policy Initiatives

- I.B.1-New Benefit Coverage Standards
- I.B.3-Colorado Choice Transitions
- I.B.8-Well-Child Visits
- I.B.12-Percent of Medicaid Clients Who Received Timely Prenatal Care
- I.B.13-Medicaid Clients Receiving Postpartum Care

I.B.1-New Benefit Coverage Standards

Strategy: New Benefit Coverage Standards are achieved through the Benefits Collaborative. The Benefits Collaborative is a stakeholder-driven process for ensuring these standards are based on the best available clinical evidence; outline the appropriate amount, duration, and scope of services; set reasonable limits upon services; and promote the health and functioning of clients. By using the Benefits Collaborative to define benefit coverage standards and incorporate them into rule, the Department can ensure appropriate utilization, statewide equity, and consistency in the delivery of Medicaid services. Clearly defined standards help ensure proper payment for benefits, improve guidance for service providers, and ensure responsible allocation of taxpayer dollars. In addition, savings may be realized as a result of more appropriate utilization of benefits. Administrative overhead may be reduced by decreasing the number of appeals and improving the defensibility of Department decisions due to increased clarity of coverage.

Evaluation of Prior Year Performance: The Department nearly met its FY 2012-13 goal of incorporating 7 Benefit Coverage Standards into rule by reference. Eight standards were initially presented to the Medical Services Board during the year, one of which was approved in September 2012 and the remaining seven were approved in July 2013.

<table>
<tr><th>Goal I. Customer</th><th colspan="2">Strategy I.B. Benefit/ Program Design</th><th colspan="6">Performance Measure I.B.1 Number of Benefit Coverage Standards Defined through the Benefits Collaborative and Incorporated into Rule</th></tr>
<tr><td rowspan="11">Improve Health Outcomes, Client Experience and Lower Per Capita Costs</td><td rowspan="11">Output</td><td rowspan="11">New Benefit Coverage Standards</td><td colspan="2">5 Years Prior
FY 2008-09</td><td colspan="2">4 Years Prior
FY 2009-10</td><td colspan="2">3 Years Prior
FY 2010-11</td></tr>
<tr><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td></tr>
<tr><td>N/A</td><td>--</td><td>N/A</td><td>--</td><td>N/A</td><td>--</td></tr>
<tr><td colspan="2">2 Years Prior
FY 2011-12</td><td colspan="2">Prior Year
FY 2012-13</td><td colspan="2">Current Year Goal
FY 2013-14</td></tr>
<tr><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td></tr>
<tr><td>N/A</td><td>--</td><td>7</td><td>1</td><td>10</td><td>--</td></tr>
<tr><td colspan="2">3 Year Goal
FY 2015-16</td><td colspan="4" rowspan="3"></td></tr>
<tr><td>Benchmark</td><td>Actual</td></tr>
<tr><td>10</td><td>--</td></tr>
</table>

I.B.3-Colorado Choice Transitions

Strategy: The Colorado Choice Transitions (CCT) program is made by possible by a $22 million, five-year federal grant. The grant is designed to build the home- and community-based services (HCBS) infrastructure to assist residents of long-term care facilities who are appropriate for community-based care to transition and receive services in a home of their choice. Clients will receive additional services through CCT for one year in addition to traditional community-based services already available in the Medicaid HCBS programs. The CCT-specific services include case management, independent-living skills trainings, community-transition services, and other services to assist clients with establishing a residence in the community and to facilitate a greater sense of independence following discharge. To be eligible for the program, a client must currently reside in a nursing home or an Intermediate Care Facility for Persons with Intellectual and/or Developmental Disabilities and be Medicaid eligible.

Evaluation of Prior Year Performance: Colorado Choice Transitions had a late start due to information technology systems changes. The program officially launched April 1, 2013 and four individuals transitioned by June 30, 2013. By mid-August, CCT had received 198 referrals (pipeline); 147 of these individuals are working with transition coordinators to move out of a long-term care facility. Twenty-seven of these individuals have decided to use CCT to transition, and five have now transitioned through CCT. In the first few months, transitions took additional time to find housing and mobilize community resources. Based on feedback from the transition coordinators, locating affordable and accessible housing continues to be a major challenge. The Department is working closely with the Colorado Department of Local Affairs to establish additional options. Additionally, since this a new program, transition coordinators and case managers still have a learning curve with their new roles and responsibilities.

Goal I. Customer	**Strategy I.B. Benefit/ Program Design**		**Performance Measure I.B.2 Number of Persons in Transition Pipeline from Facility-Based to Community-Based Long-Term Care**					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Input	Colorado Choice Transitions - Pipeline	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	86	150	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			150	--				
Goal I. Customer	**Strategy I.B. Benefit/ Program Design**		**Performance Measure I.B.3 Number of Persons Transitioned from Facility-Based to Community-Based Long-Term Care**					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Output	Colorado Choice Transitions - Transitioned	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	100	4	100	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			100	--				

Goal I. Customer	Strategy I.B. Benefit/ Program Design		Performance Measure I.B.4 Number of Clients Receiving Long-Term Services and Supports (LTSS)*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Input	Long-term Care Clients	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	38,350	N/A	39,997	N/A	41,576
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	42,965	N/A	44,979	46,828	--
			3 Year Goal FY 2015-16		*Includes clients in waiver programs administered by HCPF and DHS; PACE; and Class I and II Nursing Facilities.			
			Benchmark	Actual				
			50,424	--				

Goal I. Customer	Strategy I.B. Benefit/ Program Design		Performance Measure I.B.5 Number of Clients Receiving Home- and Community-Based Waiver Services*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Output	Long-term Care Clients - HCBS	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	27,519	N/A	28,904	N/A	30,047
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	31,324	N/A	33,051	34,734	--
			3 Year Goal FY 2015-16		*Includes clients in waiver programs administered by HCPF and DHS.			
			Benchmark	Actual				
			37,699	--				

Goal I. Customer	Strategy I.B. Benefit/ Program Design		Performance Measure I.B.6 Percent of LTSS Clients Receiving Home- and Community-Based Waiver Services (HCBS)					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Long-term Care Clients - HCBS Rate	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	72%	N/A	72%	N/A	72%
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	73%	N/A	73%	74%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			75%	--				

I.B.8-Well-Child Visits

Strategy: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. Preventive services include but are not limited to:

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations (based on Advisory Committee on Immunization Practices)
- Laboratory tests (including lead toxicity screening)
- Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

As part of its Accountable Care Collaborative Program, the Department pays a per-member per-month (PMPM) amount to Regional Care Collaborative Organizations (RCCOs) and Primary Care Medical Providers (PCMPs). Beginning in July 2012, RCCOs and PCMPs began earning $1 PMPM based on their quarterly performance for three Key Performance Indicators (KPIs):

- Hospital All-Cause Thirty (30) Day Readmissions
- Emergency Room (ER) Visits
- High Cost Imaging Services

Beginning in FY 2013-14, the Department added well-child visits as a fourth KPI. The Department will be using the EPSDT 416 well-child methodology to align with federal standards. The Department and each RCCO will work with Healthy Communities to create and disburse consistent messaging about what a well-child visit is and when they can be done, with the ultimate goal of reaching the federal requirement of 80% of eligible children receiving at least one well-child visit within the measurement year.

Evaluation of Prior Year Performance (see table I.B.8 on page 24): While the number of well-child visits under age one decreased slightly in FY 2012-13, it is still well above the 80% federal expectation. As the Department continues to maintain a high percentage in this age group, another benchmarking option to consider for future years is the number of well-child visits recommended by the periodicity schedule for babies.

Goal I. Customer	Strategy I.B. Benefit/ Program Design		Performance Measure I.B.7 Number of Medicaid Children Under Age One*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Input	Medicaid Children Under Age One	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	21,373	N/A	20,669	22,709	--
			3 Year Goal FY 2015-16		*Based on children under 1 year of age in the EPSDT program eligible for 90 continuous days. Due to reporting lag time from claims run-out period, prior federal fiscal year data are used as a proxy for data reported during the current state fiscal year. Because the reporting methodology changed in FY 2011-12, prior-year data are unavailable. FY 2013-14 and FY 2015-16 benchmarks are based on budget caseload growth projections for eligible children in the AFDC-C/BC category, page EB-1, November 1, 2013 Budget Request for FY 2014-15.			
			Benchmark	Actual				
			25,832	--				

Goal I. Customer	Strategy I.B. Benefit/ Program Design		Performance Measure I.B.8 Number of Medicaid Children Receiving a Well-Child Visit in Their First Year of Life*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Output	Well-Child Visits Under Age One	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	20,504	N/A	19,372	20,341	--
			3 Year Goal FY 2015-16		*Based on children under 1 year of age in the EPSDT program. Due to reporting lag time from claims run-out period, prior federal fiscal year data are used as a proxy for data reported during the current state fiscal year. Because the reporting methodology changed in FY 2011-12, consistent prior-year data are unavailable. Projections for FY 2013-14 and FY 2015-16 assume a 5% and 3% increase, respectively, from their prior fiscal years.			
			Benchmark	Actual				
			20,951	--				

Goal I. Customer	Strategy I.B. Benefit/ Program Design		Performance Measure I.B.9 Percent of Medicaid Children Receiving a Well-Child Visit in Their First Year of Life*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Well-Child Visits Under Age One Rate	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	96%	N/A	94%	90%	--
			3 Year Goal FY 2015-16		*Based on children under 1 year of age in the EPSDT program eligible for 90 continuous days. Due to reporting lag time from claims run-out period, prior federal fiscal year data are used as a proxy for data reported during the current state fiscal year. Because the reporting methodology changed in FY 2011-12, prior-year data are unavailable. FY 2013-14 and FY 2015-16 benchmarks equal the quotient of I.B.8/I.B.7.			
			Benchmark	Actual				
			81%	--				

I.B.12-Percent of Medicaid Clients Who Received Timely Prenatal Care
I.B.13-Medicaid Clients Receiving Postpartum Care

Strategy: In 2009, the Department utilized the Benefits Collaborative process to develop a Maternity Services Benefit Coverage Standard. This process incorporated the best available clinical evidence to define sufficiency, amount, duration, and scope of Medicaid services thereby helping to ensure appropriate utilization of services. Medicaid's coverage standard clearly outlines Medicaid's coverage for prenatal and postpartum care. Clearly defined coverage standards provide assurance for persons receiving benefits that services meet established criteria, and provide clarification for service providers. The Maternity Services Coverage Standard will go through a review process in 2014, which will provide an opportunity to update coverage specific to prenatal and postpartum care using new clinical evidence.

In addition to ensuring medically appropriate coverage policies, the Department has implemented the Accountable Care Collaborative (ACC) program. As part of this evolving delivery system, Regional Care Collaborative Organizations, in collaboration with primary care medical providers (including OB/GYNs) manage the health of their members. While the ACC program has generated very positive results in its first years of operation, focused efforts on select populations, such as pregnant and postpartum women, will ensure continued improvement. For example, establishing linkages between programs and services such as the Nurse Family Partnership and the Prenatal Plus Program will be critical to improving clients' timely access to prenatal and postpartum care.

The Department has also undertaken a major effort to link birth certificate data to Medicaid claims data. These data will provide a much richer picture of client health and service utilization, and ultimately support the streamlining of practice as it relates to prenatal and postpartum care for individuals with Medicaid coverage.

Evaluation of Prior Year Performance (see tables I.B.12 and I.B.13 on page 26): The Department has shown improvement in Medicaid clients receiving timely prenatal care and postpartum care. Both measures are trending in the right direction, however, Colorado is still below the National Medicaid average of 83.7% and 64.4%, respectively, for both of these measures.

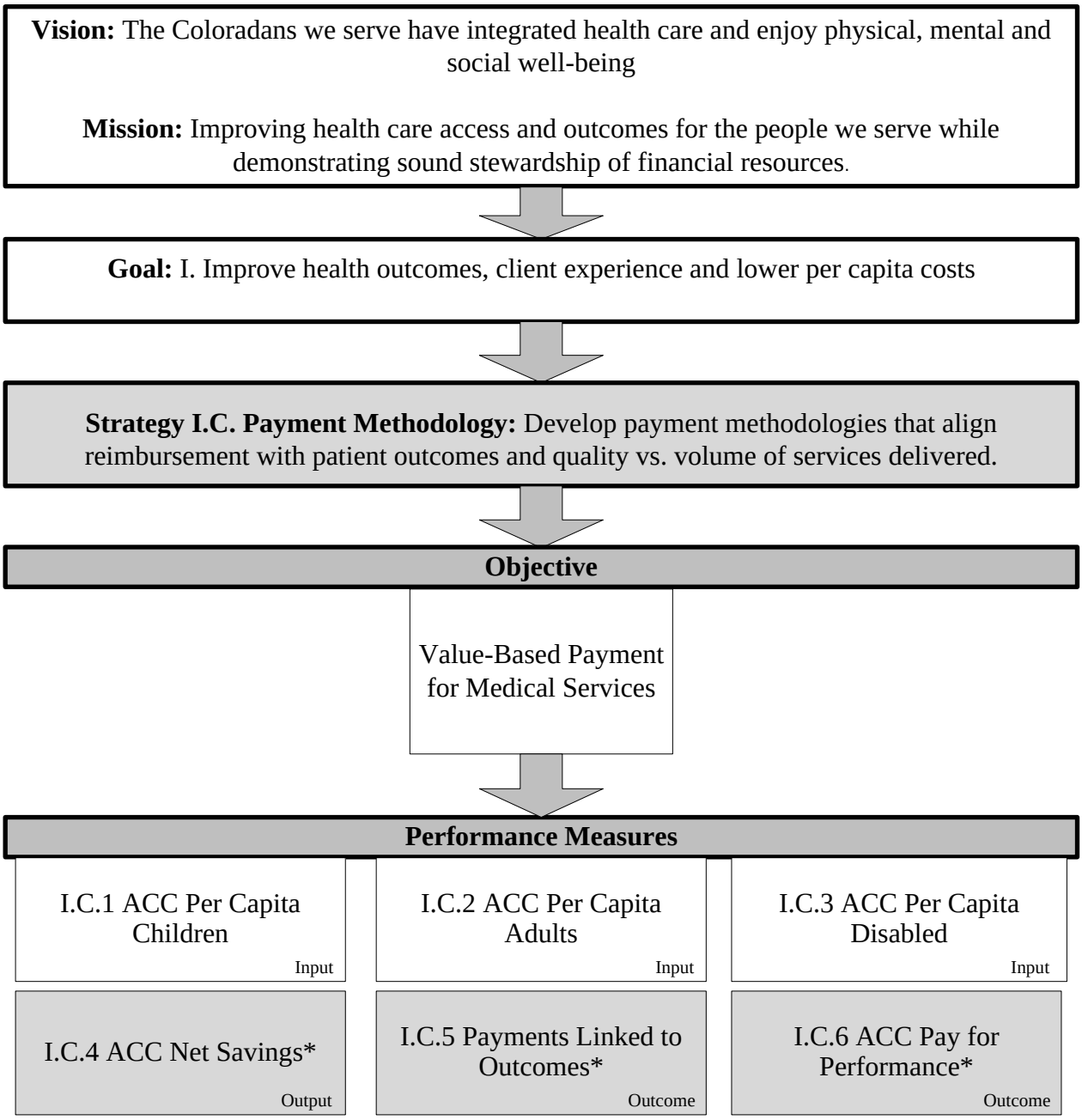
Goal I. Customer	Strategy I.B. Benefit/ Program Design		Performance Measure I.B.10 Number of Medicaid Baby Deliveries*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Input	Medicaid Baby Deliveries	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	25,552	N/A	25,953	N/A	26,101
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	25,095	N/A	24,458	25,432	--
			3 Year Goal FY 2015-16		*Projections for FY 2013-14 and FY 2015-16 are not functions of projected caseload growth, but equal the average number of deliveries over the preceding five years.			
			Benchmark	Actual				
			25,432	--				

Goal I. Customer	Strategy I.B. Benefit/ Program Design		Performance Measure I.B.11 Number of Medicaid Baby Deliveries with Prenatal Care*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Output	Medicaid Baby Deliveries with Prenatal Care	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	TBDJan14	--
			3 Year Goal FY 2015-16		*Projections for FY 2013-14 and FY 2015-16 will be based on birth certificate data. Historic actuals not available for prior years.			
			Benchmark	Actual				
			TBDJan14	--				

Goal I. Customer	Strategy I.B. Benefit/ Program Design		Performance Measure I.B.12 Percent of Medicaid Clients Who Received Timely Prenatal Care					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Medicaid Clients Receiving Timely Prenatal Care	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	56%	N/A	67%	N/A	65%
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	75%	N/A	78%	80%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			86%	--				

Goal I. Customer	Strategy I.B. Benefit/ Program Design		Performance Measure I.B.13 Percent of Medicaid Clients Who Received Postpartum Care					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Medicaid Clients Receiving Postpartum Care	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	54%	N/A	52%	N/A	60%
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	55%	N/A	61%	64%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			71%	--				

Strategy I.C.
Payment Methodology



*Shaded performance measures represent Strategic Policy Initiatives. Strategy descriptions and evaluations of prior year performance are included for these measures.

Strategic Policy Initiatives

- I.C.4-ACC Net Savings
- I.C.5-Payments Linked to Outcomes
- I.C.6-ACC Pay for Performance

I.C.4-ACC Net Savings

Strategy: Transitioning from a volume-based payment structure to a system that pays for value requires physician and health plan accountability and coordination. The goal of a value-based payment system is to support doctors with payments that incentivize them to provide optimal care for their patients in the most efficient setting, while avoiding duplicative services. A model that successfully implements these initiatives should result in lower medical costs and improved health outcomes. The Department supports the Accountable Care Collaborative (ACC) program as a first step toward this goal. A November 1, 2012 impact analysis of the ACC program shows reduced utilization rates for emergency room visits, hospital readmissions, and high-cost imaging services; lower rates of chronic health conditions such as asthma and diabetes; and reduced total cost of care for clients enrolled in the ACC program compared to clients not enrolled in the program. As of FY 2012-13, a portion of payments made to participating providers and care coordination entities is earned by achieving specific utilization targets and reducing total cost of care. Consequently, the program will demonstrate not only the impact of better care coordination, but also the effect of implementing payment methodologies that purchase value. This performance measure enables the Department to evaluate the impact of the ACC program on reducing expenditures for medical services while accounting for program investment.

Evaluation of Prior Year Performance (see table I.C.4 on page 31): In FY 2012-13, the Accountable Care Collaborative (ACC) program achieved between $44.3 million and $64 million in gross savings. This equates to net savings between $6.3 million and $26 million. The method used to arrive at these estimates compared costs for ACC enrollees against costs for clients not enrolled in the ACC. Rather than compare costs of the two groups in the same year, the Department used baseline cost data from before the implementation of the ACC and applied an actuarially-determined growth rate to account for medical inflation and create a benchmark for comparison. This model estimates a per- member per-month gross savings of:

- $9 for non-disabled children,
- $8 for non-disabled adults, and
- $213 for disabled adults and disabled children.

In FY 2011-12, the Department conservatively estimated $34 per member per month (PMPM) in gross savings across the ACC and estimates that this amount has decreased approximately 10% in past fiscal year as healthier clients (with lower health costs and hence lower potential cost savings) have been enrolled in the ACC in greater numbers. This equates to $30.60 PMPM in gross savings, totaling $44.3 million in gross savings – or $6.3 million net savings – in FY 2012-13.

I.C.5-Payments Linked to Outcomes

Strategy: The Department continues to implement initiatives that reestablish the connection between value-based outcomes and provider reimbursement. The Department is transitioning away from a pay-for-volume system to a pay-for-value system by creating financial incentives for providers to take on greater roles in maintaining and improving client health and medical service utilization. To date, Department initiatives include making incentive payments to providers for reduced emergency department utilization, reduced inpatient hospital utilization, reduced high-cost imaging usage, nursing facility pay-for-performance, and quality-based outcomes for hospitals.

Evaluation of Prior Year Performance (see table I.C.5 on page 31): The Department successfully paid its second incentive payment to Regional Care Collaborative Organizations (RCCOs) and Primary Care Medical Providers (PCMPs) in June 2013, and the transition of Children's Medical Homes from the pay-for-performance ("bump") to fee-for-service Medicaid was completed successfully on May 31, 2013. Program staff will continue to work with pediatric stakeholders and RCCOs through the end of CY13 on contracting and patient attribution issues, as well as the value proposition for pediatric practices in the Accountable Care Collaborative (ACC) program.

I.C.6-ACC Pay for Performance

Strategy: In July 2012, the Department began withholding one dollar of the per-member per-month (PMPM) capitation being paid to the ACC RCCOs and PCMPs for a pay-for-performance incentive plan. The RCCOs and PCMPs may recover this dollar if certain thresholds are achieved as measured by the four Key Performance Indicators (KPIs) below:

- Hospital All-Cause Thirty (30) Day Readmissions
- Emergency Room (ER) Visits
- High Cost Imaging Services
- Well Child Visits

Each KPI calculation is based on service utilization by the population enrolled in the ACC. Performance is measured as a percentage point improvement from the base period. To account for regional variation, each RCCO is 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: Level 1 savings indicate a 1-5% reduction in a particular KPI from the base period; and Level 2 savings indicate a greater than 5% reduction in a particular KPI relative to the base period. Incentive payments for each member are calculated based on performance of the region in which the member lives.

Evaluation of Prior Year Performance (see table I.C.6 on page 31): Currently, only two quarters of data are available on this measure. Data related to performance for the remainder of FY 2012-13 will be available January 2014.

Goal I. Customer	Strategy I.C. Payment Methodology		Performance Measure I.C.1 Per Capita Expenditures (Risk Adjusted) for Children Enrolled in the Accountable Care Collaborative*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Input	ACC Per Capita Children	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			$2,252	$2,134	$2,323	$2,208	$2,458	--
			3 Year Goal FY 2015-16		*Risk-adjusted per capita expenditures for children, adults, and clients with disabilities are calculated at the end of each fiscal year. Final actuals for FY 2013-14 and FY 2015-16 benchmark will be available on November 1, 2014.			
			Benchmark	Actual				
			TBDNov14	--				

Goal I. Customer	Strategy I.C. Payment Methodology		Performance Measure I.C.2 Per Capita Expenditures (Risk Adjusted) for Adults Enrolled in the Accountable Care Collaborative*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Input	ACC Per Capita Adults	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			$2,284	$2,181	$2,318	$2,243	$2,444	--
			3 Year Goal FY 2015-16		*Risk-adjusted per capita expenditures for children, adults, and clients with disabilities are calculated at the end of each fiscal year. Final actuals for FY 2013-14 and FY 2015-16 benchmark will be available on November 1, 2014.			
			Benchmark	Actual				
			TBDNov14	--				

Goal I. Customer	Strategy I.C. Payment Methodology		Performance Measure I.C.3 Per Capita Expenditures (Risk Adjusted) for Clients with Disabilities Enrolled in the Accountable Care Collaborative*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Input	ACC Per Capita Disabled	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			$17,885	$15,738	$18,772	$15,930	$20,658	--
			3 Year Goal FY 2015-16		*Risk-adjusted per capita expenditures for children, adults, and clients with disabilities are calculated at the end of each fiscal year. Final actuals for FY 2013-14 and FY 2015-16 benchmark will be available on November 1, 2014.			
			Benchmark	Actual				
			TBDNov14	--				

Goal I. Customer	Strategy I.C. Payment Methodology		Performance Measure I.C.4 Achieve the Annual Budgeted Net Savings Amount for the Accountable Care Collaborative*					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Output	ACC Net Savings	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	($2,708,711)	($5,929,725)	($6,300,000)	($12,000,000)	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			TBDNov14	--				

*Annual budgeted net savings benchmarks fluctuate by caseload mix – final estimates are provided each February.

Goal I. Customer	Strategy I.C. Payment Methodology		Performance Measure I.C.5 Percent of Medicaid Provider Payments Linked to Value-Based Outcomes					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Payments Linked to Outcomes	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	1.25%	1.56%	2.00%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			4.00%	--				

Goal I. Customer	Strategy I.C. Payment Methodology		Performance Measure I.C.6 Number of Regional Care Collaborative Organizations that Achieve Level 1 Pay for Performance Savings for All Key Indicators					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	ACC Pay for Performance	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	5	TBDJan14	TBDJan14	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			TBDJan14	--				

Strategy I.D.
Eligibility & Enrollment

Vision: The Coloradans we serve have integrated health care and enjoy physical, mental and social well-being

Mission: Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Goal: I. Improve health outcomes, client experience and lower per capita costs

Strategy I.D. Eligibility & Enrollment: Increase enrollment of eligible Coloradans in Medicaid and CHP+.

Objectives

- Timely Eligibility Determinations
- Expansion Population Coverage
- Interface with Marketplace

Performance Measures

I.D.1 Timely Eligibility Determinations*	I.D.2 Timely Eligibility Redeterminations*	I.D.3 Newly Eligible Medicaid Enrollment	I.D.4 Subsidized Insured
Outcome	Outcome	Output	Output

*Shaded performance measures represent Strategic Policy Initiatives. Strategy descriptions and evaluations of prior year performance are included for these measures.

Strategic Policy Initiatives

- I.D.1-Timely Eligibility Determinations
- I.D.2-Timely Eligibility Redeterminations

I.D.1-Timely Eligibility Determinations
I.D.2-Timely Eligibility Redeterminations

Strategy: The Department initiated a multi-pronged approach to achieve the benchmarks above in FY 2012-13, including:

- 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 that are not meeting percentage goals through weekly progress reports on the timeliness percentages so the Department can contact each site that is below the processing requirement to offer technical assistance and support;
- the development of additional reports on pending cases or cases identified within exceptions reports that need to be 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/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 (IEVS) interface that verifies client income through the Colorado Department of Labor and Employment. This initiative allows clients to self-declare their verifiable work income for all Medicaid programs, which decreases paperwork delays in processing complete applications and redeterminations;
- implementing the Social Security Administration (SSA) interface that verifies citizenship and identity for U.S. citizens. This initiative allows clients to self-declare their U.S. citizenship status for all Medicaid programs, which decreases paperwork delays in processing complete applications and redeterminations; and
- completing a case assignment system fix which assigned Family Medicaid/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 (see tables I.D.1 and I.D.2 on page 35): The Department increased the percentage of new medical assistance applications that meet timely processing requirements from 87% in FY 2011-12 to 94% in FY 2012-13. The percent of timely redeterminations increased from 86% in FY 2011-12 to 93% in FY 2012-13. To continue improving performance related to these measures, the Department is assisting county eligibility sites by training them on process improvements and implementing system changes within the Colorado Benefits Management System.

Goal I. Customer	Strategy I.D. Eligibility & Enrollment		Performance Measure I.D.1 Percent of All New Applications for Medical Assistance that Meet Timely Processing Requirements					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Timely Eligibility Determinations	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	87%	95%	94%	95%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			95%	--				

Goal I. Customer	Strategy I.D. Eligibility & Enrollment		Performance Measure I.D.2 Percent of All Redeterminations for Medical Assistance that Meet Timely Processing Requirements					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Timely Eligibility Redeterminations	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	86%	95%	93%	95%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			95%	--				

Goal I. Customer	Strategy I.D. Eligibility & Enrollment		Performance Measure I.D.3 Number of Newly Eligible Individuals Enrolled into Medicaid through the Connect for Health Colorado Marketplace					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Output	Newly Eligible Medicaid Enrollment	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	123,228	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			TBDJan14	--				

Goal I. Customer	Strategy I.D. Eligibility & Enrollment		Performance Measure I.D.4 Number of Individuals Enrolled into Subsidized Insurance through the Connect for Health Colorado Marketplace					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Output	Subsidized Insured	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	50,000	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			TBDJan14	--				

Strategy I.E.
Client Experience & Engagement

Vision: The Coloradans we serve have integrated health care and enjoy physical, mental and social well-being

Mission: Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Goal: I. Improve health outcomes, client experience and lower per capita costs

Strategy I.E. Client Experience & Engagement: Improve the health care experience of clients while encouraging individuals to actively participate in their own health and health care through prevention and wellness.

Objectives

- Children's Health Outcomes
- Healthy Living Initiatives
- Client Health Care Experience

Performance Measures

I.E.1 Medicaid Kids Dental* Outcome	I.E.2 CHP+ Kids Dental* Outcome	I.E.3 Tobacco Use* Outcome	I.E.4 CAHPS Global Ratings* Outcome
I.E.5 Adult Core Medicaid Quality Measures* Output	I.E.6 Phone Calls Answered Rate* Outcome	I.E.7 Phone Calls Abandoned Rate* Outcome	

*Shaded performance measures represent Strategic Policy Initiatives. Strategy descriptions and evaluations of prior year performance are included for these measures.

Strategic Policy Initiatives

- I.E.1-Medicaid Kids Dental
- I.E.2-CHP+ Kids Dental
- I.E.3-Tobacco Use
- I.E.4-CAHPS Global Ratings
- I.E.5-Adult Core Medicaid Quality Measures
- I.E.6-Phone Calls Answered
- I.E.7-Phone Calls Abandoned

I.E.1-Medicaid Kids Dental

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 (CMS) 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 implemented parts of the Action Plan on January 1, 2013. The Department had an external, comprehensive dental benefit review funded by Caring for Colorado which recommended changes to increase program efficiency. The Department will be vetting any changes through the stakeholder Benefits Collaborative process.

Evaluation of Prior Year Performance (see table I.E.1 on page 39): In FY 2012-13, approximately 51% of Medicaid children received a dental service, resulting in no increase since FY 2011-12. The Department anticipates improvement in the utilization of children's dental services once the Oral Health Care Action Plan described above is fully implemented.

Dental utilization estimates for Medicaid children are calculated from data provided to CMS for the Medicaid EPSDT CMS 416 report. The results represent the number of children continuously enrolled in Medicaid for at least 90 days who received a preventive dental service between October 1, 2011 and September 30, 2012. Due to the one-year lag in the data to evaluate this performance measure, the Department uses the most recently completed federal fiscal year as a proxy for data during the previous state fiscal year. This methodology may, however, understate the actual results, as older data cannot account for progress made during the actual measurement year.

I.E.2-CHP+ Kids Dental

Strategy: To increase the number of Children's Basic Health Plan (CHP+) members who have access to dental care and receive dental services, the Department has developed 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 includes strategies and tactics to increase oral health care benefit utilization by CHP+ members including preventive oral health care services. The Department implemented the Action Plan on July 1, 2013 and executed a new contract with Delta Dental of Colorado for administering and managing the CHP+ Oral Health Care Benefits Program. The goals, strategies, and tactics of the Action Plan are incorporated in this contract.

Evaluation of Prior Year Performance: In FY 2012-13, approximately 42% of CHP+ children received a dental service from a dental provider. This represents an increase of 2% over the previous year for CHP+ members receiving a dental service. The Department believes this is due largely to the efforts of the contractor reaching out to CHP+ members who had not recorded a dental claim in the previous nine months. The program expects further gains in utilization with the implementation of the CHP+ Oral Health Action Plan discussed above.

Dental utilization estimates are calculated from data provided by the CHP+ oral health contractor based on the methodology for the Medicaid EPSDT CMS 416 report. The results represent the number of children continuously enrolled in CHP+ for at least 90 days who received a preventive dental service between October 1, 2011 and September 30, 2012. Due to the one-year lag in the data to evaluate this performance measure, the Department uses the most recently completed federal fiscal year as a proxy for data during the previous state fiscal year. This methodology may, however, understate the actual results, as older data cannot account for progress made during the actual measurement year.

Goal I. Customer	**Strategy I.E. Client Experience & Engagement**		**Performance Measure I.E.1 Percent of Medicaid Children Age One and Older Receiving Preventive Dental Services**						
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Medicaid Kids Dental	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**		Due to reporting lag time from claims run-out period, prior federal fiscal year data are used as a proxy for data reported during the current state fiscal year. Prior year actuals were adjusted from those previously reported to focus on preventive services and exclude Medicaid children < 1 year of age. Data based on current methodology not available prior to FY 2010-11.
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	
			N/A	--	N/A	--	N/A	47%	
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**		
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	
			N/A	51%	N/A	51%	51%	--	
			3 Year Goal FY 2015-16						
			Benchmark	Actual					
			TBDJan14	--					

Goal I. Customer	**Strategy I.E. Client Experience & Engagement**		**Performance Measure I.E.2 Percent of CHP+ Children Age One and Older Receiving Preventive Dental Services**						
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	CHP+ Kids Dental	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**		Due to reporting lag time from claims run-out period, prior federal fiscal year data are used as a proxy for data reported during the current state fiscal year. Prior year actuals were adjusted from those previously reported to focus on preventive services and exclude Medicaid children < 1 year of age. Data based on current methodology not available prior to FY 2011-12.
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	
			N/A	--	N/A	--	N/A	--	
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**		
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual	
			N/A	40%	42%	42%	44%	--	
			3 Year Goal FY 2015-16						
			Benchmark	Actual					
			TBDJan14	--					

I.E.3-Tobacco Use

Strategy: The Medicaid program in Colorado now has a comprehensive tobacco cessation benefit, including coverage of all U.S. Food and Drug Administration approved tobacco cessation products and medications for two quit attempts per year, as well as referrals to the Colorado QuitLine for coaching and support. A summary of actions taken to impact this measure include:

- The Department released tool kits for providers, which give guidance on billing and reimbursement for addressing tobacco use in the primary care setting.
- The Department increased collaboration between its staff and the Colorado Department of Public Health and Environment (CDPHE) regarding the QuitLine, which led to an expansion of outreach efforts to Medicaid clients encouraging them to call the QuitLine for support.
- The Centers for Medicare and Medicaid Services now allows for federal matching funds to reimburse the QuitLine for services provided to Medicaid clients.
- The Medicaid customer service line will soon link callers directly to the QuitLine if they respond to a prompt which says, "Call the QuitLine now for help if you want to quit smoking".
- Pregnant women are now eligible for individual tobacco cessation counseling throughout pregnancy and the postpartum period.

Evaluation of Prior Year Performance: The efforts in FY 2012-13 made little to no impact on the number of Medicaid clients who use tobacco products daily or occasionally. The goal for next year is to reduce tobacco usage by 2.4%. In FY 2013-14 the Department will start getting RCCO-specific data for members which will lead to greater outreach in a medical home model. RCCOs are working with their providers to provide tobacco cessation medications, while care coordinators are working with clients to provide additional supports around this effort.

Additionally, CDPHE is working on funding for 12 new community programs for 24 additional counties. All grantees were provided continuing guidance and were recommended by the Tobacco Review Committee for annualized funding over the FY 2012-13 dollar amounts. Staff from the tobacco program reviewed and approved each of the scopes of work.

Goal I. Customer	**Strategy I.E. Client Experience & Engagement**		**Performance Measure I.E.3 Percent of Medicaid Adults Who Report Using Tobacco Everyday or Some Days**					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Tobacco Use	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	28%	N/A	27%	25%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			23%	--				

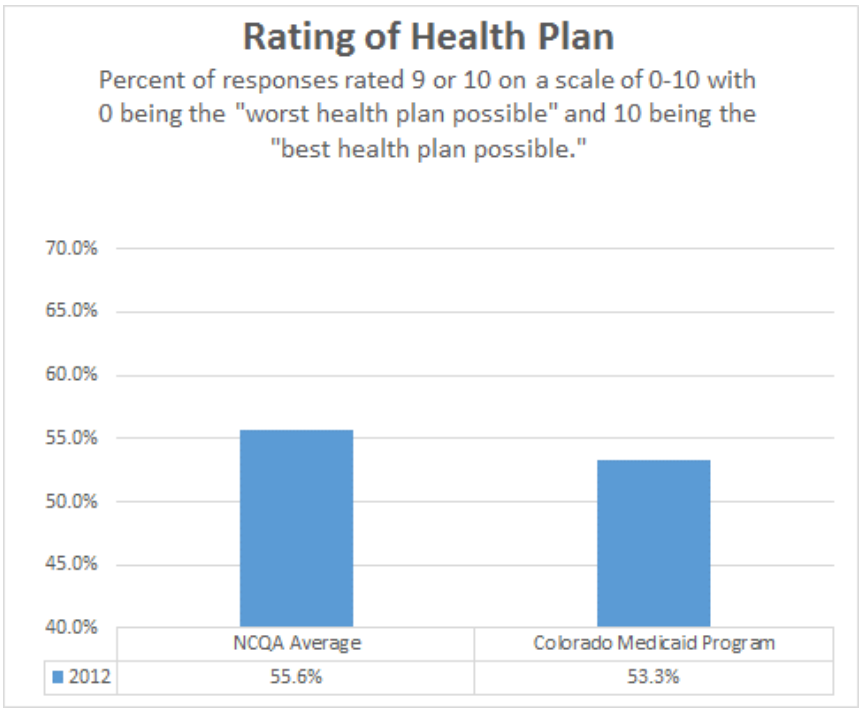
I.E.4-CAHPS Global Ratings

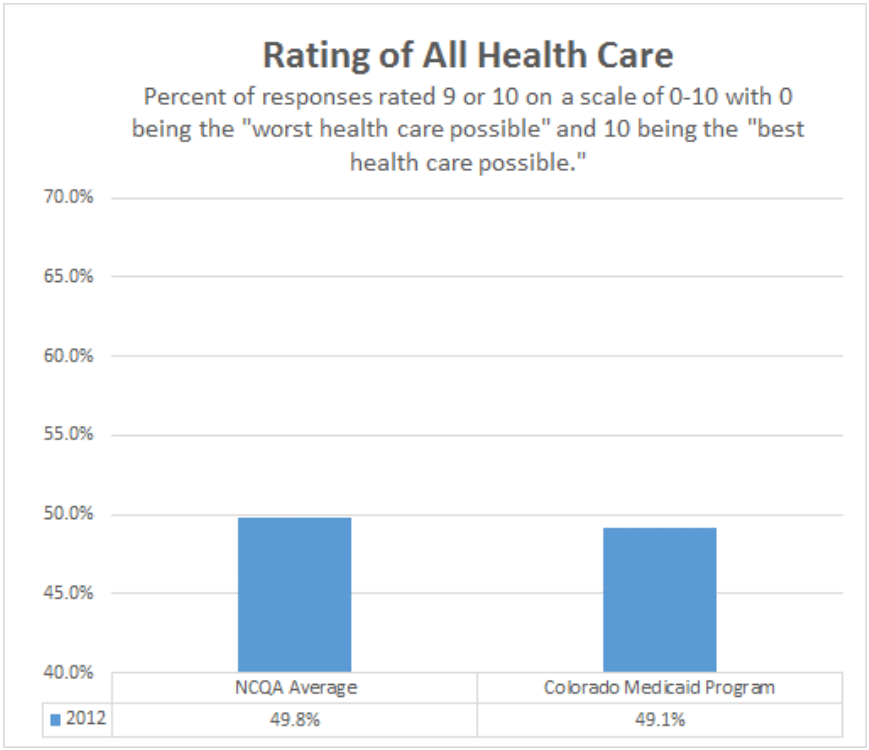
Strategy: To improve the overall health care experience of clients, the Department uses a client satisfaction survey – the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Annual Client Satisfaction Report for Adults in Medicaid[1]. The CAHPS survey allows clients who recently interacted with the Department to gauge their experience and provide input regarding satisfactory outcomes and suggested areas of improvement. The survey includes four global ratings measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. Ratings for each of these measures for the Colorado Medicaid Program are derived from the combined results of the four Colorado Medicaid plans: Fee-for-Service (FFS), Primary Care Physician Program, Denver Health Medicaid Choice, and Rocky Mountain Health Plans. The Department uses the results of the CAHPS survey to identify opportunities to improve client service experience and implement appropriate changes through its contracts for health care services.

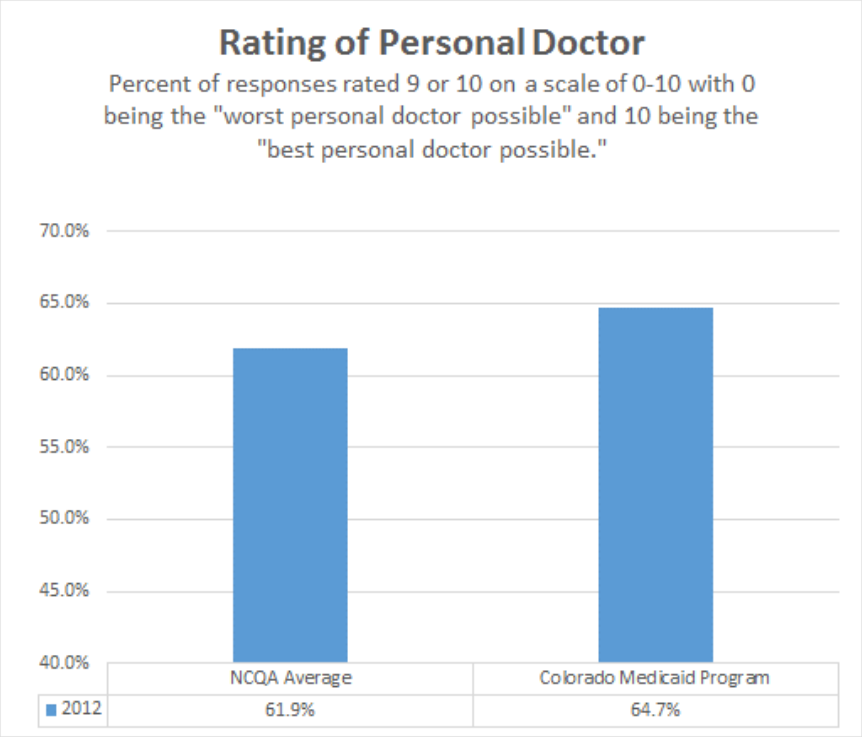
Evaluation of Prior Year Performance (see tables below and I.E.4 on page 44): The charts below, from the 2013 Adult Medicaid Client Satisfaction Report, show two of the four global ratings measures (50%) were at or above the national average in 2012 as reported by the National Committee for Quality Assurance (NCQA). These two measures were Rating of Personal Doctor and Rating of Specialist Seen Most Often. The two measures falling just below the national average were Rating of Health Plan and Rating of All Health Care. A joint project between the Department and the Colorado Health Institute (CHI) to administer CAHPS at the Regional Collaborative Care Organization (RCCO) level was completed in the summer of 2013 in order to get baselines and comparisons between traditional FFS and RCCO members. The results will enable the Department to measure patient experience and satisfaction within the Accountable Care Collaborative model being used by the seven state RCCO's.

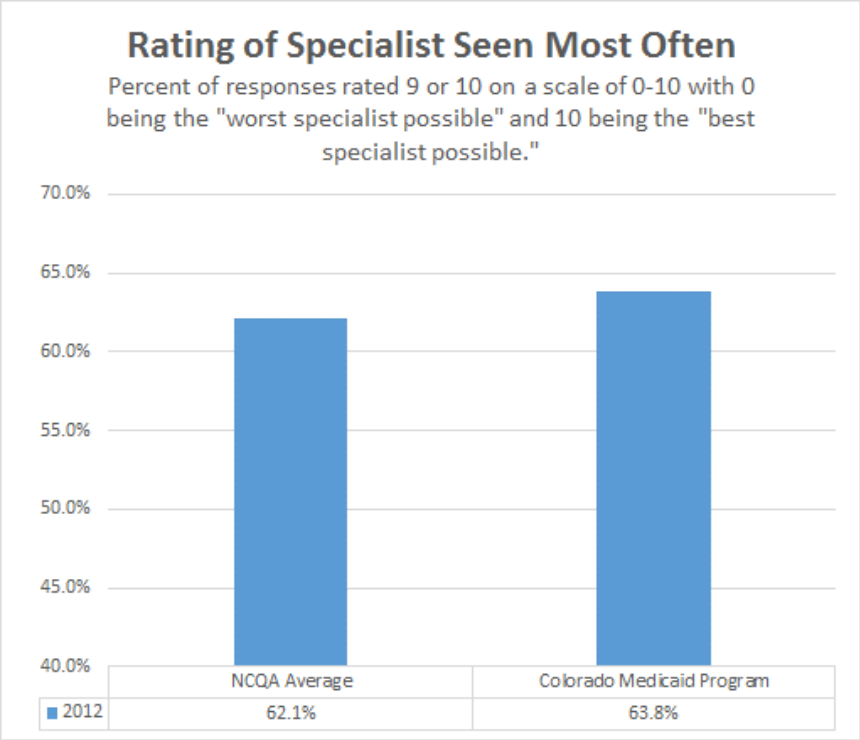
FY 2013-14 performance note: In the fall of 2012 discussions were initiated with the Centers for Medicare and Medicaid Services (CMS) to determine the surveys to be used for different populations for the 2013 CAHPS. In October it was determined that a special supplemental survey was to be administered to Child Medicaid-Children with Chronic Conditions. Due to the increased burden and short notice for the Colorado Managed Care Plans (Denver Health and Rocky Mountain) to administer this supplemental survey, they were relieved of conducting an Adult Medicaid CAHPS survey. The result was that the Adult CAHPS scores are for Fee For Service (FFS) and the Primary Care Physician Program (PCPP) only and will not include any scores from Denver Health Medicaid Choice (DHMC) or Rocky Mountain Health Plans (RMHP) for the 2013 survey. This may need to be considered when scores are compared to the national averages next year.

[1] National Medicaid Average scores are reported by the NCQA each calendar year. As of November 1, 2013, the most recent national averages available were for CY 2012. Due to the one-year lag in the data for national averages, the Department uses CY 2012 ratings for the Colorado Medicaid Program as a proxy for data in FY 2012-13.


Rating of Health Plan
Percent of responses rated 9 or 10 on a scale of 0-10 with 0 being the "worst health plan possible" and 10 being the "best health plan possible."
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
NCQA Average
Colorado Medicaid Program
2012
55.6%
53.3%


Rating of All Health Care
Percent of responses rated 9 or 10 on a scale of 0-10 with 0 being the "worst health care possible" and 10 being the "best health care possible."
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
NCQA Average
Colorado Medicaid Program
2012
49.8%
49.1%


Rating of Personal Doctor
Percent of responses rated 9 or 10 on a scale of 0-10 with 0 being the "worst personal doctor possible" and 10 being the "best personal doctor possible."
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
NCQA Average
Colorado Medicaid Program
2012
61.9%
64.7%


Rating of Specialist Seen Most Often
Percent of responses rated 9 or 10 on a scale of 0-10 with 0 being the "worst specialist possible" and 10 being the "best specialist possible."
70.0%
65.0%
60.0%
55.0%
50.0%
45.0%
40.0%
NCQA Average
Colorado Medicaid Program
2012
62.1%
63.8%

<table>
<tr><td rowspan="2">Goal I. Customer</td><td colspan="2">Strategy I.E. Client Experience & Engagement</td><td colspan="6">Performance Measure I.E.4 Percent of CAHPS Global Ratings Measures at or above National Medicaid Average for Adults in the Colorado Medicaid Program</td></tr>
<tr><td rowspan="11">Improve Health Outcomes, Client Experience and Lower Per Capita Costs</td><td rowspan="11">Outcome</td><td rowspan="11">CAHPS Global Ratings</td><td colspan="2">5 Years Prior FY 2008-09</td><td colspan="2">4 Years Prior FY 2009-10</td><td colspan="2">3 Years Prior FY 2010-11</td></tr>
<tr><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td></tr>
<tr><td>N/A</td><td>75%</td><td>N/A</td><td>50%</td><td>N/A</td><td>75%</td></tr>
<tr><td colspan="2">2 Years Prior FY 2011-12</td><td colspan="2">Prior Year FY 2012-13</td><td colspan="2">Current Year Goal FY 2013-14</td></tr>
<tr><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td></tr>
<tr><td>100%</td><td>100%</td><td>100%</td><td>50%</td><td>100%</td><td>--</td></tr>
<tr><td colspan="2">3 Year Goal FY 2015-16</td><td colspan="4" rowspan="3"></td></tr>
<tr><td>Benchmark</td><td>Actual</td></tr>
<tr><td>100%</td><td>--</td></tr>
</table>

I.E.5-Adult Core Medicaid Quality Measures

Strategy: In an effort to align performance improvement efforts throughout the country, the Centers for Medicare and Medicaid Services (CMS) recently announced a list of 26 quality measures for states to voluntarily report on an annual basis. At the present time, the Department collects data on 12 of these measures, and will report annually to CMS once federal guidance becomes available on the methodology. Performance on these measures will also be posted to the Department's web site with national Medicaid averages for comparison purposes. The 12 reported measures include:

- Adult Weight Screening and Follow-Up
- Tobacco Use Assessment and Tobacco Cessation Intervention
- Chlamydia Screening for Women ages 21-24
- Diabetes: Hemoglobin A1c testing
- Inpatient admissions for short-term complication of diabetes
- Inpatient admissions for chronic obstructive pulmonary disease
- Timeliness of postpartum care
- Diabetes: LDL screening
- Consumer Assessment of Healthcare Providers and Systems survey
- Inpatient admissions for adult asthma
- Annual monitoring for patients on persistent medications
- Inpatient admissions for congestive heart failure

By increasing the number of measures that can be reported, the Department's efforts will be more closely aligned with those identified by CMS and will provide increased transparency for the quality of care provided to Colorado Medicaid clients.

Evaluation of Prior Year Performance: The Department has made progress on this measure with the support of resources from the Centers for Medicare and Medicaid Services' (CMS') Adult Medicaid Quality Grant. The State Data Analytics Contractor for the Accountable Care Collaborative is working to create a dashboard for providers to review and improve their performance. Expanding the methods of reporting on quality measures will increase awareness of quality, cost and client satisfaction with services so that strategies for continuous improvement can be sustained.

<table>
<tr><th>Goal I. Customer</th><th colspan="2">Strategy I.E. Client Experience & Engagement</th><th colspan="6">Performance Measure I.E.5 Number of Adult Core Medicaid Quality Measures Reported</th></tr>
<tr><td rowspan="11">Improve Health Outcomes, Client Experience and Lower Per Capita Costs</td><td rowspan="11">Output</td><td rowspan="11">Adult Core Medicaid Quality Measures</td><td colspan="2">5 Years Prior
FY 2008-09</td><td colspan="2">4 Years Prior
FY 2009-10</td><td colspan="2">3 Years Prior
FY 2010-11</td></tr>
<tr><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td></tr>
<tr><td>N/A</td><td>--</td><td>N/A</td><td>--</td><td>N/A</td><td>--</td></tr>
<tr><td colspan="2">2 Years Prior
FY 2011-12</td><td colspan="2">Prior Year
FY 2012-13</td><td colspan="2">Current Year Goal
FY 2013-14</td></tr>
<tr><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td></tr>
<tr><td>N/A</td><td>--</td><td>12</td><td>10</td><td>12</td><td>--</td></tr>
<tr><td colspan="2">3 Year Goal
FY 2015-16</td><td colspan="4" rowspan="3"></td></tr>
<tr><td>Benchmark</td><td>Actual</td></tr>
<tr><td>24</td><td>--</td></tr>
</table>

I.E.6-Phone Calls Answered
I.E.7-Phone Calls Abandoned

Strategy: The Department's call center staff is focused on improved productivity to increase the number of calls answered and reduce calls abandoned. It is estimated that 68% of staffed time should be used to handle calls, with the remaining 32% used for work functions that cannot be performed with the caller on line (e.g., creating and processing client fulfillment requests). In addition, processes are being evaluated using LEAN strategies with the aim of reducing staff handling and processing time. These efforts are expected to increase the number of calls answered within the same time interval while reducing the number of calls abandoned.

Evaluation of Prior Year Performance (see tables I.E.6 and I.E.7 on page 47): The FY 2012-13 answer rate was 67.4%, with the abandon rate at 32.6%. This exceeded the goals of 65% and 35% respectively. The Customer Service Center increased answer rate performance by:

- establishing appropriate performance goals and reviewing agent performance monthly,
- managing outgoing messaging to callers effectively, and
- implementing Lean strategies to improve call processes and reduce talk time for agents

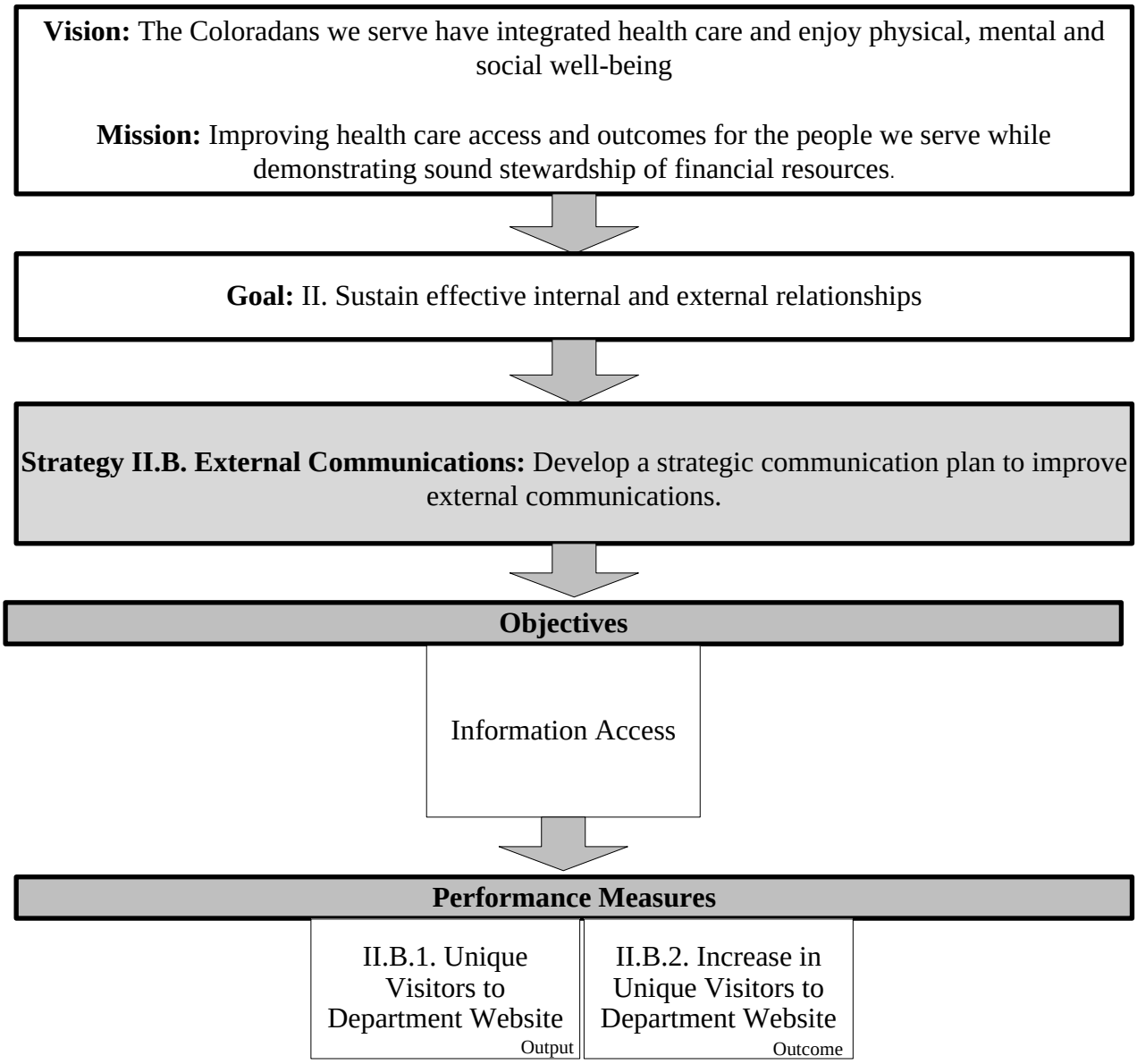
For example, billing letter procedures were revised so that only one agent was responsible for sending them. This allowed staff to simply request the letter rather than create and send the letter, reducing time on the call with the client and time off of the phone to complete the process. As another example, a call handling model was developed, ensuring a more concise and consistent handling of each call from all agents.

The Department will continue to employ Lean strategies to gain improvements in the answer and abandon rates. For example, new and improved reference materials will be developed allowing agents to provide accurate answers consistently and confidently, reducing the need for callback and ensuring first call resolution. Additionally, new technological solutions in the form of a Customer Relations Manager, and an Interactive Voice Response (IVR) system will allow clients to automate services that previously required an agent. This will enable agents to provide first contact resolution more effectively for clients. The additional call volume expected from implementation of the Affordable Care Act, and development of new technology, may challenge the Center's efforts to reach the 72% answer rate and 28% abandon rate during FY 2013-14.

Goal I. Customer	Strategy I.E. Client Experience & Engagement		Performance Measure I.E.6 Annual Average Percent of Incoming Phone Calls Answered					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Phone Calls Answered	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	50%	65%	67%	72%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			74%	--				

Goal I. Customer	Strategy I.E. Client Experience & Engagement		Performance Measure I.E.7 Annual Average Percent of Incoming Phone Calls Abandoned					
Improve Health Outcomes, Client Experience and Lower Per Capita Costs	Outcome	Phone Calls Abandoned	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	50%	35%	33%	28%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			26%	--				

Strategy II.B.
External Communications



Goal II. Communication	Strategy II.B. External Communications		Performance Measure II.B.1 Number of Unique Visitors to the Department's Website					
Sustain Effective Internal and External Relationships	Output	Website Visitors	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	54,390	N/A	59,478	65,426	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			79,165	--				

Goal II. Communication	Strategy II.B. External Communications		Performance Measure II.B.2 Percent Increase in Unique Visitors to the Department's Website					
Sustain Effective Internal and External Relationships	Outcome	Increase in Website Visitors	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	10%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			10%	--				

Strategy III.A.
Health Information Technology

Vision: The Coloradans we serve have integrated health care and enjoy physical, mental and social well-being

Mission: Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Goal: III. Provide exceptional service through technological innovation

Strategy III.A. Health Information Technology (HIT): Implement the State Medicaid HIT Plan for "meaningful use" among providers.

Objective

"Meaningful Use" of Electronic Health Records

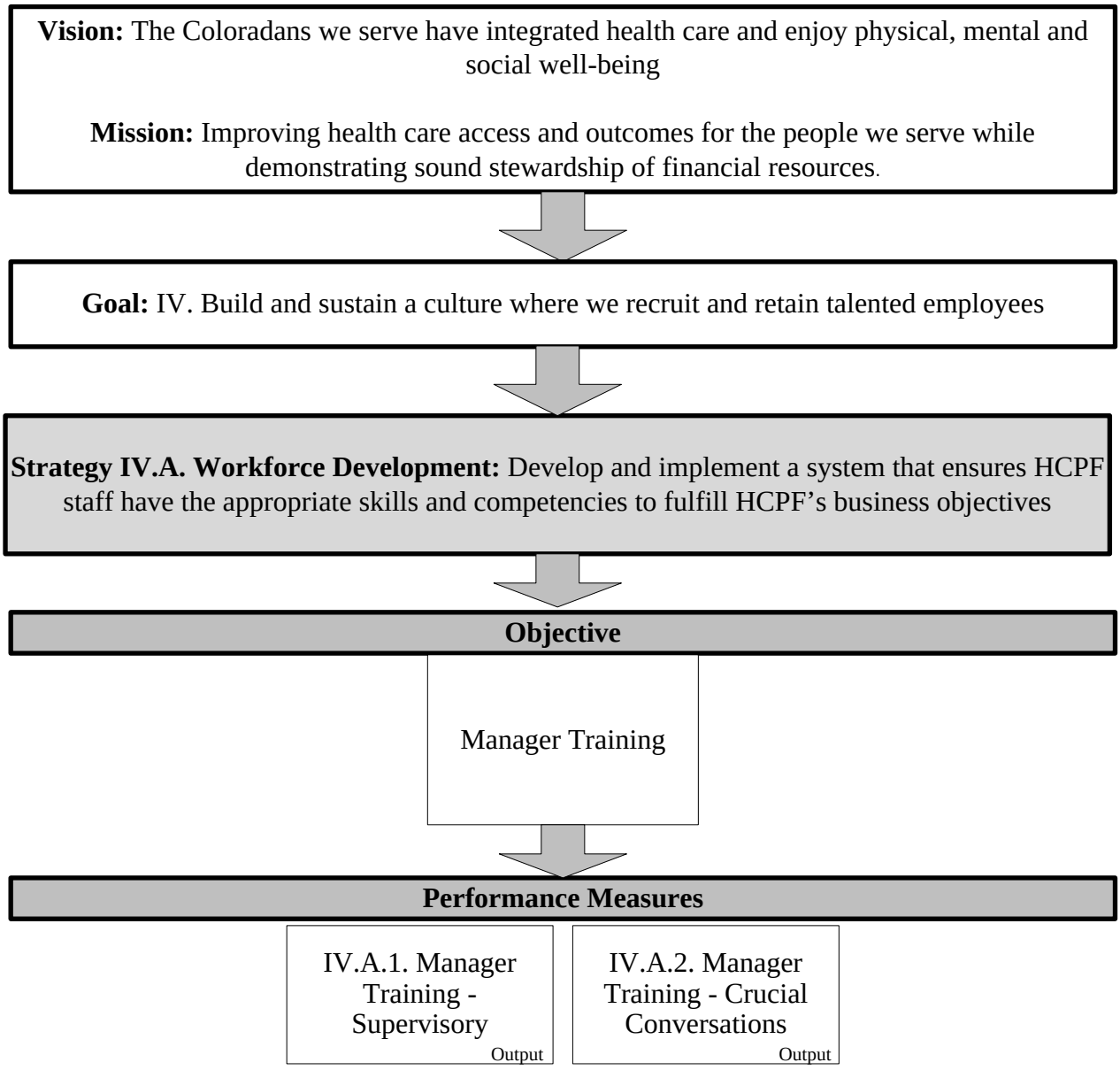
Performance Measures

III.A.1. EHR-MU Incentive Payments - Begin Attestation Input	III.A.2. EHR-MU Incentive Payments - Approved Output

Goal III. Technology	Strategy III.A. Health Information Technology		Performance Measure III.A.1 Number of Providers Who Begin the "Meaningful Use" (MU) Attestation Process in the State Level Registry for the Medicaid Electronic Health Record Incentive Program					
Provide Exceptional Service through Technological Innovation	Input	EHR-MU Incentive Payments - Begin Attestation	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	1,831	1,500	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			1,500	--				

Goal III. Technology	Strategy III.A. Health Information Technology		Performance Measure III.A.2 Number of Providers Approved for "Meaningful Use" (MU) Payments in the Medicaid Electronic Health Record Incentive Program					
Provide Exceptional Service through Technological Innovation	Output	EHR-MU Incentive Payments - Approved	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	1,560	1,300	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			1,300	--				

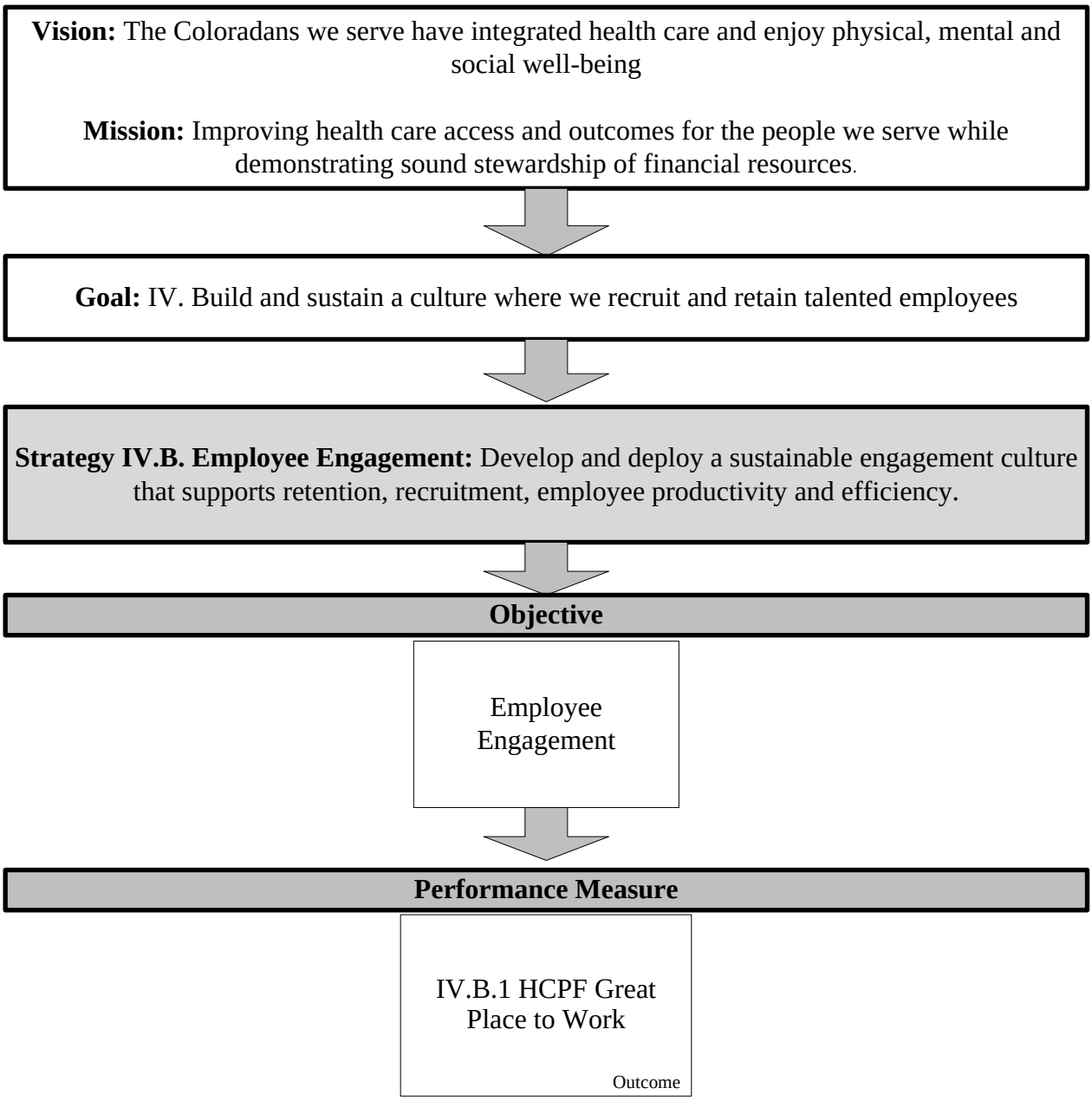
Strategy IV.A.
Workforce Development



Goal IV. People	Strategy IV.A. Workforce Development		Performance Measure IV.A.1 Number of Managers Trained in "Nuts and Bolts of Supervising"					
Build and Sustain a Culture Where We Recruit and Retain Talented Employees	Output	Manager Training - Supervisory	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	N/A	N/A	1	N/A	9
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	8	N/A	2	5	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			5	--				

Goal IV. People	Strategy IV.A. Workforce Development		Performance Measure IV.A.2 Number of Managers Trained in "Crucial Conversations"					
Build and Sustain a Culture Where We Recruit and Retain Talented Employees	Output	Manager Training - Crucial Conversations	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	N/A	N/A	N/A	N/A	3
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	3	N/A	20	20	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			20	--				

Strategy IV.B.
Employee Engagement



<table>
<tr><th>Goal IV. People</th><th colspan="2">Strategy IV.B. Employee Engagement</th><th colspan="6">Performance Measure IV.B.1 Percent of Employees Who State the Department Is a Great Place to Work</th></tr>
<tr><td rowspan="11">Build and Sustain a Culture Where We Recruit and Retain Talented Employees</td><td rowspan="11">Outcome</td><td rowspan="11">Great Place to Work</td><td colspan="2">5 Years Prior
FY 2008-09</td><td colspan="2">4 Years Prior
FY 2009-10</td><td colspan="2">3 Years Prior
FY 2010-11</td></tr>
<tr><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td></tr>
<tr><td>N/A</td><td>--</td><td>N/A</td><td>--</td><td>N/A</td><td>--</td></tr>
<tr><td colspan="2">2 Years Prior
FY 2011-12</td><td colspan="2">Prior Year
FY 2012-13</td><td colspan="2">Current Year Goal
FY 2013-14</td></tr>
<tr><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td><td>Benchmark</td><td>Actual</td></tr>
<tr><td>N/A</td><td>68%</td><td>50%</td><td>80%</td><td>80%</td><td>--</td></tr>
<tr><td colspan="2">3 Year Goal
FY 2015-16</td><td colspan="4" rowspan="3">*FY 2011-12 results from 2011 DPA Org Vitality Report, which categorized responses as favorable, neutral and unfavorable. A similar survey was not conducted by DPA in 2012; the Dept conducted its own and categorized results as either favorable or unfavorable, with no neutral responses. To compare results, all neutral responses were removed from the 2011 sample, shifting the FY 2011-12 baseline from 47% to 68%.</td></tr>
<tr><td>Benchmark</td><td>Actual</td></tr>
<tr><td>85%</td><td>--</td></tr>
</table>

Strategy IV.C.
Human Resources Transformation

Vision: The Coloradans we serve have integrated health care and enjoy physical, mental and social well-being

Mission: Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Goal: IV. Build and sustain a culture where we recruit and retain talented employees

Strategy IV.C. Human Resources Transformation: Transform Human Resources Management to a system that emphasizes consultation with managers and coordination of employee development and Human Resources processes.

Objective

Reduce Time-to-Hire for New Employees

Performance Measures

IV.C.1 Positions Vacated	IV.C.2 Positions Created	IV.C.3 Positions Filled	IV.C.4 Time to Hire
Input	Input	Output	Outcome

Goal IV. People	Strategy IV.C. Human Resources Transformation		Performance Measure IV.C.1 Number of Permanent FTE Positions Vacated					
Build and Sustain a Culture Where We Recruit and Retain Talented Employees	Input	Positions Vacated	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	60	76	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			87	--				

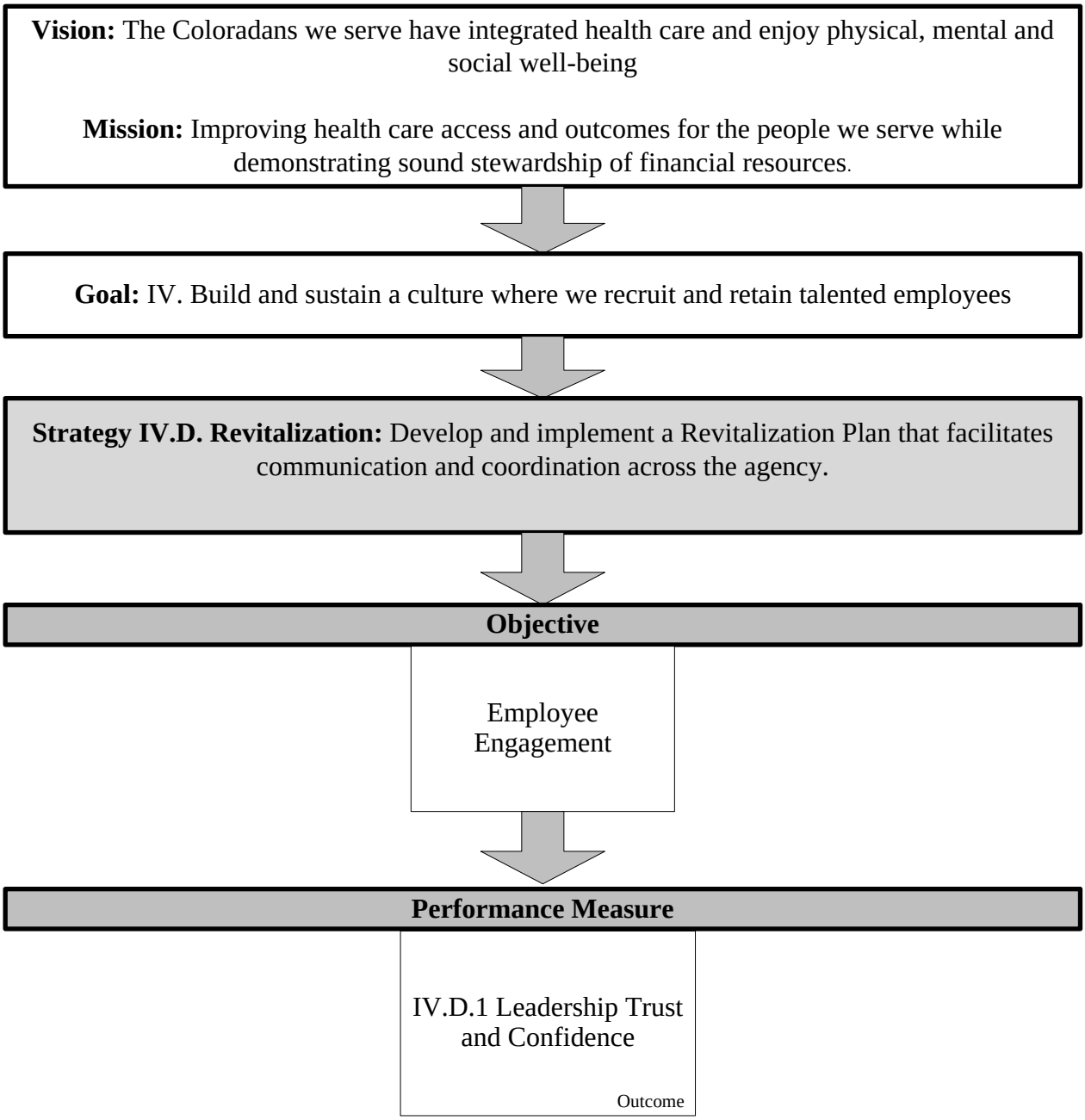
Goal IV. People	Strategy IV.C. Human Resources Transformation		Performance Measure IV.C.2 Number of Permanent FTE Positions Created*					
Build and Sustain a Culture Where We Recruit and Retain Talented Employees	Input	Positions Created	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	15	35	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			17	--				

*FY 2013-14 benchmark includes an estimated 35 employees transfering from DHS to HCPF under HB 13-1314

Goal IV. People	Strategy IV.C. Human Resources Transformation		Performance Measure IV.C.3 Number of Permanent FTE Positions Filled*					
Build and Sustain a Culture Where We Recruit and Retain Talented Employees	Output	Positions Filled	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	70	116	--
			3 Year Goal FY 2015-16		*FY 2013-14 benchmark includes an estimated 35 employees transfering from DHS to HCPF under HB 13-1314			
			Benchmark	Actual				
			87	--				

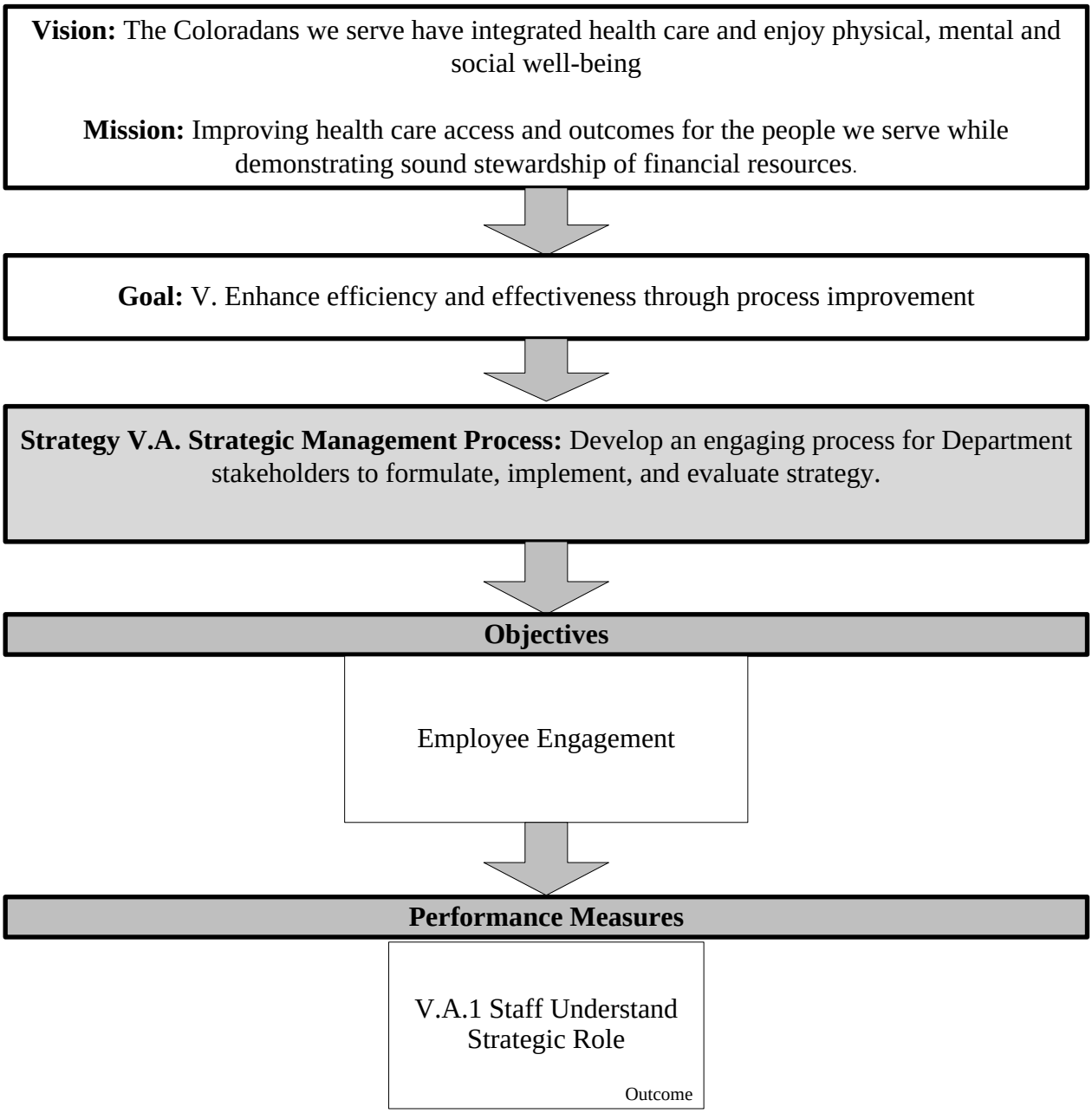
Goal IV. People	Strategy IV.C. Human Resources Transformation		Performance Measure IV.C.4 Average Number of Calendar Days to Fill Open and Approved Positions					
Build and Sustain a Culture Where We Recruit and Retain Talented Employees	Outcome	Time to Hire	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	142	114	56	60	--
			3 Year Goal FY 2015-16		*The Department is in the process of validating the measurement system for this metric, including the impacts of combined usage of NEOGOV and paper personnel action requests. Until the evaluation methodology is stabilized, variation is anticipated as reflected by the benchmark.			
			Benchmark	Actual				
			TBDJan14	--				

Strategy IV.D. Revitalization



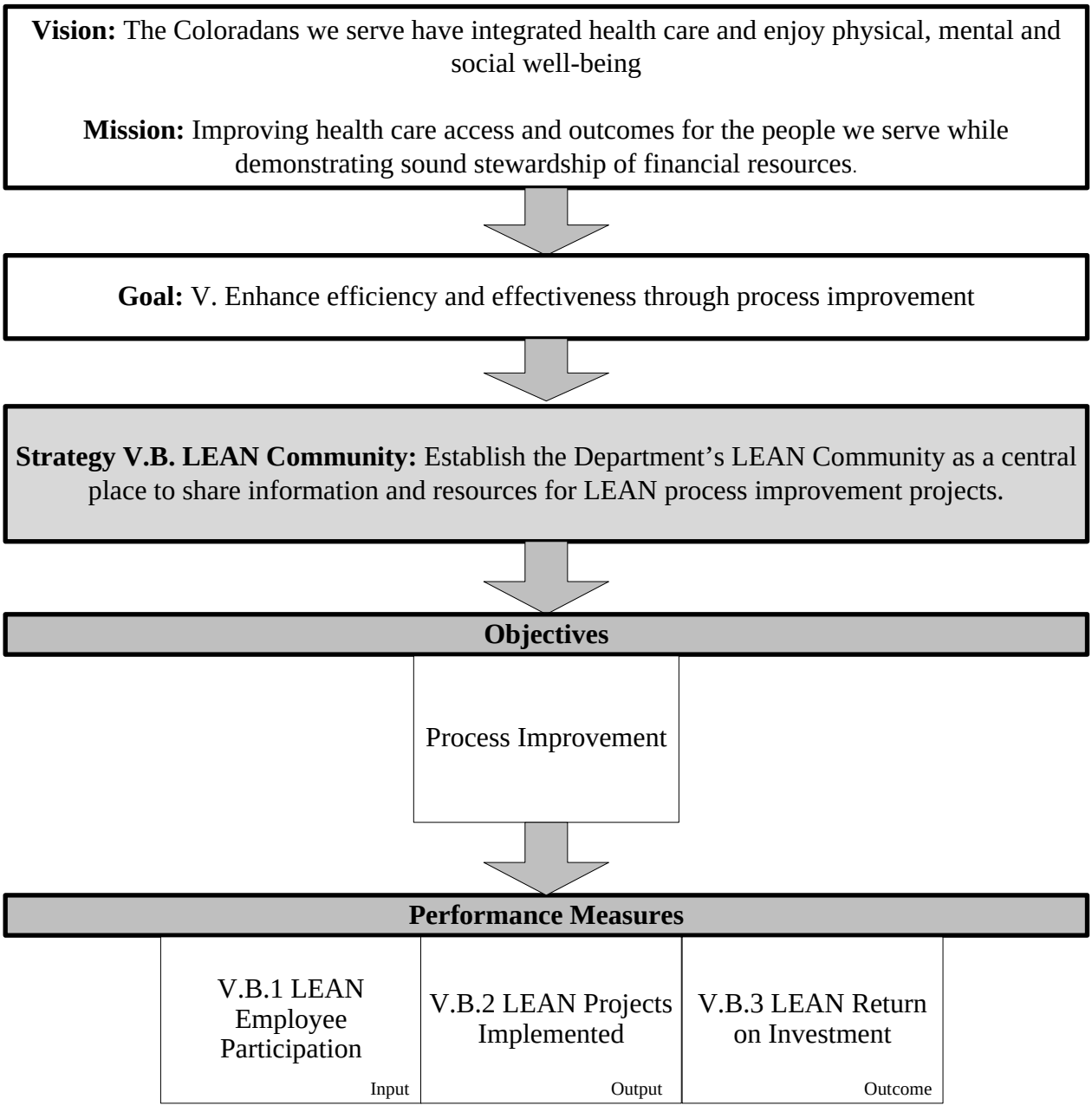
Goal IV. People	Strategy IV.D. Revitalization		Performance Measure IV.D.1 Percent of Employees Surveyed Who State They Have Trust and Confidence in the Department's Leaders					
Build and Sustain a Culture Where We Recruit and Retain Talented Employees	Outcome	Leadership Trust	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	53%	60%	68%	70%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			72%	--				

Strategy V.A.
Strategy V.A. Strategic Management Process



Goal V. Process	Strategy V.A. Strategic Management Process		Performance Measure V.A.1 Percent of Employees Who Understand Their Role in Helping the Department Achieve its Vision, Mission and Goals					
Enhance Efficiency and Effectiveness through Process Improvement	Outcome	Staff Understand Strategic Role	**5 Years Prior FY 2008-09**		**4 Years Prior FY 2009-10**		**3 Years Prior FY 2010-11**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		**Prior Year FY 2012-13**		**Current Year Goal FY 2013-14**	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	61%	70%	80%	82%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			85%	--				

Strategy V.B.
LEAN Community



Goal V. Process	Strategy V.B. LEAN Community		Performance Measure V.B.1 Number of Employees Participating in Global LEAN Projects*					
Enhance Efficiency and Effectiveness through Process Improvement	Input	LEAN Employee Participation	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	48	52	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			60	--				

*Global projects involve teams from at least two sections or divisions. "LEAN project" includes Lean workshops, Innovation and Design projects, Quick Hits, and other process improvement projects documented on the LEAN Community SharePoint site.

Goal V. Process	Strategy V.B. LEAN Community		Performance Measure V.B.2 Number of Global LEAN Projects Implemented with Sustainment Plans					
Enhance Efficiency and Effectiveness through Process Improvement	Output	LEAN Projects Implemented	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	5	7	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			12	--				

Goal V. Process	Strategy V.B. LEAN Community		Performance Measure V.B.3 Return on Investment from Implemented LEAN Projects in Estimated Equivalent Dollars					
Enhance Efficiency and Effectiveness through Process Improvement	Outcome	LEAN Return on Investment	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	TBDJan14	TBDJan14	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			TBDJan14	--				

Strategy VI.A.
Cost Containment Expertise

Vision: The Coloradans we serve have integrated health care and enjoy physical, mental and social well-being

Mission: Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Goal: VI. Ensure sound stewardship of financial resources

Strategy VI.A. Cost Containment Expertise: Strengthen the Department's cost-containment culture by using data-driven financial modeling tools and expertise.

Objectives

- Fiscal Management
- Fiscal Agent Operations

Performance Measures

VI.A.1 General Fund Expenditure - Administration Ratio (Outcome)	VI.A.2 Cash Fund Balance - Coverage Expansions (Outcome)	VI.A.3 "Clean" Claims Received (Input)
VI.A.4 "Clean" Claims Paid (Output)	VI.A.5 "Clean" Claims Paid Timely (Outcome)	

Goal VI. Financing	Strategy VI.A. Cost Containment Expertise		Performance Measure VI.A.1 Percent of General Fund Expenditures for Department Administration					
Ensure Sound Stewardship of Financial Resources	Outcome	General Fund Expenditure - Administration Ratio	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	3%	3%	3%	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			3%	--				

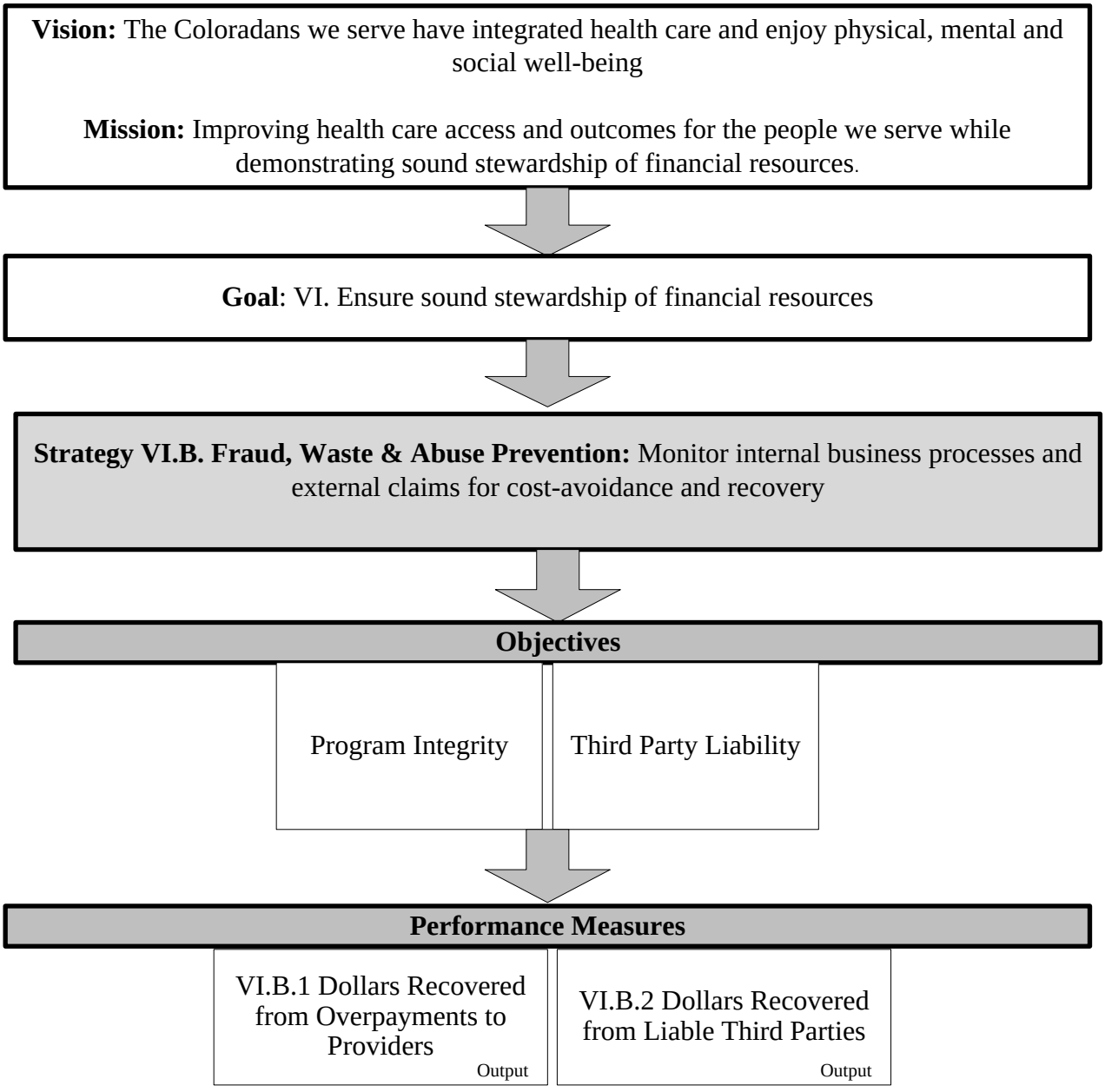
Goal VI. Financing	Strategy VI.A. Cost Containment Expertise		Performance Measure VI.A.2 Maximum Cash Fund Balance from Hospital Provider Fee at End of Fiscal Year as a Percent of Estimated Expenditures for Health Coverage Expansions					
Ensure Sound Stewardship of Financial Resources	Outcome	Cash Fund Balance - Coverage Expansions	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	5%	11%	5%	--
			3 Year Goal FY 2015-16		In FY 2012-13, the Department increased the Adults without Dependent Children enrollment cap between April and October 2013 by 9,250 persons. A surplus greater than 5% was needed in the cash fund at the end of FY 2012-13 to fund the increased enrollment. The decision to increase the number of persons receiving benefits rather than reduce fee amounts was approved by the Colorado Hospital Association and the Hospital Provider Fee Oversight and Advisory Board. As of June 30, 2013, the Hospital Provider Fee Cash Fund balance was approximately $36 million or 10.7% of estimated expenditure for health coverage expansions in the FY 2012-13 hospital provider fee model.			
			Benchmark	Actual				
			5%	--				

Goal VI. Financing	Strategy VI.A. Cost Containment Expertise		Performance Measure VI.A.3 Number of Clean Claims Received*					
Ensure Sound Stewardship of Financial Resources	Input	"Clean" Claims Received	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	4,918,507	N/A	3,950,838
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	4,791,447	N/A	TBDJan14	TBDJan14	--
			3 Year Goal FY 2015-16		*Includes claims received from practitioners, nursing facilities, and hospitals; and for which no additional information from the provider or a third party was required to make payment. Data not available prior to FY 2009-10. Q1 FY 2011-12 data unavailable and estimated to equal data from prior quarter April-June 2011. Due to reporting lag time from claims run-out period, FY 2012-13 actuals and future benchmarks will be available in January 2014.			
			Benchmark	Actual				
			TBDJan14	--				

Goal VI. Financing	Strategy VI.A. Cost Containment Expertise		Performance Measure VI.A.4 Number of Clean Claims Paid*					
Ensure Sound Stewardship of Financial Resources	Output	"Clean" Claims Paid	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	4,918,267	N/A	3,950,642
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	4,791,277	N/A	TBDJan14	TBDJan14	--
			3 Year Goal FY 2015-16		*Includes claims received from practitioners, nursing facilities, and hospitals; and for which no additional information from the provider or a third party was required to make payment. Data not available prior to FY 2009-10. Q1 FY 2011-12 data unavailable and estimated to equal data from prior quarter April-June 2011. Due to reporting lag time from claims run-out period, FY 2012-13 actuals and future benchmarks will be available in January 2014.			
			Benchmark	Actual				
			TBDJan14	--				

Goal VI. Financing	Strategy VI.A. Cost Containment Expertise		Performance Measure VI.A.5 Percent of Clean Claims Paid Within 90 Days*					
Ensure Sound Stewardship of Financial Resources	Outcome	"Clean" Claims Paid Timely	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	99.99%	N/A	99.99%
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	99.99%	N/A	TBDJan14	99.99%	--
			3 Year Goal FY 2015-16		*Includes claims received from practitioners, nursing facilities, and hospitals; and for which no additional information from the provider or a third party was required to make payment. Data not available prior to FY 2009-10. Q1 FY 2011-12 data unavailable and estimated to equal data from prior quarter April-June 2011. Due to reporting lag time from claims run-out period, FY 2012-13 actuals will be available in January 2014.			
			Benchmark	Actual				
			99.99%	--				

Strategy VI.B.
Fraud, Waste & Abuse Prevention



Goal VI. Financing	Strategy VI.B. Fraud, Waste & Abuse Prevention		Performance Measure VI.B.1 Dollars Recovered from Overpayments to Providers					
Ensure Sound Stewardship of Financial Resources	Output	Program Integrity Recoveries	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	$7,200,000	N/A	$6,200,000	N/A	$8,200,000
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	$11,700,000	$12,000,000	$11,900,000	$12,000,000	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			$12,000,000	--				

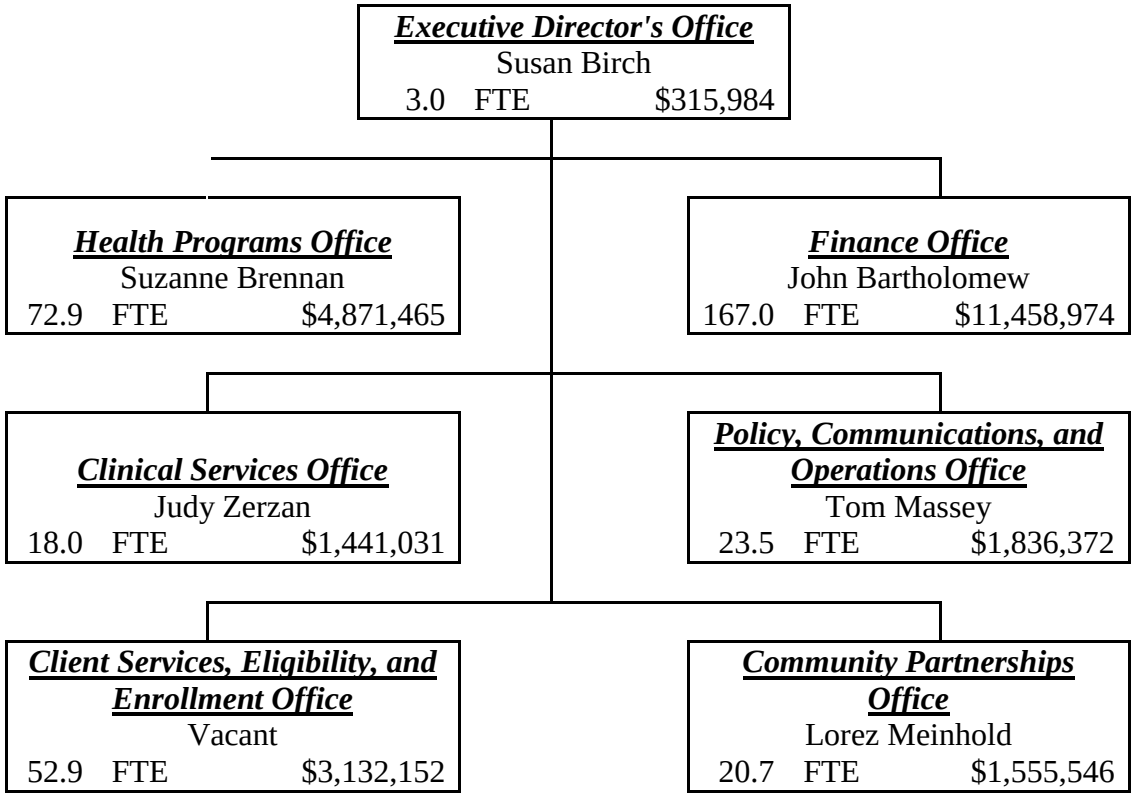
Goal VI. Financing	Strategy VI.B. Fraud, Waste & Abuse Prevention		Performance Measure VI.B.2 Dollars Recovered from Liable Third Parties					
Ensure Sound Stewardship of Financial Resources	Output	Third Party Liability Collections	5 Years Prior FY 2008-09		4 Years Prior FY 2009-10		3 Years Prior FY 2010-11	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	N/A	--	N/A	--
			2 Years Prior FY 2011-12		Prior Year FY 2012-13		Current Year Goal FY 2013-14	
			Benchmark	Actual	Benchmark	Actual	Benchmark	Actual
			N/A	--	$40,000,000	$51,447,486	$53,416,140	--
			3 Year Goal FY 2015-16					
			Benchmark	Actual				
			$61,047,017	--				

DEPARTMENT DESCRIPTION

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.



TOTAL:	358.1 FTE	$24,611,523	
General Fund	Cash Funds	Reappropriated Funds	Federal Funds
$8,410,879	$2,599,660	$1,736,842	$11,864,142

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. 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 and codified by HB 13-1314 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 Long-Term Services and Supports Medicaid Programs. The office aims to improve the health status of all clients, achieve efficiencies in health care resource utilization, and promote effective partnerships with providers and contractors to achieve improved health and functioning of clients. The office implements innovative programs and approaches to improve how health care services are delivered and paid for. 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 in a cost-effective manner. 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, the Accountable Care Collaborative, managed-care services and programs, and 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 physical health, behavioral health, and dental 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 home- and 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 and communities 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.

Finance Office

The Finance Office consists of the Budget Division, the Controller Division, the Rates and Analysis Division, the Safety Net Programs Section, the Audits and Compliance Division, and the Strategy 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 expenditure, 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 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 (CMS) to ensure that the Department is maximizing federal Medicaid revenue. In addition, the Division strives to maximize available federal funding for hospital and clinic providers who participate in Medicaid and the Colorado Indigent Care Program.

Controller Division

The Controller 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 Cash Management 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 Provider Fee Unit is primarily responsible for all accounting entries and issues related to the Medical Services Premiums and Behavioral Health Community Programs 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, the Claims System Section, and the Health Data Strategy 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 Department staff 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 implements 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.

The Health Data Strategy unit is primarily focused on implementing a Medicaid data infrastructure that supports strategic uses of Colorado health data. The unit manages existing business intelligence and data management (BIDM) vendors as well as consults on the procurement of new contracts by the Department to provide data and analytics. The unit serves as the primary point of contact for external stakeholders regarding data integration and interoperability, including entities such as the Office of Information Technology (OIT), the Center for Value and Improvement in Health Care (CIVHC), Colorado Regional Health Information Exchange (CORHIO), and Quality Health Network (QHN). In addition, the unit utilizes its technical expertise to evaluate data elements and methods for innovative reform efforts such as the Accountable Care Collaborative (ACC).

<u>Audits and Compliance Division</u>

The Audits and Compliance Division consists of the Program Integrity Section, the Internal Audits Section, and the Federally Required Eligibility and Claims Review Unit. These sections ensure

compliance with state and federal law, as well as identifying and recovering any improper Medicaid payments.

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. Within the Program Integrity section is the Claims Investigation Unit, which has the primary responsibility for detection and deterrence of provider fraud, waste, and abuse in the Medicaid program and recovering identified overpayments. The unit also conducts post-payment claims reviews, which include desk reviews, records reviews, on-site visits, and data reviews to identify provider aberrancies that directly relate to Medicaid rules and regulations. In addition, the unit prepares cases for recovery of identified overpayments and provides education to providers to comply with Medicaid standards, rules, and regulations.

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.

The Federally Required Eligibility and Claims Review Unit manages four programs: the Medicaid Eligibility Quality Control (MEQC) Program, the Payment Error Rate Measurement (PERM) Program, the Contingency Based and Recovery Audit Contract (RAC) Manager, and the Recovery Officer. The MEQC program assesses eligibility determinations to assure accuracy and timeliness of the eligibility determination to avoid inappropriate payments and client determination delays. This program is required by the federal government. The PERM program is required by CMS to comply with the Improper Payments Information Act of 2002. The purpose of the program is to examine the accuracy of eligibility determinations and claims payment to ensure that the Department only pays for appropriate expenditures. The Contingency Based and RAC Manager is to manage two large and complicated contracts. The RAC contract is required under federal law to review/ audit all provider types for inappropriate payments. The RAC and the Contingency Based Contract are a method of deterring fraud, abuse, and waste while recovery overpayments. Finally, the Recovery Officer is to track and coordinate provider overpayments pursued by RAC, Contingency Based Contract, and PERM on behalf of the FEC Unit.

<u>Strategy Section</u>

The Strategy Section performs strategic and operational planning and process improvement functions. It provides structure and cohesion for implementing and prioritizing projects that align with the Department's strategic direction. This section collaborates with staff across the Department to:

- develop strategies and performance measures for achieving strategic goals;
- develop and implement operational plans;
- evaluate and report performance;
- enhance understanding of individual staff roles in achieving the Department's vision, mission and goals;
- ensure Department projects and initiatives are aligned with strategic goals;
- lead continuous process improvement efforts;
- train staff to use LEAN methodology and tools for process improvement; and
- support the growth and integration of the Department's LEAN Community.

Clinical Services Office

The 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, Communications, and Operations Office

The Policy, Communications, and Operations Office includes the Communications Section, the Policy Coordination Section, the Workforce Development and Human Resources Sections, and the Administrative Services Unit. The office bears responsibility for management of the functions associated with government affairs, communication and media relations, and internal Department operations.

The office provides 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 Communications Section is responsible for developing a broad-scale communications plan, proactively addressing both internal and external audiences' needs. The Policy, Communications, and Operations 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 Policy Coordination 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. The Office also contains the Department's Federal Policy and Rules Officer and coordinates the Medical Services Board, the Department's rule-making body.

The Workforce Development Section sustains and improves the Department's ability to achieve its on-going mission and capacity to innovate by supporting employee engagement and professional development for all staff. The Workforce Development Section is responsible for effectively developing, managing, and improving programs to improve quality of the Department's workforce.

The Human Resources Section performs 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. Those functions include recruitment, testing and selection, classification, salary administration, dispute resolution, personnel performance management, and annual compensation/benefits. This section provides guidance, counseling, and technical assistance to Department managers and staff on the application of the State personnel system. 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 the Health Insurance Portability and Accountability Act (HIPAA).

The Administrative Services Unit is responsible for office administration, event planning and coordination, facilities management, and ensuring department-wide compliance with standard operation procedures. The Unit coordinates Department support staff and special projects. The unit also houses the Governor's Citizen's Advocate.

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 services to Coloradans. Many of the activities focus on ensuring that those applying for state medical assistance 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. Similarly, the projects within this Office are centered 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.

Eligibility Division

The Eligibility Division exists to ensure access to Medicaid for eligible individuals, families, children, the elderly, and persons with disabilities. This section defines program eligibility through policy development, implementation, and training to statewide eligibility sites and other partners. The section also provides policy expertise on Medicaid eligibility for all categories for the rules-based eligibility determination system, serving as a liaison to the Colorado Benefits Management System (CBMS), managed by the Office of Information Technology (OIT).

Client Services Division

The Client Services Division provides a high level of communication and assistance to all clients who contact the Department. The Customer Contact Center serves as the major focal point for callers who require assistance with questions about eligibility and program information and who need help navigating a complex health care system. This Division 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 coordinates relationships between the Department and partners of the Department, including advocacy organizations, payers, business, providers, and other state agencies and units of state government. The Office includes the Legal and Grants Division.

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.

PRIOR-YEAR LEGISLATION

The following is a summary of major legislation enacted in 2013 that affects Department policies and procedures.

HB 13-1068 (Young, Roberts) On-Site Inspections of Medicaid Providers
Federal law mandates that the Centers for Medicare and Medicaid Services (CMS), its designated contractors, or the State Medicaid agency have the authority to conduct unannounced on-site inspections of any and all provider locations. This bill aligns state statute with federal law to allow unannounced inspections of provider locations in order to protect clients and provide another mechanism to guard against fraud, waste, and abuse.

HB 13-1196 (Stevens, Newell) Report Waste Prevention Methods in Accountable Care Collaborative (ACC)
This bill requires the Department to report biannually to the health care committees of the General Assembly regarding specific efforts within the Regional Care Collaborative Organizations (RCCOs) – including primary care medical providers, the Statewide Data and Analytics Contractor (SDAC), and others who provide medical care within the region – to identify and implement best practices relating to cost-containment, identify ways to reduce avoidable, duplicative, variable, and inappropriate uses of health care resources, and to combat client or provider fraud.

HB 13-1199 (Pettersen, Kefalas) Nursing Home Provider Fee Statute
This bill clarifies the definition of a Continuing Care Retirement Community (CCRC) without affecting any facilities that are currently considered a CCRC. It also aligns reporting requirements of nursing facilities with original intent of SB 09-263 and the Department's current practice.

HB 13-1281 (Gerou, Hodge) Medicaid Management Information System (MMIS) Roll-Forward Authority
This bill allows the Department to roll forward appropriated dollars for MMIS system changes from one fiscal year to the next. This helps alleviate potential work stoppages when the fiscal year ends in June and any appropriated dollars revert back to the General Fund resulting in the Department waiting until February to receive a supplemental from the Joint Budget Committee (JBC) to pay the MMIS vendor for the system changes.

HB 13-1314 (Gerou, Levy, Hodge) Transfer Developmental Disabilities to HCPF
This bill transfers the powers, duties, and functions of the Department of Humans Services (DHS) relating to the programs, services, and supports for persons with intellectual and developmental disabilities to the Department of Health Care Policy and Financing (HCPF) on March 1, 2014.

SB 13-008 (Newell, McCann) Elimination of Waiting Period for Children's Basic Health Plan
Under current law, a child is eligible for Children's Basic Health Plan benefits if he or she has not been on a comparable health plan with an employer paying at least 50% of the cost for at least three months. The bill eliminates that three-month waiting period.

SB 13-044 (Nicholson, Coram) Incentive Payments in Prepaid Inpatient Health Plan (PIHP) Agreements
The Department pays a performance incentive to qualifying PIHPs if they meet certain health performance metrics. If met, current statute requires the Department to pay that incentive payment within six months of providing service. The Department has been unable to pay the PIHP incentive payment within six months as required by statute, which puts the Department at risk for disallowance of federal match by the Centers for Medicare and Medicaid Services (CMS). This bill removes the six month deadline from statute and replaces it with "within a reasonable period following the end of each fiscal year."

SB 13-137 (Roberts, Navarro) Improving Medicaid Fraud Detection
This bill directs the Department to issue a request for information (RFI) by September 30, 2013, regarding the use of predictive analytics technologies in the Medicaid program. The primary purpose of the RFI is to obtain information on proven strategies to identify and reduce fraud, waste, and abuse in Medicaid prior to payment of claims. Based on the results of the RFI, the Department is encouraged to develop requests for proposals (RFPs) to implement strategies that will: result in cost savings to the State; be integrated into existing operations without creating additional costs to the State; and not result in delays or the improper denial of legitimate claims by providers.

SB 13-200 (Aguilar, Ferrandino) Expand Medicaid Eligibility
This bill allows the income eligibility level for parents and caretaker relatives of Medicaid children and adults without a dependent child to be expanded up to 133% of the Federal Poverty Level (FPL). The new coverage, which is estimated to cover more than 160,000 Coloradoans, begins January 1, 2014. While expanding Medicaid, the Department will be improving the value of health care delivered focusing on benefit design and value-based services, delivery system reform, payment reform, Health Information Technology and administrative reform and reducing fraud, waste, and abuse.

SB 13-242 (Nicholson, Primavera) Adult Dental Benefit in Medicaid
This bill creates a limited adult dental benefit for Medicaid clients and requires the Department to determine the most cost-effective method for providing the adult dental benefit, including, but not limited to, a comparison of a capitated or fee-for-service method of payment and the purchase of dental insurance. If the Department chooses to use an Administrative Service Organization (ASO) to manage the adult dental benefit, the contract with the ASO must prohibit the contracting entity from requiring dental providers to participate in any other public or private program or to accept any other insurance products as a condition of participating as a dental provider. The Department shall retain policy-making authority, including, but not limited to, policies concerning covered benefits and rate setting.

HOT ISSUES

Successes

As federally mandated health care reform is implemented nationwide, the Department is committed to ensuring that Colorado remains at the forefront of developing innovative efficiencies in service delivery and cost-containment. The Department's successes in FY 2012-13 include the continuing development and implementation of the Accountable Care Collaborative, approval of an adult dental benefit, and expanding access to Medicaid in tandem with continued implementation of the Affordable Care Act (ACA).

Accountable Care Collaborative (ACC)

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 ACC program currently has over 350,000 Medicaid clients enrolled, and approximately 135 participating Primary Care Medical Providers (PCMPs), which includes nearly 2,300 rendering providers.

The four goals of the ACC program are:

- 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 program has three core components. The three core components of the ACC program include:

- 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 is meant to be iterative; it was designed with the understanding that delivery system reform takes time and will require continual evolution. In FY 2012-13, the program made significant strides towards delivery system reform in a number of domains:

- Payment Reform
    - The Department began to reimburse PCMPs and RCCOs based on quarterly regional performance on three key performance indicators, hospital readmissions, emergency room utilization, and high-cost imaging services. All of the RCCOs

and PCMPs received at least some incentive payment based on improvements in utilization.
    - The Department worked with stakeholders to develop a shared savings program in which cost savings to the state will be shared with RCCOs and PCMPs. That program is currently being reviewed by CMS and the Department hopes to implement within this fiscal year.
    - The Department selected a pilot payment reform proposal pursuant to HB-12-1281 for implementation by July 2014. The selected proposal from Rocky Mountain Health Plans incorporates innovative payments to providers and a global physical and behavioral health budget to achieve whole person high quality care.
- Administrative Improvements
    - The Department has begun aligning other programs with the ACC, creating internal administrative efficiencies and reducing complexity for clients and providers. The first step in this process was alignment of the Children's Medical Home Program. Providers in the ACC and the Children's Medical Home Program are now reimbursed based on the same ACC methodology as all other ACC providers
- Delivery System Redesign
    - Through the Comprehensive Primary Care Initiative, Medicaid has been able to align with Medicare and private payers to enhance primary care in a pilot group of primary care practices.

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

- the State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees (for individuals eligible for both Medicare and Medicaid);
- behavioral health integration efforts; and,
- integration of Long-Term Services and Supports.

The Department will submit a formal report to the legislature, to include program results on utilization and cost containment, on November 1, 2013.

Adult Dental Benefit

Oral health is a critical aspect of an individual's overall health status, and, in 2013, SB 13-242 created a limited Medicaid dental benefit for adults. Prior to the passage of this bill, adult Medicaid clients were generally covered for emergency dental services only. If a Medicaid client had a severe cavity, his or her only option was to have an extraction at an emergency room, even if the tooth could be saved and filled at a much lower cost. Studies published by the American Academy of Pediatric Dentistry show that the cost of providing preventive dental care is potentially 10 times less expensive than managing symptoms of dental disease in emergency rooms.[1] The Department

[1] http://www.pewstates.org/uploadedFiles/PCS_Assets/2012/A%20Costly%20Dental%20Destination%281%29.pdf

anticipates the adult dental benefit will save $750,000 General Fund by reducing clients' ER visits for emergency dental procedures.

SB 13-242 directs the Department to design and implement a limited dental benefit for adults using a collaborative stakeholder process to consider the administration of the following components of the benefit:

- cost
- best practices
- effect on health outcomes
- client experience
- service delivery models
- maximum efficiencies

Additionally, SB 13-242 requires the Department determine the most cost-effective method for providing the adult dental benefit, including, but not limited to, a comparison of a capitated or fee-for-service method of payment and the purchase of dental insurance. If the Department chooses to use an Administrative Service Organization (ASO) to manage the adult dental benefit: (a) the contract with the ASO must provide that the contracting entity is prohibited from requiring dental providers to participate in any other public or private program or to accept any other insurance products as a condition of participating as a dental provider; and (b) the Department shall retain policy-making authority, including, but not limited to, policies concerning covered benefits and rate setting.

The Department recently began the collaborative stakeholder process to help determine both the benefits and delivery model for an adult dental benefit.

Expanding Access to Medicaid

Signed into law on March 23, 2010, the Affordable Care Act (ACA) has a broad impact on those with and without insurance. To help implement the ACA, Colorado passed three laws to help expand health insurance access to more residents and provide a framework for more Coloradans to be able to purchase health insurance. The Department is implementing the Medicaid expansion, while the other laws are being implemented by the Division of Insurance and Connect for Health Colorado.

Both State and federal laws include numerous previsions that have already been implemented, with the most significant taking effect in 2014. The following notable provisions will be implemented in 2014:

Health Insurance Coverage Requirement—January 2014

Starting in January 2014, most people will be required to have health insurance coverage, or pay a penalty if they do not. Coverage may include employer-provided insurance, coverage an individual purchases on their own, Medicaid, Children's Health Plan *Plus* (CHP+), Medicare, or TRICARE. The requirement applies to individuals of all ages, including children. The adult or married couple who can claim a child or another individual as a dependent for federal income tax purposes is responsible for making the payment if the dependent does not have coverage or an exemption.

Though most people will be required to have insurance, several groups are exempt from the requirement to obtain coverage or pay the penalty, including:

- people who would have to pay more than 8% of their income for health insurance;
- people with incomes below the threshold required for filing taxes;
- those who qualify for religious exemptions;
- undocumented immigrants;
- people who are incarcerated, and;
- members of Native American tribes.

The penalty for people who forego insurance is the greater of two amounts: 1) a specified percentage of income, or 2) a specified dollar amount.

1. The percentages of income are phased in over time at 1% in 2014, 2% in 2015, and 2.5% starting in 2016.
2. The dollar amounts are also phased in at $95 in 2014, $325 in 2015, and $695 beginning in 2016 (with annual increases after that). In 2014 the fee for uninsured children is $47.50 per child.

Health insurance plans will provide documentation to clients to prove they have the minimum coverage required by law. The federal government's Internal Revenue Service (IRS) will be overseeing the enforcement of the mandate.

Private Insurance Consumer Protections – January 2014

HB 13-1266 "Alignment of Health Insurance Laws" was signed into law in 2013. The law aligns Colorado health insurance laws with federal law, providing consumers, insurance carriers, agents, and other stakeholders with one set of health insurance rules. It also creates the regulatory environment to support Connect for Health Colorado in becoming a new marketplace to purchase health insurance. The Division of Insurance is implementing this legislation. Key changes to coverage include:

- Coverage for pre-existing conditions: beginning in 2014, all health insurers will be required to sell coverage to everyone who applies, regardless of their medical history or health status. Also at that time, insurers are barred from charging more to individuals with pre-existing conditions and will no longer be able to exclude coverage for pre-existing conditions.
- Limit on out-of-pocket expenses: The ACA establishes limits on what people buying insurance plans on and off the Connect for Health Colorado marketplace will pay out-of-pocket for services.
- Ending lifetime and yearly limits: The ACA prohibits insurers from limiting lifetime coverage for essential health benefits.
- Preventative services requirement: Since July 2010, any new health insurance plans, with the exception of grandfathered plans, are required to provide coverage for preventive services.

Expanding Access to Colorado Medicaid
SB 13-200 "Expand Medicaid Eligibility" was signed in to law in 2013 and expanded Medicaid coverage for low-income Coloradans to up to 133% of the federal poverty level (FPL) – in some cases, certain individuals who earn more may still qualify. The new coverage, which is estimated to cover more than 160,000 Coloradoans, begins January 1, 2014.

While expanding Medicaid, the Department will be improving the value of health care delivered. Five key categories for improving value include:

- Benefit Design and Value-Based Services
- Delivery System Reform
- Payment Reform
- Health Information Technology
- Administrative Reform and Reducing Fraud, Waste, and Abuse

Connect for Health Colorado Marketplace—October 2013 & January 2014
SB 11-200 "Health Benefit Exchange" was signed in to law in 2011 and created the Colorado Health Benefit Exchange, which is now the Connect for Health Colorado insurance marketplace.

The Connect for Health Colorado marketplace will open for business on October 1, 2013. The marketplace will be the only place where Coloradans can access new federal financial assistance, based on income, to reduce the cost of health insurance that is purchased through the Marketplace. Through the online Marketplace, applicants will be able to see if they qualify for a new kind of tax credit to lower the cost of premiums and reduce co-pays and deductibles.

The Department is working closely with Connect for Health Colorado on a "no wrong door" approach for finding insurance coverage. Whether customers apply online, in person, on the phone, or using a paper application, they will be able to find out if they are eligible for Medicaid, CHP+, or for financial assistance to offset the cost of private insurance purchased through the marketplace.

System Enhancements for an Improved Consumer Experience
To prepare for implementing ACA, the Colorado Program Eligibility and Application Kit (PEAK), the online application for customers applying for medical assistance, has been upgraded. The consumer portal is known as PEAK and can be found at Colorado.gov/PEAK.

PEAK Upgrades
The Department has launched a three year effort to transform PEAK to a comprehensive self-service portal that is the best-in-class – efficient, effective and elegant.

When all the upgrades are complete, PEAK will serve as the entry point for a self-service user experience that will enable Colorado citizens to access a real-time application for health benefits and link Coloradans to the full spectrum of health and human service programs.

The on-going PEAK enhancements will address the need for:

- Behavioral segmentation to facilitate end users who are comfortable using web-based applications; need assistance on an interim basis (i.e., training); and will always rely on assistors.
- On-line, real-time help screens and tool tips that are context sensitive and recognize where the user is in the application.
- A user interface that optimizes use of color, typography, spacing, and the visual hierarchy and flow needed to accomplish tasks and supports ADA requirements.

The series of upgrades and the site's new design will include:

- End-to-end eligibility, enrollment and re-enrollment experience.
- Application data collection for the full spectrum of health and human service programs (medical assistance is prioritized first to meet federal health care reform requirements),
- Pathways between PEAK and Connect for Health Colorado to support "no wrong door."
- Ability to accept different forms of payment for enrollment fees and premiums, such as those required for CHP+ and other programs.
- Ability for clients to order their own benefit cards.
- Ability for the user to switch from English to Spanish.
- Access via iPad, smart phone and other mobile devices.
- Full account management within PEAK to access and update household eligibility, enrollment, benefits, provider networks, explanations of benefits, etc.
- PEAK information automatically uploaded into CBMS.

CBMS Builds

The Governor's Office of Information Technology (OIT) is working to complete numerous upgrades to the Colorado Benefits Management System (CBMS) throughout 2013. As a part of ongoing improvements, CBMS users will see changes to the system. Below is an overview of select upgrades related to the ACA implementation. For a detailed description, please visit: CBMSColorado.com.

June 2013 Build:

- PEAK User Experience (UX) 2014
- This project will modify the front end user interface of PEAK to incorporate design models, components, and themes in accordance with the Enroll UX 2014 Design Standards in order to improve the end-user experience within the application process.

September 2013 Build:

- New Rules Engine for MAGI
  CBMS will be upgraded to meet the new requirements and new way of determining eligibility, Modified Adjusted Gross Income (MAGI).
- Client Correspondence Redesign
  All current client correspondence format and language will be redesigned to improve the client experience when receiving Client Correspondence regarding their Medical Assistance benefits.

- MAGI Medicaid/CHP+ Eligibility Response to Connect for Health Colorado
  This project pertains to the marketplace's usage of the CBMS Rules Engine (commonly referred to as EES) to receive an eligibility determination for Medicaid and CHP+.
- PEAK – Apply for Benefits & Call Rules Engine
  PEAK must be updated to call the CBMS Rules Engine in order to run real time eligibility when an application is submitted online.

Collaborating to Cover More Coloradans
The state departments responsible for implementing health care reform are working collaboratively to help the general public understand what the changes mean to them through traditional and social media and through outreach with community partners throughout the State. The Department is working with other agency partners to launch a consumer-geared interdepartmental health resource center online to help answer questions and more quickly direct Coloradans to resources.

Consumer Direction

The Department continues to prioritize initiatives to further establish a customer-focused Medicaid program with improved health outcomes and client experience, delivered in a cost-effective manner. These initiatives include development of the Community Living Advisory Group (CLAG), the Community First Choice (CFC) option, and transferring the Department of Developmental Disabilities from the Department of Human Services to the Department of Health Care Policy and Financing.

Community Living Advisory Group (CLAG)
In July 2012, Governor Hickenlooper created the Office of Community Living through an Executive Order, codified by HB 13-1314, with the goal of redesigning all aspects of the long-term services and supports (LTSS) delivery system, including service models, payment structures, and data systems to create efficient and person-centered community-based care. In furtherance of this goal, the Executive Order also created the Community Living Advisory Group (Advisory Group) to consider and recommend necessary changes to the system to ensure responsiveness, flexibility, accountability, and self-directed LTSS.

The Advisory Group began its work in August 2012, and will continue to meet through September 2014. The group began by reviewing prior advisory work that had been done in the LTSS arena, including the work of the SB 05-173 Advisory Committee, the HB 07-1374 Working Group, and the 2010 Olmstead Work Group. It is working closely with the Colorado Commission on Aging and other planning groups to complete its work and build on previous discussions and recommendations. As the Advisory Group continues its work, subcommittees or other work groups will be added as needed. Currently, the Advisory Group oversees the work of the following subcommittees:

- Care Coordination
- Entry Point / Eligibility
- Regulatory
- Waiver Simplification

The Department added Advisory Group members during the work process as needed. The current Advisory Group Membership List is found on the Community Living Advisory Group Web Page[2].

The Advisory Group began to receive and consider recommendations from its subcommittees and remains an ongoing process. This work will result in a written recommendation to be submitted to the Governor by September 2014. The Department has engaged professional facilitation and planning expertise to ensure that the Advisory Group succeeds in developing and presenting a plan for LTSS system redesign in the time designated by the Governor.

Community-First Choice (CFC)

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 people whose functional need meets an institutional level of care.

In September 2012, the Department established the Community-First Choice Council (CFC Council) to explore the feasibility of CFC in Colorado. With federal grant funds, the Department has contracted with Mission Analytics Group to prepare a feasibility analysis report, which includes the input from the CFC Council. This report should be available in late 2013.

The CFC Council has been meeting monthly since September 2012 and will be making recommendations to the state in late 2013.

HB 13-1314: Transfer the Division of Developmental Disabilities to the Department of Health Care Policy and Financing

In response to a request for information (RFI) submitted to the Department of Human Services (DHS) and the Department of Health Care Policy and Financing (HCPF) in April 2011, the Departments expressed interest and advocated for moving the Developmental Disabilities Programs from DHS to HCPF. In 2013, HB 13-1314 was signed into law, transferring the Division for Developmental Disabilities in DHS to HCPF by March 1, 2014.

Primary reasons for the transfer are:

- Communication processes between program staff and the federal Centers for Medicare and Medicare Services (CMS) will be streamlined because HCPF is the single state agency responsible for Medicaid.
- Program changes are fundamentally driven by the program's budget, and allowing the state department with the most experience in budgeting Medicaid funds to manage the

[2] http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251627784788

developmental disabilities waivers is expected to improve efficiencies associated with financial management of the programs.

- The transfer will eliminate the existing dual reporting requirements to DHS and HCPF, from the Community Center Boards.

An estimated 34.5 FTE will transfer from DHS to HCPF. The transfer also moves program administration for the following home- and community-based services waivers: Comprehensive Services for Adults with Developmental Disabilities (HCBS-DD), Supported Living Services (HCBS-SLS), Children's Extensive Services (HCBS-CES), and the waivers' associated Targeted Case Management (TCM) services, as well as Family Support Services.

The departments and a representative for the developmental disability community reported to the Joint Budget Committee in September 2013 and are scheduled to report again in November 2013 on the status of the transfer. Currently, the two Departments continue to work together to achieve the transfer in compliance with the law. Until the transfer is completed in 2014, the responsibility for program administration, personnel, and other administrative functions for people with developmental disabilities remains with DHS. Therefore, line item descriptions for lines that will be transferring to the Department may be found in the Department of Human Services' FY 2014-15 Annual Budget Request.

Enhanced Federal Funding for County Administration

The Centers for Medicare and Medicaid Services (CMS) recently announced that states are eligible for a 75% federal match on certain Affordable Care Act (ACA) related activities. Based on guidance from CMS, the Department believes much of its County Administration, Hospital Provider Fee County Administration and Centralized Eligibility Vendor appropriations would be eligible for the enhanced match; however, the true amount of the enhanced match will not be known until the Department receives approval for a Maintenance and Operations Advance Planning Document (MOAPD). The Department has submitted this document to CMS on August 21, 2013 and is awaiting a reply.

The enhanced match would repurpose General Fund savings, for: ACA implementation activities, incentives for improvement in the eligibility determination process, infrastructure improvements, and Medical Assistance sites. In order to repurpose the General Fund, the Department has submitted an interim supplemental request in September 2013 requesting the removal of the (M) head note on the County Administration line item to allow the Department to repurpose General Fund for the activities described above. The Department has also submitted a FY 2014-15 decision item in November 2013, and intends to submit a supplemental request in January 2014, with proposals for the use of the surplus General Fund.

For more information, please see the Department's R-6 "County Administration Funding Changes" FY 2014-15 budget request.

Pharmacy

The Pharmacy Unit of the Department manages the pharmacy benefits for all Colorado Medicaid clients. The unit also manages drug reimbursement to pharmacies for medications, as well as ensuring appropriate use of prescribed medications. Pharmacy staff work closely with stakeholders to improve client health while balancing costs of pharmaceutical care. The unit is currently working with the Department's Rates Section to develop a new reimbursement methodology to reduce drug costs to the State. Other pharmacy-related projects include implementing an Average Acquisition Cost (AAC) pricing methodology, conducting a Cost of Dispensing (COD) survey, expanding the Department's Drug Utilization Review program, and management strategies of Physician-Administered Medications (PAMs).

Average Acquisition Cost (AAC)

AAC is a new pricing methodology implemented by the Department on February 1, 2013, to reimburse Medicaid pharmaceutical providers in Colorado. AAC is a statistically valid averaging of acquisition cost, which is the invoice price to the pharmacy of a prescription drug dispensed to a Medicaid recipient, minus the amount of all discounts and other cost reductions attributable to such dispensed drug. The purpose of utilizing an AAC methodology is to establish a transparent, timely, and accurate pharmacy reimbursement system based on actual acquisition cost (invoice) data. With the AAC pricing methodology, a pharmacy will now be paid the prevailing AAC rate for a pharmaceutical product or the prevailing Wholesale Acquisition Cost (WAC) rate if AAC is not available. Through AAC, Medicaid pharmaceutical reimbursement is more representative of Colorado pharmaceutical cost and is more transparent to both the Department and pharmaceutical community.

Cost of Dispensing (COD)

The Department completed a COD survey in July 2012 to identify the current cost required to dispense a pharmaceutical product to a client. Through this survey, the Department identified that dispensing costs vary significantly when considering a pharmacy's total prescription volume. The study concluded that, as total prescription volume increases, dispensing costs decrease. With varying dispensing costs and the Department's desire to match Medicaid reimbursement as close to pharmacy cost as possible, the Department implemented a dispensing fee methodology tiered on total annual prescription volume. A pharmacy's dispensing fee is now based on how their total annual prescription volume fits within one of several different tiers. The current dispensing fees and corresponding prescription volume tiers are provided in the table below:

Total Annual Prescription Volume	Dispensing Fee
Less than 60,000	$13.40
60,000 and 89,999	$11.49
90,000 and 109,999	$10.25
More than 110,000	$9.31

Drug Utilization Review (DUR)
Beginning July 1, 2011, the Department began contracting with the University of Colorado, Skaggs School of Pharmacy and Pharmaceutical Sciences for DUR duties. Since then, this relationship has grown to be crucial in the evaluation of the Department's pharmacy claims and the implementation of evidence-based criteria. With the help of the School of Pharmacy (SOP), the Department is now able to provide more cost-effective and more appropriate pharmaceutical care to the Medicaid clients of Colorado.

The Department is hoping to expand the scope of work that the SOP currently does for us to include more of an educational component, as well as the ability to help with the enforcement of some of our pharmacy criteria. Both of these will allow the Department to provide higher quality care for a better value. For more information, please see the Department's R-11 "Funding for Utilization Review Services" FY 2014-15 budget request.

Physician-Administered Medications (PAMs)
PAMs refer to any medications that would be given to a patient inside the physician's office or in a health care setting. These medications are typically billed to Medicaid as a medical claim and are reimbursed based on a fee schedule. There are currently no restrictions on any of these medications billed in this manner, which allows uncontrolled cost for the Department. Further, the Department has no way to ensure appropriate use. The pharmacy section is beginning to explore the options for the better management of the PAMs.

Specialty Care Payment Reform: Building the Medical Neighborhood in the ACC
Over the last three years, the Accountable Care Collaborative (ACC) has transformed Colorado Medicaid. In the ACC, Medicaid members receive coordinated care from a patient-centered medical home, and Primary Care Medical Providers have support in providing high-quality, efficient care. With over 350,000 clients and more than 2,300 rendering primary care physicians participating, the ACC has garnered the attention of various aspects of the health care system in Colorado and has built a strong foundation for continuous change.

The Regional Care Collaborative Organizations (RCCOs) have built a formal network of contracted Primary Care Medical Providers (PCMPs) and an informal (non-contracted) network of specialists. The Department plans to continue to gain efficiencies and improvements in the health care system by formalizing, expanding, and enhancing the program's specialty care component.

The Department will enhance specialty care services within the construct of the Medical Neighborhood model. In a Medical Neighborhood, PCMPs collaborate closely with specialists to use limited specialist resources in the most efficient and effective ways possible. The Department will ensure improved access and appropriate utilization of specialty care by:

- increasing the number of specialists participating in the ACC Program;
- establishing a framework for PCMP/specialty care collaboration in the ACC; and
- leveraging telehealth technologies to enhance collaboration and more effectively use the specialty care network.

Increasing Specialist Participation in the ACC

The Department is partnering with the RCCOs to expand their specialist networks by engaging in widespread outreach efforts to enroll specialists in Medicaid who do not currently serve Medicaid. Activities are focused on specialist types and geographic areas where there are shortages. To improve outreach efforts, the Department and RCCOs are identifying and addressing barriers to specialist participation in the ACC. Common challenges include reducing specialty visit no-show rates, providing timely medical history and appropriate medical information about clients, and facilitating the non-medical and medical care coordination that Medicaid clients may require.

Establishing a Framework for Primary Care: Specialty Care Collaboration in the ACC

Once the specialist is participating, the Department seeks to ensure that those specialty services are used appropriately. PCMPs and Specialists will generally collaborate four ways for Medicaid Members in the ACC:

1. Pre-consultation exchange – intended to expedite/prioritize care, or clarify need for referral
2. Formal consultation – to deal with a discrete question/procedure
3. Co-Management
    - Co-management with shared management for the disease
    - Co-management with principal care for the disease
    - Co-management with principal care for the patient for a consuming illness for a limited period
4. Transfer patient to specialist for entirety of care

By establishing a framework with different levels of primary and specialty care collaboration, providers are able to communicate directly and regularly to discuss clients and determine the appropriate level of care required for each case. In short, clients receive the right care at the right place and the right time. Improving the PCMP/specialist collaboration will ensure that comprehensive primary care is delivered in the ACC and that specialty referrals are made only when truly necessary.

In order to facilitate the PCMP/specialty care relationship, proper payment incentives must be tied to each level of collaboration contained in the framework. Rather than simply raising specialty care reimbursement rates and increasing volume to incentivize specialist participation in the ACC, specialty care payment should be reformed to provide incentives that encourage collaboration with PCMPs and financially reward specialists for providing less costly and more effective services.

Leverage Telehealth Technology to Enable Enhanced Coordination

The Department is also examining several technological solutions that could provide the necessary infrastructure to support the PCMP/Specialty care relationship. Such solutions could include:

- Telehealth consults
- Project ECHO, which uses telecommunication technology to connect PCMPs with a panel of specialists who provide clinical training and weekly physician-to-physician consultations to review client cases
- Doc2Doc, which provides an online portal that physicians and specialists use to communicate directly and immediately determine the best course of action for a client.

Telehealth programs such as these may be used to support the collaboration framework, increase comprehensive primary care, and expand specialty care capacity in the ACC.

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 the 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. Although several of these components were modern when first designed (e.g., the MMIS is accessible by Department users through a Windows interface), 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 has received funding 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. The Department is seeking a flexible and adaptable solution, with Business Intelligence and Analytics tools, that maximizes the use of cost-effective, industry-related, and application-ready Commercial Off-The-Shelf (COTS) technologies that will support the existing Colorado Medical Assistance program and future expansions and changes as directed by the Department's Medicaid Director.

The Department has released three (3) separate Requests for Proposals (RFPs) to provide flexibility for Offerors to provide innovative solutions. These RFPs are the:

- Core MMIS and Supporting Services
- Business Intelligence and Data Management Services (BIDM)
- Pharmacy Benefits Management System (PBMS).

The Core MMIS and Supporting Services implementation timeline is as follows:

Date	Milestone
8/1/2012	Draft RFP released
9/18/2012	Pre-RFP Vendor Conference #1
9/28/2012	Vendor Comments due on Draft RFP #1
11/16/2012	Draft RFP #2 released
12/3/2012	Vendor Comments due on Draft RFP #2
12/6/2012	Pre-RFP Vendor Conference #2
1/18/2013	Official RFP Release
5/17/2013	RFP Responses due from Vendors
8/19/2013 – 9/13/2013	Solution Demonstrations and Oral Presentations
9/30/2013	Notice of Intent to Award
11/1/2013	Contract Start
11/1/2013 – 4/30/2014	Business Process Re-Engineering Stage
11/1/2013 – 6/30/2016	Implementation Stage I: Online Provider Enrollment Implementation
11/1/2013 – 6/30/2016	Implementation Stage II: Core MMIS and Supporting Services Implementation
7/1/2016 – 6/30/2021	Ongoing MMIS Operations and Fiscal Agent Operations Stage
7/1/2016 – 6/30/2017	Implementation Stage III: Supplementary Supporting Services Implementation

The PBMS Implementation Timeline is as follows:

Date	Milestone
9/4/2012	Draft RFP released
9/18/2012	Pre-RFP Vendor Conference
11/5/2012	Vendor Comments due on Draft RFP
5/3/2013	Official RFP Release
10/8/2013	RFP Responses due from Vendors
5/2/2014	Notice of Intent to Award
8/1/2014	Contract Start
8/1/2014 – 6/30/2016	DDI Phase
7/1/2016 – 6/30/2021	PBMS Operations

The BIDM Implementation Timeline is as follows:

Date	Milestone
5/24/2013	Draft RFP released
6/14/2013	Vendor Comments due on Draft RFP
6/27/2013	Pre-RFP Vendor Conference
8/16/2013	Draft RFP #2 released
9/3/2013	Vendor Comments due on Draft RFP #2
10/25/2013	Official RFP Release
2/3/2014	RFP Responses due from Vendors
6/30/2014	Notice of Intent to Award
10/1/2014	Contract Start
10/1/2014 – 6/30/2016	DDI Phase
7/1/2016 – 6/30/2021	BIDM Services Operations

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®) [3] 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 (PCPP), and Medicaid fee-for-service (FFS). As part of a comprehensive quality improvement effort, the Department requires managed physical health plans to conduct the CAHPS 5.0H Survey of Adults and 5.0H 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 2012. The survey period for this questionnaire was July through December 2012, and the data was collected between February and May 2013. National averages for 2012 (the most recent comparative data available) are included.

In October of 2012, CMS directed the administration of a "Child Medicaid – Children with Chronic Conditions" supplemental CAHPS survey in 2013. Due to the extra burden and short timeline, both of the managed physical health plans (Denver Health and Rocky Mountain Health Plans) were excused from administrating an Adult Medicaid CAHPS. This resulted in the Adult Medicaid CAHPS being scored for only the Fee-for-Service (FFS) and Primary Care Physicians Program (PCPP) in 2013. Also in 2013, a joint venture with the Colorado Health Institute using a grant from The Colorado Health Foundation allowed the Department to do an additional CAHPS survey of Regional Collaborative Care Organization (RCCO) members so that a baseline comparison between non-RCCO FFS members and RCCO FFS members may be established for future comparison. This additional survey population has been budgeted to continue. The results from that survey will be available by the end of calendar year 2013.

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 or were

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

excused from being surveyed are denoted as "not available" (N/A). Health Services Advisory Group, the contracted External Quality Review Organization that calculates CAHPS, has advised that plan ratings should not be compared to national averages. Using a national average would not be practicable due its statistical sensitivity in comparison to plan results. It is equally impractical to use a statewide average, which is calculated by the National Committee for Quality Assurance, because plan results have case-mix differences factored into the numbers, while the statewide average does not factor case-mix differences.

FY 2012-13 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	★	★	N/A	N/A
Rating of All Health Care	★★	★★	N/A	N/A
Rating of Personal Doctor	★★	★★★	N/A	N/A
Rating of Specialist Seen Most Often	★★	★★	N/A	N/A
Composite Measures				
Getting Needed Care	★★★	★★★	N/A	N/A
Getting Care Quickly	★★	★★★	N/A	N/A
How Well Doctors Communicate	★★★	★★★	N/A	N/A
Customer Service	★	★★★	N/A	N/A
Shared Decision Making	★★	★★★★	N/A	N/A
★★★★★90th Percentile or Above ★★★★75th-89th Percentiles ★★★50th-74th Percentiles				
★★25th-49th Percentiles ★Below 25th Percentile **N/A** Not Available				

FY 2012-13 CAHPS Results				
	Fee-For-Service	**Primary Care Physician Program**	**Denver Health MP**	**Rocky Mountain Health Plan**
Child Medicaid- Children with Chronic Conditions				
Global Ratings				
Rating of Health Plan	★★	★★★	★★★★	★★★
Rating of All Health Care	★★★	★★★★★	★★★★★	★★★★
Rating of Personal Doctor	★★★★	★★★★	★★★★★	★★★★★
Rating of Specialist Seen Most Often	N/A	N/A	★★★★★	N/A
Composite Measures				
Getting Needed Care	★★★★★	★★★★	★★	★★★★★
Getting Care Quickly	★★★	★★★★★	★	★★★★★
How Well Doctors Communicate	★★★	★★★★★	★★★	★★★★
Customer Service	N/A	★★★★	★★	N/A
Shared Decision Making*	N/A	N/A	N/A	N/A
★★★★★80th Percentile or Above ★★★★60th-79th Percentiles ★★★40th-59th Percentiles				
★★20th-39th Percentiles ★Below 20th Percentile **N/A** Not Available				

Health Effectiveness Data and Information Set (HEDIS)

The Health Effectiveness Data and Information Set (HEDIS®) [4] 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 2013 rates reflect services provided January 1, 2012, through December 31, 2012.

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

HEDIS 2013 Medicaid Measures	RMHP	DHMC	PCPP	FFS	HMO Weighted Average[1]	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average[2]	HEDIS 2012 National Medicaid Average
Childhood Immunization Status (A)[3] (Percent of children with immunization)								
Combination 2	51.45%	81.22%	74.25%	59.52%	71.86%	59.89%	61.20%	74.48%
Combination 3	49.62%	80.87%	72.62%	56.35%	71.04%	56.77%	58.33%	70.64%
Combination 4	9.19%	80.73%	72.39%	48.57%	58.22%	49.18%	50.16%	34.19%
Combination 5	40.89%	65.75%	58.70%	41.58%	57.93%	42.01%	43.75%	51.88%
Combination 6	31.39%	69.76%	45.94%	34.30%	57.69%	34.59%	37.11%	37.93%
Combination 7	8.27%	65.61%	58.47%	36.13%	47.57%	36.70%	37.89%	27.09%
Combination 8	5.82%	69.69%	45.94%	31.72%	49.59%	32.09%	34.00%	20.89%
Combination 9	27.11%	56.96%	38.05%	26.42%	47.57%	26.72%	29.00%	30.48%
Combination 10	5.51%	56.89%	38.05%	24.44%	40.72%	24.78%	26.52%	17.30%
4 Diptheria, Tetanus, Pertussis	79.17%	81.29%	77.73%	65.47%	80.63%	65.79%	67.41%	79.81%
3 Polio Virus immunizations	88.36%	90.01%	92.34%	81.77%	89.49%	82.04%	82.85%	90.54%
1 Measles, Mumps, and Rubella	91.27%	90.01%	91.88%	81.02%	90.41%	81.30%	82.29%	90.87%
3 Haemophilus Influenza Type b	91.88%	89.52%	93.27%	82.36%	90.27%	82.64%	83.47%	90.98%
3 Hepatitis B immunizations	62.48%	92.33%	91.88%	81.17%	82.94%	81.44%	81.60%	88.78%
1 VZV (Chicken Pox) vaccine	90.66%	89.87%	91.88%	81.04%	90.12%	81.32%	82.28%	90.47%
4 Pneumococcal Conjugate	79.79%	84.18%	85.38%	66.79%	82.80%	67.26%	68.96%	79.28%
1 Hepatitis A	12.86%	89.38%	92.34%	68.10%	65.30%	68.72%	68.34%	39.16%

HEDIS 2013 Medicaid Measures	RMHP	DHMC	PCPP	FFS	HMO Weighted Average[1]	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average[2]	HEDIS 2012 National Medicaid Average
Required Number of Rotavirus	70.29%	68.21%	67.98%	55.55%	68.87%	55.87%	57.29%	62.35%
2 Influenza	54.36%	74.05%	53.60%	44.12%	67.86%	44.36%	46.93%	44.81%
Immunizations for Adolescents (A)[3] (Percent of children with immunization)								
Combination 1	53.79%	79.54%	70.66%	55.74%	71.95%	56.42%	58.11%	60.54%
Meningococcal	57.32%	80.17%	71.06%	57.32%	73.44%	57.94%	59.63%	63.18%
Tdap/Td	81.57%	81.75%	86.83%	75.15%	81.70%	75.68%	76.34%	75.80%
Percent of Children with Well-Child Visits in the First 15 Months of Life (H)								
0 visits	0.23%	1.22%	2.67%	1.95%	0.84%	1.95%	1.88%	1.95%
6 or more	82.64%	69.10%	62.00%	61.31%	74.23%	61.32%	62.19%	61.75%
Percent of Children with Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (H)	66.75%	66.91%	61.56%	60.34%	66.86%	60.38%	61.13%	72.03%
Percent of Adolescents Receiving a Well-Care Visit (H)	42.82%	49.15%	39.42%	37.71%	47.34%	37.79%	38.79%	49.71%
Percent of Children/Adolescents Receiving Weight Assessment and Counseling for Nutrition and Physical Activity (H)								
BMI Assessment - 3-11 Years	74.60%	88.08%	77.66%	53.51%	83.72%	54.32%	57.87%	45.84%
Nutrition Counseling - 3-11 Years	66.67%	75.83%	65.20%	58.67%	72.86%	58.89%	60.58%	51.58%
Physical Activity Counseling - 3-11 Yrs	57.78%	54.97%	65.93%	45.02%	55.88%	45.73%	46.95%	39.37%
BMI Assessment - 12-17 Years	67.94%	87.16%	78.26%	51.43%	81.01%	52.75%	56.05%	46.56%
Nutrition Counseling - 12-17 Years	55.73%	73.39%	54.35%	51.43%	67.75%	51.57%	53.46%	46.92%

HEDIS 2013 Medicaid Measures	RMHP	DHMC	PCPP	FFS	HMO Weighted Average[1]	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average[2]	HEDIS 2012 National Medicaid Average
Physical Activity Counseling - 12-17 Yr	54.20%	67.89%	60.14%	55.71%	63.51%	55.93%	56.82%	43.23%
BMI Assessment - Total	72.65%	87.83%	77.86%	52.80%	82.94%	53.75%	57.24%	45.99%
Nutrition Counseling - Total	63.45%	75.18%	61.56%	56.20%	71.40%	56.41%	58.20%	50.08%
Physical Activity Counseling - Total	56.73%	58.39%	63.99%	48.66%	57.86%	49.25%	50.28%	40.63%
Testing for Children with Pharyngitis	89.90%	70.30%	68.16%	73.51%	84.27%	73.36%	74.23%	66.66%
Prenatal and Postpartum Care (H)								
Timeliness of Prenatal Care	95.64%	85.40%	86.34%	78.59%	90.37%	78.76%	79.82%	82.75%
Postpartum Care	73.83%	54.99%	69.67%	56.69%	64.13%	56.97%	57.63%	64.12%
Percent of Children and Adolescents' Accessing Primary Care Practitioner								
Ages 12 to 24 Months	96.90%	92.28%	97.86%	94.64%	93.74%	94.72%	94.61%	96.07%
Ages 25 Months to 6 Years	87.14%	78.88%	86.55%	81.85%	81.42%	81.98%	81.91%	88.19%
Ages 7 to 11 Years	90.90%	83.64%	89.61%	86.35%	85.77%	86.45%	86.37%	89.54%
Ages 12 to 19 Years	89.99%	85.82%	88.78%	86.09%	87.14%	86.20%	86.30%	87.89%
Percent of Adults Accessing Preventive Care								
Total	88.81%	70.11%	83.02%	77.00%	76.45%	77.32%	77.23%	81.92%
Ages 20 to 44 Years	85.71%	66.48%	82.06%	75.83%	73.67%	76.08%	75.84%	80.04%
Ages 45 to 64 Years	91.62%	75.42%	84.62%	81.63%	80.04%	81.82%	81.60%	86.05%
Ages 65 Years and Older	96.54%	71.30%	82.83%	75.03%	79.35%	75.62%	75.93%	83.47%

HEDIS 2013 Medicaid Measures	RMHP	DHMC	PCPP	FFS	HMO Weighted Average[1]	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average[2]	HEDIS 2012 National Medicaid Average
Percent of Women Receiving Chlamydia Screening								
Total	46.15%	72.35%	28.75%	53.96%	61.49%	53.16%	54.02%	58.00%
Ages 16 to 20 Years	44.31%	71.26%	27.49%	48.78%	61.30%	48.00%	49.39%	54.91%
Ages 21 to 24 Years	47.55%	73.53%	30.28%	58.74%	61.67%	57.95%	58.33%	63.43%
Percent of Women Receiving Breast Cancer Screening	47.79%	49.16%	30.36%	27.87%	48.72%	28.06%	30.42%	50.43%
Percent of Women Receiving Cervical Cancer Screening (A)[3]	55.02%	51.13%	27.66%	44.76%	52.55%	43.99%	44.91%	66.72%
Percent of Adults Receiving BMI Assessment (H)	80.26%	86.86%	71.05%	71.29%	84.42%	71.27%	72.82%	52.57%
Anti-depressant Medication Management								
Effective Acute Phase Treatment	NB	57.14%	65.35%	64.02%	57.14%	64.05%	63.73%	51.11%
Effective Continuation Phase Treatment	NB	45.05%	48.51%	49.02%	45.05%	49.01%	48.82%	34.43%
Adherence to Antipsychotics for Individuals with Schizophrenia	†	†	80.68%	75.40%	†	75.85%	75.85%^	—
Follow-up After Hospitalization for Mental Illness								
7 days	†	†	NR	NR	†	NR	NR^	46.50%
30 days	†	†	NR	NR	†	NR	NR^	64.99%
Follow-up Care for Children Prescribed ADHD Medication								
Initiation	43.56%	24.55%	35.96%	40.15%	33.65%	39.96%	39.47%	38.83%

HEDIS 2013 Medicaid Measures	RMHP	DHMC	PCPP	FFS	HMO Weighted Average[1]	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average[2]	HEDIS 2012 National Medicaid Average
Continuation	40.63%	NA	30.95%	45.24%	29.09%	44.55%	43.63%	45.87%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment								
Initiation	NB	47.14%	25.90%	27.66%	47.14%	27.60%	29.62%	39.19%
Engagement	NB	3.31%	3.01%	5.98%	3.31%	5.87%	5.60%	11.93%
Controlling High Blood Pressure (H)	73.38%	70.07%	46.47%	40.39%	71.02%	40.83%	44.85%	56.78%
Comprehensive Diabetes Care (H)								
HbA1c Testing	92.20%	83.21%	71.29%	64.48%	85.75%	64.93%	67.43%	82.53%
HbA1c Poor Control (>9.0%)	19.24%	33.58%	57.66%	67.88%	29.53%	67.20%	62.68%	43.04%
HbA1c Control (<8.0%)	72.23%	51.09%	36.98%	27.98%	57.06%	28.58%	32.00%	48.08%
Eye Exam	62.73%	50.12%	50.36%	40.63%	53.80%	41.28%	42.80%	53.35%
LDL-C Screening	75.55%	70.32%	57.91%	53.28%	71.84%	53.59%	55.81%	75.00%
LDL-C Level <100 mg/dL	44.86%	50.36%	30.66%	23.60%	48.76%	24.07%	27.07%	35.23%
Medical Attention for Nephropathy	76.22%	80.78%	66.67%	69.10%	79.45%	68.94%	70.21%	77.84%
Blood Pressure Controlled <140/80 mm Hg	61.52%	50.61%	39.66%	37.47%	53.69%	37.62%	39.55%	39.41%
Blood Pressure Controlled <140/90 mm Hg	79.85%	70.07%	54.26%	51.34%	72.83%	51.53%	54.09%	60.95%
Percent of Clients on Persistent Medications Receiving Annual Monitoring								
Total	86.03%	84.14%	66.77%	80.26%	84.55%	79.33%	80.28%	83.86%
ACE Inhibitors or ARBs	86.67%	87.44%	72.51%	87.20%	87.29%	86.37%	86.55%	85.86%

HEDIS 2013 Medicaid Measures	RMHP	DHMC	PCPP	FFS	HMO Weighted Average[1]	PCPP & FFS Weighted Average	Colorado Medicaid Weighted Average[2]	HEDIS 2012 National Medicaid Average
Digoxin	NA	NA	NA	86.42%	91.18%	86.03%	86.85%	90.28%
Anticonvulsants	75.76%	60.81%	48.87%	52.99%	66.02%	52.56%	54.32%	65.16%
Diuretics	91.78%	86.68%	77.07%	86.41%	87.67%	85.83%	86.19%	85.39%
Asthma Medication Ratio								
Total	52.27%	44.41%	58.79%	61.76%	46.89%	61.61%	60.16%	—
5-11 years	55.43%	52.32%	63.45%	70.52%	53.19%	70.23%	68.77%	—
12-18 years	53.25%	53.78%	64.10%	60.68%	53.57%	60.88%	60.22%	—
19-50 years	48.05%	27.40%	49.50%	47.05%	34.53%	47.19%	45.81%	—
51-64 years	NA	37.14%	48.57%	54.95%	39.77%	54.27%	51.20%	—
Number of Ambulatory Care Visits/1,000 Member Months: ED Visits	62.73	44.56	57.84	67.02	50.26	66.64	64.84	62.39

HMO Weighted Averages were derived from the rates of RMHP and DHMC.

[2] Colorado Medicaid Weighted Averages were derived from the rates of RMHP, DHMC, PCPP, and FFS.

[3] The rates reported in this table were derived from administrative methodology.

— This measure was new for HEDIS 2013; therefore, the HEDIS 2012 national Medicaid average was not available.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

NB indicates that the health plan did not offer the benefit required by the measure.

NR indicates that the rate could not be publicly reported because the calculated rate was materially biased, or the health plan chose not to report the measure, or the health plan was not required to report the measure. For HEDIS 2013, the *Follow-Up After Hospitalization With Mental Illness* measure was the only measure with an audit designation of NR. Please note that the Department initially considered reporting this measure for HEDIS 2013 this year using the behavioral health encounter data submitted by contracted behavioral health organizations. However, since it was determined that the Department could not identify the specific provider types for the Federally Qualified Health Centers or the Community Mental Health Centers as prescribed by the HEDIS Technical Specifications to report this measure, the Department chose not to report the measure this year.

† For HEDIS 2013, RMHP and DHMC were not required to report this measure.

^ Since RMHP and DHMC were not required to report this measure, the Colorado Medicaid Weighted Average for this measure was derived from the rates of PCPP and FFS only.

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 2007-2011 American Community Survey conducted by the United States Census Bureau as well as 2013 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 2012-13 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 2014-15 Budget Request.

Children's Basic Health Plan

Using FY 2012-13 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:

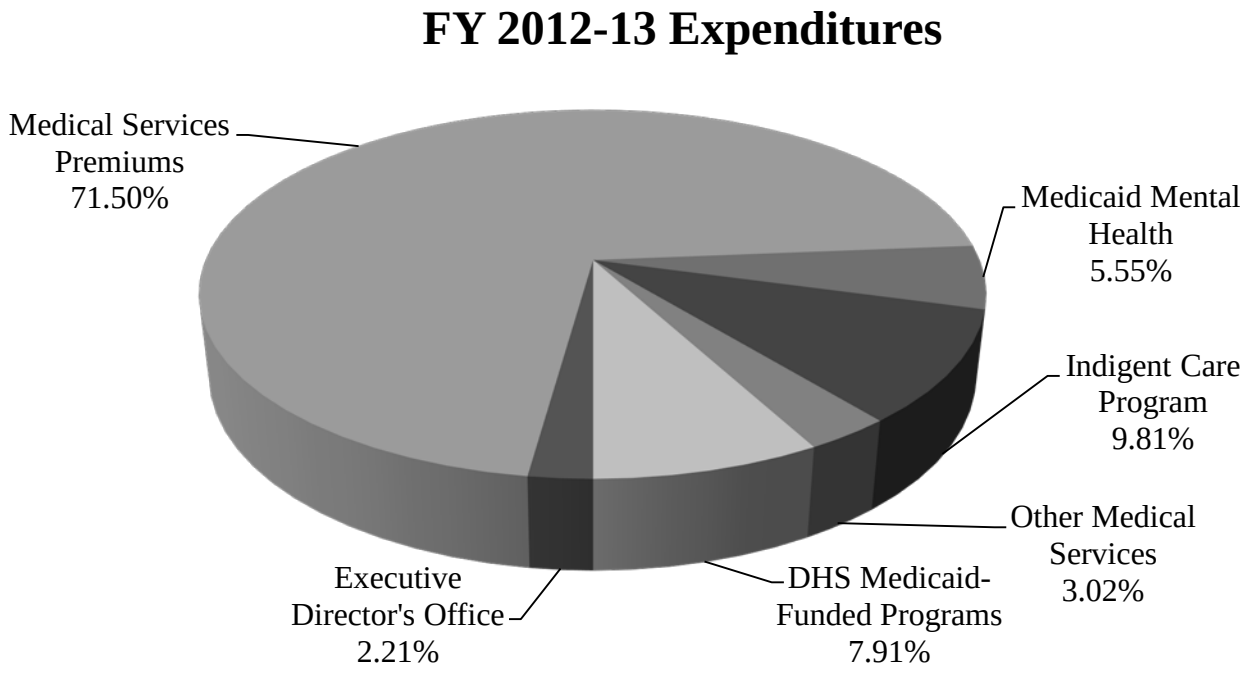
- Average Number of Children per Month;
- Percent of Population Enrolled in CHP+; and
- Children's Basic Health Plan Expenditures.

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 (2013) [1]	
Population (2007-11) [2]	
Percent of Population 16+ in Labor Force (2007-11) [2]	
Percent of Population 5+ Where Non-English is Spoken at Home (2007-11) [2]	
Percent of Households with Income Below the Poverty Level in Past 12 Months (2007-11) [2]	
Percent of Female-Headed Households (2007-11) [2]	
Medicaid Characteristics (FY 2012-13) [3]	
Average Number of Medicaid Clients per Month	
Percent of Population Who are Medicaid Clients	
Medicaid Expenditures	
Children's Basic Health Plan (CHP+) Characteristics (FY 2011-12) [4]	
Average Number of CHP+ Clients per Month	
Percent of Population Who are CHP+ Clients	
CHP+ Expenditures	
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)	
Unduplicated Client Count	
Number of CICP Providers [5]	
CICP Expenditures	

1) 2000-2040.
2) Source: 2007-2011 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml
3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients
4) CHP+ caseload does not include "CHP+ at Work" clients
5) "Number of CICP Providers" includes CICP hospitals, satellites, and clinics



Source: November 1, 2013 FY 2014-15 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 2012-13 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 2013 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 (2013) [1]	467,697	16,046	602,868	12,729
Percent of Colorado Population (2013) [1]	8.88%	0.30%	11.44%	0.24%
Population (2007-11) [2]	434,295	15,395	563,508	12,152
Percent of Colorado Population (2007-11) [2]	8.75%	0.31%	11.35%	0.24%
Percent of Population 16+ in Labor Force (2007-11) [2]	72.02%	60.14%	72.38%	61.04%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	27.58%	23.85%	21.90%	8.81%
Percent of Population Living Below the Poverty Level (2007-11) [2]	10.80%	15.00%	9.10%	5.20%
Percent of Female-Headed Households (2007-11) [2]	12.67%	11.79%	12.15%	7.19%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	80,746	4,341	75,078	1,640
Percent of Population Who are Medicaid Clients	17.26%	27.05%	12.45%	12.88%
Medicaid Expenditures	$394,343,792	$23,050,407	$416,833,890	$7,733,758
Percent of Total Medicaid Expenditures	10.53%	0.62%	11.13%	0.21%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	10,547	443	9,482	279
Percent of Population Who are CHP+ Clients	2.26%	2.76%	1.57%	2.20%
CHP+ Expenditures	$24,245,363	$1,053,042	$22,091,988	$691,450
Percent of Total CHP+ Expenditures	13.60%	0.59%	12.40%	0.39%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	19,134	8,762	13,500	0
Number of CICP Providers [5]	9	6	10	0
CICP Expenditures	$47,505,025	$3,018,204	$5,556,143	$0
Percent of Total CICP Expenditures	14.93%	0.95%	1.75%	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: 2007-2011 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

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

5) "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 (2013) [1]	3,799	6,366	307,722	60,560
Percent of Colorado Population (2013) [1]	0.07%	0.12%	5.84%	1.15%
Population (2007-11) [2]	3,807	6,164	293,205	54,592
Percent of Colorado Population (2007-11) [2]	0.08%	0.12%	5.90%	1.10%
Percent of Population 16+ in Labor Force (2007-11) [2]	61.62%	42.42%	69.95%	73.99%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	4.98%	16.15%	16.10%	13.02%
Percent of Population Living Below the Poverty Level (2007-11) [2]	14.00%	15.60%	6.50%	4.20%
Percent of Female-Headed Households (2007-11) [2]	6.63%	18.89%	7.84%	8.72%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	678	1,135	25,525	3,382
Percent of Population Who are Medicaid Clients	17.85%	17.83%	8.29%	5.58%
Medicaid Expenditures	$5,692,919	$7,497,595	$145,679,957	$23,701,134
Percent of Total Medicaid Expenditures	0.15%	0.20%	3.89%	0.63%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	97	107	3,271	611
Percent of Population Who are CHP+ Clients	2.56%	1.68%	1.06%	1.01%
CHP+ Expenditures	$196,183	$221,953	$7,278,420	$1,291,162
Percent of Total CHP+ Expenditures	0.11%	0.12%	4.08%	0.72%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	192	0	11,453	0
Number of CICP Providers [5]	1	0	6	0
CICP Expenditures	$219,162	$0	$12,787,499	$0
Percent of Total CICP Expenditures	0.07%	0.00%	4.02%	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.

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Chaffee**	**Cheyenne**	**Clear Creek**	**Conejos**
Demographic Characteristics				
Population (2013) [1]	18,726	1,924	9,009	8,456
Percent of Colorado Population (2013) [1]	0.36%	0.04%	0.17%	0.16%
Population (2007-11) [2]	17,707	2,247	9,083	8,228
Percent of Colorado Population (2007-11) [2]	0.36%	0.05%	0.18%	0.17%
Percent of Population 16+ in Labor Force (2007-11) [2]	58.87%	64.16%	73.91%	56.90%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	6.47%	8.19%	3.66%	39.24%
Percent of Population Living Below the Poverty Level (2007-11) [2]	7.50%	3.60%	3.10%	13.00%
Percent of Female-Headed Households (2007-11) [2]	6.44%	4.37%	6.13%	12.21%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	1,941	280	708	2,314
Percent of Population Who are Medicaid Clients	10.37%	14.55%	7.86%	27.37%
Medicaid Expenditures	$10,436,739	$1,335,950	$3,616,090	$11,255,587
Percent of Total Medicaid Expenditures	0.28%	0.04%	0.10%	0.30%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	389	53	90	354
Percent of Population Who are CHP+ Clients	2.08%	2.77%	1.00%	4.18%
CHP+ Expenditures	$854,469	$123,806	$202,748	$763,138
Percent of Total CHP+ Expenditures	0.48%	0.07%	0.11%	0.43%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	676	0	0	420
Number of CICP Providers [5]	3	0	0	4
CICP Expenditures	$896,933	$0	$0	$309,112
Percent of Total CICP Expenditures	0.28%	0.00%	0.00%	0.10%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Costilla**	**Crowley**	**Custer**	**Delta**
Demographic Characteristics				
Population (2013) [1]	3,716	5,914	4,543	31,741
Percent of Colorado Population (2013) [1]	0.07%	0.11%	0.09%	0.60%
Population (2007-11) [2]	3,556	5,866	3,853	30,666
Percent of Colorado Population (2007-11) [2]	0.07%	0.12%	0.08%	0.62%
Percent of Population 16+ in Labor Force (2007-11) [2]	52.88%	32.73%	53.55%	55.97%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	51.31%	14.90%	1.73%	10.52%
Percent of Population Living Below the Poverty Level (2007-11) [2]	19.40%	13.40%	7.20%	10.00%
Percent of Female-Headed Households (2007-11) [2]	11.32%	7.46%	4.21%	7.21%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	1,115	946	433	4,971
Percent of Population Who are Medicaid Clients	30.01%	16.00%	9.53%	15.66%
Medicaid Expenditures	$5,379,503	$4,931,162	$1,404,311	$22,874,217
Percent of Total Medicaid Expenditures	0.14%	0.13%	0.04%	0.61%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	87	55	63	628
Percent of Population Who are CHP+ Clients	2.35%	0.93%	1.39%	1.98%
CHP+ Expenditures	$164,544	$102,765	$140,624	$1,454,242
Percent of Total CHP+ Expenditures	0.09%	0.06%	0.08%	0.82%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	0	0	207	514
Number of CICP Providers [5]	1	0	1	1
CICP Expenditures	$0	$0	$21,578	$1,504,670
Percent of Total CICP Expenditures	0.00%	0.00%	0.01%	0.47%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Denver**	**Dolores**	**Douglas**	**Eagle**
Demographic Characteristics				
Population (2013) [1]	636,234	2,097	302,506	55,582
Percent of Colorado Population (2013) [1]	12.08%	0.04%	5.74%	1.06%
Population (2007-11) [2]	590,507	2,043	280,643	51,457
Percent of Colorado Population (2007-11) [2]	11.89%	0.04%	5.65%	1.04%
Percent of Population 16+ in Labor Force (2007-11) [2]	71.06%	65.78%	76.05%	82.73%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	27.63%	2.75%	9.04%	30.79%
Percent of Population Living Below the Poverty Level (2007-11) [2]	14.20%	8.10%	2.40%	6.40%
Percent of Female-Headed Households (2007-11) [2]	9.85%	6.77%	6.84%	7.09%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	116,167	261	10,727	3,371
Percent of Population Who are Medicaid Clients	18.26%	12.44%	3.55%	6.06%
Medicaid Expenditures	$615,984,183	$883,840	$65,751,591	$11,233,213
Percent of Total Medicaid Expenditures	16.44%	0.02%	1.76%	0.30%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	9,932	53	2,033	658
Percent of Population Who are CHP+ Clients	1.56%	2.55%	0.67%	1.18%
CHP+ Expenditures	$22,874,493	$103,278	$4,625,947	$1,426,328
Percent of Total CHP+ Expenditures	12.83%	0.06%	2.60%	0.80%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	39,342	620	0	0
Number of CICP Providers [5]	15	1	0	0
CICP Expenditures	$91,622,162	$70,620	$0	$0
Percent of Total CICP Expenditures	28.79%	0.02%	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.

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Elbert**	**El Paso**	**Fremont**	**Garfield**
Demographic Characteristics				
Population (2013) [1]	24,069	654,406	48,836	59,306
Percent of Colorado Population (2013) [1]	0.46%	12.42%	0.93%	1.13%
Population (2007-11) [2]	22,859	611,377	47,040	55,696
Percent of Colorado Population (2007-11) [2]	0.46%	12.31%	0.95%	1.12%
Percent of Population 16+ in Labor Force (2007-11) [2]	72.01%	69.80%	39.81%	74.35%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	5.15%	11.38%	10.56%	24.38%
Percent of Population Living Below the Poverty Level (2007-11) [2]	3.50%	8.60%	12.40%	7.30%
Percent of Female-Headed Households (2007-11) [2]	5.42%	11.09%	8.99%	8.52%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	1,439	83,855	7,593	7,402
Percent of Population Who are Medicaid Clients	5.98%	12.81%	15.55%	12.48%
Medicaid Expenditures	$7,674,505	$450,518,990	$50,698,646	$40,781,128
Percent of Total Medicaid Expenditures	0.20%	12.03%	1.35%	1.09%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	223	7,841	627	1,245
Percent of Population Who are CHP+ Clients	0.93%	1.20%	1.28%	2.10%
CHP+ Expenditures	$539,085	$14,506,514	$1,278,343	$2,814,694
Percent of Total CHP+ Expenditures	0.30%	8.14%	0.72%	1.58%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	0	33,972	2,281	2,750
Number of CICP Providers [5]	0	22	2	6
CICP Expenditures	$0	$39,254,466	$4,506,055	$4,091,097
Percent of Total CICP Expenditures	0.00%	12.34%	1.42%	1.29%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Gilpin**	**Grand**	**Gunnison**	**Hinsdale**
Demographic Characteristics				
Population (2013) [1]	5,637	15,016	15,982	853
Percent of Colorado Population (2013) [1]	0.11%	0.29%	0.30%	0.02%
Population (2007-11) [2]	5,241	14,634	15,274	731
Percent of Colorado Population (2007-11) [2]	0.11%	0.29%	0.31%	0.01%
Percent of Population 16+ in Labor Force (2007-11) [2]	74.26%	70.90%	73.40%	57.08%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	6.62%	11.00%	11.06%	10.98%
Percent of Population Living Below the Poverty Level (2007-11) [2]	6.40%	5.70%	5.10%	3.60%
Percent of Female-Headed Households (2007-11) [2]	6.92%	5.65%	4.20%	2.17%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	460	928	1,214	89
Percent of Population Who are Medicaid Clients	8.16%	6.18%	7.60%	10.44%
Medicaid Expenditures	$2,586,656	$4,031,895	$5,640,813	$305,109
Percent of Total Medicaid Expenditures	0.07%	0.11%	0.15%	0.01%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	64	245	283	17
Percent of Population Who are CHP+ Clients	1.13%	1.63%	1.77%	2.03%
CHP+ Expenditures	$146,429	$600,438	$616,381	$36,015
Percent of Total CHP+ Expenditures	0.08%	0.34%	0.35%	0.02%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	0	275	186	0
Number of CICP Providers [5]	1	4	1	0
CICP Expenditures	$0	$104,904	$235,017	$0
Percent of Total CICP Expenditures	0.00%	0.03%	0.07%	0.00%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Huerfano**	**Jackson**	**Jefferson**	**Kiowa**
Demographic Characteristics				
Population (2013) [1]	6,561	1,394	545,799	1,463
Percent of Colorado Population (2013) [1]	0.12%	0.03%	10.36%	0.03%
Population (2007-11) [2]	6,829	1,494	532,243	1,728
Percent of Colorado Population (2007-11) [2]	0.14%	0.03%	10.72%	0.03%
Percent of Population 16+ in Labor Force (2007-11) [2]	42.83%	70.16%	70.75%	65.14%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	19.42%	5.00%	10.20%	4.49%
Percent of Population Living Below the Poverty Level (2007-11) [2]	19.30%	12.30%	5.80%	8.90%
Percent of Female-Headed Households (2007-11) [2]	9.04%	5.03%	9.66%	9.74%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	1,659	161	49,596	206
Percent of Population Who are Medicaid Clients	25.29%	11.55%	9.09%	14.08%
Medicaid Expenditures	$11,212,224	$488,743	$366,282,794	$1,459,433
Percent of Total Medicaid Expenditures	0.30%	0.01%	9.78%	0.04%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	99	40	6,037	39
Percent of Population Who are CHP+ Clients	1.51%	2.84%	1.11%	2.63%
CHP+ Expenditures	$212,074	$85,148	$14,426,586	$84,848
Percent of Total CHP+ Expenditures	0.12%	0.05%	8.09%	0.05%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	278	0	0	0
Number of CICP Providers [5]	2	1	9	0
CICP Expenditures	$601,581	$0	$0	$0
Percent of Total CICP Expenditures	0.19%	0.00%	0.00%	0.00%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Kit Carson**	**Lake**	**La Plata**	**Larimer**
Demographic Characteristics				
Population (2013) [1]	8,235	7,839	55,104	316,031
Percent of Colorado Population (2013) [1]	0.16%	0.15%	1.05%	6.00%
Population (2007-11) [2]	8,178	7,010	50,820	296,107
Percent of Colorado Population (2007-11) [2]	0.16%	0.14%	1.02%	5.96%
Percent of Population 16+ in Labor Force (2007-11) [2]	62.12%	68.42%	69.64%	69.78%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	13.98%	29.39%	9.86%	8.87%
Percent of Population Living Below the Poverty Level (2007-11) [2]	9.10%	18.40%	6.50%	7.10%
Percent of Female-Headed Households (2007-11) [2]	9.06%	10.08%	7.81%	7.91%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	1,134	1,007	5,223	31,424
Percent of Population Who are Medicaid Clients	13.77%	12.85%	9.48%	9.94%
Medicaid Expenditures	$5,156,471	$3,769,649	$24,660,015	$169,287,854
Percent of Total Medicaid Expenditures	0.14%	0.10%	0.66%	4.52%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	284	177	1,001	4,313
Percent of Population Who are CHP+ Clients	3.45%	2.26%	1.82%	1.36%
CHP+ Expenditures	$578,417	$377,150	$2,382,491	$9,863,084
Percent of Total CHP+ Expenditures	0.32%	0.21%	1.34%	5.53%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	0	19	353	16,134
Number of CICP Providers [5]	1	1	1	9
CICP Expenditures	$0	$75,597	$2,427,910	$27,392,799
Percent of Total CICP Expenditures	0.00%	0.02%	0.76%	8.61%

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County-Level Medicaid, CHP+, and CICP Data				
Characteristics	**Las Animas**	**Lincoln**	**Logan**	**Mesa**
Demographic Characteristics				
Population (2013) [1]	15,803	5,405	22,437	150,123
Percent of Colorado Population (2013) [1]	0.30%	0.10%	0.43%	2.85%
Population (2007-11) [2]	15,549	5,462	22,417	144,766
Percent of Colorado Population (2007-11) [2]	0.31%	0.11%	0.45%	2.92%
Percent of Population 16+ in Labor Force (2007-11) [2]	56.11%	46.10%	67.18%	64.61%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	14.79%	11.54%	10.27%	9.02%
Percent of Population Living Below the Poverty Level (2007-11) [2]	13.40%	7.00%	11.50%	7.90%
Percent of Female-Headed Households (2007-11) [2]	10.23%	8.29%	12.75%	8.60%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	3,182	745	3,007	23,587
Percent of Population Who are Medicaid Clients	20.14%	13.78%	13.40%	15.71%
Medicaid Expenditures	$26,374,283	$4,227,594	$19,536,640	$118,499,567
Percent of Total Medicaid Expenditures	0.70%	0.11%	0.52%	3.16%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	242	71	367	2,731
Percent of Population Who are CHP+ Clients	1.53%	1.31%	1.63%	1.82%
CHP+ Expenditures	$505,321	$167,839	$858,888	$6,574,706
Percent of Total CHP+ Expenditures	0.28%	0.09%	0.48%	3.69%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	1,248	1,383	922	6,187
Number of CICP Providers [5]	3	1	2	6
CICP Expenditures	$1,047,514	$194,954	$2,126,324	$8,996,097
Percent of Total CICP Expenditures	0.33%	0.06%	0.67%	2.83%

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: 2007-2011 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

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

5) "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 (2013) [1]	747	13,659	26,481	41,751
Percent of Colorado Population (2013) [1]	0.01%	0.26%	0.50%	0.79%
Population (2007-11) [2]	723	13,586	25,372	40,812
Percent of Colorado Population (2007-11) [2]	0.01%	0.27%	0.51%	0.82%
Percent of Population 16+ in Labor Force (2007-11) [2]	56.60%	70.30%	63.82%	62.88%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	3.92%	11.07%	12.00%	14.20%
Percent of Population Living Below the Poverty Level (2007-11) [2]	2.90%	11.00%	14.00%	9.10%
Percent of Female-Headed Households (2007-11) [2]	0.54%	6.77%	11.63%	9.16%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	45	2,059	4,848	7,446
Percent of Population Who are Medicaid Clients	6.02%	15.07%	18.31%	17.83%
Medicaid Expenditures	$219,013	$10,131,280	$26,683,227	$31,799,239
Percent of Total Medicaid Expenditures	0.01%	0.27%	0.71%	0.85%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	6	322	702	1,259
Percent of Population Who are CHP+ Clients	0.78%	2.36%	2.65%	3.02%
CHP+ Expenditures	$18,199	$770,552	$1,513,092	$2,864,815
Percent of Total CHP+ Expenditures	0.01%	0.43%	0.85%	1.61%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	0	900	408	2,191
Number of CICP Providers [5]	0	3	7	3
CICP Expenditures	$0	$1,109,774	$621,689	$2,929,722
Percent of Total CICP Expenditures	0.00%	0.35%	0.20%	0.92%

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: 2007-2011 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

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

5) "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 (2013) [1]	29,025	19,328	4,662	16,825
Percent of Colorado Population (2013) [1]	0.55%	0.37%	0.09%	0.32%
Population (2007-11) [2]	27,943	18,795	4,371	16,259
Percent of Colorado Population (2007-11) [2]	0.56%	0.38%	0.09%	0.33%
Percent of Population 16+ in Labor Force (2007-11) [2]	65.02%	57.01%	63.24%	70.50%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	26.02%	18.70%	6.97%	3.10%
Percent of Population Living Below the Poverty Level (2007-11) [2]	12.60%	20.80%	4.30%	4.00%
Percent of Female-Headed Households (2007-11) [2]	11.36%	13.16%	3.67%	6.33%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	5,172	5,132	382	1,286
Percent of Population Who are Medicaid Clients	17.82%	26.55%	8.19%	7.64%
Medicaid Expenditures	$27,048,677	$29,894,418	$1,353,753	$5,199,530
Percent of Total Medicaid Expenditures	0.72%	0.80%	0.04%	0.14%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	639	382	107	217
Percent of Population Who are CHP+ Clients	2.20%	1.97%	2.29%	1.29%
CHP+ Expenditures	$1,445,131	$842,182	$249,287	$435,513
Percent of Total CHP+ Expenditures	0.81%	0.47%	0.14%	0.24%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	1,868	1,178	0	0
Number of CICP Providers [5]	3	3	0	0
CICP Expenditures	$1,211,652	$1,631,694	$0	$0
Percent of Total CICP Expenditures	0.38%	0.51%	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: 2007-2011 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

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

5) "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 (2013) [1]	4,335	17,598	12,730	164,280
Percent of Colorado Population (2013) [1]	0.08%	0.33%	0.24%	3.12%
Population (2007-11) [2]	4,391	16,709	12,615	157,946
Percent of Colorado Population (2007-11) [2]	0.09%	0.34%	0.25%	3.18%
Percent of Population 16+ in Labor Force (2007-11) [2]	63.47%	75.94%	65.93%	59.56%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	16.81%	15.65%	25.60%	13.87%
Percent of Population Living Below the Poverty Level (2007-11) [2]	6.90%	5.20%	18.20%	13.80%
Percent of Female-Headed Households (2007-11) [2]	6.14%	4.96%	11.75%	13.96%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	626	382	3,194	38,787
Percent of Population Who are Medicaid Clients	14.44%	2.17%	25.09%	23.61%
Medicaid Expenditures	$3,526,744	$1,905,725	$17,286,128	$242,285,471
Percent of Total Medicaid Expenditures	0.09%	0.05%	0.46%	6.47%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	99	95	394	2,407
Percent of Population Who are CHP+ Clients	2.28%	0.54%	3.10%	1.47%
CHP+ Expenditures	$223,469	$216,998	$833,832	$5,266,011
Percent of Total CHP+ Expenditures	0.13%	0.12%	0.47%	2.95%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	146	291	2,112	15,828
Number of CICP Providers [5]	2	2	6	12
CICP Expenditures	$129,359	$1,013,138	$1,515,201	$27,202,704
Percent of Total CICP Expenditures	0.04%	0.32%	0.48%	8.55%

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: 2007-2011 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

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

5) "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 (2013) [1]	6,868	12,285	24,277	6,478
Percent of Colorado Population (2013) [1]	0.13%	0.23%	0.46%	0.12%
Population (2007-11) [2]	6,616	11,913	23,201	6,165
Percent of Colorado Population (2007-11) [2]	0.13%	0.24%	0.47%	0.12%
Percent of Population 16+ in Labor Force (2007-11) [2]	67.90%	56.78%	78.03%	63.87%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	8.85%	22.24%	4.86%	33.23%
Percent of Population Living Below the Poverty Level (2007-11) [2]	1.50%	12.50%	5.30%	19.40%
Percent of Female-Headed Households (2007-11) [2]	5.40%	10.00%	6.97%	10.83%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	797	3,053	1,543	1,554
Percent of Population Who are Medicaid Clients	11.60%	24.85%	6.36%	23.99%
Medicaid Expenditures	$3,733,140	$16,076,625	$8,611,437	$5,627,949
Percent of Total Medicaid Expenditures	0.10%	0.43%	0.23%	0.15%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	95	400	484	165
Percent of Population Who are CHP+ Clients	1.39%	3.25%	1.99%	2.54%
CHP+ Expenditures	$187,243	$866,610	$1,158,655	$365,140
Percent of Total CHP+ Expenditures	0.11%	0.49%	0.65%	0.20%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	0	526	565	0
Number of CICP Providers [5]	0	5	1	0
CICP Expenditures	$0	$379,420	$1,892,347	$0
Percent of Total CICP Expenditures	0.00%	0.12%	0.59%	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: 2007-2011 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

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

5) "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 (2013) [1]	697	8,148	2,428	29,499
Percent of Colorado Population (2013) [1]	0.01%	0.15%	0.05%	0.56%
Population (2007-11) [2]	801	7,383	2,390	27,496
Percent of Colorado Population (2007-11) [2]	0.02%	0.15%	0.05%	0.55%
Percent of Population 16+ in Labor Force (2007-11) [2]	73.31%	85.28%	59.11%	81.99%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	10.17%	9.86%	8.42%	15.89%
Percent of Population Living Below the Poverty Level (2007-11) [2]	10.20%	5.20%	10.90%	4.60%
Percent of Female-Headed Households (2007-11) [2]	9.16%	5.53%	5.33%	5.47%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	80	616	431	1,650
Percent of Population Who are Medicaid Clients	11.48%	7.56%	17.75%	5.59%
Medicaid Expenditures	$287,347	$1,306,396	$3,376,240	$5,028,828
Percent of Total Medicaid Expenditures	0.01%	0.03%	0.09%	0.13%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	20	131	46	401
Percent of Population Who are CHP+ Clients	2.86%	1.61%	1.91%	1.36%
CHP+ Expenditures	$32,970	$329,047	$76,743	$868,903
Percent of Total CHP+ Expenditures	0.02%	0.18%	0.04%	0.49%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	0	287	87	766
Number of CICP Providers [4]	0	1	2	1
CICP Expenditures	$0	$93,000	$105,075	$557,168
Percent of Total CICP Expenditures	0.00%	0.03%	0.03%	0.18%

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: 2007-2011 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

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

5) "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 (2013) [1]	23,602	4,615	268,639	10,309
Percent of Colorado Population (2013) [1]	0.45%	0.09%	5.10%	0.20%
Population (2007-11) [2]	23,035	4,709	248,441	9,960
Percent of Colorado Population (2007-11) [2]	0.46%	0.09%	5.00%	0.20%
Percent of Population 16+ in Labor Force (2007-11) [2]	65.04%	65.50%	68.75%	64.93%
Percent of Homes Where Non-English is Spoken (2007-11) [2]	5.58%	6.60%	18.23%	16.28%
Percent of Population Living Below the Poverty Level (2007-11) [2]	5.00%	9.70%	9.60%	4.60%
Percent of Female-Headed Households (2007-11) [2]	7.80%	4.60%	9.43%	5.99%
Medicaid Characteristics (FY 2012-13) [3]				
Average Number of Medicaid Clients per Month	2,478	579	39,541	1,634
Percent of Population Who are Medicaid Clients	10.50%	12.55%	14.72%	15.85%
Medicaid Expenditures	$13,254,558	$3,548,000	$185,824,880	$9,280,791
Percent of Total Medicaid Expenditures	0.35%	0.09%	4.96%	0.25%
Children's Basic Health Plan (CHP+) Characteristics (FY 2012-13) [4]				
Average Number of CHP+ Clients per Month	299	127	5,179	235
Percent of Population Who are CHP+ Clients	1.27%	2.76%	1.93%	2.28%
CHP+ Expenditures	$491,646	$286,708	$11,837,796	$487,777
Percent of Total CHP+ Expenditures	0.28%	0.16%	6.64%	0.27%
Colorado Indigent Care Program (CICP) Characteristics (FY 2011-12)				
Unduplicated Client Count	473	0	31,902	598
Number of CICP Providers [5]	2	1	9	4
CICP Expenditures	$422,243	$0	$21,787,324	$1,036,274
Percent of Total CICP Expenditures	0.13%	0.00%	6.85%	0.33%

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: 2007-2011 American Community Survey 5-Year Estimates, www.factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml

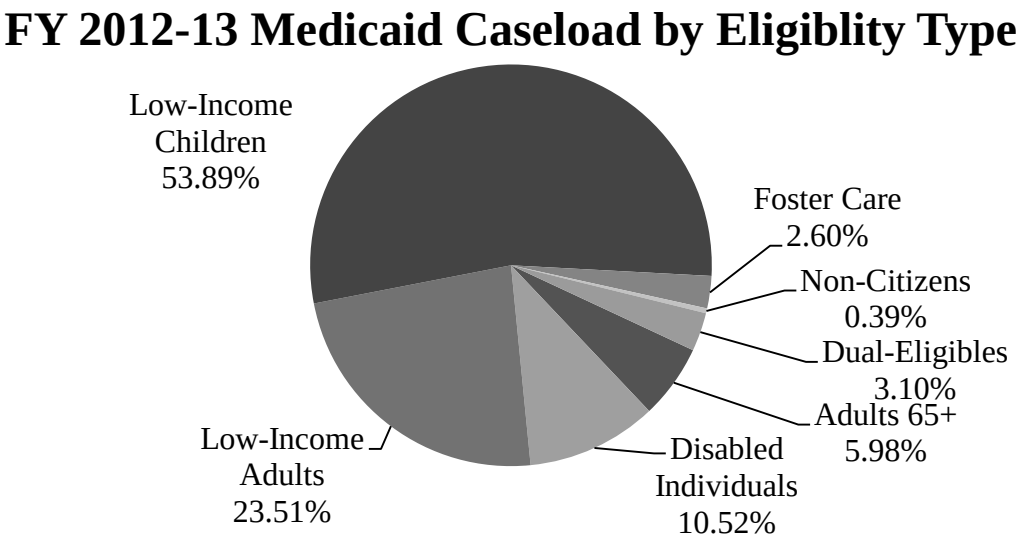
3) Medicaid caseload and expenditures do not include Presumptive Eligibility clients

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

5) "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 2012-13.[5]



[5] Source: November 1, 2013 FY 2014-15 Budget Request, Exhibit B, "Medicaid Caseload Forecast"

A. Clients

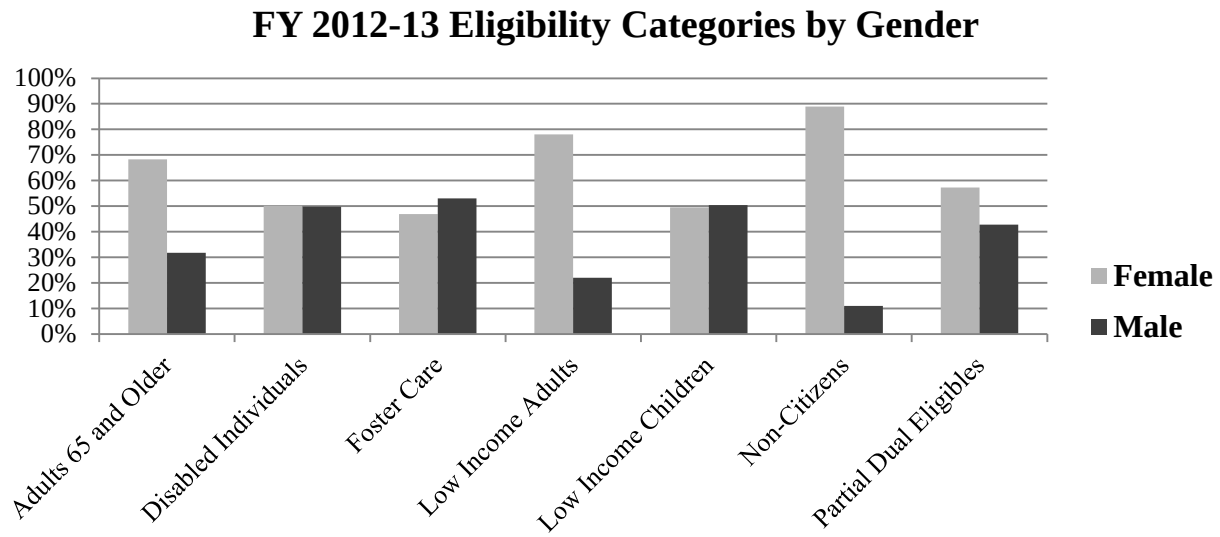
A1. 2013 Federal Poverty Levels

The table below reports the federal poverty levels (FPLs) for all states except Hawaii and Alaska from the Department of Health and Human Services. For family units of more than eight members, add $4,020 for each additional family member.

2013 Federal Poverty Guidelines for Annual Income									
Family Size	**100%**	**120%**	**133%**	**150%**	**175%**	**185%**	**190%**	**200%**	**250%**
1	$11,490	$13,788	$15,282	$15,512	$17,235	$20,108	$21,257	$22,980	$28,725
2	$15,510	$18,612	$20,628	$20,939	$23,265	$27,143	$28,694	$31,020	$38,775
3	$19,530	$23,436	$25,975	$26,366	$29,295	$34,178	$36,131	$39,060	$48,825
4	$23,550	$28,260	$31,322	$31,793	$35,325	$41,213	$43,568	$47,100	$58,875
5	$27,570	$33,084	$36,668	$37,220	$41,355	$48,248	$51,005	$55,140	$68,925
6	$31,590	$37,908	$42,015	$42,647	$47,385	$55,283	$58,442	$63,180	$78,975
7	$35,610	$42,732	$47,361	$48,074	$53,415	$62,318	$65,879	$71,220	$89,025
8	$39,630	$47,556	$52,708	$53,501	$59,445	$69,353	$73,316	$79,260	$99,075

Source: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2013-Federal-Poverty-level-charts.pdf

A2. Eligibility Categories by Gender for FY 2012-13[6]



[6] 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

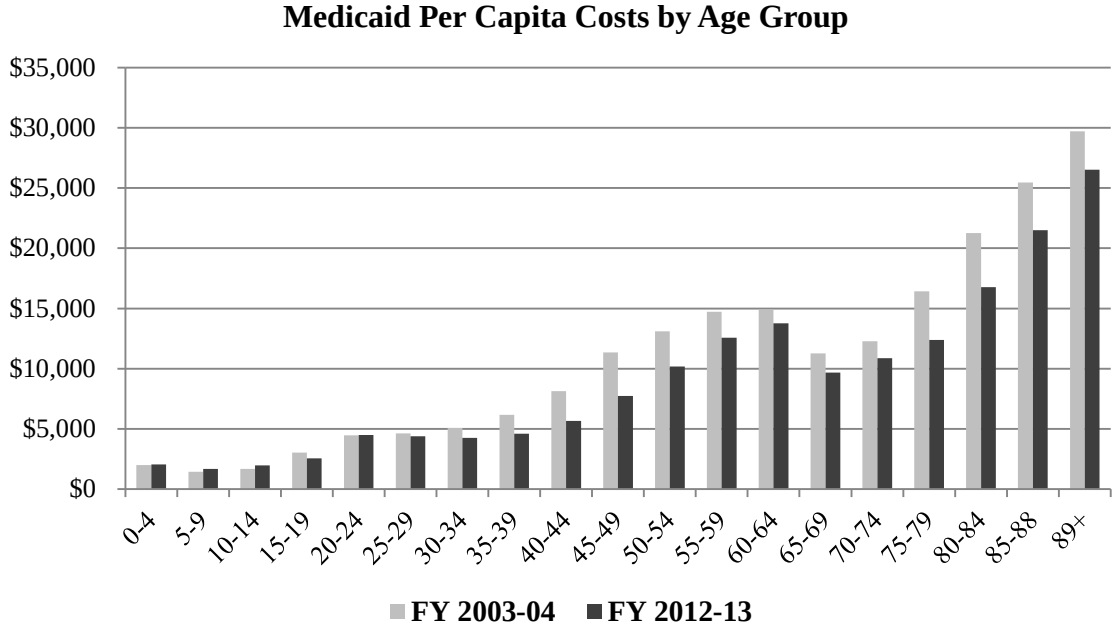
The following table shows the breakdown by client count for FY 2008-09 through FY 2012-13 for clients enrolled in health maintenance organizations, prepaid inpatient health plan, Primary Care Physician Program, and unassigned fee-for-service. Health maintenance organizations, prepaid inpatient health 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.[7]

Average Medicaid Enrollment for FY 2008-09 through FY 2012-13					
Membership Category	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**
HMOs and Prepaid Inpatient Health Plans	54,510	61,047	66,477	70,351	75,416
Primary Care Physician Program	22,717	23,240	23,380	23,264	22,953
Fee-for-Service	359,585	413,902	470,865	526,349	580,437
TOTAL	**436,812**	**498,189**	**560,722**	**619,964**	**678,806**

[7] Department of Health Care Policy and Financing June 2013 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.

B. Services

B1. Paid Medical Services Per-Capita Costs (from all claims) Across Age Groups[8]



B2. FY 2012-13 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

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

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 2012-13 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 2012-13 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-10 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.

B2a: FY 2012-13 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	25,416	64,857	49,806	6,848	37,483
Alamosa	3,090	2,961	2,954	341	1,872
Arapahoe	11,407	62,163	46,955	6,318	34,259
Archuleta	NR	1,075	1,034	123	641
Baca	108	401	412	58	274
Bent	667	778	866	66	504
Boulder	10,153	18,702	15,031	1,962	10,832
Broomfield	809	2,743	2,154	288	1,521
Chaffee	40	1,367	1,209	115	796
Cheyenne	34	159	189	NR	115
Clear Creek	158	584	500	59	271
Conejos	1,148	1,499	1,665	148	1,000
Costilla	686	621	661	72	374
Crowley	266	634	634	56	390
Custer	NR	279	247	NR	149
Delta	58	2,143	1,428	173	1,007
Denver	32,287	58,458	45,510	7,396	33,846
Dolores	84	209	163	NR	106
Douglas	415	9,612	7,440	860	4,544
Eagle	310	3,141	2,085	346	1,170
Elbert	384	1,100	973	101	570
El Paso	33,567	63,127	54,760	6,020	41,128
Fremont	575	5,562	5,381	488	3,722
Garfield	2,684	5,376	4,680	754	3,343
Gilpin	193	326	307	47	167
Grand	NR	847	637	79	444
Gunnison	NR	1,084	687	83	511
Hinsdale	NR	53	NR	NR	NR
Huerfano	92	1,149	1,033	92	743
Jackson	NR	91	91	NR	44
Jefferson	7,488	39,517	30,880	3,718	20,767
Kiowa	55	130	148	NR	89
Kit Carson	184	830	701	57	461
Lake	59	864	602	93	579
La Plata	32	4,403	3,244	378	2,399

B2a: FY 2012-13 Unduplicated Client Count for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Larimer	8,366	25,918	20,794	2,307	13,457
Las Animas	112	2,205	2,119	253	1,670
Lincoln	426	467	484	67	300
Logan	951	2,108	2,137	245	1,512
Mesa	106	8,253	5,167	850	3,358
Mineral	NR	39	NR	NR	NR
Moffat	589	1,688	1,397	167	947
Montezuma	93	3,661	3,187	339	2,290
Montrose	245	2,508	1,502	193	1,105
Morgan	1,902	3,951	3,425	457	2,482
Otero	2,020	3,886	3,573	330	2,465
Ouray	NR	167	106	NR	55
Park	125	1,076	838	89	422
Phillips	113	347	408	38	291
Pitkin	126	256	238	35	134
Prowers	1,825	2,191	2,405	221	1,593
Pueblo	10,400	30,942	27,198	2,744	19,365
Rio Blanco	NR	377	403	42	280
Rio Grande	1,788	1,998	2,042	214	1,255
Routt	120	1,457	1,003	124	590
Saguache	1,135	927	933	100	594
San Juan	NR	67	NR	NR	NR
San Miguel	180	308	197	32	63
Sedgwick	31	253	319	NR	203
Summit	219	1,593	982	150	516
Teller	1,101	1,923	1,757	191	1,309
Washington	97	371	362	38	243
Weld	16,408	32,017	26,536	3,418	18,208
Yuma	147	1,176	1,003	124	731
Suppressed Counties	129	-	113	126	82
STATEWIDE	**181,203**	**488,975**	**395,695**	**50,033**	**281,641**

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. ”NR” denotes county included in "Suppressed Counties" category.

B2b: FY 2012-13 Expenditures for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$14,151,864	$43,451,020	$34,766,005	$50,655,919	$40,409,739
Alamosa	$2,027,332	$1,531,606	$2,079,681	$2,283,254	$1,479,861
Arapahoe	$5,799,361	$40,434,277	$37,903,166	$47,997,106	$36,529,016
Archuleta	NR	$570,296	$407,139	$1,171,634	$668,528
Baca	$49,016	$194,767	$560,209	$403,931	$236,902
Bent	$392,707	$312,053	$1,218,492	$526,100	$385,792
Boulder	$5,426,172	$12,569,123	$13,282,143	$13,508,331	$10,234,867
Broomfield	$455,605	$1,830,211	$2,212,441	$2,089,951	$1,690,652
Chaffee	$12,937	$766,570	$1,061,338	$1,016,043	$763,358
Cheyenne	$10,181	$63,374	$154,599	NR	$105,687
Clear Creek	$72,111	$479,637	$412,539	$657,997	$332,249
Conejos	$630,164	$665,121	$1,119,977	$811,856	$966,703
Costilla	$424,762	$337,938	$708,053	$705,300	$343,000
Crowley	$136,191	$344,173	$694,065	$406,772	$304,106
Custer	NR	$157,471	$216,694	NR	$238,160
Delta	$33,165	$879,890	$670,232	$1,264,748	$982,551
Denver	$17,652,674	$38,838,693	$33,550,390	$70,211,620	$39,569,963
Dolores	$48,883	$91,652	$95,055	NR	$87,888
Douglas	$174,742	$7,226,051	$7,900,321	$6,546,786	$5,039,195
Eagle	$194,448	$1,645,915	$1,484,716	$2,774,787	$1,612,874
Elbert	$160,308	$788,062	$1,080,667	$1,007,970	$816,998
El Paso	$20,205,408	$42,835,055	$48,658,764	$41,241,965	$38,796,669
Fremont	$256,416	$3,559,523	$5,608,686	$4,156,352	$3,115,182
Garfield	$1,555,774	$2,831,037	$2,918,311	$5,361,893	$4,480,120
Gilpin	$83,836	$327,008	$265,897	$469,679	$247,109
Grand	NR	$506,723	$557,113	$460,180	$884,264
Gunnison	NR	$484,994	$348,154	$616,321	$624,506
Hinsdale	NR	$27,749	NR	NR	NR
Huerfano	$72,974	$717,591	$1,337,342	$679,056	$774,542
Jackson	NR	$39,122	$53,759	NR	$126,665
Jefferson	$3,997,502	$28,133,232	$30,894,559	$29,100,559	$25,224,475
Kiowa	$16,483	$43,714	$201,314	NR	$75,181
Kit Carson	$63,070	$319,201	$470,313	$499,928	$511,888
Lake	$18,752	$433,236	$454,971	$704,754	$491,409
La Plata	$12,708	$2,684,323	$2,222,283	$2,770,032	$2,193,080

B2b: FY 2012-13 Expenditures for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Larimer	$3,938,837	$16,237,637	$19,584,502	$15,258,877	$12,652,940
Las Animas	$61,667	$1,568,996	$2,058,229	$2,042,275	$1,719,131
Lincoln	$234,766	$267,797	$449,989	$445,875	$340,233
Logan	$576,744	$1,136,855	$2,212,483	$1,838,652	$1,347,605
Mesa	$42,365	$3,342,747	$1,986,854	$5,536,735	$3,349,730
Mineral	NR	$18,160	NR	NR	NR
Moffat	$299,010	$763,087	$973,737	$927,268	$1,500,661
Montezuma	$44,508	$2,020,279	$2,302,665	$2,515,752	$2,210,926
Montrose	$105,005	$975,292	$684,215	$1,594,714	$916,644
Morgan	$1,067,760	$2,047,594	$2,355,910	$2,735,926	$2,150,384
Otero	$1,086,519	$1,811,810	$3,385,325	$2,344,016	$1,649,839
Ouray	NR	$68,547	$108,413	NR	$160,582
Park	$57,485	$624,715	$793,944	$751,417	$483,012
Phillips	$44,897	$156,667	$520,023	$228,478	$354,440
Pitkin	$86,353	$126,256	$233,526	$284,258	$179,421
Prowers	$1,046,073	$826,692	$1,799,512	$1,691,939	$1,362,227
Pueblo	$7,304,282	$21,484,296	$29,022,089	$21,611,953	$19,547,406
Rio Blanco	NR	$136,608	$280,598	$292,575	$380,108
Rio Grande	$1,098,311	$1,036,919	$1,384,058	$1,654,939	$1,188,310
Routt	$38,362	$729,595	$809,577	$872,822	$714,963
Saguache	$695,703	$405,872	$665,863	$740,763	$423,478
San Juan	NR	$26,678	NR	NR	NR
San Miguel	$68,479	$122,211	$202,819	$194,333	$62,465
Sedgwick	$12,308	$119,117	$346,326	NR	$242,648
Summit	$60,760	$920,615	$658,619	$1,008,146	$636,808
Teller	$593,225	$1,157,364	$1,576,286	$1,551,007	$1,324,166
Washington	$38,015	$152,276	$466,018	$200,364	$292,614
Weld	$8,783,423	$19,918,375	$21,006,150	$22,987,393	$17,390,712
Yuma	$51,641	$588,986	$1,050,296	$835,693	$1,015,942
Suppressed Counties	$48,012	$0	$164,121	$985,406	$132,252
STATEWIDE	**$101,620,058**	**$314,912,450**	**$332,651,535**	**$381,232,400**	**$294,072,823**

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. “NR” denotes county included in "Suppressed Counties" category.

B2c: FY 2012-13 Average Cost Per Client for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Adams	$557	$670	$698	$7,397	$1,078
Alamosa	$656	$517	$704	$6,696	$791
Arapahoe	$508	$650	$807	$7,597	$1,066
Archuleta	$534	$531	$394	$9,525	$1,043
Baca	$454	$486	$1,360	$6,964	$865
Bent	$589	$401	$1,407	$7,971	$765
Boulder	$534	$672	$884	$6,885	$945
Broomfield	$563	$667	$1,027	$7,257	$1,112
Chaffee	$323	$561	$878	$8,835	$959
Cheyenne	$299	$399	$818	$6,838	$919
Clear Creek	$456	$821	$825	$11,152	$1,226
Conejos	$549	$444	$673	$5,486	$967
Costilla	$619	$544	$1,071	$9,796	$917
Crowley	$512	$543	$1,095	$7,264	$780
Custer	$472	$564	$877	$7,312	$1,598
Delta	$572	$411	$469	$7,311	$976
Denver	$547	$664	$737	$9,493	$1,169
Dolores	$582	$439	$583	$5,070	$829
Douglas	$421	$752	$1,062	$7,613	$1,109
Eagle	$627	$524	$712	$8,020	$1,379
Elbert	$417	$716	$1,111	$9,980	$1,433
El Paso	$602	$679	$889	$6,851	$943
Fremont	$446	$640	$1,042	$8,517	$837
Garfield	$580	$527	$624	$7,111	$1,340
Gilpin	$434	$1,003	$866	$9,993	$1,480
Grand	$355	$598	$875	$5,825	$1,992
Gunnison	$330	$447	$507	$7,426	$1,222
Hinsdale	$300	$524	$991	$8,981	$2,499
Huerfano	$793	$625	$1,295	$7,381	$1,042
Jackson	$309	$430	$591	$6,766	$2,879
Jefferson	$534	$712	$1,000	$7,827	$1,215
Kiowa	$300	$336	$1,360	$3,633	$845
Kit Carson	$343	$385	$671	$8,771	$1,110
Lake	$318	$501	$756	$7,578	$849
La Plata	$397	$610	$685	$7,328	$914

B2c: FY 2012-13 Average Cost Per Client for Selected Acute Care Service Categories by County					
County	**FQHCs**	**Physician and EPSDT**	**Pharmacy Prescriptions**	**Inpatient Hospital**	**Outpatient Hospital**
Larimer	$471	$627	$942	$6,614	$940
Las Animas	$551	$712	$971	$8,072	$1,029
Lincoln	$551	$573	$930	$6,655	$1,134
Logan	$606	$539	$1,035	$7,505	$891
Mesa	$400	$405	$385	$6,514	$998
Mineral	$387	$466	$2,072	$4,181	$820
Moffat	$508	$452	$697	$5,553	$1,585
Montezuma	$479	$552	$723	$7,421	$965
Montrose	$429	$389	$456	$8,263	$830
Morgan	$561	$518	$688	$5,987	$866
Otero	$538	$466	$947	$7,103	$669
Ouray	$323	$410	$1,023	$6,816	$2,920
Park	$460	$581	$947	$8,443	$1,145
Phillips	$397	$451	$1,275	$6,013	$1,218
Pitkin	$685	$493	$981	$8,122	$1,339
Prowers	$573	$377	$748	$7,656	$855
Pueblo	$702	$694	$1,067	$7,876	$1,009
Rio Blanco	$271	$362	$696	$6,966	$1,358
Rio Grande	$614	$519	$678	$7,733	$947
Routt	$320	$501	$807	$7,039	$1,212
Saguache	$613	$438	$714	$7,408	$713
San Juan	$170	$398	$1,478	$12,512	$1,488
San Miguel	$380	$397	$1,030	$6,073	$992
Sedgwick	$397	$471	$1,086	$13,056	$1,195
Summit	$277	$578	$671	$6,721	$1,234
Teller	$539	$602	$897	$8,120	$1,012
Washington	$392	$410	$1,287	$5,273	$1,204
Weld	$535	$622	$792	$6,725	$955
Yuma	$351	$501	$1,047	$6,739	$1,390
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. “NR” denotes county included in "Suppressed Counties" category.

B3a: FY 2012-13 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	1,999	790	439	1,200	1,294
Alamosa	428	59	0	132	115
Arapahoe	3,073	1,157	452	1,266	1,367
Archuleta	115	NR	0	NR	70
Baca	93	NR	0	NR	71
Bent	109	NR	0	43	55
Boulder	1,443	475	NR	585	721
Broomfield	226	74	NR	96	149
Chaffee	121	45	0	51	79
Cheyenne	NR	NR	0	0	NR
Clear Creek	73	NR	0	NR	NR
Conejos	204	NR	0	78	73
Costilla	195	NR	0	63	NR
Crowley	115	NR	0	NR	31
Custer	NR	0	0	NR	0
Delta	318	71	120	148	118
Denver	4,688	784	855	1,719	2,029
Dolores	NR	0	0	NR	NR
Douglas	658	191	NR	259	207
Eagle	66	NR	0	NR	NR
Elbert	70	0	196	1,693	1,459
El Paso	2,990	955	0	NR	NR
Fremont	539	115	0	178	401
Garfield	361	115	0	72	199
Gilpin	71	NR	0	NR	NR
Grand	54	NR	0	NR	NR
Gunnison	65	NR	0	NR	38
Hinsdale	NR	0	0	0	0
Huerfano	159	37	0	NR	81
Jackson	NR	0	0	0	NR
Jefferson	2,611	1,010	509	1,133	1,728
Kiowa	NR	0	0	NR	NR
Kit Carson	53	NR	0	NR	NR
Lake	NR	NR	0	85	110
La Plata	387	62	0	NR	NR

B3a: FY 2012-13 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	1,653	506	NR	803	936
Las Animas	573	68	0	51	118
Lincoln	76	NR	0	NR	NR
Logan	221	91	0	39	105
Mesa	1,685	407	NR	331	515
Mineral	NR	NR	0	NR	NR
Moffat	102	32	0	NR	64
Montezuma	430	37	0	142	165
Montrose	356	122	177	118	184
Morgan	301	51	NR	75	240
Otero	462	87	0	187	169
Ouray	NR	NR	0	NR	NR
Park	52	NR	0	NR	NR
Phillips	49	NR	0	NR	31
Pitkin	46	0	0	NR	NR
Prowers	257	43	0	74	89
Pueblo	2,062	585	196	1,287	763
Rio Blanco	73	NR	0	NR	37
Rio Grande	194	NR	0	88	138
Routt	48	35	0	NR	50
Saguache	166	NR	0	52	NR
San Juan	NR	0	0	NR	0
San Miguel	NR	NR	0	NR	NR
Sedgwick	37	NR	0	NR	NR
Summit	36	NR	0	NR	NR
Teller	160	NR	0	51	58
Washington	37	NR	0	NR	34
Weld	1,675	400	NR	855	677
Yuma	162	NR	0	NR	90
Suppressed Counties	142	248	NR	383	198
STATEWIDE	**32,339**	**8,652**	**2,958**	**13,337**	**15,056**

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. “NR” denotes county included in "Suppressed Counties" category.

B3b: FY 2012-13 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	$17,094,329	$28,458,920	$14,339,549	$15,492,069	$47,742,880
Alamosa	$2,577,161	$2,581,097	$0	$401,920	$3,500,496
Arapahoe	$31,147,029	$43,844,739	$13,954,106	$19,217,431	$50,944,034
Archuleta	$862,421	NR	$0	NR	$2,230,877
Baca	$196,619	NR	$0	NR	$2,828,306
Bent	$400,457	NR	$0	$249,579	$1,867,964
Boulder	$11,009,577	$17,744,888	NR	$6,475,465	$24,886,155
Broomfield	$1,851,392	$2,442,958	NR	$1,362,552	$4,630,898
Chaffee	$556,387	$1,549,672	$0	$471,558	$2,247,450
Cheyenne	NR	NR	$0	$0	NR
Clear Creek	$385,641	NR	$0	NR	NR
Conejos	$1,250,690	NR	$0	$190,663	$2,912,305
Costilla	$1,293,156	NR	$0	$180,313	NR
Crowley	$604,558	NR	$0	NR	$1,012,176
Custer	NR	$0	$0	NR	$0
Delta	$2,746,450	$2,014,649	$4,139,724	$1,055,248	$4,318,924
Denver	$53,268,384	$24,107,898	$27,221,074	$19,619,828	$75,362,296
Dolores	NR	$0	$0	NR	NR
Douglas	$6,163,260	$4,979,773	NR	$4,385,570	$7,300,547
Eagle	$545,612	NR	$0	NR	NR
Elbert	$653,683	NR	$6,614,360	$39,212,461	$56,063,741
El Paso	$31,290,448	$33,779,791	$0	NR	NR
Fremont	$4,069,750	$4,862,757	$0	$1,924,793	$12,705,573
Garfield	$2,259,658	$5,145,298	$0	$380,297	$8,825,338
Gilpin	$533,433	NR	$0	NR	NR
Grand	$409,178	NR	$0	NR	NR
Gunnison	$602,753	NR	$0	NR	$1,559,361
Hinsdale	NR	$0	$0	$0	$0
Huerfano	$1,335,673	$1,166,892	$0	NR	$2,671,623
Jackson	NR	$0	$0	$0	NR
Jefferson	$24,229,012	$35,253,890	$15,653,320	$17,129,298	$65,796,150
Kiowa	NR	$0	$0	NR	NR
Kit Carson	$374,296	NR	$0	NR	NR
Lake	NR	NR	$0	$666,234	$3,839,948
La Plata	$3,357,159	$2,014,589	$0	NR	NR

B3b: FY 2012-13 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	$10,190,929	$19,504,938	NR	$7,886,893	$31,038,134
Las Animas	$6,530,829	$2,176,759	$0	$148,686	$4,367,846
Lincoln	$577,737	NR	$0	NR	NR
Logan	$1,544,428	$3,748,242	$0	$426,129	$3,106,478
Mesa	$20,420,401	$26,729,625	NR	$2,783,354	$17,055,093
Mineral	NR	NR	$0	NR	NR
Moffat	$484,929	$1,455,290	$0	NR	$1,902,041
Montezuma	$3,945,475	$1,173,807	$0	$1,157,329	$4,954,976
Montrose	$2,462,422	$4,080,974	$5,532,421	$1,663,068	$6,132,058
Morgan	$1,952,598	$1,670,930	NR	$286,945	$7,515,622
Otero	$2,577,743	$3,855,318	$0	$1,928,861	$5,532,677
Ouray	NR	NR	$0	NR	NR
Park	$317,252	NR	$0	NR	NR
Phillips	$302,673	NR	$0	NR	$1,071,970
Pitkin	$661,892	$0	$0	NR	NR
Prowers	$974,987	$1,774,942	$0	$281,449	$3,417,683
Pueblo	$15,673,440	$32,113,430	$5,221,714	$18,838,420	$24,870,739
Rio Blanco	$300,850	NR	$0	NR	$1,570,199
Rio Grande	$843,368	NR	$0	$304,126	$4,523,825
Routt	$155,727	$1,412,695	$0	NR	$2,543,635
Saguache	$967,855	NR	$0	$121,098	NR
San Juan	NR	$0	$0	NR	$0
San Miguel	NR	NR	$0	NR	NR
Sedgwick	$299,526	$635,554	$0	NR	NR
Summit	$289,503	NR	$0	NR	NR
Teller	$1,208,412	NR	$0	$1,182,904	$1,316,583
Washington	$150,176	NR	$0	NR	$1,165,198
Weld	$14,254,987	$15,063,651	NR	$8,591,255	$21,552,043
Yuma	$950,279	NR	$0	NR	$2,917,434
Suppressed Counties	$999,986	$6,430,117	NR	$1,884,912	$6,323,366
STATEWIDE	**$290,106,569**	**$331,138,526**	**$92,991,027**	**$175,895,830**	**$536,124,644**

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. “NR” denotes county included in "Suppressed Counties" category.

B3c: FY 2012-13 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	$8,551	$36,024	$32,664	$12,910	$36,896
Alamosa	$6,021	$43,747	$0	$3,045	$30,439
Arapahoe	$10,136	$37,895	$30,872	$15,180	$37,267
Archuleta	$7,499	NR	$0	NR	$31,870
Baca	$2,114	NR	$0	NR	$39,835
Bent	$3,674	NR	$0	$5,804	$33,963
Boulder	$7,630	$37,358	NR	$11,069	$34,516
Broomfield	$8,192	$33,013	NR	$14,193	$31,080
Chaffee	$4,598	$34,437	$0	$9,246	$28,449
Cheyenne	NR	NR	$0	$0	NR
Clear Creek	$5,283	NR	$0	NR	NR
Conejos	$6,131	NR	$0	$2,444	$39,895
Costilla	$6,632	NR	$0	$2,862	NR
Crowley	$5,257	NR	$0	NR	$32,651
Custer	NR	$0	$0	NR	$0
Delta	$8,637	$28,375	$34,498	$7,130	$36,601
Denver	$11,363	$30,750	$31,838	$11,414	$37,143
Dolores	NR	$0	$0	NR	NR
Douglas	$9,367	$26,072	NR	$16,933	$35,268
Eagle	$8,267	NR	$0	NR	NR
Elbert	$9,338	NR	$33,747	$23,162	$38,426
El Paso	$10,465	$35,372	$0	NR	NR
Fremont	$7,551	$42,285	$0	$10,813	$31,685
Garfield	$6,259	$44,742	$0	$5,282	$44,348
Gilpin	$7,513	NR	$0	NR	NR
Grand	$7,577	NR	$0	NR	NR
Gunnison	$9,273	NR	$0	NR	$41,036
Hinsdale	NR	$0	$0	$0	$0
Huerfano	$8,400	$31,538	$0	NR	$32,983
Jackson	NR	$0	$0	$0	NR
Jefferson	$9,280	$34,905	$30,753	$15,119	$38,076
Kiowa	NR	$0	$0	NR	NR
Kit Carson	$7,062	NR	$0	NR	NR
Lake	NR	NR	$0	$7,838	$34,909
La Plata	$8,675	$32,493	$0	NR	NR

B3c: FY 2012-13 Average Cost Per Client for Selected Long-Term Care Categories by County					
County	**HCBS Waivers Administered by HCPF**	**HCBS Waivers Administered by DHS**	**Program of All-Inclusive Care for the Elderly**	**Home Health**	**Nursing Facilities (Class I and II)**
Larimer	$6,165	$38,547	NR	$9,822	$33,160
Las Animas	$11,398	$32,011	$0	$2,915	$37,016
Lincoln	$7,602	NR	$0	NR	NR
Logan	$6,988	$41,189	$0	$10,926	$29,586
Mesa	$12,119	$65,675	NR	$8,409	$33,117
Mineral	NR	NR	$0	NR	NR
Moffat	$4,754	$45,478	$0	NR	$29,719
Montezuma	$9,176	$31,725	$0	$8,150	$30,030
Montrose	$6,917	$33,451	$31,257	$14,094	$33,326
Morgan	$6,487	$32,763	NR	$3,826	$31,315
Otero	$5,580	$44,314	$0	$10,315	$32,738
Ouray	NR	NR	$0	NR	NR
Park	$6,101	NR	$0	NR	NR
Phillips	$6,177	NR	$0	NR	$34,580
Pitkin	$14,389	$0	$0	$476	NR
Prowers	$3,794	$41,278	$0	$3,803	$38,401
Pueblo	$7,601	$54,895	$26,641	NR	$32,596
Rio Blanco	$4,121	NR	$0	$1,551	$42,438
Rio Grande	$4,347	NR	$0	NR	$32,781
Routt	$3,244	$40,363	$0	$810	$50,873
Saguache	$5,830	NR	$0	NR	NR
San Juan	NR	$0	$0	NR	$0
San Miguel	NR	NR	$0	NR	NR
Sedgwick	$8,095	$45,397	$0	NR	NR
Summit	$8,042	NR	$0	$1,796	NR
Teller	$7,553	NR	$0	NR	$22,700
Washington	$4,059	NR	$0	$6,717	$34,271
Weld	$8,510	$37,659	NR	NR	$31,835
Yuma	$5,866	NR	$0	$925	$32,416
STATEWIDE	**$7,277**	**$38,405**	**$31,534**	**$8,093**	**$34,756**

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. “NR” denotes county included in "Suppressed Counties" category.

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 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**
FY 2012-13	23,527	1,204	275	3,248	57	85	162	**28,324**
*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 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**
FY 2012-13	90	3,350	4,490	433	**8,204**
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 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
FY 2012-13	13,047	2,765	14,122	21	14,143
Source: Medicaid paid claims from MMIS-DSS. To prevent unduplicated client counts presented in these tables from being skewed by accounting adjustments, data is based on those clients who had a paid claim with a date-of-service within the fiscal year and only claims processed up to three months (FY 2003-06) one and one-half months (FY 2006-07) after the end of the fiscal year have been included. Unduplicated client counts represent the number of unique clients who received a service in each category only. Totals are not the sum of categories.					

B4a: FY 2012-13 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Adams	3,548	$25,662,049	$7,233
Alamosa	153	$1,181,761	$7,724
Arapahoe	3,081	$23,067,081	$7,487
Archuleta	67	$454,223	$6,779
Baca	NR	NR	$7,341
Bent	NR	NR	$7,376
Boulder	937	$6,441,608	$6,875
Broomfield	150	$953,330	$6,356
Chaffee	50	$386,155	$7,723
Cheyenne	NR	NR	$8,920
Clear Creek	NR	NR	$6,940
Conejos	73	$522,669	$7,160
Costilla	NR	NR	$11,067
Crowley	31	$191,639	$6,182
Custer	NR	NR	$7,150
Delta	188	$1,189,930	$6,329
Denver	4,412	$33,588,414	$7,613
Dolores	NR	NR	$6,866
Douglas	353	$2,511,781	$7,116
Eagle	219	$1,797,028	$8,206
Elbert	NR	NR	$6,174
El Paso	3,017	$21,944,599	$7,274
Fremont	206	$1,463,363	$7,104
Garfield	424	$3,300,055	$7,783
Gilpin	NR	NR	$10,026
Grand	42	$280,997	$6,690
Gunnison	53	$333,049	$6,284
Hinsdale	NR	NR	$5,372
Huerfano	33	$263,096	$7,973
Jackson	NR	NR	$7,187
Jefferson	1,616	$12,288,873	$7,605
Kiowa	NR	NR	$8,364
Kit Carson	NR	NR	$6,646
Lake	42	$304,572	$7,252
La Plata	212	$1,400,440	$6,606

B4a: FY 2012-13 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Mother's County on Delivery Date			
County Name	**Unique Deliveries**	**Total Payments**	**Average Payment**
Larimer	1,257	$8,678,865	$6,904
Las Animas	91	$614,607	$6,754
Lincoln	35	$273,635	$7,818
Logan	126	$1,125,428	$8,932
Mesa	1,033	$6,594,569	$6,384
Mineral	NR	NR	$10,603
Moffat	93	$672,944	$7,236
Montezuma	173	$1,412,156	$8,163
Montrose	281	$1,980,794	$7,049
Morgan	264	$1,946,002	$7,371
Otero	157	$995,457	$6,340
Ouray	NR	NR	$6,626
Park	32	$222,340	$6,948
Phillips	NR	NR	$10,872
Pitkin	NR	NR	$6,507
Prowers	96	$911,176	$9,491
Pueblo	1,154	$9,415,955	$8,159
Rio Blanco	NR	NR	$6,458
Rio Grande	92	$716,006	$7,783
Routt	64	$459,625	$7,182
Saguache	50	$377,497	$7,550
San Juan	NR	NR	$15,756
San Miguel	NR	NR	$5,093
Sedgwick	NR	NR	$7,217
Summit	94	$655,836	$6,977
Teller	64	$438,868	$6,857
Washington	NR	NR	$5,060
Weld	1,672	$12,058,159	$7,212
Yuma	71	$534,652	$7,530
Suppressed Counties	366	$2,666,316	$7,285
STATEWIDE	**26,172**	**$192,277,600**	**$7,347**

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. "NR" denotes county included in "Suppressed Counties" category.

B4b: FY 2012-13 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Delivery Type			
Delivery Type	**Unique Deliveries**	**Total Payments**	**Average Payment**
Caesarian	5,772	$55,680,231	$9,647
Vaginal	18,423	$124,227,329	$6,743
Unknown/No Delivery Information	1,977	$12,370,040	$6,257
Total	**26,172**	**$192,277,600**	**$7,347**

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 2012-13 Medicaid Deliveries and Associated Gestational/Post-Partum Expenditures by Age on Delivery Date			
Age Group	**Unique Deliveries**	**Total Payments**	**Average Payment**
<=14	NR	NR	$5,607
15-19	3,351	$23,421,444	$6,989
20	1,631	$12,193,049	$7,476
21-24	6,947	$51,234,188	$7,375
25-34	11,679	$86,317,345	$7,391
35+	2,529	$18,948,151	$7,492
Unknown	NR	NR	$1,960
Total	**26,172**	**$192,277,600**	**$7,347**

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. “NR” denotes data is suppressed.

B4d: FY 2012-13 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	303	$3,496,041	$11,538
Low-Income and Expansion Adults	9,544	$77,974,721	$8,170
Eligible Children	975	$6,906,575	$7,084
Foster Care	103	$1,070,219	$10,390
Baby Care Adults	9,151	$68,605,373	$7,497
Baby Care Children	670	$4,589,206	$6,850
Non-Citizens	4,609	$23,644,506	$5,130
Legal Immigrant Prenatal	804	$5,869,940	$7,301
Other Medicaid Eligibility Types	13	$121,018	$9,309
Total Medicaid	**26,172**	**$192,277,600**	**$7,347**

B4e: FY 2012-13 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)	337	144	193	$10,317,564	$2,173,797	$8,143,767
Very Low BW (1000 - 1499 grams)	327	72	255	$6,724,988	$385,808	$6,339,181
Low BW (1500-2499 grams)	2,721	603	2,118	$10,637,616	$1,053,351	$9,584,265
All LBW Clients	**3,385**	**819**	**2,566**	**$27,680,168**	**$3,612,955**	**$24,067,213**
Preterm Infants Not Classified as Low Birthweight						
Very Preterm (<32 weeks gestation)	460	181	279	$3,921,819	$700,873	$3,220,946
Moderately Preterm (32 to 36 weeks gestation)	591	121	470	$1,850,541	$284,412	$1,566,129
All Preterm Infants not identified via LBW	**1,051**	**302**	**749**	**$5,772,360**	**$985,284**	**$4,787,075**
Infants Treated in the NICU Not Due to LBW or Preterm						
NICU - Other, Including Normal Birthweight	1,379	100	1,279	$4,169,615	$271,186	$3,898,429
TOTAL	**5,815**	**1,221**	**4,594**	**$37,622,143**	**$4,869,426**	**$32,752,717**

*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 2012-13 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	$80,764
Full-Term Neonate with Major Problems	795	$3,684,511
Neonate with Other Significant Problems	1,410	$3,185,822
Neonates < 1,000 grams	96	$6,868,077
Neonates 1,000-1,499 grams	179	$5,284,024
Neonates 1500-1,999 grams	361	$4,557,463
Neonates > 2,000 grams with RDS	249	$3,840,270
Neonates > 2,000 grams, Premature with Major Problems	273	$2,017,146
Neonate, Low Birthweight Diagnosis, Over 28 Days	NR	$170,672
TOTAL NICU Payments		**$29,688,749**

*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. "NR" denotes data is suppressed.

B5a: FY 2012-13 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	$82,771,439	22,839	$3,624
2	4	Respiratory System	$36,081,415	5,410	$6,669
3	15	Conditions of Newborns	$30,638,245	4,354	$7,037
4	8	Musculoskeletal System and Connective Tissue	$27,403,744	2,501	$10,957
5	6	Digestive System	$26,186,039	3,395	$7,713
6		Pre-MDC Other	$25,314,842	305	$82,999
7	5	Circulatory System	$24,479,202	1,824	$13,421
8	1	Nervous System	$20,787,531	2,184	$9,518
9	18	Infectious and Parasitic Diseases	$18,650,174	1,791	$10,413
10	11	Kidney and Urinary Tract	$16,717,013	1,400	$11,941
		Top 10 Totals	**$309,029,643**	**46,003**	**$6,718**

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 2012-13 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	$37,806,262	13,551	$2,790
2	370	Cesarean Section with Complicating Diagnoses	$15,383,244	2,170	$7,089
3	541	Tracheotomy with Mechanical Ventilator with Major Operating Room Procedure	$15,376,142	164	$93,757
4	371	Cesarean Sections without Complicating Diagnoses	$10,667,907	3,106	$3,435
5	372	Vaginal Delivery with Complicating Diagnoses	$10,266,163	2,779	$3,694
6	576	Septicemia without Mechanical Ventilator, 96+ hours, age >17	$7,619,187	937	$8,131
7	898	Bronchitis and Asthma, Age <17 with Complicating Diagnoses	$7,517,293	1,861	$4,039
8	801	Neonates < 1,000 Grams	$6,868,077	96	$71,542
9	317	Admit for Renal Dialysis	$6,856,096	73	$93,919
10	578	Infectious and Parasitic Disease with Operating Room Procedure	$5,487,913	216	$25,407
		Top 10 Totals	**$123,848,285**	**24,953**	**$4,963**

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 2012-13 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	$17,056,699	21,912	$778
2	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$11,004,331	19,614	$561
3	521	Diseases of Hard Tissues of Teeth	$9,561,278	6,086	$1,571
4	780	General Symptoms	$8,595,594	19,282	$446
5	V58	Other and Unspecified Aftercare	$6,529,421	3,998	$1,633
6	787	Symptoms Involving Digestive System	$5,476,433	15,189	$361
7	784	Symptoms Involving Head and Neck	$4,998,776	9,498	$526
8	V57	Care Involving Use of Rehabilitation Procedures	$4,392,649	13,927	$315
9	474	Chronic Disease of Tonsils and Adenoids	$4,262,763	2,577	$1,654
10	724	Other and Unspecified Disorders of Back	$4,196,271	10,570	$397
		Top 10 Totals	**$76,074,214**	**122,653**	**$620**

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 2012-13 Top 10 Outpatient Surgical Procedures Ranked by Expenditures					
Rank	**Surgical Procedure Code**	**Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	66.29	Other Bilateral Endoscopic Destruction or Occlusion of Fallopian Tubes	$266,464	110	$2,422
2	68.41	Laparoscopic Total Abdominal Hysterectomy	$145,840	NR	$4,861
3	68.59	Other Vaginal Hysterectomy	$107,468	NR	$4,299
4	68.31	Laparoscopic Supracervical Hysterectomy [LSH]	$67,443	NR	$4,817
5	66.32	Other Bilateral Ligation and Division of Fallopian Tubes	$58,875	37	$1,591
6	68.51	Laparoscopically Assisted Vaginal Hysterectomy (LAVH)	$57,269	NR	$5,206
7	81.45	Other Repair of the Cruciate Ligaments	$31,211	NR	$7,803
8	51.23	Laparoscopic Cholecystectomy	$26,618	NR	$3,803
9	66.22	Bilateral Endoscopic Ligation and Division of Fallopian Tubes	$25,120	NR	$1,794
10	86.59	Closure of Skin and Subcutaneous Tissue of Other Sites	$18,289	31	$590
		Top 10 Totals	**$804,597**	**283**	**$2,843**

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. "NR" denotes data is suppressed due to client counts equal to or smaller than 30.

B5e: FY 2012-13 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	$16,186,929	63,224	$256
2	V72	Special Investigations and Examinations*	$14,341,927	48,095	$298
3	V22	Normal Pregnancy	$6,766,509	7,837	$863
4	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$3,650,684	18,021	$203
5	V04	Need For Prophylactic Vaccination and Inoculation Against Certain Viral Diseases	$2,044,712	13,321	$153
6	724	Other and Unspecified Disorders of Back	$1,870,330	6,394	$293
7	250	Diabetes Mellitus	$1,805,281	4,570	$395
8	V25	Encounter For Contraceptive Management	$1,699,465	5,955	$285
9	382	Suppurative and Unspecified Otitis Media	$1,518,906	7,028	$216
10	719	Other and Unspecified Disorder of Joint	$1,420,658	5,550	$256
		Top 10 Totals	**$51,305,401**	**179,995**	**$285**

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 2012-13 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	$1,164,813	5,803	$201
2	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$505,253	2,805	$180
3	382	Suppurative and Unspecified Otitis Media	$377,506	2,005	$188
4	462	Acute Pharyngitis	$320,466	2,195	$146
5	V72	Special Investigations and Examinations*	$309,308	994	$311
6	724	Other and Unspecified Disorders of Back	$287,019	1,251	$229
7	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$266,903	1,808	$148
8	780	General Symptoms	$258,630	1,716	$151
9	461	Acute Sinusitus	$233,117	1,532	$152
10	789	Other Symptoms Involving Abdomen and Pelvis	$232,309	1,311	$177
		Top 10 Totals	**$3,955,324**	**21,420**	**$185**

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 2012-13 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	$18,448,042	120,160	$154
2	315	Specific Delays in Development	$11,163,221	6,604	$1,690
3	367	Disorders of Refraction and Accommodation	$10,446,421	64,908	$161
4	650	Normal Delivery	$8,550,004	11,551	$740
5	789	Other Symptoms Involving Abdomen and Pelvis	$7,954,618	47,376	$168
6	V25	Encounter For Contraceptive Management	$7,819,992	23,903	$327
7	786	Symptoms Involving Respiratory System and Other Chest Symptoms	$6,655,820	65,838	$101
8	780	General Symptoms	$6,021,692	49,210	$122
9	784	Symptoms Involving Head and Neck	$4,983,601	28,581	$174
10	465	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	$4,091,146	55,050	$74
		Top 10 Totals	**$86,134,556**	**473,181**	**$182**

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 2012-13 Top 10 Dental Procedures Ranked by Expenditures					
Rank	**Procedure Code**	**Procedure Description**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	D8090	Comprehensive Ortho Adult Dentition	$11,588,117	3,919	$2,957
2	D2930	Prefab Stainless Steel Crown Primary	$7,508,525	24,858	$302
3	D1120	Prophylaxis Child	$6,196,354	159,782	$39
4	D8080	Comprehensive Ortho Adolescent Dentition	$5,239,973	1,969	$2,661
5	D7140	Extraction Erupted Tooth/Exposed Root	$4,465,517	33,037	$135
6	D0120	Periodic Oral Evaluation	$4,321,732	153,060	$28
7	D2392	Resin Based Comp Two Surfaces Posterior	$3,779,587	26,446	$143
8	D7210	Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap	$3,749,699	15,099	$248
9	D2391	Resin Based Comp One Surface Posterior	$3,705,784	33,840	$110
10	D0330	Panoramic Image	$3,113,060	60,492	$51
		Top 10 Totals	**$53,668,348**	**512,502**	**$105**

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 2012-13 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	$2,802,053	47,422	$59
2	87591	Nisseria Gonorrhea, DNA, Amplified Probe Technique	$2,758,965	46,864	$59
3	80101	Drug Screen, Single	$1,713,462	9,910	$173
4	80053	Comprehensive Metabolic Panel	$1,605,617	71,369	$22
5	85025	Complete Blood Count with Automated White Blood Cells Differential	$1,562,187	94,954	$16
6	84443	Thyroid Stimulus Hormone	$1,345,396	50,331	$27
7	83901	Molecular Diagnostics; Amplification	$1,136,603	2,422	$469
8	80050	General Health Panel	$1,057,398	22,522	$47
9	88305	Tissue Exam by Pathologist	$950,257	14,290	$66
10	80061	Lipid Panel	$887,076	43,995	$20
		Top 10 Totals	**$15,819,015**	**404,079**	**$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 2012-13 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	$14,223,143	14,344	$992
2	E0442	Stationary Oxygen, Liquid	$5,643,040	4,743	$1,190
3	B4160	Enteral Formula for Pediatrics, Calorie Dense	$4,448,755	1,489	$2,988
4	B4161	Enteral Formula for Pediatrics, Hydrolyzed/Amino Acid	$2,533,949	542	$4,675
5	E0441	Stationary Oxygen, Gas	$2,429,081	2,593	$937
6	T4527	Adult Disposable Diaper, Large	$2,391,118	3,221	$742
7	B4035	Enteral Feed Supplement, Pump, per day	$2,281,407	1,298	$1,758
8	A4554	Disposable Underpads	$2,082,792	7,805	$267
9	T4526	Adult Disposable Diaper, Medium	$2,043,244	3,579	$571
10	T4535	Disposable Liner/Shield/Pad	$1,853,362	5,473	$339
		Top 10 Totals	**$39,929,888**	**45,087**	**$886**

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 2012-13 Top 10 Prescription Drugs Ranked by Expenditures					
Rank	**Drug Name**	**Therapeutic Class**	**Expenditures**	**Unduplicated Client Count**	**Average Cost**
1	Abilify	Antipsychotics	$21,264,971	5,888	$3,612
2	Aciphex	Proton Pump Inhibitors	$9,074,841	3,627	$2,502
3	Norditropin	Anabolic Steroid	$7,385,722	356	$20,746
4	Advair	Beta-Adrenergics and Glucocort	$6,299,372	7,219	$873
5	Synagis	Monoclonal Antibody (prevention/treatment of respiratory virus in infants)	$6,125,684	617	$9,928
6	Lantus	Insulins	$5,115,506	4,249	$1,204
7	Oxycodone	Analgesics	$5,016,055	50,710	$99
8	Methylphenidate	Anti-Narcolepsy/Anti-Hyperkin	$4,769,091	6,959	$685
9	Oxycontin	Analgesics	$4,668,052	1,088	$4,290
10	Adderall	Adrenergic, Aromat, Non-Catechol	$4,337,814	3,391	$1,279
		Top 10 Total	**$74,057,107**	**84,104**	**$881**

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 2012-13 Top 10 Prescription Drugs Ranked by Number of Prescriptions Filled					
Rank	**Drug Name**	**Therapeutic Class**	**Total Prescriptions Filled**	**Expenditures**	**Average Cost**
1	Oxycodone	Analgesic	177,082	$5,016,055	$28
2	Hydrocodon	Analgesic	149,826	$2,513,344	$17
3	Amoxicillin	Antibiotics	118,204	$1,340,039	$11
4	Azithromycin	Macrolides	66,722	$1,620,576	$24
5	Lisinopril	ACE Inhibitor	65,984	$561,622	$9
6	Levothyroxine	Thyroid Hormone	63,126	$660,002	$10
7	Ibuprofen	NSAID	62,093	$559,173	$9
8	Proair	Beta-adrenergic agents	61,195	$3,383,585	$55
9	Tramadol	Analgesics, Narcotics	58,098	$561,090	$10
10	Cyclobenzaprine	Skeletal Muscle Relaxants	53,119	$450,747	$8
		Top 10 Total	**808,426**	**$14,559,127**	**$19**

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.