Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-01

Request Titles

R-01 Medical Services Premiums

Dept. Approval By: Josh Block

OSPB Approval By:

	Supplemental FY 2014-15
X	Change Request FY 2015-16
	Base Reduction FY 2015-16
	Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$5,724,352,770	$0	$5,768,568,225	$557,958,547	$860,510,995
	FTE	-	-	-	-	-
	GF	$1,608,812,454	$0	$1,654,584,623	$130,769,564	$193,455,177
	CF	$622,898,368	$0	$628,705,349	$54,975,173	$106,552,254
	RF	$0	$0	$0	$0	$0
	FF	$3,492,641,948	$0	$3,485,278,253	$372,213,810	$560,503,564

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
	Total	$5,724,352,770	$0	$5,768,568,225	$557,958,547	$860,510,995
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	CF	$622,898,368	$0	$628,705,349	$54,975,173	$106,552,254
	FF	$3,492,641,948	$0	$3,485,278,253	$372,213,810	$560,503,564
	GF	$1,608,812,454	$0	$1,654,584,623	$130,769,564	$193,455,177

Letternote Text Revision Required? Yes X No

If Yes, describe the Letternote Text Revision:
See Exhibit D

Cash or Federal Fund Name and CORE Fund Number: FF: Title XIX CF: See Exhibit D

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

Approval by OIT? Yes No Not Required: X

Schedule 13s from Affected Departments: N/A

Other Information: N/A

COLORADO

Department of Health Care Policy & Financing

Department of Health Care Policy and Financing
Medical Services Premiums

FY 2014-15, FY 2015-16, and FY 2016-17 Budget Request

November 1, 2014

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MEDICAL SERVICES PREMIUMS

MAJOR FORECAST CHANGES

- Acute Care – The current request is approximately $54.9 million over the S-1 request, accounting for legislation. The growth is primarily due to changes in expected caseload in three eligibility categories: MAGI Parents/Caretakers to 68% FPL, Eligible Children, and SB 11-008 Eligible Children. Current caseload estimates for the above mentioned categories increased over the S-1 estimates, with adjustments made for the impact of new legislation, by approximately 30,000, 7,800, and 25,000 clients respectively. While per capita cost estimates for each of these categories except Eligible Children fell, this reduction was not large enough to account for the increase due to caseload. The impact for each of these categories separately was between $29 and $39 million. These increases were tempered by lower per capita estimates for MAGI Adults and Disabled Buy-In, and lower per capita and caseload estimates for MAGI Parents/Caretakers 69% to 133% FPL and Disabled Individuals to 59.
- Community-Base Long-Term Care – The current request is approximately $14.2 million under the S-1 request, accounting for legislation. The reduction is mostly due to client utilization of high per capita services growing at a slower pace than anticipated.
- Class I Nursing Facilities - The current request is approximately $22.4 million over the S-1 request, accounting for legislation. Patient days were under forecasted in FY 2013-14, bringing down the FY 2014-15 estimate in the S-1. The current forecast also includes a $2 million audit finding requiring the State to pay back federal funds incorrectly claimed.
- Program for All-Inclusive Care for the Elderly – The current request is approximately $9.5 million over the S-1 request, accounting for legislation. There are systems issues causing enrollment in the MMIS to be lower than actual clients receiving services; the February request assumed that this would be fixed by the end of FY 2013-14. The systems issues were not fixed as anticipated, but are expected to be resolved by the end of FY 2014-15, resulting in expected back payments in FY 2014-15 for services previously rendered.
- Prepaid Inpatient Health Plan Administration - The current request is approximately $14.8 million over the S-1 request, accounting for legislation. This is entirely driven by enrollment in the Accountable Care Collaborative. All of this cost is offset by savings in Acute Care.
- Hospital Provider Fee Supplemental Payments – The current request is approximately $63.7 million over the S-1 request, accounting for legislation. Increasing caseload due to Medicaid expansion is putting upward pressure on the upper payment limit, or the maximum amount of supplemental payments the Department can make. Coupled with increased federal match rates reducing the need for provider fee to cover the costs of certain Medicaid populations, the increase in the upper payment limit is allowing the Department to increase the amount of supplemental payments made to providers; the forecast has been revised to reflect the higher level of payments.

I. BACKGROUND

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

Further discussion depends on several key points that complicate the projection of this line item. They are summarized as follows:

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

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

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

2. The Department's request includes a number of references to various budget items and early supplemental budget reductions. July 1, 2009, September 1, 2009, December 1, 2009, July 1, 2010, July 1, 2011, and July 1, 2012, the Department implemented various reductions to reduce its budget in order to meet the revenue shortages being predicted by the various revenue forecasts and to bring the State into compliance with its balanced-budget requirement. In response, the Department began a process of identifying possible targets for reduction, engaging stakeholders regarding those possibilities, and submitting various budget change requests to reduce funding. Since experiencing economic recovery, the Department has continued to implement efficiencies, but has been able to restore provider rate increases. In FY 2013-14, rates were increased by 2% for Acute Care services and 8.26% for HCBS services, and in and FY 2014-15, rates were increased 2% across the board. Some services received varying targeted rate increases in FY 2014-15 as well.

3. The Department's request identifies, and in some cases amends, the fiscal impact of these reductions through a series of bottom-line impacts. Bottom-line impacts can be found by service category (e.g., Acute Care, Community-Based Long-Term Care, Long-

Term Care, Insurance, etc.) in the respective sections of this request. Those bottom-line impacts include the identification number of the originally submitted request, so that the bottom-line impact in the current year may be traced to the originally submitted budget change request document. Additionally, the annualization of a particular reduction's fiscal impact will be found in the out-year bottom-line impacts. Revisions to bottom-line impacts between requests are primarily limited to changes in implementation timeline. The Department generally does not adjust fiscal impact assumptions unless a deviation from assumptions in the original budget action is clear and significant.

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

5. The Department's request also incorporates estimates for revised eligibility requirements and new expansion populations, which gain eligibility as a result of HB 09-1293 and SB 13-200. This includes the expansion of eligibility to MAGI Adults and parents with Medicaid-eligible children up to 133% of the federal poverty level in FY 2013-14. These expansions increase Medicaid caseload and are discussed further in Sections II and III of this narrative.

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

7. The Department's request includes a forecast for FY 2014-15, FY 2015-16, and FY 2016-17. Some previous requests included only forecasts for the current and request years, therefore additional exhibits and changes in formatting to accommodate the additional year are present throughout.

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

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

10. The Department's request includes SB 13-242, which created an adult dental benefit as well as the Adult Dental Benefit Fund to finance the design and implementation of the adult dental benefit program, effective April 1, 2014. The Department added a new

calculation to estimate the impact of the adult dental benefit program, to Exhibit F. Please see the narrative for Exhibit F and section V for additional information.

11. The presence of varying funding mechanisms makes the Department's request more complex. Different Medicaid services have different federal match rates and are pertinent to different populations under Medicaid. Certain categories of service have historically been federally matched at different percentages than others. Indian Health Services, described further in this narrative, have historically received a 100% FMAP while Family Planning Services receive a 90% FMAP. BCCP services are matched at 65% FMAP. Medicaid expansion populations receive a different match rate than existing populations. Expansion Adults to 133% and the MAGI Adults populations for instance, receive a 100% FMAP in FY 2014-15, FY 2015-16 and FY 2016-17. The former CHP+ population that transferred to Medicaid with SB 11-008 (Eligible Children) and SB 11-250 (Eligible Pregnant Adults) receives the enhanced CHP+ FMAP of 65%. FMAP adjustments result in 65.53% FMAP for these populations in FY 2014-15. This enhanced FMAP only applies to the SB 11-250 Eligible Pregnant Adults population through July 31, 2015, after which time the FMAP associated with this population falls to the standard FMAP. The enhanced FMAP continues for the SB 11-008 Eligible Children population, until October 2015, when this population will receive an additional 23 percentage point FMAP increase; the enhanced FMAP is expected to be 82.96% in FY 2015-16 and 88.71% in FY 2016-17.

12. Under the Affordable Care Act, states are eligible for a one percentage point increase in the FMAP for adult vaccines and clinical preventive services if the state covers all of the recommended services without cost-sharing. The recommended services are those that have been given an A or B rating by the United States Preventive Services Task Force. The preventive services that are currently not included in the Colorado Medicaid benefit package are depression screening for adults, aspirin for the prevention of cardiovascular disease, counseling about screening for breast cancer susceptibility (BRCA), BRCA testing, shingles vaccines, and counseling interventions about tobacco use for non-pregnant adults. There is a bottom line adjustment in Exhibit F, Acute Care, for the estimated impact of providing these services. A further explanation of how these amounts were calculated is contained in this narrative under Acute Care.

13. Eligibility categories have changed to incorporate the Affordable Care Act's expansion population as well as other minor changes. Historical information has been updated to reflect the new eligibility categories. Please refer to the caseload narrative for more information.

14. The Centers for Medicare and Medicaid Services (CMS) has notified the Department that the State's FMAP for Medicaid services will increase from 50.00% to 51.01% beginning October 1, 2014. The Department assumes that the increase would remain in effect for the out year of the request and beyond, as well. For this reason, FMAP for FY 2014-15 would be 50.00% for the first quarter and 51.01% for the latter three quarters, resulting in an effective FMAP of 50.76% for the fiscal year. FMAP for FY 2015-16 would be 51.01%. This FMAP change applies to Medicaid services only; Medicaid administrative costs will continue to receive a 50.00%

FMAP. Although, the Department assumes the new FMAP rate will remain constant into FY 2015-16, there is the possibility that it does change again. If the FMAP does change, the Department will submit a supplemental funding request to account for the change in federal funds.

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

II. MEDICAID CASELOAD

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

III. BASIC APPROACH TO MEDICAL SERVICES PREMIUMS CALCULATIONS

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

A significant difference between this Budget Request and previous requests is the grouping and/or naming of the eligibility categories. Many categories remain unchanged, but the following changes have gone into effect:

- Categorically Eligible Low-Income Adults (AFDC-A) and Expansion Adults to 60% FPL have been combined into a single category, MAGI Parents/Caretakers to 68% FPL; historical information has been updated to reflect the merger of these eligibility categories in this Budget Request,
- Expansion Adults to 133% FPL has been renamed to MAGI Parents/Caretakers 69%-133% FPL,
- Adults without Dependent Children (AwDC) has been renamed to MAGI Adults,
- Baby Care Program – Adults has been renamed to MAGI Pregnant Adults,

- And two new eligibility categories have been added for the clients transitioning from CHP+ to Medicaid, SB 11-008 Eligible Children and SB 11-250 Eligible Pregnant Adults; these populations have been carved out of the Eligible Children and MAGI Pregnant Adults categories respectively, including historical information.

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

Rationale for Grouping Services for Projection Purposes

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

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

Acute Care:

- Physician Services and the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
- Emergency Transportation
- Non-emergency Medical Transportation
- Dental Services
- Family Planning
- Health Maintenance Organizations
- Inpatient Hospitals
- Outpatient Hospitals
- Lab & X-Ray
- Durable Medical Equipment
- Prescription Drugs
- Drug Rebate
- Rural Health Centers

- Federally Qualified Health Centers
- Co-Insurance (Title XVIII-Medicare)
- Breast and Cervical Cancer Treatment Program
- Prepaid Inpatient Health Plan Services
- Other Medical Services
- Home Health
- Presumptive Eligibility

Community Based Long-Term Care:

- Home-and Community-Based Services: Elderly, Blind and Disabled
- Home-and Community-Based Services: Community Mental Health Supports
- Home-and Community-Based Services: Disabled Children
- Home-and Community-Based Services: Persons Living with AIDS
- Home-and Community-Based Services: Consumer Directed Attendant Support
- Home-and Community-Based Services: Brain Injury
- Home-and Community-Based Services: Children with Autism
- Home-and Community-Based Services: Children with Life Limiting Illness
- Home-and Community-Based Services: Spinal Cord Injury Adult
- Private Duty Nursing
- Hospice

Long-Term Care:

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

Insurance:

- Supplemental Medicare Insurance Benefit
- Health Insurance Buy-In

Service Management:

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

Financing:

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

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

IV. PROJECTION METHODOLOGY AND DESCRIPTION OF EXHIBITS

EXHIBIT A - CALCULATION OF TOTAL REQUEST AND FUND SPLITS

Summary of Request

For the current year, the Department sums total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from page EA-2. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the current year.

For the request year, the Department starts with the prior year's appropriation, including special bills, and adds in any required annualizations. This total is the Base Amount for the request year. The total Base Amount is compared to the total projected estimated request year expenditure from page EA-3. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the request year.

For the out year, the Department starts with the prior year's appropriation, including special bills, and adds in any required annualizations. This total is the Base Amount for the out year. The total Base Amount is compared to the total projected estimated out year expenditure from page EA-4. The difference between the two figures is the Department's request for the Medical Services Premiums line item for the out year.

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

Federal Medical Assistance Percentages

The Department's standard federal medical assistance percentage (FMAP) is 50%. The FMAP for Medicaid is recomputed by the Federal Funds Information Service (FFIS) each year and is based on a statewide per capita earnings formula that is set in federal law. In October 2014, the FMAP for Medicaid services increased to 51.01%. The Department assumes that the FMAP for Medicaid services will continue at 51.01%. Although the Department assumes that the new FMAP rate would remain constant into FY 2015-16 and FY 2016-17, there is a possibility that the FMAP rate could change in late Fall 2014. If the FMAP rate changes the Department would follow the Budget Process and submit a supplemental to account for the change in federal funds.

Certain populations and services receive different FMAPs than the new standard 51.01%. This is summarized below. Clients transitioning from CHP+ to Medicaid receive the CHP+ FMAP, which is usually 65% but has been recalculated at 65.71% effective October 2014. Section 2105(b) of the Social Security Act further modifies the enhanced FMAP for CHP+ clients, and thus clients transitioning from CHP+ to Medicaid who are funded under Title XXI, by an additional 23 percentage points, effective October 1, 2015 through September 30, 2019. Therefore, FMAP for clients transitioning from CHP+ to Medicaid receive 82.96% FMAP in FY 2015-16 and 88.71% FMAP in FY 2016-17. Clients in the BCCP program also receive a 65% match, or 65.71% effective October 2014. Since the FMAP increase occurs at the start of the second quarter of FY 2014-15, the FMAP would be 50% for quarter one and 51.01% for the remainder of the year, resulting in a final FMAP of 50.76% for FY 2014-15. The same logic is applied the to the populations receiving 65% for quarter one and 65.71% the remainder of the fiscal year, resulting in final FMAP of 65.53% for FY 2014-15. The expansion populations, MAGI Parents/Caretakers 69% to 133% and MAGI Adults, receive a match of 100% beginning January 1, 2014. The Disabled Buy-In population receives the standard 51.01% match for expenditures net of patient premiums.

Calculation of expenditure by financing type can be found in Exhibit A.

Population-Based FMAPs			
Fiscal Year	**FMAP**	**Population(s)**	**Comments**
FY 2014-15	65.53%	Qualifying clients transitioned from CHP+ to Medicaid, Clients in the BCCP program	Please see Exhibit F
	100%	MAGI Parents/Caretakers 69% to 133%, FPL, MAGI Adults	Please see Exhibit J
	50.76%	Disabled Buy-In	Hospital Provider Fee portion matched at 50.76%, Medicaid Buy-In Fund 0%
FY 2015-16	82.96%	Qualifying children transitioned from CHP+ to Medicaid	Please see Exhibit F
	52.24%	Qualifying prenatal clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.71%	Clients in the BCCP Program	Please see Exhibit F
	100%	MAGI Parents/Caretakers 69% to 133%, FPL, MAGI Adults	Please see Exhibit J
	51.01%	Disabled Buy-In	Hospital Provider Fee portion matched at 51.01%, Medicaid Buy-In Fund 0%
FY 2016-17	88.71%	Qualifying children transitioned from CHP+ to Medicaid	Please see Exhibit F
	51.01%	Qualifying prenatal clients transitioned from CHP+ to Medicaid	Please see Exhibit F
	65.71%	Clients in the BCCP Program	Please see Exhibit F
	97.50%	MAGI Parents/Caretakers 69% to 133%, FPL, MAGI Adults	Please see Exhibit J
	51.01%	Disabled Buy-In	Hospital Provider Fee portion matched at 51.01%, Medicaid Buy-In Fund 0%

Service-Based FMAPs			
Fiscal Year	**FMAP**	**Service**	**Comments**
FY 2014-15	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	51.76%	ACA Preventive Services	Please see bottom line adjustment in Exhibit F
	90%	Family Planning Services	Please see Exhibit F
	100%	Physicians to 100% of Medicare: ACA Section 1202	Please see bottom line adjustment in Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2015-16	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	52.01%	ACA Preventive Services	Please see bottom line adjustment in Exhibit F
	90%	Family Planning Services	Please see Exhibit F
	100%	Physicians to 100% of Medicare: ACA Section 1202	Please see bottom line adjustment in Exhibit F
	100%	Indian Health Services	Please see Exhibit F
FY 2016-17	100%	Affordable Care Act Drug Rebate Offset	Please see Exhibit F
	52.01%	ACA Preventive Services	Please see bottom line adjustment in Exhibit F
	90%	Family Planning Services	Please see Exhibit F
	100%	Indian Health Services	Please see Exhibit F

Calculation of Fund Splits

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

In order to calculate appropriate fund splits, the Department selectively breaks out the large service groups (e.g., Acute Care) by programs funded with either a different state source or a different FMAP rate. The majority of programs in Medical Services Premiums are paid with 50% General Fund and 50% federal funds, though this changed to 48.99% General Fund and 51.01% federal funds in October 2014. However, the following programs are paid for using different funding mechanisms:

- Breast and Cervical Cancer Program: This program receives a 65% federal financial participation rate, increased to 65.71% effective October 2014. Per 25.5-5-308(9)(g), C.R.S (2014), enacted in HB 14-1045, the state's share of expenditure shall be appropriated one hundred percent from the Breast and Cervical Cancer Prevention and Treatment Fund.

- Family Planning: The Department receives a 90% FMAP available for all documented family planning expenditures. This includes those services rendered through health maintenance organizations. Please see Exhibit F for calculations.

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

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

- Affordable Care Act Preventive Services: Under the Affordable Care Act, states are eligible for a one percentage point increase in the FMAP for adult vaccines and clinical preventive services if the state covers all of the recommended services without cost-sharing.

- SB 11-008 "Aligning Medicaid Eligibility for Children": This bill specifies that the income eligibility criteria for Medicaid that applies to children aged five and under shall also apply to children from ages 6 to 19. Effective January 1, 2013, children under the age of 19 are eligible for Medicaid if their family income is less than 133% of the federal poverty level (FPL). The Department assumes FMAP for these clients will remain at the same level as if the clients had enrolled in the Children's Basic Health Plan (CHP+) instead of Medicaid, or 65%, though the enhanced FMAP increased to 65.71% effective October 2014. Section 1205(b) of the Social Security Act increases the enhanced FMAP by an additional 23 percentage points, effective October 2015 through September 2019. Therefore, FMAP for this population for FY 2014-15, FY 2015-16, and FY 2016-17 is expected to be 65.53%, 82.96%, and 88.71% respectively.

- SB 11-250 "Eligibility for Pregnant Women in Medicaid": This bill increases the upper income limit for Medicaid eligibility among pregnant women from the current level of 133% to 185% of federal poverty level (FPL) in order to comply with federal law. By changing income limits, it also allows eligible pregnant women to move from CHP+ to Medicaid effective January 1, 2013. As with SB 11-008, the Department assumes the same level of FMAP, 65%, will be available for these clients, though the enhanced FMAP is increased to 65.71% effective October 2014. The State has authority to claim the enhanced FMAP on this population through July 31, 2015; after this date, the FMAP is reduced to the standard Medicaid match rate.

- MAGI Parents/Caretakers 69% to 133% FPL: HB 09-1293, the Colorado Health Care Affordability Act of 2009, authorizes the Department to collect provider fees from hospitals for the purpose of obtaining federal financial participation for the State's medical assistance programs and using the combined funds to: 1) increase reimbursement to hospitals for providing medical care under the medical assistance program and the Colorado Indigent Care Program, 2) increase the number of persons covered by public medical assistance to 100% of the federal poverty line, and 3) pay the administrative costs to the Department in implementing and administering the program. These adjustments allocate the hospital provider fee to each applicable service category. Additionally, SB 13-200 amended Medicaid eligibility for parents and caretakers of eligible children from 100% of the federal poverty line to 133% of the federal poverty line in keeping with Medicaid expansion under the Affordable Care Act, which also ensures that MAGI Parents/Caretakers 69% to 133% of the federal poverty line receive a 100% federal match rate through the end of CY 2016, effective January 1, 2014. In CY 2017, the federal match rate for this population is reduced to 95%. See Exhibit J for additional information and detailed calculations.

- MAGI Adults: This population began participation in Medicaid in FY 2011-12 and was previously labeled Adults without Dependent Children (AwDC). The population was originally funded with a combination of federal funds and Hospital Provider Fee; however, SB 13-200 amended the Medicaid eligibility criteria for MAGI Adults to 133% of the federal poverty line in accordance with Medicaid expansion under the Affordable Care Act. Effective January 1, 2014, the Affordable Care Act provides this population a 100% federal match rate from CY 2014 through CY 2016 and a 95% federal match rate in CY 2017. This results in a 100% federal match rate for this population from FY 2014-15 through FY 2015-16 and approximately a 97.5% federal match rate in FY 2016-17. Calculations and information regarding this population can be found in Exhibit J.

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

- Non-Newly Eligibles: Historically, MAGI Parents/Caretakers 69% to 133% FPL and MAGI Adults were funded with a combination of federal funds and Hospital Provider Fee. As explained above under those categories, the Affordable Care Act provides both populations with a 100% federal match rate, effective January 1, 2014. A caveat of this enhanced federal match rate is that the population receiving 100% FMAP cannot have been eligible for Medicaid services prior to 2009 (or else those clients are not considered part of the Medicaid expansion population). A subset of the population may have been eligible for Medicaid services prior to 2009 under disability criteria, had the clients chosen to provide asset information when they applied for Medicaid services. For this population, the Department is unable to prove that these clients would not have been eligible for Medicaid services prior to 2009 if they had provided asset information, and therefore cannot claim 100% FMAP on their expenditure. These clients are now eligible for Medicaid under the expansion, and receive standard FMAP with the State portion funded through the Hospital Provider Fee, as is required by statute. The Department is pursuing a resource proxy, which is a mechanism that would allow the State to collect a higher FMAP for this specific population. Please refer to Exhibit J for calculations and additional details.

- MAGI Parents/Caretakers 60% to 68% FPL: Historically, Parents/Caretakers over 60% FPL were funded with a combination of federal funds and Hospital Provider Fee. As explained above, the Affordable Care Act provides MAGI Parents/Caretakers 69% to 133% FPL with a 100% federal match rate, effective January 1, 2014. Due to new MAGI conversion rules (please refer to the Caseload Narrative for additional details), the non-expansion eligibility category MAGI Parents/Caretakers to 68% FPL now includes FPL levels over 60%. The MAGI Parents/Caretakers to 68% FPL clients who have FPL levels over 60% are funded with Hospital Provider Fee for the State's contribution, rather than General Fund, as is required by statute. Please refer to Exhibit J for calculations and additional details.

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

- Adult Dental Benefit Financing: SB 13-242 creates a limited dental benefit for adults in the Medicaid program, to be implemented by April 1, 2014. To fund the design and implementation of the adult dental benefit, SB 13-242 created the Adult Dental Fund effective July 1, 2013, financed by the Unclaimed Property Trust Fund. The majority of the design and implementation of the dental benefit is funded by a federal funds appropriation of $27,943,609, and the Adult Dental Fund cash fund appropriation is increased by $27,056,015. Beginning in FY 2014-15, the financing for populations not funded through the Adult Dental Fund are reported in their respective lines and savings are attributed to the Base Acute line.

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

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

- Supplemental Medicare Insurance Benefit: Medicare premiums are not federally matched for clients who exceed 134% of the federal poverty level. Premiums for clients between 120% and 134% of the federal poverty level receive federal financial participation. In aggregate, the Department estimates that approximately 84.5% of the total will receive federal financial participation in FY 2014-15, 84.5% in FY 2015-16, and 81.0% in FY 2016-17. The Department anticipates a decline in the portion of premiums matched with federal funds as a result of increased Disabled Buy-In enrollment over time.

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

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

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

- Denver Health Outstationing: Federal funds are drawn to reimburse Denver Health Federally Qualified Health Centers for the federal share of their actual expenditures in excess of the current reimbursement methodology. This reimbursement does not require any increase in General Fund. The FY 2014-15, FY 2015-16, and FY 2016-17 totals are based on the total amount Denver Health Medical Center was able to certify in prior fiscal years.

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

- Service Fee Fund: SB 13-167 moved collection authority for provider fees collected from intermediate care facilities from the Department of Human Services (DHS) to the Department as of July 1, 2013. This eliminates the need to transfer funds between DHS and the Department in order to obtain the federal match to reimburse covered expenses incurred at intermediate care facilities. This changes the source of the provider fees from a reappropriated fund from DHS to a cash fund for the Department.

- Hospital Provider Fee for Continuous Eligibility: Continuous eligibility for children provides children with twelve months of continuous coverage through Medicaid, even if the family experiences an income change during any given year. The Department has the authority to use the Hospital Provider Fee Cash Fund to fund the State share of continuous eligibility for Medicaid children through FY 2014-15, after which time the General Fund will fund the State share. Because this population is not an expansion population, it receives the standard federal financial participation rate.

- Cash Funds Financing: This item includes the impact of legislation which reduces General Fund expenditure through cash fund transfers. Please refer to Section V for more detailed information on the legislation which authorized the transfers.

  The table below shows the impact by cash fund for FY 2014-15, FY 2015-16, and FY 2016-17.

Cash Funds	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**
Tobacco Tax Cash Fund (SB 11-210)	$2,230,500	$2,230,500	$2,230,500
Hospital Provider Fee Cash Fund (SB 13-200) - Continuous Eligibility	$6,431,818	$0	$0
Hospital Provider Fee Cash Fund (SB 13-230) - Upper Payment Limit Backfill	$15,700,000	$15,700,000	$15,700,000
Old Age Pension Health and Medical Care Fund (SB 13-200)	$5,495,027	$5,369,479	$5,240,893
Service Fee Fund (SB 13-167)	$200,460	$200,460	$200,460
Total	**$30,057,805**	**$23,500,439**	**$23,371,853**

EXHIBIT B - MEDICAID CASELOAD PROJECTION

Page EB-1 contains historical and projected caseload for all eligibility types from FY 1996-97 through FY 2016-17. Adjustments for caseload effects which are not captured in trends are shown on page EB-2. Totals unadjusted for special populations are shown on EB-3.

Pages EB-4 through EB-6 provide historical monthly caseload without retroactivity for each of the eligibility types for FY 2006-07 through FY 2013-14.

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

Changes to the Eligibility Categories

The Department has chosen to alter the eligibility categories to reflect the different Federal Medical Assistance Percentage (FMAP) that is applied to different categories. Several steps in Medicaid expansion (described below) introduced new categories with an enhanced FMAP. Forecasting caseload by eligibility and FMAP categories allows for a more accurate expenditure estimate for each funding source. Beginning with the August 2014 JBC Monthly Report, caseload is restated to align with the eligibility categories described below.

- "Categorically Eligible Low-Income Adults" and "Expansion Adults to 60%" were combined into one category called "MAGI Parents/Caretakers to 68% FPL."

- "Expansion Adults to 133% FPL" is now titled "MAGI Parents/Caretakers 69%-133% FPL"

- On January 1, 2013, Colorado implemented SB 11-008 and SB 11-250 which expanded Medicaid Eligible Children to 133% FPL for all ages and expanded Baby-Care Adults to 185%. The incremental increase in eligibility receives an enhanced match equal to the CHP+ FMAP of 65%. Eligible Children and Baby-Care Adults are now separated into two categories each; Eligible Children and SB 11-008 Eligible Children, and Baby-Care Adults and SB 11-250 Eligible Pregnant Adults.

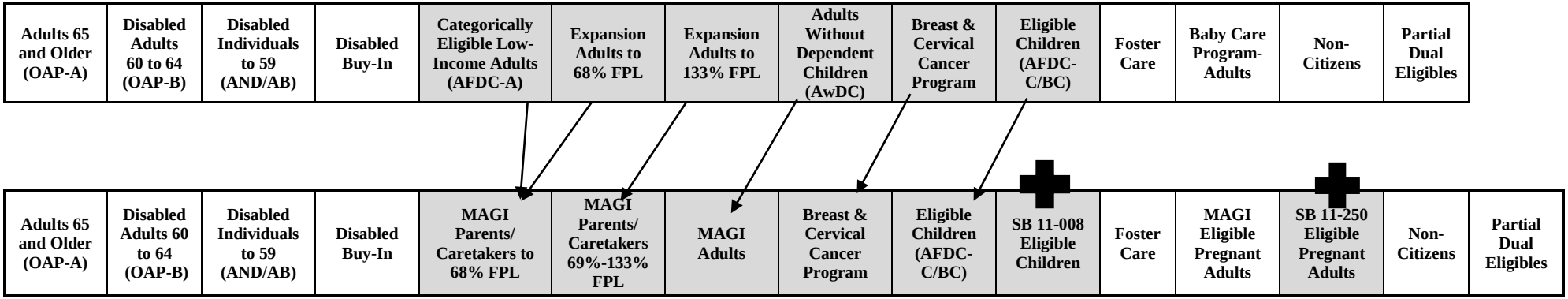


EXHIBIT C - HISTORY AND PROJECTIONS OF PER CAPITA COSTS

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

For FY 2002-03 through FY 2008-09, expenditures for the Prenatal State-Only program are included in the Non-Citizens aid category. The Prenatal State-Only program allows legal immigrants that entered the United States after August 22, 1996 to have State funded prenatal care and Emergency only Medicaid benefits for labor and delivery. These expenditures are included in the MAGI Pregnant Adults aid category for beginning in FY 2009-10. HB 09-1353 was passed in FY 2009-10, which allowed legal immigrants that have lived in the United States less than 5 years to qualify for Medicaid as pregnant adults, Medicaid children, or CHP+ clients, provided available funding. Funding for Medicaid pregnant adults was available July 2010. The population that was Prenatal State-Only now represents pregnant adults that are eligible under HB 09-1353. These expenditures are still included in the MAGI Pregnant Adults aid category.

Effective with the November 1, 2014 Budget Request, the Department included a total cost of care per capita exhibit, including both Title XIX expenditure and Title XXI expenditure, by eligibility category.

EXHIBIT D - CASH FUNDS REPORT

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

EXHIBIT E - SUMMARY OF PREMIUM REQUEST BY SERVICE GROUP

Summary of Total Requested Expenditure by Service Group

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

Comparison of Request to Long Bill Appropriation and Special Bills

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

EXHIBIT F – ACUTE CARE

Calculation of Acute Care Expenditure

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

same methodology is applied to the projected request year per capita, including a per capita trend factor and bottom-line impacts. The total estimated expenditure for Acute Care is added to total estimated expenditure in other service groups and bottom-line impacts to generate the total request for Medical Services Premiums.

Calculation of Per Capita Percent Change

The per capita percent change for several different years is computed for each eligibility category on a per capita cost basis. The period of time that was selected for computing the trend or annual rate of change was FY 2006-07 through FY 2013-14. Prior year information is provided for historical reference. This period was selected for two reasons: first, it is a recent period and second, because Medicaid benefits over this period have remained mostly the same. At the bottom of page EF-1, the Department has provided a list of historic trends. Included are two-year, three-year, four-year, and five-year trends, ending in the three most recent historical years. Typically, the same percentage selected to modify current-year per capita costs is used to modify the request-year per capita costs, although the Department makes adjustments to the selected trend where necessary.

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

The table below describes the trend selections for FY 2014-15, FY 2015-16, and FY 2016-17. In some cases, though not all, the Department has held the trend constant among the three years. In Exhibit F, the selected trend factors have been bolded for clarification. As described in the Department's caseload narrative, populations sensitive to economic conditions are growing at substantial rates. Historically, rapid caseload growth has led to per capita declines due to several factors. First, clients may not receive services immediately upon receiving eligibility; there is typically a lag between when eligibility is determined to when clients receive services and when those services are billed. For this reason, under cash accounting where services are accounted for in the period where the claim is paid, expenditure growth will typically lag caseload growth, causing a per capita decline. Additionally, new caseload for economically sensitive populations may previously have had health insurance and may generally be healthier than populations who have not had access to care. These clients may require fewer services, further lowering the overall per capita cost.

The selected trend factors for FY 2014-15, FY 2015-16, and FY 2016-17, with the rationale for selection, are as follows:

Aid Category	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
Adults 65 and Older (OAP-A)	0.36%	0.86%	0.86%	While FY 2013-14 per capita expenditures saw growth, the Department has identified that the vast majority of the growth can be attributed to rate increases for home health services. Because underlying utilization is both small and stable, the Department has selected trends accordingly of less than 1% annual growth. Rate increases are added via bottom line impact and need not be included in the base per capita trend
Disabled Adults 60 to 64 (OAP-B)	0.35%	0.58%	0.58%	The Department has identified that increases in per capita expenditure in FY 2013-14 are largely attributable to rate increases for home health services. Because utilization of these services is stable, the Department has selected trends of less than 1% annual growth. Rate increases are added via bottom line impacts and need not be included in the base per capita trend.
Disabled Individuals to 59 (AND/AB)	0.80%	1.30%	1.30%	The Department has identified that increases in per capita expenditure in FY 2013-14 are largely attributable to rate increases for home health services. Because utilization of these services rose slightly in FY 2013-14, the Department has selected trends close to 1% annual growth. Rate increases are added via bottom line impacts and need not be included in the base per capita trend.
Disabled Buy-in	5.00%	5.00%	5.00%	With little history to predict expenditure for this category, the Department is anticipating a 5.00% growth rate to modify per capita as caseload growth put strong downward pressure in FY 2013-14 that is not expected to continue.

Aid Category	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
MAGI Parents/ Caretakers to 68% FPL	-7.50%	-2.78%	-2.78%	The Department has selected an aggressive downward trend as significant per capita decreases seen in FY 2013-14 are expected to continue due to strong caseload growth in this category and lower utilization of services from new clients that have been eligible for services but have failed to seek care for some time.
MAGI Parents/ Caretakers 69% to 133% FPL	-9.78%	-2.78%	-2.78%	Per capita for this population was roughly 80% that of the MAGI Parents/Caretakers to 68% FPL in FY 2013-14, the Department is maintaining this ratio to modify per capita costs in FY 2014-15, FY 2015-16, and FY 2016-17.
MAGI Adults	10.00%	5.00%	2.50%	The Department is anticipating strong pent-up demand for services from this population, thus an aggressive trend has been selected to modify per capita expenditure. The Trend has been halved in FY 2015-16 and FY 2016-17 as the strong effects of pent-up demand subside.
Breast & Cervical Cancer Program (Page EF-6)	0.00%	0.00%	0.00%	See the section in this Budget Narrative titled "Breast and Cervical Cancer Program per Capita Detail and Fund Splits" for a description of this trend factor.

Aid Category	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
Eligible Children (AFDC-C/ BCKC-C)	-6.00%	0.00%	0.00%	The Department has chosen an aggressive downward trend for three main reasons. First, strong caseload growth is expected to put downward pressure on per capita costs throughout FY 2014-15. Second, the department anticipates that many new clients signing up for Medicaid services will be less expensive as they have been eligible for some time but did not seek services. Lastly, the Department believes that strong utilization of primary care in FY 2013-14 coupled with strong ACC enrollment for Eligible Children will put additional downward pressure on per-capita costs. In the request year, as well as the out year the Department believes that per capita costs will stabilize and so a zero growth trend was applied to modify per-capita costs.
SB 11-008 Eligible Children	-6.00%	0.00%	0.00%	The Department assumes a near doubling of caseload expected in 2014-15 will put strong downward pressure on per capita costs. The growth trend for this population is tied to the Eligible Children's population as the Department believes utilization patterns will be very similar.
Foster Care	-8.00%	0.00%	0.00%	Strong caseload growth and a number of prescription drug patent expirations contribute to the aggressive trend selected. The Department believes that per capita costs will stabilize in the request year and the out year as the effects of patent expiration and caseload growth are built into the per capita cost.

Aid Category	FY 2014-15 Trend Selection	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
MAGI Pregnant Adults	0.00%	0.00%	0.00%	The Department does not expect the per capita growth within this category to continue.
SB 11-250 Eligible Pregnant Adults	0.00%	0.00%	0.00%	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.
Non-Citizens	2.95%	2.95%	2.95%	The Department has lowered the per capita growth trend for this population given actual per capita decreases in FY 2013-14.
Partial Dual Eligibles	2.67%	2.67%	2.67%	The Department has lowered the per capita growth trend for this population given lower than expected growth in FY 2013-14.

Legislative Impacts and Bottom-line Adjustments

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

- SB 10-117, OTC MEDS allows for pharmacists to prescribe certain over-the-counter drugs to Medicaid Clients. The program reduces expenditure by reducing more costly visits to the emergency room or physicians for over-the-counter prescriptions.
- Physician Rate Increase to 100% of Medicare (Section 1202 of Health Care and Education Reconciliation Act) accounts for the increase in primary care physician rates as mandated by federal health care reform legislation. This is effective January 1, 2013.
- Accountable Care Collaborative (ACC) savings accounts for reductions in Acute Care expenditure resulting from ACC program activities. Saving estimates were previously reported under S-6 (FY 2010-11), BA-9 (FY 2011-12) and LRFI-6 (FY 2012-13); savings estimates have been consolidated. Additional detail can be found both in section V and in Exhibit I.

- BRI-1 (FY 2011-12), Client Over-Utilization, expanded the Department's Client Over-Utilization Program (COUP). The program reduces expenditure by identifying clients that over-utilize ER, pharmaceutical, or physician services and assisting them in managing their care in a more cost-effective manner.
- BA-9 (FY 2011-12), Limit Number of Physical and Occupational Therapy Units for Adults, limited the number of units of therapy an adult can receive to 48 per year, regardless of prior authorization.
- Estimated Impact of Increasing PACE Enrollment accounts for the Department's initiative to increase enrollment of new PACE clients. The Department anticipates that this increased enrollment will cause a shift in expenditure from the Acute Care and Community-Based Long-Term Care service groups to the PACE service category.
- SB 10-167, Colorado False Claims Act increases enrollment in the Health Insurance Buy-In (HIBI) program. As of June 2014, there were 463 enrollees in the program. The Department expects to increase enrollment by approximately 2% per month through FY 2016-17.which is more expensive than CDASS, resulting in savings allocated to acute care.
- Colorado Choice Transitions adjusts for increased home health service expenditure associated with clients transitioning to alternative care settings. Additional detail can be found in Exhibit G.
- R-6 (FY 2012-13), Dental Efficiency, reflects a refinement of Department policy regarding provision of orthodontics. Payment structure and clinical qualifying criteria for authorization are being evaluated.
- R-6 (FY 2012-13), Augmentative Communication Devices, accounts for the availability of new, cheaper, communication assistance technology for clients with disabilities impairing their ability to communicate.
- R-5 (FY 2012-13) ACC Gainsharing allows the Department to share budgetary savings with primary care medical providers (PCMPs) and Regional Care Collaborative Organizations (RCCOs) in the ACC. Prior Behavioral Health Organization (BHO) and Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Gainsharing have been consolidated under ACC Gainsharing.
- Fifty-Three Pay Periods in FY 2013-14 accounts for the Department's claims processing cycle including a 53rd payment period every seven years. This adjustment accounts for the additional payment period in FY 2013-14, which results in a reduction in expenditure in FY 2014-15.
- R-7 (FY 2013-14), Substance Use Disorder Benefit, accounts for savings associated with enhancing the existing substance abuse disorder benefit by adding appropriate services to make a more robust program.
- R-9 (FY 2013-14), Dental ASO, accounts for savings associated with implementing a dental administrative service organization (ASO) for the Medicaid children's dental benefit.
- R-13 (FY 2013-14), 2% Provider Rate Increase, accounts for added expenditures associated with increasing provider rates by 2% for services impacted by rate reductions in recent years.
- SB 13-242, Adult Dental Benefit accounts for added expenditures associated with providing a dental benefit for adults in the Medicaid program.

- SB 13-200 Medicaid Expansion adjustment is an adjustment made to account for lower average per capita expenditure expectations for clients newly entering the Medicaid program. The Department has revised the adjustment in FY 2014-15 based on actual expenditure in FY 2013-14.
- Preventive Services accounts for the differences in the benefits packages between the expansion requirements and the current Colorado Medicaid benefits package. Colorado Medicaid offers preventive services not required under the expansion but still available to clients. An adjustment is made to account for this difference.
- Fluoride Benefit Expansion for Children accounts for additional costs associated with the expansion of fluoride varnish services to certain providers as required in a 2013 Long Bill footnote.
- CDASS Service Expansion into the Brain Injury (BI) Waiver – clients on the CBLTC BI waiver would utilize the CDASS as a service delivery option for health maintenance activities rather than long-term home health, which is more expensive than CDASS, resulting in savings allocated to acute care.
- R-7 (FY 2014-15), Adult Supported Living Service Waiting List Reduction, accounts for savings resulting from clients utilizing SLS waiver services in place of state plan services.
- R-8 (FY 2014-15), Development Disabilities New Full Program Equivalents, accounts for savings resulting from clients utilizing DIDD waiver services in place of state plan services.
- R-9 (FY 2014-15), Medicaid Community Living Initiative, accounts for added expenditure for counseling nursing home residents regarding community-based living options.
- R-10 (FY 2014-15), Primary Care Specialty Collaboration, accounts for added expenditure for primary care providers and specialists to acquire and utilize technology that allows remote specialty consultation.
- R-11 (FY 2014-15), Community Provider Rate Increases, accounts for added expenditure from a 2% across the board increase for eligible providers.
- R-11 (FY 2014-15), Targeted Community Provider Rate Increase, accounts for added expenditure from targeted rate increase for the purpose of addressing issues with clients access to cost-effective services. The separate components of the rate increase are broken out in Exhibit F1.
- BA 10 (FY 2014-15), Dental Provider Network Adequacy, accounts for added expenditure to provide tiered incentive payments to dental providers who take additional Medicaid patients.
- BA 10 (FY 2014-15), Continuation of 1202 Provider Rate Increases, accounts for added expenditure to pay for primary care services at 100% of Medicare Rates.
- BA 12 (FY 2014-15), State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees, accounts for added expenditure to enroll clients dually eligible for Medicaid and Medicaid in the Accountable Care Collaborative (ACC) so that they will receive care coordination.
- HB 14-1252, Intellectual and Developmental Disabilities Services System Capacity, accounts for savings resulting from clients utilizing waiver services in place of State Plan services.

- FY 2014-15 JBC Action, Matching Incentives to Ambulatory Surgery Center Facilities, accounts for added expenditure for matching funds paid to Surgeons accounted for within the R-11 Targeted Community Provider Rate Increase.
- FY 2014-15 JBC Action, Family Planning Rate Increase, accounts for added expenditure to standardize oral contraceptive rates and increase Family Planning rates by 15%.
- FY 2014-15 JBC Action, Raising FQHC Rate Increase to APM, accounts for added expenditure to bring rates for Federally Qualified Health Centers up to the rate called for in Colorado's Alternative Payment Method.
- FY 2014-15 JBC Action, Full Denture Benefit, accounts for added expenditure to provide clients with full dentures with prior authorization as part of the Adult Dental Benefit.
- EPSDT Personal Care adjustment accounts for added expenditure from personal care services deemed medically necessary for EPSDT eligible children. In late FY 2013-14 the Department received notice from CMS that personal care is a covered benefit under EPSDT if deemed medically necessary. The Department anticipates that clients utilizing personal care under EPSDT will fall into three categories: clients substituting long-term home services with less costly personal care services; resulting in savings in acute care, clients directly substituting units under the state plan from waivers, resulting in an increase in acute care expenditure and decrease to HCBS wavier expenditure, and clients who have never had access to personal care that have a medical necessity, resulting in an increase in acute care expenditure.

Breast and Cervical Cancer Program Per Capita Detail and Fund Splits

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

Per Capita Cost

In the Department's November 1, 2006 Budget Request, the Department observed the expenditure and per capita costs in FY 2005-06 grew at an unexpected rate. The Department investigated the issues involved and determined the total expenditure in FY 2005-06

contained a large amount of retroactive transactions, which caused the expenditure for FY 2005-06 to appear overstated. The residual effects of this experience continue, as the affected caseload is very small and changes to total expenditure therefore have a large impact on per capita calculations. Per capita expenditure has grown from year-to-year by as much as 26.55% and has been reduced by as much as 32.73%.

For this reason, the Department has been using only the most recent months of expenditure history to forecast per capita for this program. In the past few years, however, program caseload has grown at a steep rate, resulting in substantial decreases in per capita expenditures. The Department assumes the decline in the per capita expenditures is a temporary product of increasing caseload and, as the new clients incur costs, the per capita rate will begin to slow down in its decline. For the current year trend, the Department assumes that per capita costs will remain unchanged from FY 2013-14.

Fund Splits

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

HB 14-1045 extended the repeal date of the program through July 1, 2019. Per 25.5-5-308(9)(g), C.R.S (2014), enacted in HB 14-1045, the state's share of expenditure shall be appropriated one hundred percent from the Breast and Cervical Cancer Prevention and Treatment Fund. All Breast and Cervical Cancer Program expenditures receive a 65.53% federal match rate.

Adult Dental Benefit Per Capita Detail

In 2013, the General Assembly passed SB 13-242, which established the Adult Dental Benefit program along with the Adult Dental Cash Fund which is funded through the Unclaimed Property Tax Fund. The Adult Dental Cash Fund provides the funding for the state share of the Dental Benefit program. In 2014, the General Assembly passed HB 14-1336 which provided funding for the addition of full dentures as part of the Adult Dental Benefit. The Department previously covered dental services for adults only in emergencies or in the case of co-occurring conditions that required dental services. The Department does not have a way to systematically distinguish between dental services received in the case of emergency or co-occurring conditions and those covered under the Adult Dental Benefit. The Adult Dental Exhibit reports total Dental expenditure and subtracts out the estimated expenditure for emergency and co-occurring conditions to estimate expenditure from the Adults Dental Cash Fund.

Antipsychotic Drugs

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

The Department experienced a large decrease in gross aggregate and per-capita acute antipsychotic pharmaceutical expenditure in FY 2012-13 due to several antipsychotic drugs going generic and per-unit costs decreasing significantly.

Federal Funds Only Pharmacy Rebates

The Affordable Care Act (ACA) increased the amount of pharmaceutical rebates the Department receives. Under section 2501 of the ACA, the entire increase in the drug rebates is due to the federal government. Drug rebates are recorded as an offset to total funds expenditure in Acute Care (Exhibit F), and the Department's total funds expenditure projection reflects the estimated expenditure after the increase in the drug rebates. In order to properly account for this decrease in expenditure, the Department shows the estimated increase in drug rebates as a federal funds decrease in Exhibit A, as the increased drug rebate will offset total federal funds expenditure. In this exhibit, the Department estimates the incremental amount of rebates that are federal funds only. Estimates are based on data through quarter four of FY 2013-14. Historical actuals have been restated as the Department has transitioned from accrual-based accounting to cash-based accounting.

Family Planning - Calculation of Enhanced Federal Match

Certain services that are family planning in nature are eligible for 90% federal financial participation. However, in order to claim the enhanced match, the State must be able to uniquely identify these services. Some family planning services are provided through fee-for-service, and, beginning in late FY 2001-02, the Department was also able to identify those family planning services provided by health maintenance organizations. Therefore, the State receives the enhanced match on about 95% of the family planning services provided to Medicaid clients. Totals listed on page EF-11 are taken directly from the Department's reporting to the Centers for Medicare and Medicaid Services for enhanced federal funds.

As of FY 2005-06, the Department no longer has contingency-fee based contracts to calculate the managed care portion of the enhanced family planning match rate. This calculation is now done by the Department. Historically, calculations for fee-for-service and health

maintenance organizations were done independently. However, due to changes in the Department's managed care program, the totals were combined beginning in FY 2008-09, and a single combined estimate is now produced. In FY 2009-10 the Department submitted a managed care claiming methodology proposal to the Center for Medicare and Medicaid Services (CMS). The Department did not claim managed care family planning until the methodology was approved in FY 2010-11. As a result, managed care claims for the stagnant period were realized in FY 2010-11 through a large, but temporary, increase in managed care expenditure.

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

In light of the Department's view of the increase between FY 2007-08 and FY 2008-09 as a one-time level shift, the FY 2014-15 estimate for total reported expenditure is the average of annual total reported expenditures increase since the program's inception, attributing 8.0% growth, in addition to the JBC action which raised reimbursement rates on oral contraceptives for family planning purposes, which attributes 16.68% additional growth over FY 2013-14. This methodology is motivated by the Department's expectation of an upward expenditure trend, despite the sporadic behavior of total annual expenditures observed over the previous fiscal years. As the Department anticipates family planning expenditures to resolve into a more stable growth pattern, estimates for FY 2015-16 and FY 2016-17 total expenditures are the result of the application of the average of annual growth rates for FY 2010-11 and FY 2012-13 to the previous year's estimated expenditure. The Department selected this time period as a model for future expenditure growth because it represents the most recent occasion for which moderate growth was observed in consecutive fiscal years.

As drug rebates become an increasingly larger component of total reported expenditure, the Department has begun to explicitly show the impact of rebates on the total expenditure with this request. After analyzing recent data on family planning expenditure, it has been determined that the Department is ineligible to claim the 90% federal match on about five percent of total expenditure. Expenditure not eligible for the enhanced match is claimed at the standard Medicaid match. Fund split calculations for the current year and the request year are shown in EF-4.

SB 11-177 "Sunset Teen Pregnancy and Dropout Program" is expected to contribute $29,160 in local funds for FY 2014-15, $30,026 in local funds for FY 2015-16, and $5,153 in local funds for FY 2016-17. The Department continues to explore opportunities to expand this program.

Indian Health Service

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

The Department uses historical expenditure to estimate total expenditure for services to these clients. In FY 2008-09, Indian Health Service expenditure grew by 44.48%; in FY 2011-12, expenditure decreased by 14.21%. In an effort to forecast FY 2014-15 expenditure growth in a fashion representative of more regular patterns observed in other fiscal years, half the average annual growth for FY 2007-08 through FY 2013-14 was applied to FY 2013-14 expenditure. With the uncertainty of expenditure for this population, as seen by extreme fluctuations in expenditure historically, the growth rate chosen for FY 2014-15 has been held constant in FY 2015-16 and FY 2016-17. The Department will monitor expenditure through the first half of FY 2014-15 and make adjustments to growth rates as necessary.

Prior-Year Expenditure

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

EXHIBIT G - COMMUNITY-BASED LONG-TERM CARE

Community-Based Long-Term Care (CBLTC) services are designed to provide clients who meet the nursing facility level of care with services in the community. The increased emphasis on utilizing community-based services has served to keep the census in Class I nursing facilities relatively flat. In FY 1981-82, with the implementation of the first wave of Home- and Community-Based Service (HCBS) waivers, Class I nursing facility census was over 12,500 clients. Almost immediately, the census dropped to just over 10,000 clients. The HCBS census generally remained in this range though FY 2002-03. However, since that time, HCBS utilization has risen sharply; in FY 2013-14, the Department paid HCBS claims for an average of 25,937 clients per month.

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

- Elderly, Blind and Disabled Adult Waiver
- Community Mental Health Supports Adult Waiver[1]
- Disabled Children's Waiver
- Persons Living with AIDS Adult Waiver
- Consumer Direct Attendant Support State Plan Waiver
- Brain Injury Adult Waiver
- Children with Autism Waiver
- Children with Life Limiting Illness Waiver[2]
- Spinal Cord Injury Adult Waiver[3]

Calculation of Community-Based Long-Term Care Expenditure

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

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

[1] Previously known as "Persons with Mental Illness"
[2] Previously known as "Pediatric Hospice Waiver"
[3] Previously known as "Alternative Therapies Waiver"

The selected enrollment trend factors for FY 2014-15, FY 2015-16, and FY 2016-17, with the rationale for selection, are below. In most cases, the Department kept the trend for the out year the same as the request year. In situations where the out years do not carry the same trend, the variation is noted.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Elderly, Blind and Disabled Waiver	FY 2014-15 through FY 2016-17: Linear: 6.62%, 4.85%, and 4.36% respectively	FY 2014-15: -1.74% - Adjusted linear. FY 2015-16 through FY 2016-17: 1.37%, 1.37%, average growth from FY 2010-11 to FY 2012-13	Enrollment history is very steady, growing at approximately 5% per year. The enrollment trend selected continues historical growth both in the request year and the out year. Due to a systems issue, enrollment in the first half of FY 2013-14 came in lower than expected, though the issue was resolved and enrollment resumed normal levels thereafter. However, actual enrollment did not fall, and so per enrollee cost is inflated in FY 2013-14. Per enrollee costs did not increase as much expected in the past year, primarily driven by slower growth in client utilization of CDASS than anticipated. Also, a large decrease in non-medical transportation per utilizer cost due to a rate negotiation put downward pressure on per enrollee cost. The inflation of per enrollee cost due to systems issues resulted in a necessary negative trend in FY 2014-15, to return to the correct per enrollee cost level.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Community Mental Health Supports Waiver (CMHS)	FY 2014-15 through FY 2016-17: Constant: 8.70%	FY 2014-15: -4.21%, Adjusted linear. FY 2015-16 and FY 2016-17: Constant: 0.00%	This waiver has seen historically high growth in enrollment, with higher growth recently. To account for the recent growth, a trend of 8.70% (linear trend for FY 2014-15) is held constant through the out year, as the Department expects growth to continue. Per enrollee cost has decreased in recent fiscal years, with the increase in FY 2013-14 overstated due to systems issues that make enrollment appear to be lower than it actually was. The true per enrollee cost trend for FY 2013-14 was negative, resulting from the low percent change in unique clients using services for this waiver coupled with high enrollment growth. The negative trend is continued in FY 2014-15, but then held constant at 0.00% for the request year and the out year.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Disabled Children's Waiver	FY 2014-15 through FY 2016-17: Trends reflect program expectations: 3.40%, 3.23%, and 2.57% respectively	FY 2014-15 through FY 2016-17: constant, 41.90%	Historically, enrollment growth was negative; however, the Department has made significant efforts to eliminate the waitlist for this waiver by enrolling clients. Therefore, the Department expects positive growth in the request year forward as the waitlist is enrolled and as stakeholders become aware of the elimination of the waitlist. For this reason, the Department chose a positive trend for the November Budget submission that reflects current expectations for enrollment in the waiver. Only two services are offered on the waiver: In-home Supportive Services (IHSS) - Health Maintenance Activities and case management. While IHSS is expensive, it is less costly than Long-Term Home Health services. Very large growth in per-utilizer costs were driven by IHSS - Health Maintenance Activities client utilization. The number of clients utilizing this service has increased dramatically in the past few fiscal years, and the penetration rate of clients utilizing IHSS compared to those enrolled in this waiver reached 14.38% in FY 2013-14. This has driven the increase in per enrollee cost for this waiver. Client utilization of IHSS is expected to continue to grow, and so the Department held the average yearly growth rate from FY 2008-09 to FY 2013-14 (41.90%) constant for each of the years in this Budget Request.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Persons Living with AIDS Waiver	N/A	N/A	The clients on this waiver were fully phased into the Elderly, Blind, and Disabled Adult Waiver. There was no enrollment on this waiver at the end of FY 2013-14.
Consumer Directed Attendant Support-State Plan	FY 2014-15 through FY 2016-17: Linear Growth: -22.58%, -12.50%, and -14.29% respectively	FY 2014-15 through FY 2016-17: Constant, 0.00%	Additional enrollment in this program is currently prohibited; the chosen negative growth rates reflect clients leaving the program. The Department moved to a needs-based allocation plan in FY 2011-12 to align with the CDASS waiver benefit; interestingly, the average cost per enrollee reached its peak in FY 2011-12 and then decreased in FY 2012-13 and FY 2013-14, suggesting that client allocations have reached stability. Therefore, the Department chose to keep the growth of the per-enrollee cost flat, at the same level selected in the February Request.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Brain Injury Waiver	FY 2014-15 through FY 2016-17: Linear Growth: 9.29%, 7.13%, and 7.36% respectively	FY 2014-15 through FY 2016-17: Constant: -1.71%	Historically there has been slow and steady growth in BI enrollment. The Department saw this growth increase rapidly in FY 2012-13, which continued in FY 2013-14. The Department expects waiver enrollment to grow in FY 2014-15 and beyond at a linear growth rate, due to the Department's work to dispel myths regarding who is eligible and what services can be accessed under this waiver, as well as proactive stakeholder education for this waiver. There has been negative per enrollee cost growth over the last few years. Due to the large waiver growth and clients slowly entering the HCBS system, the cost per-enrollee trend decreased in FY 2012-13 and FY 2013-14. The Department expects negative growth to continue, and has used the average growth rate from FY 2008-09 to FY 2013-14 to select the per enrollee cost trend for this Budget Request.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Children with Autism Waiver	FY 2014-15 through FY 2016-17: Constant: 5.45%	FY 2014-15 through FY 2016-17: Constant: 0.00%	This waiver is capped at 75 clients. This cap has already been met, and the waiver currently has a waiting list. Average monthly enrollment is consistently below 75 clients because of client churn; however, there are no available spots on the waiver. The waiver has seen above average growth in FY 2012-13. The apparent decrease in enrollment in FY 2013-14 is primarily due to systems issue that made it appear as though enrollment fell, when in actuality it did not. The growth is linear, but because of recent waitlist prioritization changes, slight growth is expected to continue. The current trend selection does not cause enrollment to exceed the cap. It is likely that costs per enrollee have been dropping because clients are not on the waiver very long before they age out. As a result, the clients do not receive many services while on the waiver. Client access issues have been addressed and service utilization should increase. However, per enrollee cost has continued to decrease, though at a decreasing rate. The Department has selected a 0.00% growth rate to account for this.

Home- and Community-Based Waivers Enrollment Trends and Justification			
Waiver	**Enrollment Trend Selection**	**Per Enrollee Trend Selection**	**Justification**
Children with Life Limiting Illness Waiver	FY 2014-15 through FY 2016-17: Constant: 3.81%	FY 2014-15 through FY 2016-17: Linear Growth: 9.19%, 8.42%, and 7.77% respectively	Waiver programmatic changes have improved the program resulting in large positive growth, though recent growth has been negative. The waiver is capped at 200 clients and average enrollment is anticipated to be around 169 clients. Therefore, the Department anticipates a positive growth rate, as enrollment is expected to approach the waiver's cap of 200 clients. Client utilization of expressive therapy and counseling increased significantly between FY 2012-13 and FY 2013-14 (by 57.63% and 22.73% respectively), resulting in a very large increase in per enrollee cost. The Department anticipates this to continue but at a lesser rate and used a linear trend to forecast per enrollee cost.
Spinal Cord Injury Adult Waiver	FY 2014-15 through FY 2016-17: growth to the cap, 29.41%, 1.52%, and 0.00% respectively	FY 2014-15 through FY 2016-17: No change, 0.00%	Enrollment in the waiver grew slower than anticipated in FY 2013-14, but the Department anticipates the waiver enrollment to be around the cap of 67 clients by the end of FY 2014-15. There will be little turnover as clients are likely to remain on the waiver for an extended period of time as they receive services. For per-enrollee growth, the Department chose to keep the trend flat, as clients cost more in the first year of receiving services than in later years.

Legislative Impacts and Bottom-Line Adjustments

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

Expenditure

- HB 14-1252: "Intellectual and Developmental Disabilities Service System Capacity" – HB 14-1252 is the bill that incorporates the Department's BA-5/S-5 request "Community Living Caseload and Per Capita Changes". The impact to HCBS waivers is due to the increased caseload and per capita costs for the Department of Intellectual and Developmental Disabilities (DIDD) Medicaid waivers attributable to those formerly on Medicaid HCBS waivers (in this case, the Elderly, Blind, and Disabled Adult Waiver). This shows as savings to HCBS waivers.
- HB 14-1357: "In-Home Support Services in Medicaid Program" – HB 14-1357 expands In-Home Support Services (IHSS) into the Spinal Cord Injury Waiver, allows for the delivery of IHSS in the community, permits the person receiving services, or his or her representative, in conjunction with the in-home support services agency to determine the amount of nurse oversight needed in connection with the person's in-home support services, and permits family members to be reimbursed for in-home support services provided to eligible persons and requiring the medical services board to promulgate rules, as necessary, regarding reimbursement for services.
- Annualization of Adjustment for 53 pay periods – there are normally 52 periods; in FY 2013-14 there is an extra pay period. This impact annualizes out the effect of FY 2013-14's extra pay period for FY 2014-15.
- Children with Life Limiting Illness Waiver Audit Recommendations – Audit recommendations found services in the CLLI waiver to be non-sufficient for the clients the waiver supports. Recommendations include simplifying services that providers found confusing and expanding service components to better meet client needs.
- Colorado Choice Transitions – The Department was awarded Money Follows the Person federal grant monies to implement a program designed to transition clients from nursing facilities into community-based services. The program began enrolling clients in May 2013.
- Annualization of the 8.26% Rate Adjustment – In FY 2012-13, the Joint Budget Committee approved an 8.26% rate increase for HCBS services effective July 1, 2013. This adjustment annualizes the impact to account for run out in FY 2014-15.
- Annualization of Expansion of the Consumer Directed Attendant Support Services (CDASS) option into the Brain Injury wavier – Participant direction of personal care, homemaker, and health maintenance activities were added to the Brain Injury Waiver, resulting in movement of clients from the Consumer Directed Attendant Support—State Plan to the Brain Injury Waiver.

- Annualization of Alternative Therapies Waiver Chiropractic Rate Increase – The rate was too low compared to the private sector and the Department was having trouble recruiting providers for this short-term pilot program. Increasing the rate was expected to bring new providers on in time before the pilot waiver expires. This accounts for the annualization of this impact in FY 2014-15.
- Raising the Cap on Home Modifications – A Joint Budget Committee action raised the cap on home modifications in FY 2014-15, resulting in an impact to waivers that include home modifications.
- FY 2014-15 R#7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase" – This impact shows as savings to HCBS waivers (the Elderly, Blind, and Disabled Adult Waiver) due to the waitlist reduction of the DIDD Adult Supported Living Services waiver for the clients formerly on the EBD waiver who transitioned over.
- FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents" – This impact shows as savings to HCBS waivers (the Elderly, Blind, and Disabled Adult Waiver) due to the new full program equivalents on the DIDD Developmental Disabilities waiver who were formerly on the EBD waiver but transitioned over.
- FY 2014-15 R#11: "Community Provider Rate Increase" Targeted - Pediatric Hospice Services 20% – The Joint Budget Committee approved a 20% rate increase to Pediatric Hospice Services, effective July 1, 2014, which affects the Children with Life Limiting Illness Waiver.
- FY 2014-15 R#11: "Community Provider Rate Increase" 2% Across the Board – The Joint Budget Committee approved a 2% across-the-board rate increase, effective July 1, 2014, which affects services provided by HCBS waivers.
- FY 2014-15 R#12: "Administrative Contract Reprocurement" – The Department requested funding to help transition contracts for Financial Management Services (FMS) for the CDASS program between vendors. The current contract expires 12/31/2014.
- EPSDT Personal Care – accounts for a decrease in expenditure from personal care services in the waivers deemed medically necessary for EPSDT eligible children, which accompanied by an increase in state plan expenditure. In late FY 2013-14 the Department received notice from CMS that personal care is a covered benefit under EPSDT if deemed medically necessary. The Department anticipates that clients utilizing personal care under EPSDT will fall into three categories: clients substituting long-term home services with less costly personal care services; resulting in savings in acute care, clients directly substituting units under the state plan from waivers, resulting in an increase in acute care expenditure and decrease to HCBS wavier expenditure, and clients who have never had access to personal care that have a medical necessity, resulting in an increase in acute care expenditure.
- CDASS Administrative FMS & Training Contract Competitive Reprocurement – Because of the competitive reprocurement of the FMS contract, client per member per month (PMPM) administrative expenditures are expected to come in less than the current PMPM expenditure resulting in savings to the EBD, CMHS, BI, and SCI waivers.

Colorado Choice Transitions

The Department was awarded the Money Follows the Person federal grant designed to help clients currently residing in nursing facilities to transition into Community-Based Long-Term Care. The grant allows the Department to provide transitional services to ease the movement from nursing facility to the community and provides an enhanced federal match to those services, existing HCBS waiver services, and home health services. The grant is designed to offer clients enhanced services for one year after transitioning from a nursing home to allow them to adapt to the community setting. Savings from the enhanced match are required to be used to improve the long-term care service system as the Department outlined in the operational protocol submitted to the Center for Medicare and Medicaid Services. The Colorado Choice Transitions exhibit illustrates the total cost of the program by delineating the two types of services the Department will offer through the program, demonstration (new services offered through the program), and qualified services (existing waiver services and home health). These costs are reflected in Exhibits F and G, Community-Based Long-Term Care as a bottom line impact. The exhibit then reports the savings anticipated from transitioning clients from nursing facilities which is reflected in Exhibit H, Class I Nursing Facilities as a bottom-line impact. Following the net impact of the program, the Department reports on the rebalancing funds the Department anticipates earning. Rebalancing funds are calculated as 25% of total expenditure and are 100% federal funds.

The Department delayed implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The program was implemented on March 1, 2013, with the first client transitioning in May 2013. The Department currently anticipates approximately 100 clients will transition per 365 days beginning in May 2013. The Department estimates the total impact to Medical Services Premiums to be a reduction of $2,563,885 total funds in FY 2014-15 and a reduction of $7,147,288 in FY 2015-16. These figures do not include any expenditure from the rebalancing fund.

Prior-Year Expenditure

As an additional reasonableness check, the Department has split FY 2013-14 actual expenditure into two half-year increments to analyze the changing rates of expenditure over time.

Hospice

Hospice expenditure for FY 2014-15, FY 2015-16, and FY 2016-17 is forecasted as the sum of two primary categories of services. The first – Nursing Facility Room and Board expenditure – are expenses incurred on a per-diem basis for clients receiving hospice services in a full-time capacity at a nursing facility. These expenditures represented approximately 75% of total hospice expenditure in FY 2013-14. The remaining portion of hospice expenditure is represented under the Hospice Services category and includes Hospice General

Inpatient Care, Hospice Routine Home Care, Hospice Inpatient Respite, Hospice Continuous Home Care, and vision, dental, hearing, and other Post-Eligibility Treatment of Income (PETI) benefits.

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

To create the patient days forecast, the Department used claims information adjusted by an incurred-but-not-reported (IBNR) analysis to determine historical patient day counts; then, the Department used an autoregressive model with seasonality to estimate patient days for the years covered in this request. As hospice client nursing facility per diems are linked to the per diem for Class I Nursing Facility clients, they are assumed to grow at the same 3% per-year rate. Rate reductions are accounted for in the same fashion as they are for nursing facilities: their impact is included in calculations as a bottom-line impact. Hospice nursing facility room-and-board total expenditure estimates for a particular fiscal year are the product of forecasted patient days and forecasted patient per diem, with additional bottom-line impact adjustments made for rate cuts applied to claims paid that were incurred in the previous fiscal year.

Please refer to the portion of the narrative devoted to Class I Nursing Facilities for a more detailed description of IBNR analysis, the 3% general fund growth cap for nursing facility rates, and nursing facility rate reductions. Additional information is available in footnotes (1) through (7) in the footnotes section of the hospice forecast.

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

The largest component of this expenditure category is Hospice Routine Home Care; this is considered the standard level of hospice care provided to hospice clients in their homes typically two to three times per week, generally by nurses. In FY 2013-14, Hospice Routine Home Care expenditure was approximately $9.2 million and thus represented 84% of hospice services expenditure and 21% of total hospice expenditure. Hospice Routine Home Care expenditure is computed as a product of patient days and the daily rate. The Department arrives at estimates for days for FY 2014-15, FY 2015-16, and FY 2016-17 by using an autoregressive model with seasonality and linear time trend. The Hospice Routine Home Care per diem is forecasted by applying a linear time trend to observed daily rates between FY 2007-08 and FY 2013-14.

The next-largest component of hospice services expenditures is Hospice General Inpatient Care. These expenditures are incurred for services provided to hospice patients at inpatient facilities under severe circumstances. In FY 2013-14, the Department paid approximately $1.6 million for Hospice General Inpatient Care. The Department selected a linear time trend applied to historical claims

data with seasonal dummy variables added depending on whether the expenditure took place in the first or second half of the year to develop expenditure forecasts for FY 2014-15, FY 2015-16, and FY 2016-17.

The remaining components of hospice services expenditures in total represent approximately $75,000 of expenditure for FY 2013-14; in every prior year except FY 2012-13, they accounted for less than $50,000 of combined expenditure. As such, the Department chose to aggregate the remaining expenditure and apply the average growth rate for FY 2012-13 to the FY 2013-14 observation for the same aggregation to develop an estimate for FY 2014-15 expenditure. FY 2015-16 and FY 2016-17 expenditure estimates are results of the application of the same growth rate to the previous fiscal year's estimate.

Private Duty Nursing

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

As PDN expenditure is the product of the hourly rate and the number of hours, and the Department expects rates to remain constant, expenditure forecasts for FY 2014-15, FY 2015-16, and FY 2016-17 are primarily based on hours forecasts for those fiscal years. The hours forecast is separated into three pieces that are consistent with the three rate groups: RN hours; RN-group, LPN, and blended hours; and LPN-group hours.

In FY 2013-14, the Department paid claims for 1,493,899 total hours for PDN services; 898,452 were billed as RN hours. Linearly regressing RN hours between FY 2008-09 and FY 2011-12 explains 98.8% of the variation in hours. As such, the Department chose to apply a linear time trend to historical claims data over this time frame to produce estimates for FY 2014-15, FY 2015-16, and FY 2016-17. This model predicts growth at 18% per fiscal year.

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

trend exists in changes of hours per distinct client per month. For all three categories of PDN service, changes in usage appear to be driven entirely or almost entirely by the addition of new clients. To ensure proper delivery of services, The Department is working with its utilization review contractor to make sure that the clients receiving PDN services are doing so out of medical necessity.

As is consistent with RN services, paid hours for the intermediate-rate group of PDN services – RN-group, LPN, and blended – were largely stable between FY 2005-06 and FY 2008-09 before reporting rapid growth in FY 2009-10 and FY 2010-11. Unlike RN services, however, growth for these services was very small between FY 2010-11 and FY 2011-12, but then jumped up again from FY 2011-12 to FY 2012-13, growth above historical growth continued in FY 2013-14. In FY 2013-14, the Department paid claims for 567,865 total hours for the intermediate-rate group services or 38.01% of total PDN hours. To this end, the Department elected to estimate hours for the next three fiscal years for these services by applying a linear trend of 14.48%.

LPN-group services have both the smallest rate and represent by far the smallest portion of PDN claims. In FY 2013-14, these services accounted for only 27,582 hours of claims, or 1.84% of total hours. Due to erratic growth rates in recent years the Department chose to forecast FY 2014-15, FY 2015-16, and FY 2016-17 linearly at 6.44%.

Final expenditure estimates for FY 2014-15, FY 2015-16, and FY 2016-17 are produced by multiplying projected hours by the projected rate for each of the three service categories and then summing these figures. The Department is forecasting large growth in FY 2014-15, 18.91%, which includes a 2% rate increase and significant increases in utilization for all services but the LPN-group service. The trend is decreased in the request and out-years to 18.48% and 16.80% respectively, which is on par with historical growth.

EXHIBIT H - LONG TERM CARE AND INSURANCE SERVICES

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

- Class I Nursing Facilities
- Class II Nursing Facilities
- Program of All-Inclusive Care for the Elderly (PACE)
- Supplemental Medicare Insurance Benefits
- Health Insurance Buy-In

Summary of Long Term Care and Insurance Request

This exhibit summarizes the total requests from the worksheets within Exhibit H.

Class I Nursing Facilities

Class I Nursing Facility costs are a function of the application and interpretation of rate reimbursement methodology specified in detail in State statute, the utilization of the services by Medicaid clients, and the impact of the effect of cost offsets such as estate and income trust recoveries. The traditional strategy for estimating the cost of these services is to predict: 1) the costs driven by the estimated Medicaid reimbursement methodology (the weighted average per diem allowable Medicaid rate and the estimated average patient payment), 2) the estimated utilization by clients (patient days without hospital backup and out of state placement), and 3) the estimated cost offsets from refunds and recoveries and the expected adjustments due to legislative impacts.

Overall, patient days have declined since FY 1999-00, although caseload in the Department's Adults 65 and Older, Disabled Adults 60 to 64, and Disabled Individuals to 59 eligibility categories has increased by approximately 20.8% between FY 1999-00 and FY 2009-10. This is due to efforts by the Department to place clients in Home- and Community-Based Services (HCBS) and in the Department's Program for All-Inclusive Care for the Elderly (PACE). Recent history makes it difficult for the Department to anticipate the behavior of patient days; patient days had been trending upward, but fell unexpectedly in FY 2012-13, but then grew slightly in FY 2013-14.

Patient payment is primarily a function of client income. As clients receive cost-of-living adjustments in their supplemental security income, their patient payment has increased accordingly.

HB 08-1114 directed the Department to change the existing method of reimbursing Class I Nursing Facilities. In addition, the legislation authorized a new quality assurance fee to be collected by the Department from certain Class I Nursing Facilities, including facilities that do not serve Medicaid clients. The fee can be used for administrative costs related to assessing the fee and to limit growth of General Fund expenditures to 3% annually. The Department received federal approval of both the nursing facility fee and the new rate reimbursement method from the federal Centers for Medicare and Medicaid Services (CMS) on March 26, 2009, effective retroactive to July 1, 2008.

The new reimbursement methodology was further amended by SB 09-263, which specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period, adjusted the cap on General Fund growth, specified conditions for supplemental payments, created an upper limit on the nursing facility provider fee, replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate, included a hold harmless provision for administration and general services under certain circumstances, and made changes to the method of implementing pay-for-performance payments. The Department received federal approval of the changes to the reimbursement methodology in December 2009, effective retroactive to July 1, 2009.

HB 10-1324 imposed a 1.5% reduction to FY 2009-10 rates, effective March 1, 2010. HB 10-1379 imposed a 2.5% reduction to FY 2010-11 rates, effective July 1, 2010. The effect of the rate reductions is not cumulative; that is, the total reduction in FY 2010-11 is 2.5%. The rate is restored to the full level effective July 1, 2011. HB 10-1379 also reduced the maximum General Fund growth of the core per-diem rate to 1.9% for FY 2010-11, increasing to 3% in FY 2011-12 and subsequent years.

SB 11-125 reprioritized the components of nursing facility supplemental payments made from the Nursing Facility Provider Fee as well as increased the maximum allowable fee per non-Medicare day. These changes, however, had no impact on the General Fund portion of nursing facility rates. SB 11-215 continued the 1.5% rate reduction of HB 10-1324 into FY 2011-12 effective July 1, 2011. The additional 1.0% rate decrease from HB 10-1379 expired at the end of FY 2010-11.

HB 12-1340 extended the 1.5% rate reduction of SB 11-125 into FY 2012-13. The reduction expired June 30, 2013.

HB 13-1152 extended the 1.5% rate reduction of HB 12-1340 permanently, effective July 1, 2013. As all other rate reductions expired before the start of FY 2013-14, this reduction represents the total value of the rate reduction for FY 2013-14. For complete information regarding specific calculations, the footnotes in pages EH-6 through EH-9 describe calculations of individual components. The methodology for the Class I request in Exhibit H is as follows[4]:

- The estimate starts with the estimated per diem allowable Medicaid rate for core components in claims that will be incurred in FY 2014-15.
- Using historic claims data from the Medicaid Management Information System (MMIS), the Department calculates the estimated patient payment for claims that will be incurred in FY 2014-15. The difference between the estimated per-diem rate for core components and the estimated patient payment is an estimate of the amount the Department will reimburse nursing facilities per day in FY 2014-15 for core components.
- Using the same data from above, the Department calculates the estimated number of patient days for FY 2014-15.
- The product of the estimated Medicaid reimbursement per day for core components and the estimated number of patient days yields the estimated total reimbursement for core components in claims incurred in FY 2014-15.
- Of the estimated total reimbursement for claims incurred in FY 2014-15, only a portion of those claims will be paid in FY 2014-15. The remainder is assumed to be paid in FY 2015-16. The Department estimates that 92.86% of claims incurred in FY 2014-15 will also be paid during FY 2014-15. Footnote 4 details the calculation of the percentage of claims that will be incurred and paid in FY 2014-15.

[4] For clarity, FY 2014-15 is used as an example. The estimates for FY 2015-16 and FY 2016-17 are based on the estimate for FY 2014-15, and follow the same methodology.

- During FY 2014-15, the Department will also pay for some claims incurred during FY 2013-14 and prior years ("prior year claims"). In Footnote 5, the Department applies the percentages calculated in Footnote 4 to claims incurred during FY 2013-14 to calculate an estimate of outstanding claims to be paid in FY 2014-15.
- The sum of the current year claims and the prior year claims is the estimated expenditures in FY 2014-15 prior to adjustments.
- Other non-rate factors are then added or subtracted from this estimate. These include the hospital backup program, recoveries from Department overpayment reviews, and program reductions. Information and calculations regarding these adjustments are contained in Footnotes 6 and 7.
- Legislative impacts are added as bottom-line adjustments. For FY 2014-15, this includes HB 13-1152, which permanently continued the HB 12-1340 rate reduction effective July 1, 2013. SB 14-130, which increases the personal care allowance for nursing facilities from $50.00 to $75.00 monthly is also included.
- Once the "non-rate" factors are estimated, the non-rate adjustments are added into the current estimate to yield the total estimated FY 2014-15 expenditure.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes that are not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts have been included in the FY 2014-15, FY 2015-16, and FY 2016-17 calculations for Class I Nursing Facilities:

- Expenditures for the Hospital Backup Program are included as bottom-line adjustments for FY 2014-15 through FY 2016-17. Please refer to Footnote 6 on page EH-8 for more detail. The estimate for FY 2014-15 is calculated by averaging the percent growth from FY 2008-09 through FY 2013-14 and trending the FY 2013-14 actual expenditures forward by that amount. In FY 2013-14 the Department experienced an abnormal growth in expenditure, over 54%. The Department chooses to place a conservative growth factor to FY 2014-15 because of the uncertainty of how real that growth actually was, or if it was a result of re-enrolling clients.
- Prior to FY 2010-11, the Department reduced expenditure by the amount received in estate and income trust recoveries. The Department will no longer be including these recoveries as an offset to expenditure. See the narrative section for Exhibit L for further detail.
- The Department recovers funds from in-house audits of nursing facilities; the estimated amount of recoveries is included as a bottom line impact for FY 2014-15, FY 2015-16, and FY 2016-17. FY 2010-11 BRI-2, "Coordinated Payment and Payment Reform," increased the number of Department auditors resulting in additional audits of nursing facilities. As such, there was a large increase in recoveries observed in FY 2011-12 related to the prior fiscal year and the following fiscal years. This bottom line impact has

been incorporated into the forecast of overpayment recoveries. Footnote 7 on page EH-8 contains additional detail about these recoveries.

- HB 12-1340 implemented a 1.5% rate reduction for Class I Nursing Facilities per diems effective July 1, 2012, through June 30, 2013. As a result of claims run-out, the fiscal impact of this bill extends into FY 2013-14. Footnote 8 on page EH-9 contains additional detail regarding the fiscal impact of this bill.
- SB 11-125 reprioritized the components of nursing facility supplemental payments. Growth beyond the General Fund cap now has the lowest priority. Quality incentives and acuity adjustments now take higher priority. Additionally, the maximum allowable fee per non-Medicare day increased to $12.00 per day plus inflation with this legislation. As a result, the Nursing Facility Provider Fee will be able to fully fund quality/performance incentives and acuity based adjustments but will be unable to fully fund growth beyond the General Fund cap. The Department estimates approximately 57% of growth beyond the General Fund cap will be supported by the provider fee.
- HB 13-1152 extended the 1.5% nursing facility per diem rate cut of HB 12-1340 permanently, effective July 1, 2013.
- The Colorado Choice Transitions adjustment accounts for the reduction in Class I Nursing Facility expenditure associated with clients transitioning to alternative care settings as part of the Money Follows the Person initiative. Additional detail can be found in Exhibit G.
- Estimated savings due to client movement from Class I Nursing Facilities to HCBS through the Colorado Choice Transitions (CCT) program are added as a bottom line adjustment for each fiscal year of the request.
- SB 14-130 raises the basic minimum amount payable for personal needs to any recipient admitted to a nursing facility or intermediate care facility for intellectuals with disabilities from $50.00 to $75.00, monthly.
- In FY 2014-15, the Department is required to make a General Fund only payment relating to an OIG audit finding concerning Nursing Facility Supplemental Payments. The OIG audit found that the Department made payments that exceeded applicable upper payment limits (UPLs). These payments took place between FY 2009-10 and FY 2010-11 and as a result of the overpayment, the Department incorrectly claimed federal reimbursement amounting to $2,470,450. The payment will be used to refund the federal government for the matching funds incorrectly claimed. This payment is in FY 2014-15 only, and will not be required in future years. The Department has developed internal processes to ensure that payments are made according to the approved Medicaid State Plan and within the upper payment limits so this does not occur in the future.

Incurred-But-Not-Reported Adjustments

As part of the estimates for the allowable per-diem rate, patient payment, and patient days, the Department utilizes the most recent four years of incurred claims to calculate estimates for the current year and the request year. However, because not all claims which have been incurred have been reported, the Department must adjust the incurred data for the expected incidence of claims which will be paid

in the future for prior dates of service. Without such an adjustment, the claims data would appear to drop off at the end of the year, erroneously introducing a negative trend into the estimate.

The Department uses an extensive model that examines past claims by month of service and month of payment to estimate the claims that will be paid in the future. This is known as an "Incurred But Not Reported" (IBNR) adjustment. IBNR adjustments analyze the prior pattern of expenditure (the lag between when past claims were incurred and when they were paid) and applies that pattern to the data. This enables the Department to use its most recent data, where there is a significant volume of claims which have yet to be paid.

Separate IBNR adjustment factors are calculated for each month, based upon the number of months between the time claims in that month were incurred and the last month in the data set. These adjustments are applied to the collected data, and the Department calculates the estimate of nursing facility expenditure using the methodology described above. This adjustment is most apparent in the Department's estimate of claims paid in the current year for current year dates of service, particularly Footnotes 4 and 5 of Exhibit H, page EH-7. In these footnotes, the Department uses the calculated monthly IBNR adjustment factors to estimate the percentage of claims in FY 2013-14 that will be paid in FY 2014-15 and the percentage of claims incurred in FY 2014-15 that will be paid in FY 2014-15 and subsequent years. The Department applies the same factor to the FY 2015-16 and FY 2016-17 estimates.

The Department uses the IBNR adjustment calculation for the November 2014 Request using paid claims data through June 2014. For reference, the following table lists IBNR factors calculated for previous Change Requests and compares them with the current IBNR factor. There is a slight increase in the factors over time, suggesting the time between the date of service and the payment date of a typical claim may be decreasing.

Date of Change Request:	IBNR Factor:
November 2006	91.54%
February 2007	91.82%
November 2007	91.78%
February 2008	91.94%
November 2008	92.75%
February 2009	92.27%
November 2009	92.27%
February 2010	92.27%
November 2010	92.89%
February 2011	92.46%
November 2011	92.30%
February 2012	92.47%
November 2012	92.43%
February 2013	92.75%
November 2013	92.95%
February 2014	93.35%
November 2014	92.86%

Patient Days Forecast Model

To forecast patient days, the Department selected an auto-regressive model without a linear time trend and a dummy variable for FY 2010-11 to account for the fall in days expected from that time period forward.

The Department presents statistical results supporting the selection of this forecasting model: the F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. The Adjusted R Squared of the model is 0.9999, indicating that 99% of the variance in the data is explained by this model.

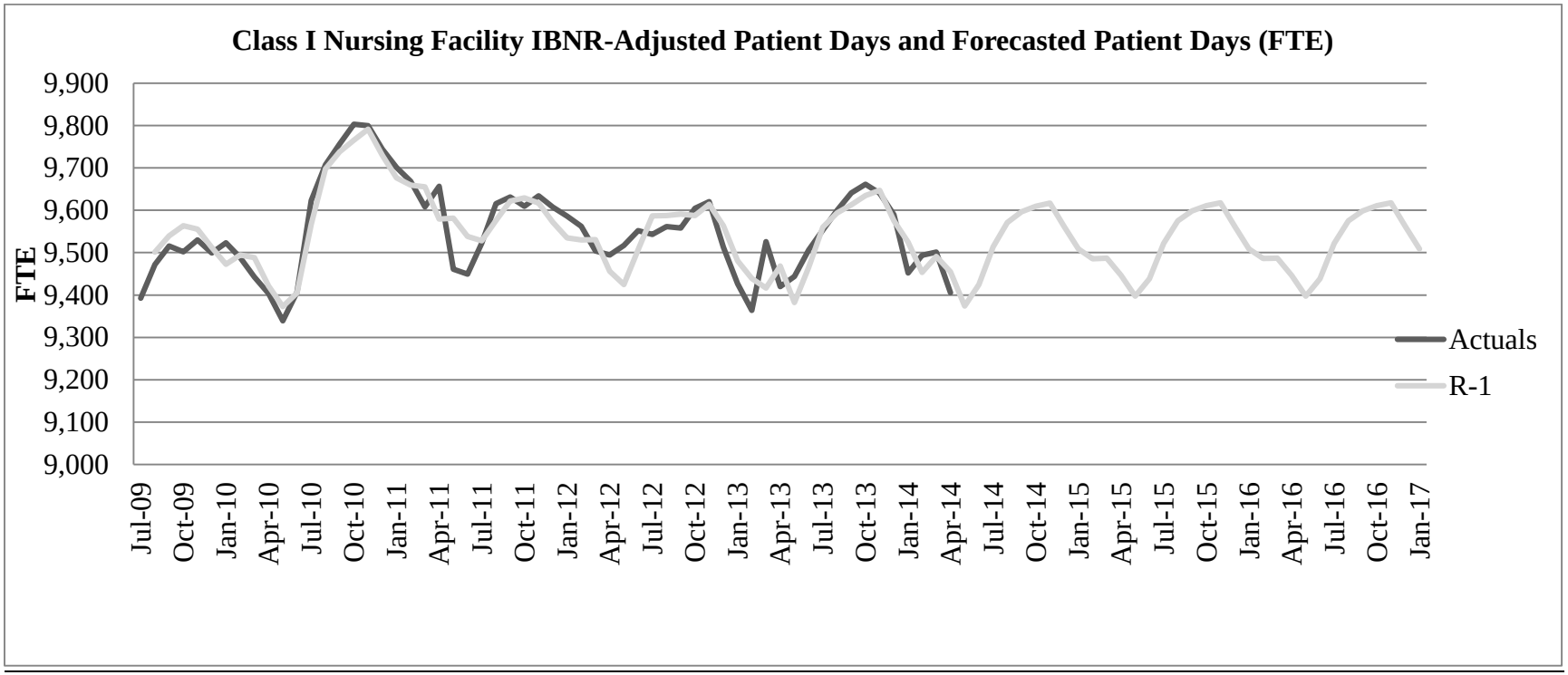
Testing the Overall Predictive Ability of the Model

The F-statistic from the analysis of variance test of the model represents the overall statistical significance of the model. This test indicates how well the components of the model together generate valid forecasts. With a p-value of 0.0000, the patient days model is statistically significant at the 99% confidence level.

Forecasting Patient Days

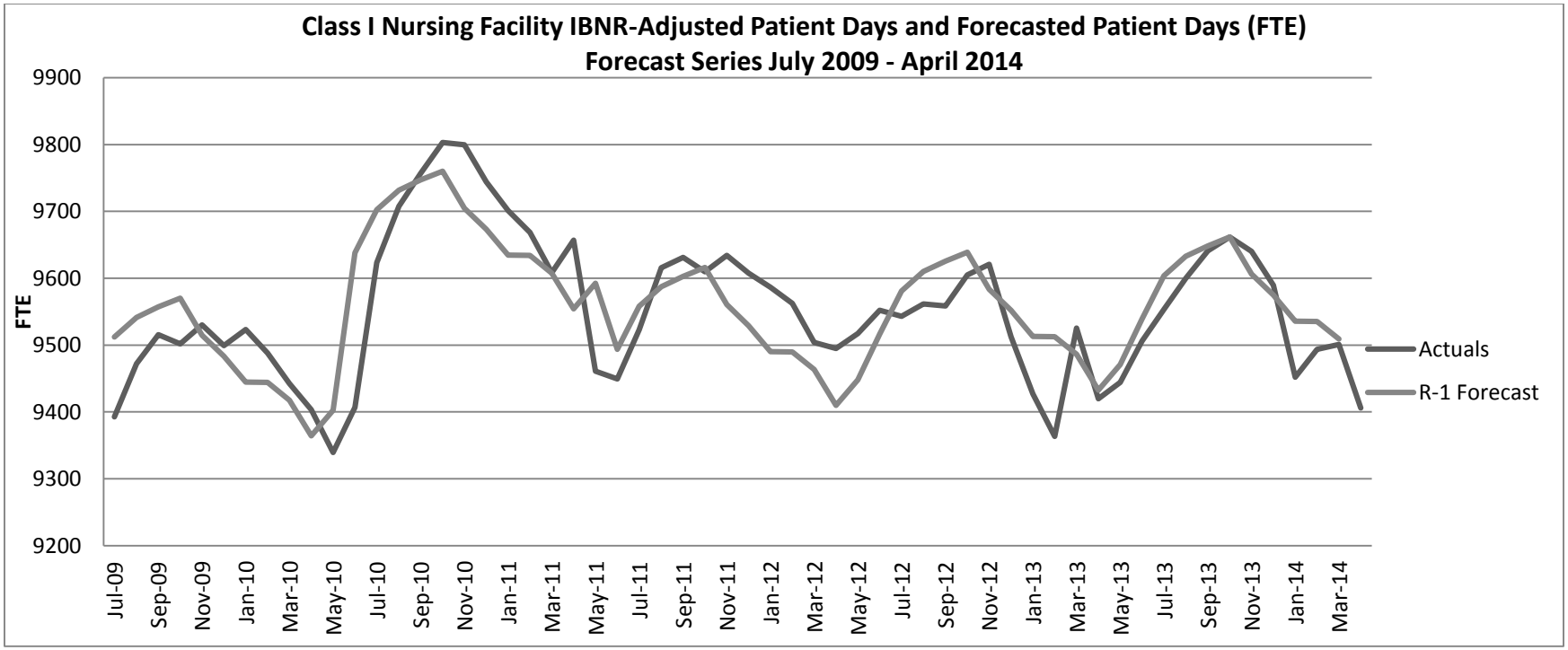
Since the number of monthly patient days is influenced by the number of days in each month, the data needs to be normalized before trending calculations are executed. The total number of patient days in each month is divided by the number of days in the month to create the number of FTE (full time equivalent) days. Trending is done using the FTE days, and then the total patient days are calculated by multiplying the FTE figures by the number of days in each month.

Historically, the Department's efforts toward increasing utilization of Home- and Community-Based Services have resulted in downward pressure on the Class I Nursing Facility days trend. However, in the face of an aging population and ever-increasing demand for long-term care services, recent years have displayed a return to marginal annual growth in patient days. However, data from FY 2012-13 forward has shown a drop in patient days of 0.91%, but in FY 2013-14, the Department experienced a minor uptick in days, growing by 0.21%. Because of the uncertainty of future behavior of patient days, the Department assumes days will fall slightly in FY 2014-15 and FY 2016-17 and increase slightly in FY 2015-16 to remain fiscally conservative.



Ex Post/In-sample Forecasts

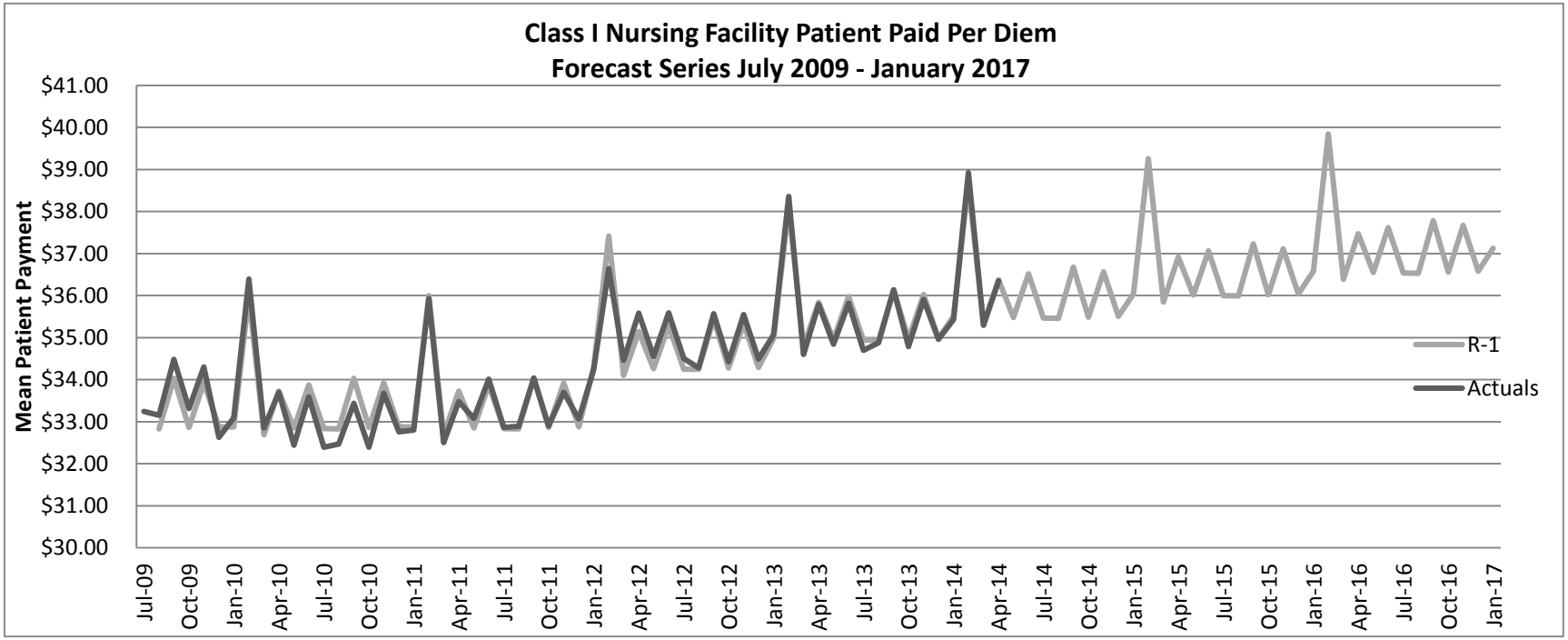
Because ex post/in-sample forecasts usually serve as an additional test of the reasonableness and robustness of forecasts, the Department calculated an in-sample forecast (using the data from July 2009 through October 2013) and compared the results to actual data reported for October 2013 through April 2014. Rather than serving as a test of reasonableness and robustness, the in-sample forecast highlights the abnormality of the most recent data points.



The ex post forecast model overestimates FTE in the forecast period for October 2013 through April 2014. Observed patient days in FY 2013-14 make a departure from previously observed seasonality. More information is necessary to determine whether the data will return to previous levels.

Patient Payment Forecast Model

The Department utilizes a seasonally adjusted model with a dummy variable to account for cost of living adjustment (COLA) increases to forecast patient payment. Neither the current time period nor the previous time period are relevant to this forecast. The only indicators of patient payment are the number of days in the month and the COLA increase for a given year. For this reason, neither a linear nor an autoregressive model was used, as they did not add value to the forecast.



Testing the Overall Predictive Ability of the Model

Utilizing the F-statistic, an analysis of the model's overall statistical significance can be done. The patient payment model has a p-value of 0.0004 and is statistically significant at the 99% confidence level. The Adjusted R-squared for the model is 0.9777, suggesting 97.77% of the variation in this series can be explained by the monthly seasonality and COLA increases.

Nursing Facility Rate Methodology Changes

The following is a timeline of changes to Class I Nursing Facility policy:

FY 1997-98	8% Health Care Cap and 6% Administrative Cap Implemented
FY 1998-99	No change
FY 1999-00	8% Health Care Cap temporarily removed and Case Mix Cap Implemented
FY 2000-01	No change
FY 2001-02	8% Health Care Cap permanently removed and Quality of Care Incentive Program/Resident Centered Quality Improvement Program discontinued
FY 2002-03	Administrative Incentive Allowance removed for three months then reinstated
FY 2004-05	8% Health Care Cap reinstated
FY 2005-06	No change
FY 2006-07	8% Health Care Cap removed for facilities with an average annual Medicaid resident census that exceeds 64% of the number of actual residents in that facility for that same period. Established a rate floor of 85% of the statewide average rate, or 110% of the facility's current year rate, whichever is lower (SB 06-131). Provisions from SB 06-131 are applicable for FY 2006-07 only.
FY 2007-08	Established the Nursing Facility Grant Rate Program (HB 07-1183). Providers affected by the end of provisions implemented in SB 06-131 are given additional funding to mitigate the impact of the end of the rate floor.
FY 2008-09	New methodology introduced for calculating nursing facility reimbursement rates (HB 08-1114): the 8% Health Care and 6% Administrative and General caps are removed, and an Administrative and General price is set based on 105% of the median cost for all facilities. Add-on rates are implemented for performance and for facilities with residents who have moderate to very severe mental health conditions, cognitive dementia, or acquired brain injury. The Department is authorized to collect a provider fee from nursing facilities statewide.
FY 2009-10	The new methodology established in HB 08-1114 was further amended by SB 09-263 which: specified the method for calculating the General Fund share of payments during the federal American Recovery and Reinvestment Act (ARRA) time period; adjusted the cap on General Fund growth; specified conditions for supplemental payments; created a maximum for the nursing facility provider fee; replaced the 8% cap on the direct and indirect health care services component of the reimbursement rate; included a hold harmless provision for administration and general services under certain circumstances; and made changes to the method of implementing pay-for-performance payments. HB 10-1324 implemented a 1.5% rate reduction to the core rate components effective March 1, 2010 through June 30, 2010.

FY 2010-11	HB 10-1379 implemented a 2.5% rate reduction to the core rate components effective July 1, 2010, through June 30, 2011. This bill also reduced the maximum general funds portion of the core per-diem rate to 1.9% growth for FY 2010-11.
FY 2011-12	SB 11-125 increased the level of the provider fee to $12.00 per non-Medicare day plus annual inflation. Additionally the bill reprioritized the hierarchy for the components of nursing facility supplemental payments. Growth beyond the General Fund cap is prioritized last under the new hierarchy.
FY 2011-12	SB 11-215 extended the 1.5% rate reduction from the prior year. The rate reduction expired July 1, 2012.
FY 2012-13	HB 12-1340 extended the 1.5% rate reduction from the prior year. The rate reduction expired July 1, 2013.
FY 2013-14	HB 13-1152 extended the 1.5% rate reduction from the prior year. The rate reduction is permanent.
FY 2014-15	SB 14-130 raises the basic minimum payable for personal needs to any recipient admitted to a nursing facility or intermediate care facility for intellectuals with disabilities from $50.00 to $75.00, monthly.

Department Forecast Methodology Change

With the Department's November 1, 2011 Budget Request, the forecast methodology has been altered to increase the predictive capability of the model while aligning the components of the forecast with the rate-setting methodology in statute. To generate the nursing facility forecast using the previous methodology, claims that were 100% patient paid were excluded from the data set. This was done to prevent patient days with no associated Medicaid payment from inflating forecasted expenditure when multiplied by the effective per diem. As current legislation allows the aggregate statewide average per diem net of patient payment to grow by a fixed amount annually, claims that have 100% patient payment impact the next year's rate. To more accurately forecast the per-diem rates, the revised forecast methodology, claims with 100% patient payment are included in the data set. This has several noticeable effects; both patient payment and days increase when these claims are included in the data set. Restated historical values can be found in the footnotes section of Exhibit H.

This methodology allows for a more accurate forecast of the statewide aggregate per-diem net of patient payments. Additionally, with this methodology, patient payment and patient days more accurately reflect what were actually paid or incurred.

The Department updated its methodology for calculating the nursing facility per diem for the November 2012 request. The Department developed the weighted average per diem for FY 2012-13 by weighing FY 2012-13 per diems for each provider by the FY 2011-12 provider days distribution. Previously, the Department forecasted per diems in aggregate; this methodology would only be accurate if the provider-days distribution were uniform. As this is not the case, the Department's new methodology addresses variance between the forecasted per diem and the observed per diem in two ways: first, the current year per diem is based on actual rates rather than a

projection of rates, and, second, the Department used provider days from FY 2011-12 as a proxy for provider days for FY 2012-13 rather than assume the distribution to be uniform.

Class I Nursing Facilities – Cash-Based Actuals and Projections by Aid Category

For comparison purposes to other service categories, this exhibit lists prior-year expenditure along with the projected expenditure from page EH-3. Estimated totals by aid category are split proportionally to the most recent year of actual expenditure. Additionally, the Department calculates per capita costs for each year. Supplemental payments made to Class I Nursing Facilities through the Nursing Facility Provider Fee program are not included in total expenditure.

Totals for each aid category are used to calculate total expenditure by aid category in Exhibit E, and total per capita by aid category in Exhibit C.

Class II Nursing Facilities

This service category is for specialized private nursing facility care for developmentally disabled clients, which was the focus of the Department of Human Services' initiative to deinstitutionalize these clients by placing them in appropriate care settings. The deinstitutionalization strategy was completed in April of FY 1997-98. Beginning in FY 1998-99, the service category was limited to one facility. There are no plans to eliminate this facility, as it functions more like a group home than an institutional facility. At the end of FY 2005-06, the provider increased its enrollment from 16 clients to 20 clients. During FY 2006-07, the census at this facility remained constant**.** Additionally, this facility received an annual cost-based rate adjustment, similar to Class I Nursing Facilities. As a result, this service category experienced expenditure growth that differs sharply from previous years. FY 2009-10 enrollment rates were slightly lower than in the previous years. However, for FY 2010-11 and FY 2011-12, enrollment returned to the 20 client enrollment level. There was a rate increase for FY 2012-13 based on audited cost reports from CY 2011, which more than doubled expenditure for FY 2012-13 compared to the previous year. The growth rate for FY 2013-14 was based on anticipated changes in per-diem reimbursement using information from unaudited cost reports for CY 2012, which showed a 30% drop in the rate from FY 2012-13 to FY 2013-14. This can be seen in the approximately -30% growth in expenditure. Because all clients are paid the same rate regardless of aid category, and anticipated changes in per-diem reimbursement using information from unaudited cost reports for CY 2013 show high growth in the rate from FY 2013-14 to FY 2014-15, the Department has selected a trend of approximately 20% for the per-diem rate for FY 2014-15, reducing the rate in the request and out years. The Department anticipates that expenditure per aid category will only change if enrollment varies by aid category. However, total expenditure would still remain the same; therefore, differences between aid categories are less relevant.

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

The Program of All-Inclusive Care for the Elderly (PACE) is a Medicare/Medicaid managed care system that provides health care and support services to persons 50 years of age and older. The goal of PACE is to assist frail individuals to live in their communities as independently as possible by providing comprehensive services depending on their needs. PACE is only used by Adults 65 and Older (OAP-B), Disabled Adults 50-59 (OAP-B), and Disabled Adults to 59 (AND/AB). PACE rates are adjusted once per year, generally on January 1 of each year.

Effective with the November 1, 2007 Budget Request, the Department has substantially revised the methodology used to calculate the projections for PACE expenditure. In prior years, the Department performed a per capita-based estimate, similar to the Acute Care and Community-Based Long-Term Care projections. However, enrollment trends in PACE are different from the overall Medicaid population. Therefore, the standard per capita measure is unreliable, in that it does not reflect the true cost of serving a client enrolled in PACE.

HB 08-1374 removed the requirement that the Department reimburse PACE providers at 95% of the equivalent fee-for-service cost, effective July 1, 2008. The Department now pays providers the lesser of the 100% rate or the federal upper payment limit.

To better forecast expenditure, the Department began providing two new metrics in FY 2008-09: average monthly enrollment and average cost per enrollee. The average monthly enrollment is based on the number of distinct clients for whom capitations were paid to PACE providers in each fiscal year, as determined by claims information from the Medicaid Management Information System (MMIS). The average cost per enrollee is the total expenditure divided by the average monthly enrollment for each fiscal year.

In recent years, the Department has added a number of new PACE providers. Senior Community Care of Colorado (Volunteers of America), a new provider, began serving clients on August 1, 2008, in Montrose and Delta counties. The organization originally planned to open a third facility in Grand Junction in the spring of 2010, however this plan is on hold. Rocky Mountain Health Care began serving clients on December 1, 2008, in El Paso County. InnovAge (formerly Total Long Term Care), the Department's oldest PACE organization, opened a facility in late 2009 to serve clients in Pueblo, and another facility is scheduled to open in northern Colorado in fall of CY 2014. The Department anticipates this new facility will begin serving clients during late fall of 2014. The Department received enrollment estimates from the future administration of the new facility and anticipates that the initial enrollment pattern for this facility will follow these estimates, rather than those for more mature facilities in other parts of the state.

Expenditure estimates for PACE for FY 2014-15, FY 2015-16, and FY 2016-17 are the product of two pieces: projected enrollment and cost per enrollee. As is consistent with convincing historical enrollment data suggesting linear trends for PACE enrollment, linear regression models are used to estimate future enrollment on a by-provider by-eligibility-type basis. Enrollment caps are not anticipated

to limit growth for the forecast period as a result of the manner in which PACE services are provided: that is, clients are not full-time residents of PACE facilities. Systems issues have resulted in clients who are eligible for Medicaid and receiving PACE services showing up in the MMIS as not having an enrollment span in the program, causing a delay in monthly capitation payments for these clients. In the February Request, the Department assumed that this systems issue would be resolved by the end of FY 2013-14 with retroactive payments made by that time as well. As this did not occur, a bottom line impact has been added to FY 2014-15 of this Budget Request, which accounts for an estimate of retroactive payments that would be made in FY 2014-15 for services accrued in FY 2013-14, with the assumption that the systems issues will be resolved by the end of FY 2014-15.

Per-enrollee costs for FY 2014-15 are determined by cross-walking the actual FY 2014-15 rates for PACE services with an eligibility-type distribution estimate derived from FY 2014-15 enrollment projections. As such, they only represent an estimate to the extent that eligibility-type and provider distributions for FY 2014-15 are unknown. The rates were determined at the beginning of the fiscal year and are known for this forecast.

PACE rates have been declining since FY 2008-09. The Department believes rate cuts for other services that are components of the PACE rate calculations have contributed significantly to this trend. Additionally, there has been a shift in the methodology for the calculation of institutional-to-non-institutional client splits for PACE, which has resulted in a dramatically different view of the client population. Previously, the calculation – prepared externally – reflected a proportion of high-cost institutional clients as high as 85%. A revision to this process resulted in estimates of high-cost clients of only 50% to 55%. As the Department views this revision as representative of a level-shift in reported client distribution, this source of downward rate pressure is not expected to drive changes in PACE rates in the future. PACE rates for FY 2013-14 increased by an average of approximately 10% over the previous year's rates, considered to be due to the rate increase for Home- and Community-based Long-Term Care. Further, the Department anticipates other components of the PACE rate calculation will demonstrate upwardly-trending behavior, as demonstrated by the increase in PACE rates for FY 2014-15 of approximately 4% over FY 2013-14 rates. To this end, the Department is projecting moderate growth in cost-per-enrollee figures for FY 2015-16 and FY 2016-17. The rate trend is the average of FY 2007-08 through FY 2012-13 cost-per-enrollee growth (1.27%) and is applied to each eligibility type separately rather than in an aggregate fashion.

Supplemental Medicare Insurance Benefit (SMIB)

The Supplemental Medicare Insurance Benefit (SMIB) consists of two parts: Medicare Part A, the insurance premium for hospital care, and Medicare Part B, the insurance premium for Medicare-covered physician and ambulatory care services. Only premiums are paid in this service category; co-payments and deductibles are paid under Acute Care. Medicaid clients who are dual-eligible (clients who have both Medicaid and Medicare coverage) or Partial Dual Eligible receive payment for Medicare Part B and, in some cases, Medicare Part A. The Partial Dual Eligible aid category has two distinct groups: Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries. The Part A premium payments are made for a small subset of the Qualified Medicare Beneficiary eligibility

group only.[5] The Supplemental Medicare Insurance Benefit service category includes the estimate of payments for both Part B for all Medicare beneficiary client types and Part A payments for Qualified Medicare Beneficiary clients. Premium payments for Medicare clients who do not meet the Supplemental Security income limit do not receive a federal match.

The federal law that requires Medicaid to pay the Medicare Part B premium for qualifying individuals whose income is between 120% and 135% of the federal poverty level was scheduled to expire September 30, 2003. However, eligibility was extended. This population was referred to as "Medicare Qualified Individual (1)." Legislation for the second group, referred to as "Medicare Qualified Individual (2)," comprised of individuals whose income was between 135% and 175% of the federal poverty level and expired April 30, 2003. Formerly, Medicaid paid the portion of the increase in the Part B premium due to the shift of home health services from Medicare Part A to Part B insurance. Qualified Individuals are 100% federally funded, subject to an annual cap.

Supplemental Medicare Insurance Benefit (SMIB) expenditure is related to two primary factors: the number of dual-eligible clients and the increase in the Medicare premiums. For reference, the historical increases in the Medicare premiums are listed in the table below:[6]

History of Medicare Premiums

Calendar Year	Part A	% Change	Part B	% Change
2003	$316.00	-	$58.70	-
2004	$343.00	8.54%	$66.60	13.46%
2005	$375.00	9.33%	$78.20	17.42%
2006	$393.00	4.80%	$88.50	13.17%
2007	$410.00	4.33%	$93.50	5.65%
2008	$423.00	3.17%	$96.40	3.10%
2009	$443.00	4.73%	$96.40	0.00%
2010	$461.00	4.06%	$110.50	14.63%
2011	$450.00	-2.39%	$115.40	4.43%
2012	$451.00	0.22%	$99.90	-13.43%
2013	$441.00	-2.21%	$104.90	5.01%
2014	$426.00	-3.40%	$104.90	0.00%

[5] Most Medicare beneficiaries do not make a Part A payment, because they have contributed to Medicare for 40 or more quarters during their working life. The Department only subsidizes Part A payments for Qualified Medicare Beneficiaries who do not meet the 40 quarter requirement.

[6] Premium information taken from the Centers for Medicare and Medicaid Services, http://www.medicare.gov/MedicareEligibility/Home.asp?dest=NAV|Home|GeneralEnrollment|PremiumCostInfo#TabTop

These premiums reflect the standard Medicare premiums paid by most Medicare recipients or by the Department on their behalf. Clients with between 30 and 39 work quarters of Medicare Covered Employment require a higher Part A premium. Additionally, some clients pay higher Part B premiums based on higher adjusted gross income; however, the Department is only required to pay the base premium cost.

To forecast FY 2014-15, the Department inflates the actual expenditure in the second half FY 2013-14 by half the estimated increase in caseload from FY 2013-14 to FY 2014-15. This generates the anticipated expenditure for the first half of FY 2014-15. As there were no increases to Medicare Part B premiums for CY 2014, the estimate for the first half of FY 2014-15 is complete. Then, the Department inflates the estimated first half expenditure by half the estimated caseload trend for FY 2015-16 and the estimated increase in the Medicare premium to estimate the second half expenditure. The premium is not expected to change in CY 2015 and is therefore unnecessary in this calculation. The total estimated expenditure for FY 2014-15 is the sum of the first half estimated expenditure and the second half estimated expenditure.

To forecast FY 2015-16, the Department first inflates the estimated expenditure from the second half of FY 2014-15 by half the estimated caseload trend for FY 2015-16 as reported in Exhibit B. This figure represents the approximate expenditure for the first half of FY 2015-16. Then, the Department inflates the estimated first half expenditure by half the estimated caseload trend for FY 2015-16 and the estimated increase in the Medicare premium to estimate the second half expenditure. The total estimated expenditure for FY 2015-16 is the sum of the first half and second half estimates. The forecast of FY 2016-17 expenditure utilizes the same methodology as the forecast of FY 2015-16.

Health Insurance Buy-In (HIBI)

The Medicaid program purchases the premiums for private health insurance for individuals eligible for Medicaid if it is cost-effective. This is known as the Health Insurance Buy-In (HIBI) program, permitted under 25.5-4-210, C.R.S. (2013). In recent years, HIBI expenditure has fluctuated significantly due to numerous policy and administrative changes. In particular, during FY 2005-06, due to the implementation of the Medicare Modernization Act, many of the health plans that were previously cost-effective became ineffective, since the costs of those health plans included a drug benefit. This caused a significant decrease in HIBI expenditure and enrollment in FY 2005-06. Additionally, the Department found that, with rare exceptions, it was no longer cost effective to purchase commercial insurance for clients in the Adults 65 and Older (OAP-A) aid category. Instead, the majority of expenditure was shifted to Disabled Individuals to 59 (AND/AB) for clients who do not qualify for the Medicare Part D benefit.

In FY 2006-07, the Department experienced significant growth in the program, although the cause appears to be related to administrative changes rather than other factors. For example, a single outside agency had referred approximately 50 new clients to the Department for enrollment in the program. Additionally, during FY 2006-07, the Department examined and upgraded the existing process to determine client eligibility for the program. This change enabled the Department to process clients more efficiently, resulting in an increase in caseload.

Contrary to previous budget submissions where the Department examined per capita growth trends to forecast the HIBI budget, and contrary to the February Request where the Department examined total expenditure trends to estimate expenditure, the Department instead estimated expenditure based directly on the contractor's program enrollment estimates, in order to calculate provider and premiums payments for clients enrolled in HIBI. The Department believes this methodology to be more accurate as HIBI enrollment does not bear a direct relationship to Medicaid caseload and enrollment is the primary driver in differences between cost estimates and actuals.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the per capita or trend factors, the Department previously added total-dollar bottom-line impacts to the projected expenditure. For complete information on legislative impacts, see section V, Additional Calculation Considerations. The following impacts were included in February Request calculations for the Health Insurance Buy-In Program, but are the sole source of the estimates in the current Budget Request:

- SB 10-167 "Medicaid Efficiency and Colorado False Claims Act" impacts the HIBI program in FY 2014-15 forward by requesting the purchase of private health insurance coverage through the Health Insurance Buy-In Program for eligible clients to create cost savings for the State. The contractor estimates approximately 2% growth in enrollment per month for FY 2014-15. Savings as a result of SB 10-167 are captured in the Acute Care exhibit. The Department has adjusted costs associated with this bill by changing the payment methodology for the contractor from a contingency fee to a per-member per-month payment. In addition, adjustments were made to reflect additional premium payments that would be made as the number of clients utilizing the program increases. The estimate was also adjusted for delays in the implementation timeline and enrollment capabilities of the contractor. Please see section V for a complete description of the bill and changes.

EXHIBIT I – SERVICE MANAGEMENT

This service group includes administrative-like contract services within the Medical Services Premiums budget. The group is comprised of Single Entry Point agencies, disease management, and administrative fees for prepaid inpatient health plans.

Summary of Service Management

This exhibit summarizes the total requests from the worksheets within Exhibit I.

Single Entry Points

Single entry point agencies (SEPs) were authorized by HB 91-1287. Statewide implementation was achieved July 1, 1995. The single entry point system was established for the coordination of access to existing services and service delivery for all long-term care clients in order to provide utilization of more appropriate services by long-term care clients over time and better information on the unmet service needs of clients, pursuant to section 25.5-6-105, C.R.S. (2013). A SEP is an agency in a local community through which persons 18 years or older can access needed long-term care services.

The SEP is required to serve clients of publicly funded long-term care programs including nursing facility care, Home- and Community-Based Services (HCBS) for the elderly, blind and disabled, HCBS for persons living with acquired immune deficiency syndrome, HCBS for persons with brain injury, HCBS for persons with mental illness, HCBS for persons with spinal cord injuries, long-term home health care, home care allowance, alternative care facilities, adult foster care, and certain in-home services available pursuant to the federal Older Americans Act of 1965.

The major functions of SEPs include providing information, screening and referral, assessing clients' needs, developing plans of care, determining payment sources available, authorizing provision of long-term care services, determining eligibility for certain long-term care programs, delivering case management services, targeting outreach efforts to those most at risk of institutionalization, identifying resource gaps, coordinating resource development, recovering overpayment of benefits and maintaining fiscal accountability. SEPs also serve as the utilization review coordinator for all community based long term care services.

The Department pays SEPs a case-management fee for each client admitted into a community-based service program. SEPs also receive payment for services provided in connection with the development and management of long-term home health prior authorization requests for work associated with client appeals and for utilization review services related to HCBS and nursing facilities.

On November 1, 2002, the Department submitted a report for Footnote 52 of HB 02-1420, describing the payment methodology for SEPs. However, recently it has come to light that the process described in the footnote report is not being used. Instead, individual SEP contract amounts are determined using data from each SEP's previous year's history of client and activity counts. At the end of the contract year, the actual client and activity counts are reconciled against the projected client and activity counts. This process results in either funds owed to SEPs for services delivered in excess of funds received or funds owed to the Department for payments made in excess of services delivered. The Department then issues a reconciliation statement to collect for overpayment or adjust for

underpayment up to the amount allocated. This payment methodology, combined with close Department oversight, encourages SEPs to enroll only those clients who are appropriate for community-based services.

Annual financial audits are conducted by the Department to verify expenditures were made according to the contract scope of work and to assure SEP compliance with general accounting principles and federal Office of Management and Budget (OMB) circulars. If the audit identifies misused funds, the amount misused is collected through a recovery order.

SB 04-206 directed the Department to implement a pediatric hospice program; the impact of this legislation is fully annualized in the budget request. Entry into the program must be approved by SEPs. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to add a pediatric hospice effective January 1, 2008.

Also fully annualized in the budget request is the impact of HB 05-1243, which allowed the Department to add consumer-directed care to home- and community-based waiver services. These services must be approved by SEPs. The Department received approval from CMS to add consumer-directed care to the Elderly, Blind, and Disabled waiver and the Mental Illness waiver in 2007. The Department began to provide these services effective January 1, 2008. Consumer-directed care has since been expanded to the Spinal Cord Injury and Brain Injury waivers.

Effective with the November 1, 2007 Budget Request, the Department revised the methodology used to calculate this portion of the Request. Because of the administrative nature of the service, SEPs are generally paid a fixed fee for each year, although this amount may be adjusted based on actual experience. In recent years, the number of clients processed by SEPs has increased at a much faster rate than overall Medicaid caseload. Without an increase to the fixed-price contracts, SEPs would be required to serve an increasing population with the same funding.

Therefore, the Department's request includes an increase to SEP contracts. The requested increase is based on the expected increase in HCBS enrollment, as determined by average monthly enrollment in the Department's HCBS programs. This figure is therefore consistent with the caseload growth of the HCBS waivers in Medical Services Premiums. The Department believes that growth in enrollment is a good proxy for growth in SEP caseload.

In FY 2010-11 the Department began reporting cost per HCBS waiver utilizer to provide additional information about SEP expenditure and to use in trending expenditure forward.

For FY 2014-15, the Department's projection uses the total base contracts amount, which is the current amount allocated to SEPs in the FY 2014-15 Long Bill appropriation (as determined by information provided by the Joint Budget Committee during Figure Setting), and adds legislative impacts (see below). In FY 2014-15, the Joint Budget Committee agreed to a 10% rate increase for SEPs, resulting

in an increase, outside of enrollment increases, of $1,229,790 for FY 2014-15. The Department's projection uses the total waiver enrollment forecast and the number of clients utilizing services in FY 2013-14 to proportion trends for all eligibility categories.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department does not anticipate any new changes that impact expenditure for SEPs from FY 2014-15 through FY 2016-17, beyond the FY 2014-15 10% rate increase previously mentioned and accounted for.

Disease Management

Beginning in July 2002, the Department implemented several targeted disease management pilot programs, as permitted by HB 02-1003. Specifically, the Department was authorized "to address over- or under-utilization or the inappropriate use of services or prescription drugs, and that may affect the total cost of health care utilization by a particular Medicaid recipient with a particular disease or combination of diseases" (25.5-5-316, C.R.S. (2013)). Initially, pilot programs were funded solely by pharmaceutical companies; the programs began and ended at different times between July 2002 and December 2004.

During the pilot program, the Department initiated seven disease management programs to identify the most appropriate strategies to contain rising health care costs, improve access to services, and improve the quality of care for the fee-for-service Medicaid clients. The targeted disease conditions included high-risk infants, clients with asthma, clients with diabetes, clients with schizophrenia, female clients with breast and cervical cancer, and clients with chronic obstructive pulmonary disease. Additionally, the Care Management Organization pilot was established to coordinate all of the disease management programs and to establish a means for additional fee-for-service clients to obtain intensive case management or health counseling.

The pilot programs revolved around three key managed care principles: appropriate and timely access to health care services, evaluation and support for adherence to appropriate medical regimens/treatments, and provision of nationally recommended practice guidelines for each chronic disease. The pilot programs enabled the Department to obtain actual Colorado Medicaid disease management data and experience to be utilized for future program development.

As a result of the pilot programs, the Department entered into permanent contracts with two disease management companies for two health conditions: clients with asthma and clients with diabetes. In order to provide appropriate management to achieve cost-savings by reducing hospitalizations and emergency room visits, the Department contracted with Alere Medical Incorporated for clients with asthma and with McKesson Health Solutions for clients with diabetes. Over time, the Department has added and changed contracts as appropriate to ensure that Medicaid clients continue to receive quality care.

At the start of FY 2008-09, the Department had five disease management contracts covering specific conditions: asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), high risk obstetrics, and weight management. The Department also employed a contractor to do more general disease management via telemedicine. The Department's funding for these contracts was a combination of General Fund, Prevention Early Detection and Treatment Fund, and federal funds. Certain restrictions, specified in section 24-22-117(2)(d)(IV.5), C.R.S. (2013), limit the use of Prevention Early Detection and Treatment Fund. Therefore, the Department separated the amount of base funding (contracts financed with General Fund) and the amount of expansion funding (contracts financed with Prevention Early Detection and Treatment Fund) in order to ensure that its request reflects the correct amount from each funding source. For FY 2008-09 only, this separation was reflected as a bottom-line impact.

The Department's disease management contractors operated on a fixed budget (specified in the contract), and client enrollment could not exceed a fixed number of clients that the Department determined should be managed on that budget. Contractors accepted new clients only up to the enrollee limit as specified in the contract.

Effective June 30, 2009, the Department discontinued the five specific Disease Management programs. The remaining funds were applied toward services related to the treatment of the health conditions specified in 24-22-117(2)(d)(V), C.R.S. (2013) (further described in Exhibit A). The Department's telemedicine program had two months of expenditures encumbered for FY 2009-10. The Department did not renew the telemedicine contract when it expired on September 30, 2009.

FY 2014-15, FY 2015-16, and FY 2016-17 expenditures are affected only by caseload and bottom line impacts. In FY 2011-12, the Department requested a transfer of spending authority from DPHE for the purpose of attaining federal funds to establish the Smoking Cessation Quitline for Medicaid Clients. A bottom line impact of $773,859 reflects this change in FY 2014-15.

Prepaid Inpatient Health Plan Administration

Prepaid inpatient health plans (formerly known as Administrative Service Organizations) are an alternative to traditional health maintenance organizations. They offer the case management and care coordination services of a health maintenance organization for a fixed fee. The organizations do this by not taking on the risk traditionally assumed by health maintenance organizations. The Department began using this type of organization to deliver health care to Medicaid clients during FY 2003-04. In FY 2005-06, the Department ended its contract with Management Team Solutions. Until FY 2009-10, the Department contracted with only one prepaid inpatient health plan, Rocky Mountain Health Plans. The Department then contracted with three additional prepaid inpatient health plans in FY 2009-10. These included Colorado Access and Kaiser Foundation Health Plan, jointly part of the Colorado Regional Integrated Care Collaborative (CRICC), and Colorado Alliance & Health Independence (CAHI). In FY 2010-11, the Department implemented the Accountable Care Collaborative (ACC). The monthly management fees paid to the Regional Care Collaborative

Organizations (RCCOs), the Primary Care Providers (PCPs), and the Statewide Data Analytic Contractor (SDAC) are administrative fees that are incorporated in the prepaid inpatient health plan exhibit.

Prepaid inpatient health plans receive a fixed amount administrative fee per client. Exhibit EI-9 depicts the administrative fee expenditures for the Department's current contractors, including estimated cost-avoidance payments for Rocky Mountain Health Plans. The service costs for these organizations are included in Acute Care and Community-Based Long-Term Care. In the current request, the Department forecasts enrollment and costs for each program separately.

Rocky Mountain Health Plans

Through HB 12-1281, the Department accepted proposals for innovative payment reform pilots. The Department solicited proposals from the seven RCCOs in the State and on July 1, 2013, announced that it selected a Medicaid payment reform proposal submitted by Rocky Mountain Health Plans. The two-year pilot program will begin on or before July 1, 2014 and will focus on clients in certain counties within the state. As part of Rocky Mountain Health Plan's proposal, the pilot will also disenroll clients in the prepaid inpatient health plan and enroll clients into this pilot. The transition to the pilot did not occur as quickly as anticipated in the February Request; therefore, administrative fees associated with Rocky Mountain Health Plans still apply in FY 2014-15, but have been removed for FY 2015-16 and FY 2016-17 to account for this adjustment. Currently, the enrollment shift is expected to take place by December 2014. Therefore, the Department will update future requests accordingly as information is available.

The administrative fees remain the same in FY 2014-15. As such, the Department uses actual enrollment to forecast expenditure for Rocky Mountain Health Plan for FY 2014-15, accounting for phase out by December of 2014. In prior budget requests, enrollment for Rocky Mountain Health Plan was forecasted by eligibility group. For this request, enrollment is forecasted in aggregate based on actuals. The administrative fees paid are the same regardless of the eligibility category of the clients served.

To forecast enrollment in Rocky Mountain Health Plan for the current year, the Department assumes the provider will be concentrating the majority of its resources to enroll new clients into the ACC and its network as a RCCO instead of into its health plan. Therefore, the Department estimates that the linear growth for FY 2014-15 of -77.95% will be appropriate. The Department assumes in this request that Rocky Mountain Health Plan will transition all clients into the pilot program by the end of CY 2014, and therefore assumes no enrollment in the prepaid inpatient health plan after FY 2014-15.

In addition to an estimate for the amount of administrative fees, the Department has added bottom-line impacts for the estimated contracted cost-avoidance payments to Rocky Mountain Health Plan. During FY 2007-08, the Department and Rocky Mountain Health Plan were unable to come to an agreement on the correct amount of cost avoidance for the contract year FY 2005-06, and no payment was made. At that time, the Department anticipated it may make a combined payment for FY 2005-06 and FY 2006-07 in FY 2008-09

with existing funding. In addition, the Department anticipated making a single contracted payment in FY 2009-10 for services rendered in FY 2007-08. However, since that time, federal Centers for Medicare and Medicaid Services (CMS) directed the Department to cease making any cost avoidance payments until all historical encounter data for prepaid inpatient health plan claims is integrated into the Medicaid Management Information System (MMIS). The Department has completed all CMS requirements pertaining to Rocky Mountain Health Plan and made a cost-avoidance payment to Rocky Mountain Health Plan for services rendered in FY 2009-10 in the latter half of FY 2011-12. Rocky Mountain Health Plan and the Department agreed with the methodology used to calculate the payment and will use it as the standard methodology for all future payments. They also agreed no cost avoidance payments will be made for fiscal years prior to FY 2009-10, as they were not able to compromise on the correct amount to be paid. In addition to the FY 2009-10 payment, the Department also made a cost avoidance payment in FY 2011-12 for services rendered in FY 2010-11. For all subsequent fiscal years, the Department will make one cost avoidance payment for the prior year.

For FY 2014-15, the Department assumes the cost avoidance payments will be similar in magnitude to the calculated payment for FY 2013-14 and carried that amount forward. The final payments will differ from the budgeted amount, as the Department will calculate the actual amount of cost avoidance, which may be higher or lower than the estimated levels.

Colorado Regional Integrated Care Collaborative Programs (Colorado Access and Kaiser Foundation Health Plan)

The Colorado Regional Integrated Care Collaborative (CRICC) is part of a larger national collaborative sponsored by the Center for Health Care Strategies (CHCS). This program aims to better serve Medicaid clients with the highest needs and costs by coordinating physical, mental health, and substance abuse services. The Colorado Access contract for CRICC was altered from a risk-based, capitated program to an Administrative Services Organization (ASO) after the provider informed the Department that the risk-based model would no longer be sustainable. The Department and the provider negotiated an alternative that would allow for continuity of services while altering the reimbursement structure to a more sustainable model. This transition occurred on April 1, 2010. Expenditure for administrative fees to Access as an ASO is accounted for in the prepaid inpatient health plan exhibit. The contract for Colorado Access in the CRICC program expired on June 30, 2011, at which time all of the clients in the program were disenrolled. A study on the effectiveness of the program is being completed by MDRC, a nonprofit, nonpartisan policy research organization. The study will analyze the program in terms of quality of care, utilization, and expenditure. MDRC's evaluation of Colorado Access was completed in 2012.

Kaiser Foundation Health Plan began enrolling clients for CRICC in August of 2009. The claims for Kaiser are not paid for through the MMIS; therefore, there is no information in the system on the number of enrolled clients by month as there is for Colorado Access. This program was discontinued effective June 30, 2012.

Colorado Alliance & Health Independence (CAHI)

Colorado Alliance & Health Independence (CAHI) was authorized in SB 06-128 as a new, integrated approach to care for people with disabilities up to age 64 designed to provide a network of services that are high-quality and cost-effective. It is funded through the Coordinated Care for People with Disabilities Program. The pilot program was launched on January 1, 2010. The claims for CAHI are now paid for through the MMIS, allowing the Department to forecast enrollment based on actual clients served by month. Effective January 1, 2013, clients currently enrolled in the CAHI program began transitioning into the Accountable Care Collaborative program. No expenditure is anticipated in FY 2013-14 or subsequent request years.

Accountable Care Collaborative (ACC)

The Accountable Care Collaborative (ACC) is a Department initiative requested originally in FY 2009-10 DI-6 "Medicaid Value Based Care Coordination Initiative" and revised in FY 2010-11 S-6/BA-5 "Accountable Care Collaborative." The Department enrolled the first clients into the program in May 2011 and enrollment increased to 60,000 by December 2011. Enrollment expanded to 123,000 clients in May 2012, which was requested in FY 2011-12 BA-9 "Medicaid Budget Balancing Reductions." The Department has since expanded enrollment in the program and reached an enrollment total of approximately 454,000 by the end of FY 2013-14. The cost savings estimated for this program are included in Acute Care; please see Exhibit F and Section V for more information on its impact to Acute Care. The monthly management fees are estimated in the prepaid inpatient health plan exhibit. The fees in FY 2014-15 include $3,367,500 paid to the SDAC, a weighted average PMPM of $9.50 PMPM paid to the RCCOs, $3.00 PMPM paid to the primary care providers for each client who has been enrolled with them for at least a month, and a $2.00 monthly incentive payment divided between the providers and the RCCOs. An additional $3 PMPM was added to AwDC PMPMs to RCCOs in FY 2012-13 and will not be included in request years.

Based on the experience from the first year of program operations, the Department assumes that approximately 25% of clients enrolled in the ACC program will not be attributed to a PCMP and that only the RCCO administrative fee will be paid for these clients. The fees in FY 2015-16 and FY 2016-17 are the same. In the current and request years, the Department assumes the full $2.00 incentive will be paid out to the RCCOs and PCMPs for each of their members even though the incentive payment will only be paid out if the providers meet certain predetermined benchmarks; the total PMPM for the program may be less if providers are not meeting their benchmarks. The Department will analyze this in the upcoming February Request and may estimate a lower PMPM depending on the average percentage of the incentive payments paid to providers.

Enrollment in the ACC grew at a high rate between FY 2012-13 and FY 2013-14, due to Medicaid expansion and the enrollment of clients who were eligible for Medicaid prior to expansion, but not enrolled previously. The Department has passively enrolled expansion clients and will continue to do so.

Dually Eligible Medicaid and Medicare Pilot Project

The Department negotiated with the Centers for Medicare and Medicaid Services (CMS) throughout FY 2013-14 regarding the implementation of a pilot program targeting clients fully eligible for both Medicare and Medicaid. Research has shown that coordinating care for this population has the potential to create significant cost savings. However, to achieve these savings, both payers must work collaboratively to ensure providers have the support and data needed to provide coordinated care, and that savings are distributed between the payers equitably. To provide this coordinated care environment, the Department proposed to leverage existing infrastructure and enroll dually eligible clients in the Accountable Care Collaborative with an enhanced PMPM to account for the greater resource intensity needed to provide care coordination for this complex population. The pilot was approved late FY 2013-14 and enrollment of full benefit Medicare-Medicaid eligible clients into the ACC began September 1, 2014. Extensive analysis by the Department and the Department's actuaries has shown that, even with an enhanced PMPM, there is significant savings opportunity. The impact of this pilot program is incorporated as a bottom-line impact for savings to Acute Care, and is also accounted for as a bottom-line impact to the prepaid inpatient health plan administration exhibit, to account for infrastructure-building costs that are funded with federal grant funding in the first demonstration year.

Legislative Impacts and Bottom-Line Adjustments

To account for programmatic changes not incorporated in the prior per capita or trend factors, the Department adds total-dollar bottom-line impacts to the projected expenditure. The Department has added bottom-line impacts for the estimated contracted cost avoidance payments to Rocky Mountain Health Plans and the implementation of the Dually Eligible Medicaid and Medicare Pilot Project, as detailed above.

EXHIBIT J - HOSPITAL PROVIDER FEE FUNDED POPULATIONS

Summary of Cash Funded Expansion Populations

These exhibits summarize the source of funding for Health Care Affordability Act of 2009 cash-funded expansion populations. These estimates are incorporated into the Calculation of Fund Splits in Exhibit A. Information regarding Tobacco Tax funds has been removed from this exhibit with the Department's November 1, 2011 request as Tobacco Tax funding is now appropriated to the Department at a fixed value that is independent of the actual caseload or per capita costs associated with clients that would have otherwise been funded by Tobacco Tax.

Hospital Provider Fee Fund

HB 09-1293 established this fund, which provides for the costs of the following expansion populations that impact the Medical Services Premiums budget:

MAGI Parents/Caretakers 69% to 133% FPL

While the Health Care Expansion Fund originally provided funding for parents of children enrolled in Medicaid from approximately 24% to at least 60% of the federal poverty level (see above), the Hospital Provider Fee Fund extends eligibility to parents from 61% to 100% of the federal poverty level (FPL). This expansion population receives the standard Medicaid benefits. SB 13-200 extended this eligibility through 133% FPL, effective July 1, 2013; the Hospital Provider Fee Fund is funding this population up to 100% FPL in the interim before the Affordable Care Act's 100% enhanced federal match begins and the population expands to 133% FPL on January 1, 2014.

The Department assumed the medical and mental health per capita costs for this expansion group will be approximately 95% of those for the Medicaid Expansion Adults to 60% FPL. Per capita cost estimates for this population have been updated to reflect the most recent projection of per capita costs for the Expansion Adults population.

For caseload estimates and methodology, please see the Section II of this narrative.

MAGI Adults

This expansion allows MAGI Adults to be eligible for Medicaid benefits. Eligibility for this population began in May 2012. The Department was granted a Section 1115 Demonstration Waiver in order to implement eligibility of the population. The Department submitted the Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) in December 2011, and rules were approved by the State Medical Services Board (MSB) in January 2012. With the advent of SB 13-200, effective July 1, 2013, MAGI Adults are now covered up to 133% FPL as of January 1, 2014. Similar to MAGI Parents/Caretakers 69% to 133% FPL, the Hospital Provider Fee Fund is funding this population in the interim before the population expands and the enhanced federal match begins on January 1, 2014.

To project caseload for this population, the Department utilized data from the Colorado Health Institute where American Community Survey data from 2009 was analyzed on the economic statistics of disabled and uninsured Colorado residents. The data showed there were 143,191 uninsured MAGI Adults in Colorado in 2009, 49,511 of which were in the 0-10% FPL bracket. This data, along with a cost analysis, led the Department to conclude that it must initially cap enrollment for this expansion under HB 09-1293 at 10,000.

The Department assumes the per capita costs for this population will be a blend of the historical per capita for this population from 0-10% FPL with an increase in per capita estimates based on the assumed health needs of this population beyond the 10,000 enrollment cap that was in place prior to January 1, 2014, and estimated per capita for this population from 11-133% FPL, since no historic data exists for the expansion population. The Department assumes these clients will be the most high-need clients, with significant pent-up demand. To allow for potentially higher-than-anticipated costs with the rollout of a new population, the Department is remaining conservative in determining per capita estimates. If expenditure falls short of the requested amount, all funds will remain in the hospital provider fee cash fund.

Non-Newly Eligibles

Medicaid expansion clients who were eligible for Medicaid prior to 2009 are not eligible for the 100% federal medical assistance percentage (FMAP) that occurred January 1, 2014. Clients who may be eligible for Medicaid through Home- and Community-Based Services waivers due to a disability are required to provide asset information in order to be determined eligible for Medicaid waiver services. With Medicaid expansion, clients who may have been eligible but did not provide asset information can still be eligible under different eligibility categories, such as MAGI Adults. It is difficult for the State to prove whether these clients would have been eligible for Medicaid services prior to 2009, had they provided their asset information at that time. For this reason, some clients under expansion categories are not eligible for 100% FMAP. Instead, these clients receive standard FMAP, and the State portion is funded through the Hospital Provider Fee Fund in compliance with statute.

MAGI Parents/Caretakers 60% to 68% FPL

Historically, clients who fell under the Expansion Parents to 133% FPL eligibility category (any client over 60% FPL) were considered expansion clients and the State's share of funding was provided through the Hospital Provider Fee Fund. The MAGI conversion has resulted in some clients with over 60% FPL falling into the MAGI Parents/Caretakers 60% to 68% FPL category. The State share of funding for these clients comes from the Hospital Provider Fee Fund, in compliance with statute.

Medicaid Buy-in Fund

This fund is administered by the Department to collect buy-in premiums and support expenditures for the Buy-in for Individuals with Disabilities expansion population, as authorized by HB 09-1293.

Buy-in for Individuals with Disabilities

This expansion allows for disabled individuals with income up to 450% of the federal poverty level to purchase Medicaid benefits. Eligibility for the working adults with disabilities with income up to 450% of the FPL began in March 2012, with eligibility to children with disabilities with income up to 300% of the FPL following in June 2012. The Department does not have an implementation timeframe for non-working adults with disabilities at this time.

To project initial caseload for this population, the Department utilized data from the Colorado Health Institute, which analyzed American Community Survey data from 2009 on the economic statistics of disabled and uninsured Colorado residents. The Department first excluded individuals who, due to income, would either already be eligible for Medicaid or who would be required to pay the full cost of their services under federal regulations. As there is always some portion of a given population that is eligible but not enrolled for a given program, the Department assumed penetration rates depending on FPL bracket and adult/child category. The Department assumed children would have a higher penetration rate than adults and assumed the penetration rate would vary by FPL group due to interactions with other programs. Furthermore, while the Department acknowledges that, as individuals' incomes increase, they may be more likely to obtain their own insurance. The Department learned many may buy into the program to receive "wraparound" benefits, where they would receive benefits not available through their own plan.

The Department assumes most clients in the Buy-In program will have lower utilization of many Home- and Community-Based Services (HCBS) waivers and other Long-Term Care services than the current Medicaid Disabled Individuals to 59 (AND/AB). The Department assumes proportionally fewer individuals with the ability to work would meet the level of care for either a waiver or nursing facility than in the current Disabled Adults to 59 population. In addition, clients who are working are more likely to have access to employer-sponsored insurance, which would be utilized to the maximum of the offered benefits before Medicaid services are utilized. In addition, the Department also assumes 75% of the adult population would be dual-eligible for Medicare, which will decrease the costs to the Medicaid program as Medicare will pay for most of the utilized services. Buy-in participants will also be eligible for Consumer Directed Attendant Support Services (CDASS) through either the Department's HCBS waivers or the existing state plan option, and the Department assumes 10% of the population will use these services.

Hospital Provider Fee Supplemental Payments

Hospital payments are increased for Medicaid hospital services through a total of 13 supplemental payments, 11 of which are paid out of Medical Services Premiums directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, Colorado Indigent Care Program (CICP) and Disproportionate Share Hospital (DSH) payments, and targeted payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to ensure access to hospital services for Medicaid and CICP clients. Hospital provider fee supplemental payments have been updated to reflect the most current model which takes into account new information such as Medicaid Expansion.

Increased caseload due to Medicaid expansion has placed upward pressure on the upper payment limit, or the maximum amount of supplemental payments the Department can make. Coupled with increased federal match rates reducing the need for provider fee to cover the costs of certain Medicaid populations, the increase in the upper payment limit has allowed the Department to increase the amount of supplemental payments made to providers; the forecast has been revised to reflect the higher level of payments.

EXHIBIT K - UPPER PAYMENT LIMIT FINANCING

The Upper Payment Limit (UPL) financing methodology accomplishes the following:

- Increases the Medicaid payment up to the federally allowable percentage for all public government owned or operated home health agencies, outpatient hospitals, and nursing facilities without an increase in General Fund.
- Maximizes the use of federal funds available to the State under the Medicare upper payment limit through the use of certification of public expenditures.
- Reduces the necessary General Fund cost by using the federal funds for a portion of the State's share of the expenditures.

The basic calculation for UPL financing incorporates the difference between Medicare and Medicaid reimbursement amounts, with slight adjustments made to account for different types of services and facilities. Because actual Medicare and Medicaid reimbursement amounts are not yet known for the current fiscal year, prior year's data for discharges, claims, and charges are incorporated into the current year calculation.

Funds received through the UPL for home health services and nursing facilities are used to offset General Fund expenditures. These offsets started in FY 2001-02. While nursing facilities account for the larger portion of Upper Payment Limit funding, home health has expenditures that are relatively small by comparison and will experience little impact related to changes in reimbursement rates.

In FY 2005-06, the Department certified expenditure for only a half year due to a federal audit requiring the Department to certify expenditure on a calendar-year basis. During Figure Setting in March 2006, the Department's FY 2006-07 Base Reduction Item 2 (November 15, 2005) was approved. Starting in FY 2006-07, the Department will record exactly the certified amount as Cash Funds Exempt.

During FY 2007-08, the Department was informed by the Centers for Medicare and Medicaid Services (CMS) it would no longer be permitted to certify public expenditure for nursing facilities. However, in FY 2008-09, CMS and the Department came to an agreement which allowed for a certification process as long as it included a reconciliation process to provider cost. Therefore, the Department has included expenditure for certification of public nursing facility expenditure. Where applicable, the Department's estimates will be adjusted for any reconciliation performed.

In prior fiscal years, the Department was able to utilize UPL financing for outpatient hospital services as well. However, FY 2010-11 was the last year the Department was able to certify public expenditure for Outpatient Hospital services. This was due to HB 09-1293, which allowed the Department to use other State funds to draw federal funds to the upper payment limit.

EXHIBIT L – DEPARTMENT RECOVERIES

This exhibit displays the Department's forecast for estate recoveries, trust recoveries, and tort/casualty recoveries. Prior to FY 2010-11, these recoveries were utilized as an offset to expenditure in Medical Services Premiums. In compliance with State Fiscal Rule 6-6, the Department now reports the recovery types listed above as revenue.

In addition to anticipated recovery revenue, Exhibit L also shows the anticipated contingency fee to be paid to contractors for recovery efforts. The Department's revised forecast for the activity reflects changes to contingency fee paid to the contractor as the contract was reprocured in FY 2011-12. Total revenue used to offset General Fund and federal funds, as shown in Exhibit A, is the sum of all recoveries less contingency fee paid to contractors.

Recoveries made for dates of service under periods where the State received an enhanced federal match are given the same federal match as was applicable when the services were rendered. The Department previously assumed a larger percentage of recoveries would fall under periods of enhanced federal match. However, the most recent expenditure data indicates a smaller percentage of recoveries are from periods with enhanced federal match. Consequently, the Department has revised assumptions regarding federal match on recoveries accordingly.

EXHIBIT M – CASH-BASED ACTUALS

Actual final expenditure data by service category for the past 11 years are included for historical purpose and comparison. This history is built around cash-based accounting, with a 12-month period for each fiscal year, based on paid date. This exhibit displays the estimated distribution of final service category expenditures by aid category from the estimated final expenditures by service categories. This is a necessary step because expenditures in the Colorado Financial Reporting System (COFRS) are not allocated to eligibility categories. The basis for this allocation is data obtained from the Department's Medicaid Management Information System (MMIS). This data provides detailed monthly data by eligibility category and by service category, as defined by a general ledger code structure. From that step, the percent of the total represented by service-specific eligibility categories was computed and then applied to the final estimate of expenditures for each service category within each major service grouping: Acute Care, Community-Based Long-Term Care, Long-Term Care and Insurance (including subtotals for long term care and insurance pieces separately), and Service Management.

Effective with the November 1, 2007 Budget Request, the Department has made several labeling changes to this exhibit:

Service Group	**Old Title**	**New Title**
Acute Care	Administrative Service Organizations - Services	Prepaid Inpatient Health Plan Services
Community-Based Long-Term Care	Home- and Community-Based Services - Case Management	HCBS - Elderly, Blind, and Disabled
Community-Based Long-Term Care	Home- and Community-Based Services - Mentally Ill	HCBS - Mental Illness
Community-Based Long-Term Care	Home- and Community-Based Services-Children	HCBS - Disabled Children
Community-Based Long-Term Care	Home- and Community-Based Services - People Living with AIDS	HCBS - Persons Living with AIDS
Community-Based Long-Term Care	Consumer Directed Attendant Support	HCBS - Consumer Directed Attendant Support
Community-Based Long-Term Care	Brain Injury	HCBS - Brain Injury
Service Management	Administrative Service Organizations Administrative Fee	Prepaid Inpatient Health Plan Administration

Effective with the February 15, 2008 Budget Request, the Department restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 2006-07. The Department has adjusted the allocation to exclude categories that did not utilize this service category. The total amount in aggregate remains the same.

Effective with the November 3, 2008 Budget Request, the Department restated actuals for Single Entry Points from, by using HCBS utilization rates as opposed to total expenditure in Community-Based Long-Term Care and Long-Term Care service categories.

Effective with the November 1, 2010 Budget Request, the Department provided three pages for FY 2009-10 expenditure: cash-based actuals, the total amount delayed in FY 2009-10 as a result of a mandated payment delay, and the estimated FY 2009-10 expenditure adjusted for the payment delay.

Effective with the November 1, 2011 Budget Request, the Department made numerous changes to this exhibit:

- The Department restated actuals for the Prepaid Inpatient Health Plan Services service category for FY 2002-03 forward. The Department altered the methodology for distributing expenditure between eligibility types to more accurately reflect expenditure actually incurred in the service category.
- The Department separated Expansion Adults into Expansion Adults to 60% and Expansion Adults to 100%.
- The Department included totals for financing categories in Medical Services Premiums. As a result, this exhibit now matches the totals shown in other places in the budget, notably the Schedule 3.
- The Department removed historical totals prior to FY 2002-03. These pages remain available on the Department's website and upon request.

Effective with the November 1, 2012 Budget Request, the Department is reporting expenditure for MAGI Adults and Disabled Buy-in eligibility types.

Effective with the November 1, 2014 Budget Request, the Department made numerous changes to this exhibit; historical actuals have been adjusted accordingly:

- Categorically Eligible Low-Income Adults (AFDC-A) and Expansion Adults to 60% FPL have been combined into a single category, MAGI Parents/Caretakers to 68% FPL; historical information has been updated to reflect the merger of these eligibility categories in this Budget Request,
- Expansion Adults to 133% FPL has been renamed to MAGI Parents/Caretakers 69% to 133% FPL,
- Adults without Dependent Children (AwDC) has been renamed to MAGI Adults,
- Baby Care Program – Adults has been renamed to MAGI Pregnant Adults,
- And two new eligibility categories have been added for the clients transitioning from CHP+ to Medicaid, SB 11-008 Eligible Children and SB 11-250 Eligible Pregnant Adults; these populations have been carved out of the Eligible Children and MAGI Pregnant Adults categories respectively, including historical information.

EXHIBIT N – EXPENDITURE HISTORY BY SERVICE CATEGORY

Annual rates of change in medical services by service group from FY 2002-03 through FY 2013-14 final actual expenditures are included in this Budget Request for historical purpose and comparison.

Effective with the November 1, 2010 Budget Request, the Department included a second version of this exhibit that adjusts for the payment delays imposed in FY 2009-10.

Effective with the November 1, 2014 Budget Request, the Department included a new exhibit detailing the total cost of care for Medicaid, separating Title XIX and Title XXI fund sources.

EXHIBIT O – COMPARISON OF BUDGET REQUESTS AND APPROPRIATIONS

This exhibit displays the FY 2013-14 final actual total expenditures for the Medical Services Premiums, including fund splits, the remaining balance of the FY 2013-14 appropriation, and the per capita cost per client. The per capita cost in this exhibit includes Upper Payment Limit and financing bills. This exhibit will not match Exhibit C due to these inclusions.

Additionally, this exhibit compares the Department's Budget Requests by broad service category to the Department's Long Bill and special bills appropriations for FY 2013-14, FY 2014-15 and FY 2015-16 in the chronological order of the requests/appropriations.

EXHIBIT P – GLOBAL REASONABLENESS

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

In places where the Department does not expect the prior year cash flow pattern to be relevant to the current year, the Department has made adjustments based on knowledge of current program trends.

V. ADDITIONAL CALCULATION CONSIDERATIONS

Several bills passed during prior legislative sessions affect the Department's Request for Medical Services Premiums. Additionally, the Department has added several bottom-line impacts for factors which are not reflected in historical trends. This section details the adjustments the Department has made to the Request for Medical Services Premiums.

New Legislation and Impacts from FY 2014-15 Budget Cycle Requests

This section describes the impact from legislation passed during the 2014 Legislative Session and includes impacts from the Department's FY 2014-15 budget cycle requests. Information from budget requests has been updated to be consistent with any approval granted by the legislature.

HB 14-1336 – FY 2014-15 Long Bill

The FY 2014-15 Long Bill contained funding for a number of initiatives the Department proposed as Change Requests as well as Joint Budget Committee actions during the 2014 Legislative Session that impact the Medical Services Premiums budget request. Except where noted, the Department uses the appropriated value as the bottom-line impact. All figures listed are total funds.

- CDASS Service Expansion into the Brain Injury Waiver – Consumer Directed Support Services (CDASS) was expanded to the Brain Injury Waiver, most of the clients transitioning from the 1915(i) option, but new clients would substitute long-term home health for the health maintenance component of CDASS increase HCBS expenditure and decreasing acute care expenditure by $128,943 in FY 2014-15.
- R-7 (FY 2014-15) Adult Supported Living Service Waiting List Reduction: The Department was approved funding to decrease the waitlist for the Supported Living Services waiver. Savings to Acute Care and Community-Based Long Term Care result from clients utilizing waiver services in place of State Plan services. This is expected to decrease expenditure by $6,796,524 in FY 2014-15.
- R-8 (FY 2014-15) Development Disabilities New Full Program Equivalents: The Department was approved funding to allow for emergency enrollments, youth transitions, and de-institutionalizations onto the DD waiver. Savings result from clients utilizing waiver services in place of State Plan services. This is expected to decrease expenditure by $284,637 in FY 2014-15.
- R-9 (FY 2014-15) Medicaid Community Living Initiative: The Department was approved funding for counseling nursing home residents regarding community-based living options. This is expected to increase expenditure by $364,073 in FY 2014-15.
- R-10 (FY 2014-15) Primary Care Specialty Collaboration: The Department was approved funding to establish and maintain a system for primary care doctors to communicate with specialty care providers. This is expected to decrease expenses related to additional appointment for specialty providers. This Is expected to increase expenditures by $237,497 in FY 2014-15.
- R-11 (FY 2014-15) Community Provider Rate Increases: The Department was approved funding to increase provider rates 2.00% across the board. This is expected to increase expenditures by $64,321,150 in FY 2014-15.
- R-11 (FY 2014-15) Targeted Community Provider Rate Increase: The Department was approved funding for the purpose of addressing issues with clients access to cost-effective services. The separate components of the rate increase are broken out in Exhibit F1. The total impact of the targeted rate increases is $13,880,911 in FY 2014-15.
- BA 10 (FY 2014-15), Dental Provider Network Adequacy. The department was approved funding to provide incentive payments to Dental providers to provide services to Medicaid clients as part of push to increase provider enrollment after the addition of the Adult Dental Benefit. The Department will decide on appropriate levels of incentive payments to make when providers see Medicaid clients in FY 2014-15. The impact of this program is $5,000,000 in FY 2014-15.
- BA 10 (FY 2014-15) Continuation of 1202 Provider Rate Increases: The Department was approved funding to continue rate increases that were included in section 1202 of the Health Care and Education Reconciliation Act that required that states

- BA 12 (FY 2014-15) State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees: The Department was granted funding to enroll clients dually eligible for Medicaid and Medicaid in the Accountable Care Collaborative (ACC) so that they will receive care coordination. The total impact is $63,635 in FY 2014-15.
- FY 2014-15 JBC Action, Matching Incentives to Ambulatory Surgery Center Facilities: The 2014 Long Bill included $500,000 in funding to match payments made to Surgeons accounted for within the R-11 Targeted Community Provider Rate Increase. Current implementation is delayed until October, 2014 so the Department assumes an impact of $333,333 in FY 2014-15.
- FY 2014-15 JBC Action, Family Planning Rate Increase: The 2014 Long Bill included $1,817,275 in funding for the Department to standardize rates for oral contraceptives as well as a 15% rate increase for Family Planning Services.
- FY 2014-15 JBC Action, Raising FQHC Rate Increase to APM: The 2014 Long Bill included $7,261,751 in funding to increase rates to Federally Qualified Health Centers to Colorado's Alternative Payment Method.
- FY 2014-15 JBC Action, Full Denture Benefit: The 2014 Long Bill included funding for the Department to provide full dentures as a part of the Adult Dental Benefit established in SB 13-242. The Department estimates this will increase expenditure by $24,509,713 in FY 2014-15.

HB 14-1045 – Continuation of BCCP

HB 14-1045 extended the repeal date of the Breast and Cervical Cancer Program through July 1, 2019. This will ensure that these clients do not experience any lapse in coverage. Beginning in FY 2014-15 100% of the state share of the funding for this program will be from the Breast and Cervical Cancer Prevention and Treatment Fund. All Breast and Cervical Cancer Program expenditures receive a 65.53% federal match rate in FY 2014-15. This is expected to increase expenditure by $6,096,581 in FY 2014-15.

HB 14-1252 – Intellectual and Developmental Disabilities Services System Capacity

HB 14-1252 was an adjustment to existing appropriations between waiver services. The Department had experienced significant under-expenditure in the HCBS-DD and the HCBS-CES waiver programs that was used to rebalance over-expenditure in the HCBS-SLS waiver program. The request included funding for additional FPE to allow more clients to be served on the waiver programs in place of State Plan services, resulting in a negative fiscal impact.

The total impact of this legislation is a decrease of $1,222,015 in FY 2014-15.

HB 14-1357 – In-Home Support Services in Medicaid Program

HB 14-1357 makes several changes to in-home support services (IHSS) provided by the Department. This bill allows IHSS to be provided inside the home or within the community, adds spouses as an eligible family member to act as an attendant providing IHSS to

an HCBS waiver client, allows eligible clients or their representative the ability to determine the amount of oversight needed, allows family members to be reimbursed for providing IHSS, expands IHSS to clients receiving services through the Spinal Cord Injury waiver, and adds IHSS to the list of services under the Elderly, Blind, and Disabled waiver program.

Implementation of these program changes is on track for FY 2014-15 and is expected to increase expenditure by $297,986.

SB 14-130 – Increase Personal Care Allowance Nursing Facility

SB 14-130 raises the personal need allowance (PNA) of Medicaid nursing facility residents from $50 to $75. The increase would actually decrease the patient payment made to nursing facilities, resulting in a loss of revenue. The Department is offsetting the loss in revenue to nursing facilities due to the increase in PNA with General Fund. The PNA allows for the purchase of clothing and other goods and services that are not reimbursed by any state or federal program. The increase is expected to increase expenditure by $1,057,300 in FY 2014-15.

Prior-Year Legislation, Impacts from Previous Budget Cycles, and Other Adjustments

SB 10-117 – Concerning Over-the-Counter Medication for Medicaid Clients

SB 10-117 allows pharmacists to directly prescribe certain medications, as approved by the Department, to Medicaid clients. By including only drugs that, when access is increased, reduce the likelihood of more expensive exacerbation of conditions, savings can be achieved. Avoided ER visits, physician office visits to obtain prescriptions for over-the-counter drugs (as is current policy for over-the-counter drug coverage under Medicaid), and avoided births are the primary vectors of savings. Through an extensive stakeholder outreach process, the Department has developed a list of medications that is anticipated to generate savings.

Emergency contraceptives generate the most significant amount of savings as the costs associated with birth are nontrivial. The Department's analysis excludes first-year-of-life costs and thus represents a conservative estimate of savings.

Because of the significant health consequences associated with smoking, expenditure on nicotine replacement therapies have been shown to reduce health care expenditure as quickly as one year post investment. Returns continue to increase over time. While there is an initial increase in expenditure associated with covering nicotine replacement therapy under the provisions of SB 10-117, the Department anticipates short-term returns on investment. Further, the increase in expenditure is completely offset by savings achieved by other drugs in the program.

Over-the-counter medications such as fever reducers are likely to reduce the utilization of emergency/urgent care services when easily accessible. While the Department has not estimated the savings associated with avoided emergency/urgent care service utilization, the

Department believes that, as the estimated costs are sufficiently low, costs are offset by savings from other drugs on the list, and there are likely cost savings, that inclusion of these drugs on the list are appropriate.

Implementation of this program is currently on hold due to systems issues.

Section 1202 of the Health Care and Education Reconciliation Act – Primary Care Physician Rates to 100% of Medicare

Section 1202 of the Health Care and Education Reconciliation Act (part of the Affordable Care Act) states that for calendar years 2013 and 2014, states must provide for payment for primary care services at a rate not less than 100% of the Medicare rate. The difference in rates between July 1, 2009, and January 1, 2013, will be paid for by the federal government through an enhanced federal medical assistance percentage (FMAP). The increased FMAP rate will apply to certain primary care services -- including evaluation and management and immunizations -- performed by physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine.

The Department estimates the difference in rates between July 1, 2009, and January 1, 2013, will generate an estimated $31,918,911 total funds impact in FY 2013-14 and a negative $9,575,251 total funds impact in FY 2014-15, and a negative $29,339,171 total funds impact in FY 2015-16, all of which will be 100% federally funded. In addition, the Department will need to increase physician rates from the level at which they are currently set to the rates that were effective on July 1, 2009. This gap represents rate cuts that were taken since July 1, 2009, due to budget reduction measures. The Department estimates increasing rates to the July 1, 2009 level will increase expenditure by $3,512,863 in FY 2013-14, a negative $1,865,815 in FY 2014-15, and a negative $2,388,616 in FY 2015-16. These amounts will be matched by the federal government at the standard FMAP rates. The enhanced federal funding is not available in CY 2015. Consequently, the bottom line impact in Acute Care, Exhibit F for FY 2014-15 accounts for a half year impact after which expenditure returns to original levels.

ACC Savings

The Accountable Care Collaborative (ACC) was originally requested in FY 2010-11 S-6, BA-5 as a pilot program of 60,000 clients and expanded in FY 2011-12 BA-9 to 123,000 clients. The program is designed to improve clients' health and reduce costs. Clients in the ACC receive the regular Medicaid benefits package, and the Department makes additional payments to doctors and care coordination organizations to help manage clients' care. The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds providers accountable for health outcomes. The program began in the spring of 2011, and enrollment reached 123,000 Medicaid clients statewide in FY 2011-12. The program continues to expand and is currently at an enrollment level of 454,447 for FY 2014-15. The central goals of the program are

to improve health outcomes through a coordinated, client-centered system and to control costs by reducing avoidable, duplicative, variable, and inappropriate use of health care resources.

The key components of the ACC are the Regional Care Collaborative Organizations, the Primary Care Medical Providers, and the Statewide Data and Analytics Contractor, which are outlined below.

The Regional Care Collaborative Organizations (RCCOs) are regional entities that provide for the coordination and integration of care within the ACC framework and are contracted with the Department through competitive procurement. There are seven RCCOs, which provide the following services:

- medical management, particularly for medically and behaviorally complex clients, to ensure they get the right care, at the right time and in the right setting;
- care-coordination among providers and with other services such as behavioral health, long-term care, single entry point (SEP) programs, and other government social services such as food, transportation, and nutrition; and
- provider support, such as assistance with care-coordination, referrals, clinical performance and practice improvement, and redesign.

Primary Care Medical Providers (PCMPs) are contracted with RCCOs and act as "health homes" for ACC members. As a health home, the PCMP provides comprehensive primary care and coordinates and manages a client's health needs across specialties and along the continuum of care.

The Statewide Data and Analytics Contractor (SDAC) builds and implements the ACC data repository, creates reports using advanced health care analytics, hosts and maintains a web portal, provides a continuous feedback loop of critical information, fosters accountability and ongoing improvement among RCCOs and providers, and identifies data-driven opportunities to improve care and outcomes. The SDAC is paid through a fixed-price contract.

Medicaid clients who are enrolled in the ACC are assigned to a RCCO based on the client's county of residence and are linked with a PCMP via existing claims data that shows a relationship between the client and the provider, if that data is available. The RCCO and the PCMP are both paid a per-member per-month (PMPM) amount and are responsible for providing enhanced care coordination services, improving health outcomes, and reducing unnecessary costs.

The Department estimates the PMPM costs for the RCCOs and PCMPs, as well as the fixed-price contract for the SDAC, in Exhibit I. The Department estimates the savings that will accrue as a result of the program in Exhibit F. Due to attrition and replacement enrollments, it is no longer possible to isolate an original 60,000 member cohort or expansion cohort. Consequently, expenditure and savings adjustments are shown in aggregate for the program. Because children make up a large portion of caseload in Medicaid, the

greatest opportunity for ACC expansion lies within this population. As children also have relatively lower per capita expenditure, the savings opportunity from enrollment in the ACC for this population is smaller than other populations. The Department has assumed a decreasing return to investment in each subsequent year on a per client basis. Further, RCCO rates have been adjusted to reflect the new case mix under an expanded program. In FY 2013-14 and subsequent years, the savings distribution has been adjusted to account for more actual savings in the disabled populations than children.

The chart below shows program expenditure and estimated savings for FY 2014-15, FY 2015-16, and FY 2016-17.

Accountable Care Collaborative Expenditure and Assumed Savings

Service Category		FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
Program Administration (Exhibit I, PIHP)	**SDAC**	$2,700,000	$2,902,500	$2,950,000	$3,467,500	$3,350,000	$3,350,000
	RCCO	$12,303,473	$27,696,161	$52,945,462	$90,104,598	$107,780,201	$115,912,831
	PCMP	$2,904,360	$6,130,270	$12,674,868	$26,958,377	$32,246,737	$34,679,939
	Total Administration	**$17,907,833**	**$36,728,931**	**$68,570,330**	**$120,530,475**	**$143,376,938**	**$153,942,770**
Program Savings (Exhibit F, Acute)	**Total**	**($20,616,544)**	**($43,647,968)**	**($81,781,107)**	**($140,673,766)**	**($166,266,952)**	**($177,329,106)**
	Incremental[(1)]		**($23,031,424)**	**($33,928,883)**	**($58,892,659)**	**($25,593,186)**	**($11,062,154)**
Net ACC Program Fiscal Impact			**($6,919,037)**	**($13,210,777)**	**($20,143,291)**	**($22,890,014)**	**($23,386,336)**

(1) The incremental value shown is equal to the annualization values in Exhibit F, Acute Care.

Client Overutilization Program Expansion (BRI-1)

This BRI originally sought to increase enrollment to 200 clients in the Client Overutilization Program (COUP) by paying providers an incentive payment to participate and changing some of the criteria in the MMIS to allow a broader range of providers to participate as lock-in providers. This program generates savings by decreasing excessive use of medical services and thereby reducing the expenditure for medically unnecessary claims. The program criteria primarily target the abuse of prescription medication but also include inappropriate use of emergency room and/or physician services. The expansion has been delayed due to a delay in the required system changes. It is uncertain at this time when the Department will be able to make incentive payments through the MMIS, as that change has not yet been prioritized. The Department is currently re-evaluating the COUP program as it was originally designed and as such savings have been removed from the budget until an implementation plan is in place and assumptions are re-evaluated. The Department intends to adjust savings estimates in future requests as the COUP program is re-evaluated.

Medicaid Budget Balancing Reductions (2011-12 BA-9)

In this budget amendment, the Department proposed to reduce Medicaid expenditure through a series of initiatives, including: an expansion of the Accountable Care Collaborative, deinstitutionalization efforts through the Department's "Money Follows the Person" federal grant, and a combination of service limitations and rate reductions. Only one part of this initiative remains to be implemented, limiting the number of physical and occupational therapy units for adults.

- Limit Number of Physical and Occupational Therapy Units for Adults: Limit number of physical and occupational therapy units that adults can receive to 48 total units of service per year, regardless of prior authorization. Implementation of this has been delayed from July 2011 until July 1, 2016 to make use of the new MMIS system. The Department adjusted its request accordingly.

Estimated Impact of Increasing PACE Enrollment

As described in the narrative for Exhibits F and H, the Department is currently in the process of adding several new Program of All-Inclusive Care for the Elderly (PACE) providers to the Medicaid program. Like other risk-based managed care organizations (including the Department's health maintenance organizations and behavioral health organizations), the monthly payment to the provider covers all services provided by the provider –in the instance of a PACE provider, the payment covers acute care and long-term care. While the Department does not adjust its request for each additional client enrolled in PACE – enrollments in existing providers are considered part of the base trend – the addition of new providers will cause an expenditure shift from fee-for-service categories to the PACE service category.

The impact to Acute Care and Community-Based Long-Term Care (CBLTC) is not "dollar-for-dollar." The PACE program is designed to keep clients who have high community-based long-term care needs out of nursing facilities. The clients who move into the PACE program, typically, are those clients whose needs are no longer met by an HCBS program. Thus, clients are moving from a lower-cost option (HCBS) to a higher-cost option (PACE). However, the Department still anticipates the move is at least budget neutral in the long-term; clients who do not move to a PACE program will typically require nursing facility coverage, which is more expensive than PACE coverage.

The impact to acute care and CBLTC is calculated as the percentage of the PACE cost per enrollee attributable to those services (based on the actuarially certified capitation rates), adjusted for the cash-flow issues related to transitioning a client from fee-for-service to managed care under cash accounting. The cash-flow impact is calculated as one-twelfth the total enrollment impact and distributed proportionally to the acute care and HCBS reductions.

The estimated decrease in expenditures due to increased PACE enrollment is $4,995,171 in FY 2014-15 $2,738,876 in FY 2015-16, and $2,227,278 in FY 2016-17.

SB 10-167 - Concerning Increased Efficiency in the Administration of the "Colorado Medical Assistance Act," and, in Connection Therewith, Creating the "Colorado Medicaid False Claims Act"

This bill creates efficiencies in the Department by creating the Colorado Medicaid False Claims Act, as described below. The bill originally reduced Department expenditure $2,390,570 in FY 2010-11, and annualizing to $3,699,827 in FY 2011-12, by requiring the Department to implement a number of initiatives. The Department has been able to partially implement the components of SB 10-167, though full implementation is ongoing. Consequently, a portion of the savings originally anticipated in FY 2012-13 has been shifted to FY 2013-14 and subsequent years. The initiatives are as follows:

National Correct Coding Initiative

With this initiative, the MMIS is enhanced to perform prepayment review of claims. The system checks for medically unlikely billing code pairs and medically unlikely unit quantities. Due the magnitude of changes required to the MMIS as well as issues in rate structures that need to occur for the coding edits to be effective, there have been delays in the implementation of this component of SB 10-167. In FY 2010-11 the Department manually implemented approximately 200 of the highest utilized coding pairs (out of over 3 million in total) to achieve savings despite delays in implementation. NCCI was fully implemented in April 2013. The Department expects a partial year savings in FY 2013-14 of $629,100 and for savings to be incorporated into the base in subsequent years.

Health Insurance Buy-In Program Expansion

The Department anticipates purchasing private health insurance coverage through the Health Insurance Buy-In (HIBI) Program for an additional 1,500 eligible clients to create cost savings for the State by enrolling clients into individual insurance plans where enrollment is deemed cost-effective. This initiative was delayed to implement in FY 2013-14 to allow for contract execution. The Department has identified a vendor and has begun the enrollment process, but it has gone more slowly than anticipated. As of June 2014, there were 463 clients enrolled in HIBI. The vendor had previously anticipated approximately 70 clients would be enrolled per month until the maximum of 2,000 clients was reached; however, this did not occur, and so assumptions have been adjusted to account for approximately 2% enrollment growth per month through FY 2016-17.

In addition to adjusting savings estimates for implementation delays in the HIBI expansion, the Department has revised both cost and savings estimates to better reflect the impact the Department anticipates with the increased enrollment in this program. First, the Department changed the payment methodology from a contingency based payment plan to PMPM payment. The Department believes this methodology better allows the Department to reimburse for managing payments to clients' primary insurance agencies. In addition,

the Department adjusted the monthly savings based on FY 2012-13 per capita costs. Finally the Department added costs associated with premium reimbursement to the estimated cost of the bill. This captures the additional costs to the Department for increased enrollment in the HIBI program. The following table illustrated the full impact of SB 10-167 on the HIBI program for FY 2014-15through FY 2015-16.

FY 2014-15 and FY 2015-16 Total HIBI Impact from SB 10-167

Item	FY 2014-15	FY 2015-16
Provider Payment	$172,948	$217,168
Premiums Payment	$2,273,217	$2,854,443
Total Savings (Realized in Acute Care)	($4,221,689)	($5,301,109)
Incremental Savings for Bottom-Line Impact in Exhibit F	($731,697)	($1,079,421)
Total Impact	**($1,775,524)**	**($2,229,498)**

Colorado Choice Transitions (Money Follows the Person Grant)

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

The Department had to delay implementation of the program as necessary system changes were unable to be completed by the original July 2012 start date goal. The program was implemented March 1, 2013, with the first client transitioning in May 2013. The Department anticipates approximately 100 clients will transition per 365 day period beginning in May 2013. The Department estimates the total impact to Medical Services Premiums to be $155,748 total funds in FY 2013-14, $1,026,418 savings in FY 2014-15, and $4,133,659 savings in FY 2015-16. These figures do not include any expenditure from the rebalancing fund.

Medicaid Budget Reductions (2012-13 R-6)

This budget action encompassed 16 different policy initiatives targeted at addressing the statewide budget shortfall. The majority of the proposals are efficiency measures that align Medicaid practices with industry standards to maximize clinical efficacy while maintaining fiscal responsibility. Only some elements of this budget action have not been implemented.

- *Dental Efficiencies*: The Department will clarify rules regarding eligibility for orthodontics. These clarifications are expected to reduce utilization of orthodontics for all cases except those where the client has a severely handicapping malocclusion. Until the Dental Benefits Collaborative process is complete in January 2015, full implementation of this reduction cannot be implemented. The adjustment of a negative $464,900 in FY 2014-15 indicates a partial implementation. Full implementation is noted in FY 2015-16 with an additional reduction of $1,394,699.
- *Augmentative Communication Devices:* The Department's efforts to provide new, less expensive communication assistance technology for clients with disabilities impairing their ability to communicate have met with difficulty in two areas: The first is a systems issue that causes claims for these devices to be rejected and the second is a proprietary license issue that causes vendors to have difficulty in obtaining these devices to supply to clients. The Department is proactively looking for solutions in both areas and the problems are expected to be resolved before the end of FY 2014-15. The adjustment of negative $246,000 in FY 2014-15 accounts for the delayed implementation as the Department resolves these issues. Full implementation is expected in FY 2015-16 and the initiative is annualized for a reduction of $246,000 in that fiscal year as well.

Medicaid Fee-for-service Reform (2012-13 R-5)

Three initiatives were included in the budget action: Behavioral Health Organization gainsharing, Federally Qualified Health Center and Rural Health Center gainsharing, and Accountable Care Collaborative gainsharing. Each of these initiatives provides financial incentives for different provider types to engage clients and care management differently to improve outcomes and generate savings. Because these changes require an investment on the part of the provider, gainsharing becomes a mechanism for compensating providers for the investment without an upfront outlay of funding by the State. Through stakeholder engagement with CMS and the provider community, the Department has revised the gainsharing proposal to facilitate an alignment of financial incentives to support the Accountable Care Collaborative care management system. All three gainsharing activities have been streamlined into a single gainsharing program wherein care management entities, behavioral health organizations, and primary care providers must work together collaboratively to produce savings through integration of behavioral health and physical health to improve total health outcomes. The Department estimates a savings of $2,802,007 in FY 2013-14 and a savings of $1,401,004 in FY 2014-15.

53 Pay Periods in FY 2013-14

The Department must account for an additional pay period in FY 2013-14. The decrease estimated in the February request was $38,288,901 in FY 2013-14. The Department updated this estimate to a decrease of $49,726,790 in FY 2014-15. The change from the February S-1 requests reflects actual expenditure in FY 2013-14 used to estimate the FY 2014-15 impact.

FY 2013-14 R-7: Substance Abuse Disorder Benefit

The Department was approved funding to enhance the current substance use disorder benefit through the Behavioral Health Organizations (BHOs), expanding limitations on current services and adding appropriate services to create a more robust program due to a high number of individuals with mental health disorders having a co-occurring substance abuse disorder. Integrating substance use disorder services with the BHO benefit will provide clients with better care coordination and ensure that clients receive services necessary for recovery. Previously, substance use disorder services are provided in a fee-for-service setting and were unmanaged. This program has a negative $1,485,982 impact in FY 2014-15 as a result of properly managed mental health and/or substance use disorders.

FY 2013-14 R-9: Dental ASO for Children

The Department was approved funding to implement a dental administrative services organization (ASO) for the Medicaid children's benefit. The program will allow the Department to deliver and manage dental services for children and increase the available provider network while increasing savings through the reduction of preventable and costly restorative services. This program is anticipated to have a budget savings of $576,072 in FY 2014-15.

SB 13-200: Medicaid Expansion

This bill amends Medicaid eligibility criteria for parents and caretakers of eligible children from 100% of the federal poverty line to 133% of the federal poverty line. It also amends the Medicaid eligibility criteria for MAGI Adults to 133% of the federal poverty line and ages 19 through 64. This bill also expanded the funds to the SDAC by $250,000 per year.

SB 13-242: Adult Dental Benefit

This bill implements a limited dental benefit for adults using a collaborative stakeholder process to consider the components of the benefit. Dental services were previously available to only children 21 years of age and under through the EPSDT program. For clients over 21, the Department previously only reimbursed for emergency dental services. This program is expected to increase State expenditures by $82,118,666 in FY 2014-15 as well as an increased service management cost of $567,726.

Fluoride Benefit Expansion

The 2013 Long Bill also added a requirement that the Department will allow primary care providers to receive reimbursement for providing oral health risk assessments and applying fluoride varnishes up to three times per year for children five years and older. The fiscal impact of this implementation is included as a bottom line adjustment in Exhibit F.

FY 2013-14 R-13: 2% Provider Rate Increase

The Department increased provider rates for services impacted by rate reductions in recent years. During the economic recession, the state imposed multiple provider rate reductions to create General Fund relief. This placed financial strain on providers and potentially put client's health care at risk. The annualization of these rate increases are expected to increase expenditures by $5,507,961 in FY 2014-15.

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Exhibits for the Medical Services Premiums Budget Request

Exhibit A - Summary of Request

Calculation of Request

FY 2014-15

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2014-15 Appropriation						
FY 2014-15 Long Bill Appropriation (HB 14-1336)	$5,716,177,008	$897,312,543	$710,835,957	$620,547,350	$0	$3,487,481,158
HB 14-1045 "Continuation of BCCP"	$6,820,477	$0	$0	$2,351,018	$0	$4,469,459
HB 14-1357 "In-home Support Services in Medicaid Program"	$297,985	$145,983	$0	$0	$0	$152,002
SB 14-130 "Increase Personal Care Allowance Nursing Facility"	$1,057,300	$517,971	$0	$0	$0	$539,329
FY 2014-15 Total Spending Authority	**$5,724,352,770**	**$897,976,497**	**$710,835,957**	**$622,898,368**	**$0**	**$3,492,641,948**
Total Projected FY 2014-15 Expenditure	$5,866,244,550	$981,659,919	$710,835,957	$648,065,968	$0	$3,525,682,706
FY 2014-15 Requested Change from Appropriation	**$141,891,780**	**$83,683,422**	**$0**	**$25,167,600**	**$0**	**$33,040,758**
Percent Change	2.48%	9.32%	0.00%	4.04%	0.00%	0.95%

Calculation of Request

FY 2015-16

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2014-15 Appropriation Plus Special Bills	$5,724,352,770	$897,976,497	$710,835,957	$622,898,368	$0	$3,492,641,948
Bill Annualizations						
Annulalization of Long Bill FY 2014-15 (HB 14-1336)	$46,124,729	$44,843,934	$0	$7,038,782	$0	($5,757,987)
HB 08-1373 Annualization "Breast and Cervical Cancer Fund"	($834,968)	($287,793)	$0	$0	$0	($547,175)
HB 14-1045 Annualization "Continuation of BCCP"	($3,556,502)	$0	$0	($1,231,801)	$0	($2,324,701)
HB 14-1357 Annualization "In-home Support Services in Medicaid Program"	$893,956	$437,949	$0	$0	$0	$456,007
SB 14-130 Annualization "Increase Personal Care Allowance Nursing Facility"	$1,588,240	$778,079	$0	$0	$0	$810,161
Total Annualizations	$44,215,455	$45,772,169	$0	$5,806,981	$0	($7,363,695)
FY 2015-16 Total Spending Authority	**$5,768,568,225**	**$943,748,666**	**$710,835,957**	**$628,705,349**	**$0**	**$3,485,278,253**
Total Projected FY 2015-16 Expenditure	$6,326,526,772	$1,074,094,630	$711,259,557	$683,680,522	$0	$3,857,492,063
FY 2015-16 Requested Change from Appropriation	**$557,958,547**	**$130,345,964**	**$423,600**	**$54,975,173**	**$0**	**$372,213,810**
Percent Change	9.67%	13.81%	0.06%	8.74%	0.00%	10.68%

Calculation of Request

FY 2016-17

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2015-16 Appropriation Plus Special Bills	$5,768,568,225	$943,748,666	$710,835,957	$628,705,349	$0	$3,485,278,253
Bill Annualizations						
Total Annualizations	$0	$0	$0	$0	$0	$0
FY 2016-17 Total Spending Authority	**$5,768,568,225**	**$943,748,666**	**$710,835,957**	**$628,705,349**	**$0**	**$3,485,278,253**
Total Projected FY 2016-17 Expenditures	$6,629,079,220	$1,136,780,243	$711,259,557	$735,257,603	$0	$4,045,781,817
FY 2016-17 Requested Change From Appropriation	**$860,510,995**	**$193,031,577**	**$423,600**	**$106,552,254**	**$0**	**$560,503,564**
Percent Change	14.92%	20.45%	0.06%	16.95%	0.00%	16.08%

Calculation of Fund Splits
FY 2014-15

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
Acute Care Services							
Base Acute	$2,116,761,188	$1,042,293,209	$0	$0	$1,074,467,979	50.76%	
Breast and Cervical Cancer Program	$6,094,937	$0	$2,100,925	$0	$3,994,012	65.53%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
Family Planning	$12,453,015	$1,216,301	$29,000	$0	$11,207,714	90.00%	CF: Local Funds
Indian Health Service	$1,513,089	$0	$0	$0	$1,513,089	100.00%	
Affordable Care Act Drug Rebate Offset	($13,545,247)	$0	$0	$0	($13,545,247)	0.00%	
Affordable Care Act Preventive Services	$31,230,202	$15,065,449	$0	$0	$16,164,753	51.76%	
SB 11-008: "Aligning Medicaid Eligibility for Children"	$68,946,135	$23,765,733	$0	$0	$45,180,402	65.53%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$16,159,056	$5,570,027	$0	$0	$10,589,029	65.53%	
MAGI Parents/Caretakers to 133% FPL	$146,077,167	$0	$0	$0	$146,077,167	100.00%	100% FFP January 1, 2014
MAGI Adults	$927,616,687	$0	$0	$0	$927,616,687	100.00%	100% FFP January 1, 2014
Disabled Buy-In	$44,429,269	$0	$22,960,246	$0	$21,469,023	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$13,322,419	$0	$6,559,959	$0	$6,762,460	50.76%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$9,928,122	$0	$4,888,607	$0	$5,039,515	50.76%	CF: Hospital Provider Fee Fund
Adult Dental Benefit Financing	$54,865,536	$0	$26,990,728	$0	$27,874,808	Variable	CF: Adult Dental Fund and Hospital Provider Fee Fund
Physicians to 100% of Medicare: 100% Federal Funds Portion	$31,095,529	$0	$0	$0	$31,095,529	100.00%	
Acute Care Services Sub-Total	$3,466,947,104	$1,087,910,719	$63,529,465	$0	$2,315,506,920		
Community Based Long-Term Care Services							
Base Community Based Long-Term Care	$464,598,955	$228,768,525	$0	$0	$235,830,430	50.76%	
Children with Autism Waiver Services	$814,249	$0	$400,936	$0	$413,313	50.76%	CF: Colorado Autism Treatment Fund
MAGI Parents/Caretakers to 133% FPL	$185,851	$0	$0	$0	$185,851	100.00%	100% FFP January 1, 2014
MAGI Adults	$2,331,549	$0	$0	$0	$2,331,549	100.00%	100% FFP January 1, 2014
Disabled Buy-In	$1,618,222	$0	$836,268	$0	$781,954	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$190,158	$0	$93,634	$0	$96,524	50.76%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$0	$0	$0	$0	$0	50.76%	CF: Hospital Provider Fee Fund
Community Based Long-Term Care Sub-Total	$469,738,984	$228,768,525	$1,330,838	$0	$239,639,621		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$579,627,819	$286,662,738	$0	$0	$292,965,081	50.76%	
Class II Nursing Facilities	$4,214,187	$2,075,066	$0	$0	$2,139,121	50.76%	
PACE	$139,607,769	$68,742,865	$0	$0	$70,864,904	50.76%	
Supplemental Medicare Insurance Benefit (SMIB)	$135,739,015	$78,389,281	$0	$0	$57,349,734	50.00%	Approximately 15.5% of Total is State-Only
Health Insurance Buy-In	$1,789,227	$881,015	$0	$0	$908,212	50.76%	
MAGI Parents/Caretakers to 133% FPL	$0	$0	$0	$0	$0	100.00%	100% FFP January 1, 2014
MAGI Adults	$0	$0	$0	$0	$0	100.00%	100% FFP January 1, 2014
Disabled Buy-In	$400,180	$0	$206,806	$0	$193,374	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$0	$0	$0	$0	$0	50.76%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$0	$0	$0	$0	$0	50.76%	CF: Hospital Provider Fee Fund
Long-Term Care and Insurance Sub-Total	$861,378,197	$436,750,965	$206,806	$0	$424,420,426		
Service Management							
Base Service Management	$34,426,591	$17,213,295	$0	$0	$17,213,296	50.00%	
Accountable Care Collaborative	$83,176,044	$40,955,884	$0	$0	$42,220,160	50.76%	
Tobacco Quit Line	$1,300,812	$0	$640,520	$0	$660,292	50.76%	CF: Tobacco Education Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$2,827,868	$974,766	$0	$0	$1,853,102	65.53%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$68,343	$23,558	$0	$0	$44,785	65.53%	
MAGI Parents/Caretakers to 133% FPL	$9,536,049	$0	$0	$0	$9,536,049	100.00%	100% FFP January 1, 2014
MAGI Adults	$33,509,605	$0	$0	$0	$33,509,605	100.00%	100% FFP January 1, 2014
Disabled Buy-In	$164,820	$0	$85,176	$0	$79,644	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$58,731	$0	$28,919	$0	$29,812	50.76%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$670,822	$0	$330,313	$0	$340,509	50.76%	CF: Hospital Provider Fee Fund
Service Management Sub-Total	$165,739,685	$59,167,503	$1,084,928	$0	$105,487,254		
FY 2014-15 Estimate of Total Expenditures for Medical Services to Clients	**$4,963,803,970**	**$1,812,597,712**	**$66,152,037**	**$0**	**$3,085,054,221**		
Financing							
Upper Payment Limit Financing	$5,065,793	($5,075,036)	$5,065,793	$0	$5,075,036	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($19,721,253)	$39,442,506	$0	($19,721,253)	50.00%	CF: Department Recoveries
Denver Health Outstationing	6,408,699.00	$0	$3,204,349	$0	$3,204,350	50.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$757,053,890	$0	$372,792,262	$0	$384,261,628	50.76%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$92,730,698	$0	$45,660,596	$0	$47,070,102	50.76%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$5,619,125	($295,743)	$2,957,434	$0	$2,957,434	50.00%	CF: Certification of Public Expenditure
Memorial Hospital High Volume Payment	5,562,375	$0	$2,781,187	$0	$2,781,188	50.00%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($64,951,999)	$64,951,999	$0	$0	N/A	CF: Health Care Expansion Fund
Intergovernmental Transfer for Difficult to Discharge Clients	$30,000,000	$0	$15,000,000	$0	$15,000,000	50.00%	CF: Intergovernmental Transfer
Cash Funds Financing[1]	$0	($30,057,805)	$30,057,805	$0	$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$902,440,580	($120,101,836)	$581,913,931	$0	$440,628,485		
Total Projected FY 2014-15 Expenditures[2]	**$5,866,244,550**	**$1,692,495,876**	**$648,065,968**	**$0**	**$3,525,682,706**		

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

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

(2) Of the General Fund total, $710,835,957 is General Fund Exempt.

Exhibit A - Summary of Request

Calculation of Fund Splits
FY 2015-16

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
Acute Care Services							
Base Acute	$2,251,273,117	$1,102,898,700	$0	$0	$1,148,374,417	51.01%	
Breast and Cervical Cancer Program	$2,811,897	$0	$964,199	$0	$1,847,698	65.71%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
Family Planning	$13,179,026	$1,288,903	$29,000	$0	$11,861,123	90.00%	CF: Local Funds
Indian Health Service	$1,578,720	$0	$0	$0	$1,578,720	100.00%	
Affordable Care Act Drug Rebate Offset	($15,930,611)	$0	$0	$0	($15,930,611)	0.00%	
Affordable Care Act Preventive Services	$33,875,400	$16,256,804	$0	$0	$17,618,596	52.01%	
SB 11-008: "Aligning Medicaid Eligibility for Children"	$74,595,915	$12,711,144	$0	$0	$61,884,771	82.96%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$18,116,831	$8,652,598	$0	$0	$9,464,233	52.24%	
MAGI Parents/Caretakers to 133% FPL	$154,785,190	$0	$0	$0	$154,785,190	100.00%	100% FFP January 1, 2014
MAGI Adults	$1,110,961,738	$0	$0	$0	$1,110,961,738	100.00%	100% FFP January 1, 2014
Disabled Buy-In	$53,419,480	$0	$27,460,787	$0	$25,958,693	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$13,588,868	$0	$6,657,186	$0	$6,931,682	51.01%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$10,126,685	$0	$4,961,063	$0	$5,165,622	51.01%	CF: Hospital Provider Fee Fund
Adult Dental Benefit Financing	$59,086,942	$0	$28,944,365	$0	$30,142,577	Variable	CF: Adult Dental Fund
Acute Care Services Sub-Total	$3,781,469,198	$1,141,808,149	$69,016,600	$0	$2,570,644,449		
Community Based Long-Term Care Services							
Base Community Based Long-Term Care	$508,427,956	$249,078,856	$0	$0	$259,349,100	51.01%	
Children with Autism Waiver Services	$857,684	$0	$420,179	$0	$437,505	51.01%	CF: Colorado Autism Treatment Fund
MAGI Parents/Caretakers to 133% FPL	$201,221	$0	$0	$0	$201,221	100.00%	100% FFP January 1, 2014
MAGI Adults	$2,663,816	$0	$0	$0	$2,663,816	100.00%	100% FFP January 1, 2014
Disabled Buy-In	$1,812,973	$0	$931,976	$0	$880,997	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$193,961	$0	$95,021	$0	$98,940	51.01%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$0	$0	$0	$0	$0	51.01%	CF: Hospital Provider Fee Fund
Community Based Long-Term Care Sub-Total	$514,157,611	$249,078,856	$1,447,176	$0	$263,631,579		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$590,482,278	$289,277,268	$0	$0	$301,205,010	51.01%	
Class II Nursing Facilities	$4,711,461	$2,308,145	$0	$0	$2,403,316	51.01%	
PACE	$145,181,513	$71,124,423	$0	$0	$74,057,090	51.01%	
Supplemental Medicare Insurance Benefit (SMIB)	$143,021,819	$82,595,100	$0	$0	$60,426,719	50.00%*	Approximately 15.5% of Total is State-Only
Health Insurance Buy-In	$2,414,673	$1,182,948	$0	$0	$1,231,725	51.01%	
MAGI Parents/Caretakers to 133% FPL	$0	$0	$0	$0	$0	100.00%	100% FFP January 1, 2014
MAGI Adults	$0	$0	$0	$0	$0	100.00%	100% FFP January 1, 2014
Disabled Buy-In	$407,674	$0	$209,569	$0	$198,105	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$0	$0	$0	$0	$0	51.01%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$0	$0	$0	$0	$0	51.01%	CF: Hospital Provider Fee Fund
Long-Term Care and Insurance Sub-Total	$886,219,418	$446,487,884	$209,569	$0	$439,521,965		
Service Management							
Base Service Management	$35,078,409	$17,539,204	$0	$0	$17,539,205	50.00%	
Accountable Care Collaborative	$87,418,600	$42,826,372	$0	$0	$44,592,228	51.01%	
Tobacco Quit Line	$1,264,880	$0	$619,665	$0	$645,215	51.01%	CF: Tobacco Education Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$2,938,736	$500,761	$0	$0	$2,437,975	82.96%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$71,607	$34,200	$0	$0	$37,407	52.24%	
MAGI Parents/Caretakers to 133% FPL	$10,397,853	$0	$0	$0	$10,397,853	100.00%	100% FFP January 1, 2014
MAGI Adults	$37,604,169	$0	$0	$0	$37,604,169	100.00%	100% FFP January 1, 2014
Disabled Buy-In	$166,926	$0	$85,810	$0	$81,116	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$59,906	$0	$29,348	$0	$30,558	51.01%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$684,238	$0	$335,208	$0	$349,030	51.01%	CF: Hospital Provider Fee Fund
Service Management Sub-Total	$175,685,324	$60,900,537	$1,070,031	$0	$113,714,756		
FY 2015-16 Estimate of Total Expenditures for Medical Services to Clients	**$5,357,531,551**	**$1,898,275,426**	**$71,743,376**	**$0**	**$3,387,512,749**		
Financing							
Upper Payment Limit Financing	$5,158,379	($5,239,181)	$5,158,379	$0	$5,239,181	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($18,933,877)	$45,514,128	$0	($26,580,251)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$6,408,699	$0	$3,204,350	$0	$3,204,349	50.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$820,149,821	$0	$401,791,397	$0	$418,358,424	51.01%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$96,096,822	$0	$47,077,833	$0	$49,018,989	51.01%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$5,619,125	($295,743)	$2,957,434	$0	$2,957,434	50.00%	CF: Certification of Public Expenditure
Memorial Hospital High Volume Payment	$5,562,375	$0	$2,781,187	$0	$2,781,188	50.00%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($64,951,999)	$64,951,999	$0	$0	N/A	CF: Health Care Expansion Fund
Intergovernmental Transfer for Difficult to Discharge Clients	$30,000,000	$0	$15,000,000	$0	$15,000,000	50.00%	CF: Intergovernmental Transfer
Cash Funds Financing[1]	$0	($23,500,439)	$23,500,439	$0	$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$968,995,221	($112,921,239)	$611,937,146	$0	$469,979,314		
Total Projected FY 2015-16 Expenditures[2]	**$6,326,526,772**	**$1,785,354,187**	**$683,680,522**	**$0**	**$3,857,492,063**		

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

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

(2) Of the General Fund total, $710,835,957 is General Fund Exempt.

Calculation of Fund Splits
FY 2016-17

Item	Total Request	General Fund and General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
Acute Care Services							
Base Acute	$2,281,648,134	$1,117,779,421	$0	$0	$1,163,868,713	51.01%	
Breast and Cervical Cancer Program	$976,876	$0	$334,971	$0	$641,905	65.71%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
Family Planning	$13,947,363	$1,365,736	$29,000	$0	$12,552,627	90.00%	CF: Local Funds
Indian Health Service	$1,647,198	$0	$0	$0	$1,647,198	100.00%	
Affordable Care Act Drug Rebate Offset	($18,736,045)	$0	$0	$0	($18,736,045)	0.00%	
Affordable Care Act Preventive Services	$36,744,646	$17,633,756	$0	$0	$19,110,890	52.01%	
SB 11-008: "Aligning Medicaid Eligibility for Children"	$79,365,127	$8,960,323	$0	$0	$70,404,804	88.71%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$19,034,727	$9,325,113	$0	$0	$9,709,614	51.01%	
MAGI Parents/Caretakers to 133% FPL	$157,794,346	$0	$3,944,859	$0	$153,849,487	97.50%	CF: Hospital Provider Fee Fund
MAGI Adults	$1,261,007,396	$0	$31,525,185	$0	$1,229,482,211	97.50%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$62,743,677	$0	$32,212,501	$0	$30,531,176	Variable	CF: Hospital Provider Fee Fund
Non-Newly Eligibles	$13,860,645	$0	$6,790,330	$0	$7,070,315	51.01%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$10,329,218	$0	$5,060,284	$0	$5,268,934	51.01%	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Adult Dental Benefit Financing	$62,123,393	$0	$30,434,252	$0	$31,689,141	Variable	CF: Adult Dental Fund
Acute Care Services Sub-Total	$3,982,486,701	$1,155,064,349	$110,331,382	$0	$2,717,090,970		
Community Based Long-Term Care Services							
Base Community Based Long-Term Care	$557,854,271	$273,292,807	$0	$0	$284,561,464	51.01%	
Children with Autism Waiver Services	$899,865	$0	$440,844	$0	$459,021	51.01%	CF: Colorado Autism Treatment Fund
MAGI Parents/Caretakers to 133% FPL	$216,504	$0	$5,413	$0	$211,091	97.50%	CF: Hospital Provider Fee Fund
MAGI Adults	$2,992,017	$0	$74,800	$0	$2,917,217	97.50%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$2,015,293	$0	$1,034,648	$0	$980,645	Variable	CF: Hospital Provider Fee and Disabled Buy-in Premiums
Non-Newly Eligibles	$197,840	$0	$96,922	$0	$100,918	51.01%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$0	$0	$0	$0	$0	51.01%	CF: Hospital Provider Fee Fund
Community Based Long-Term Care Sub-Total	$564,175,790	$273,292,807	$1,652,627	$0	$289,230,356		
Long-Term Care and Insurance							
Base Class I Nursing Facilities	$596,261,385	$292,108,453	$0	$0	$304,152,932	51.01%	
Class II Nursing Facilities	$4,989,438	$2,444,326	$0	$0	$2,545,112	51.01%	
PACE	$162,589,375	$79,652,535	$0	$0	$82,936,840	51.01%	
Supplemental Medicare Insurance Benefit (SMIB)	$151,957,328	$90,414,610	$0	$0	$61,542,718	50.00%*	Approximately 19% of total is State-Only
Health Insurance Buy-In	$3,211,651	$1,573,388	$0	$0	$1,638,263	51.01%	
MAGI Parents/Caretakers to 133% FPL	$0	$0	$0	$0	$0	97.50%	CF: Hospital Provider Fee Fund
MAGI Adults	$0	$0	$0	$0	$0	97.50%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$411,664	$0	$211,348	$0	$200,316	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$0	$0	$0	$0	$0	51.01%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$0	$0	$0	$0	$0	51.01%	CF: Hospital Provider Fee Fund
Long-Term Care and Insurance Sub-Total	$919,420,841	$466,193,312	$211,348	$0	$453,016,181		
Service Management							
Base Service Management	$37,412,024	$18,706,012	$0	$0	$18,706,012	50.00%	
Accountable Care Collaborative	$93,705,646	$45,906,396	$0	$0	$47,799,250	51.01%	
Tobacco Quit Line	$1,357,340	$0	$664,961	$0	$692,379	51.01%	CF: Tobacco Education Fund
SB 11-008: "Aligning Medicaid Eligibility for Children"	$3,016,542	$340,568	$0	$0	$2,675,974	88.71%	
SB 11-250: "Eligibility for Pregnant Women in Medicaid"	$73,570	$36,042	$0	$0	$37,528	51.01%	
MAGI Parents/Caretakers to 133% FPL	$11,359,334	$0	$283,983	$0	$11,075,351	97.50%	CF: Hospital Provider Fee Fund
MAGI Adults	$42,592,025	$0	$1,064,801	$0	$41,527,224	97.50%	CF: Hospital Provider Fee Fund
Disabled Buy-In	$172,501	$0	$88,561	$0	$83,940	Variable	CF: Hospital Provider Fee Fund and Medicaid Buy-in Fund
Non-Newly Eligibles	$61,104	$0	$29,935	$0	$31,169	51.01%	CF: Hospital Provider Fee Fund
MAGI Parents/Caretakers 60% to 68% FPL	$697,923	$0	$341,912	$0	$356,011	51.01%	CF: Hospital Provider Fee Fund
Service Management Sub-Total	$190,448,009	$64,989,018	$2,474,153	$0	$122,984,838		
FY 2016-17 Estimate of Total Expenditures for Medical Services to Clients	**$5,656,531,341**	**$1,959,539,486**	**$114,669,510**	**$0**	**$3,582,322,345**		
Financing							
Upper Payment Limit Financing	$5,222,722	($5,438,069)	$5,222,722	$0	$5,438,069	Variable	CF: Certification of Public Expenditure
Department Recoveries Adjustment	$0	($17,442,022)	$52,520,392	$0	($35,078,370)	50.00%	CF: Department Recoveries
Denver Health Outstationing	$6,408,699	$0	$3,204,350	$0	$3,204,349	50.00%	CF: Certification of Public Expenditure
Hospital Provider Fee Supplemental Payments	$820,149,821	$0	$401,791,397	$0	$418,358,424	51.01%	CF: Hospital Provider Fee Cash Fund
Nursing Facility Supplemental Payments	$99,585,137	$0	$48,786,759	$0	$50,798,378	51.01%	CF: Medicaid Nursing Facility Cash Fund
Physician Supplemental Payments	$5,619,125	($295,743)	$2,957,434	$0	$2,957,434	50.00%	CF: Certification of Public Expenditure
Memorial Hospital High Volume Payment	$5,562,375	$0	$2,781,187	$0	$2,781,188	50.00%	CF: Certification of Public Expenditure
Health Care Expansion Fund Transfer Adjustment	$0	($64,951,999)	$64,951,999	$0	$0	N/A	CF: Health Care Expansion Fund
Intergovernmental Transfer for Difficult to Discharge Clients	$30,000,000	$0	$15,000,000	$0	$15,000,000	50.00%	CF: Intergovernmental Transfer
Cash Funds Financing[1]	$0	($23,371,853)	$23,371,853	$0	$0	N/A	CF: Various, see Narrative
Financing Sub-Total	$972,547,879	($111,499,686)	$620,588,093	$0	$463,459,472		
Total Projected FY 2016-17 Expenditures[2]	**$6,629,079,220**	**$1,848,039,800**	**$735,257,603**	**$0**	**$4,045,781,817**		

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

(1) This line adjusts for transfers from cash funds to the General Fund as provided by for the special bills listed on page EA-2.

(2) Of the General Fund total, $710,835,957 is General Fund Exempt.. Add footnote about 97.5% FMAP Change

(3) On January 1, 2017 The ACA expansion Federal Match decreases from a 100% Federal Match rate to 95% Federal Match rate.

Exhibit B - Medicaid Caseload

Final Request

Official Medicaid Caseload Actuals and Projection without Retroactivity from REX01/COLD (MARS) 474701 Report

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 1996-97 Actuals	32,080	4,429	46,090	-	33,250	-	-	-	110,586	-	9,261	5,476	-	4,610	4,316	250,098
FY 1997-98 Actuals	32,664	4,496	46,003	-	27,179	-	-	-	103,912	-	10,453	4,295	-	5,032	4,560	238,594
% Change from FY 1996-97	1.82%	1.51%	-0.19%	-	-18.26%	-	-	-	-6.04%	-	12.87%	-21.57%	-	9.15%	5.65%	-4.60%
FY 1998-99 Actuals	33,007	4,909	46,310	-	22,852	-	-	-	102,074	-	11,526	5,017	-	5,799	6,104	237,598
% Change from FY 1997-98	1.05%	9.19%	0.67%	-	-15.92%	-	-	-	-1.77%	-	10.26%	16.81%	-	15.24%	33.86%	-0.42%
FY 1999-00 Actuals	33,135	5,092	46,386	-	23,515	-	-	-	109,816	-	12,474	6,174	-	9,065	7,597	253,254
% Change from FY 1998-99	0.39%	3.73%	0.16%	-	2.90%	-	-	-	7.58%	-	8.22%	23.06%	-	56.32%	24.46%	6.59%
FY 2000-01 Actuals	33,649	5,157	46,046	-	27,081	-	-	-	123,221	-	13,076	6,561	-	12,451	8,157	275,399
% Change from FY 1999-00	1.55%	1.28%	-0.73%	-	15.16%	-	-	-	12.21%	-	4.83%	6.27%	-	37.35%	7.37%	8.74%
FY 2001-02 Actuals	33,916	5,184	46,349	-	33,347	-	-	-	143,909	-	13,121	7,131	-	4,028	8,428	295,413
% Change from FY 2000-01	0.79%	0.52%	0.66%	-	23.14%	-	-	-	16.79%	-	0.34%	8.69%	-	-67.65%	3.32%	7.27%
FY 2002-03 Actuals	34,704	5,431	46,647	-	40,798	-	-	47	169,311	-	13,967	7,823	-	4,084	8,988	331,800
% Change from FY 2001-02	2.32%	4.76%	0.64%	-	22.34%	-	-	-	17.65%	-	6.45%	9.70%	-	1.39%	6.64%	12.32%
FY 2003-04 Actuals	34,329	5,548	46,789	-	47,562	-	-	105	195,279	-	14,914	8,398	-	4,793	9,842	367,559
% Change from FY 2002-03	-1.08%	2.15%	0.30%	-	16.58%	-	-	123.40%	15.34%	-	6.78%	7.35%	-	17.36%	9.50%	10.78%
FY 2004-05 Actuals	35,780	6,082	47,929	-	57,140	-	-	87	222,472	-	15,795	5,984	-	5,150	9,605	406,024
% Change from FY 2003-04	4.23%	9.63%	2.44%	-	20.14%	-	-	-17.14%	13.93%	-	5.91%	-28.74%	-	7.45%	-2.41%	10.46%
FY 2005-06 Actuals	36,207	6,042	47,855	-	58,885	-	-	188	214,158	-	16,460	5,119	-	6,212	11,092	402,218
% Change from FY 2004-05	1.19%	-0.66%	-0.15%	-	3.05%	-	-	116.09%	-3.74%	-	4.21%	-14.46%	-	20.62%	15.48%	-0.94%
FY 2006-07 Actuals	35,888	6,059	48,799	-	55,850	-	-	228	205,390	-	16,724	5,182	-	5,201	12,908	392,229
% Change from FY 2005-06	-0.88%	0.28%	1.97%	-	-5.15%	-	-	21.28%	-4.09%	-	1.60%	1.23%	-	-16.27%	16.37%	-2.48%
FY 2007-08 Actuals	36,284	6,146	49,933	-	53,473	-	-	270	204,022	-	17,141	6,288	-	4,191	14,214	391,962
% Change from FY 2006-07	1.10%	1.44%	2.32%	-	-4.26%	-	-	18.42%	-0.67%	-	2.49%	21.34%	-	-19.42%	10.12%	-0.07%
FY 2008-09 Actuals	37,619	6,447	51,355	-	61,874	-	-	317	235,129	-	18,033	6,976	-	3,987	15,075	436,812
% Change from FY 2007-08	3.68%	4.90%	2.85%	-	15.71%	-	-	17.41%	15.25%	-	5.20%	10.94%	-	-4.87%	6.06%	11.44%
FY 2009-10 Actuals	38,487	7,049	53,264	-	74,839	3,238	-	425	275,672	-	18,381	7,830	-	3,693	15,919	498,797
% Change from FY 2008-09	2.31%	9.34%	3.72%	-	20.95%	-	-	34.07%	17.24%	-	1.93%	12.24%	-	-7.37%	5.60%	14.19%
FY 2010-11 Actuals	38,879	7,767	56,285	-	81,114	27,167	-	531	302,410	-	18,393	7,868	-	3,213	17,090	560,717
% Change from FY 2009-10	1.02%	10.19%	5.67%	-	8.38%	739.01%	-	24.94%	9.70%	-	0.07%	0.49%	-	-13.00%	7.36%	12.41%
FY 2011-12 Actuals	39,740	8,383	59,434	52	93,224	35,461	1,134	597	334,633	-	18,034	7,630	-	2,770	18,871	619,963
% Change from FY 2010-11	2.21%	7.93%	5.59%	-	14.93%	30.53%	-	12.43%	10.66%	-	-1.95%	-3.02%	-	-13.79%	10.42%	10.57%
FY 2012-13 Actuals	40,827	9,051	61,920	888	99,392	41,545	10,634	623	359,843	8,236	17,777	8,024	344	2,684	21,206	682,994
% Change from FY 2011-12	2.74%	7.97%	4.18%	1607.69%	6.62%	17.16%	837.74%	4.36%	7.53%	-	-1.43%	5.16%	-	-3.10%	12.37%	10.17%
FY 2013-14 Actuals	41,836	9,853	64,424	2,560	124,680	47,082	87,243	559	397,362	27,015	18,267	13,160	1,057	2,481	23,378	860,957
% Change from FY 2012-13	2.47%	8.86%	4.04%	188.29%	25.44%	13.33%	720.42%	-10.27%	10.43%	228.01%	2.76%	64.01%	207.64%	-7.56%	10.24%	26.06%
FY 2014-15 Projection	41,932	10,838	66,648	3,700	155,667	64,563	223,775	368	439,097	52,304	20,614	15,124	1,767	2,808	27,261	1,126,466
% Change from FY 2013-14	0.23%	10.00%	3.45%	44.53%	24.85%	37.13%	156.50%	-34.17%	10.50%	93.61%	12.85%	14.92%	67.17%	13.18%	16.61%	30.84%
FY 2015-16 Projection	43,060	11,442	69,042	4,359	170,935	70,573	255,924	169	468,884	56,726	20,920	15,333	1,971	2,742	29,785	1,221,865
% Change from FY 2014-15	2.69%	5.57%	3.59%	17.81%	9.81%	9.31%	14.37%	-54.08%	6.78%	8.45%	1.48%	1.38%	11.54%	-2.35%	9.26%	8.47%
FY 2016-17 Projection	44,025	11,975	71,205	4,951	187,003	76,305	286,845	59	498,180	61,422	21,204	15,503	2,120	2,677	32,600	1,316,074
% Change from FY 2015-16	2.24%	4.66%	3.13%	13.58%	9.40%	8.12%	12.08%	-65.09%	6.25%	8.28%	1.36%	1.11%	7.56%	-2.37%	9.45%	7.71%
FY 2014-15 Appropriation	43,419	10,537	67,688	3,653	125,572	68,592	163,808	464	431,244	27,093	18,248	14,346	2,119	2,473	24,820	1,004,076
Difference between the Total FY 2014-15 Projection and Appropriation	(1,487)	301	(1,040)	47	30,095	(4,029)	59,967	(96)	7,853	25,211	2,366	778	(352)	335	2,441	122,390

(1) In February 2014, the Department merged Categorically Eligible Low-Income Adults (AFDC-A) and Expansion Adults to 60% FPL. The Eligible Children's and Baby Care Adults Categories were split into four categories. The new categories are Eligible children, SB 11-008 Eligible Children, MAGI Pregnant Adults, and SB 11-250 Eligible Pregnant Adults.

Exhibit B - Medicaid Caseload

Medicaid Caseload Adjustments																
Item	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
SB 13-200 Medicaid Expansion	-	-	-	-	-	7,144	68,564	-	-	-	432	-	-	184	-	76,324
SB 13-200 EBNE	-	-	-	-	4,802	1,813	-	-	10,190	693	-	-	-	-	-	17,498
MAGI Effects	-	-	-	-	10,062	(10,062)	-	-	-	-	-	-	-	-	-	-
HB 14-1045 Breast and Cervical Cancer Program	-	-	-	-	-	-	-	12	-	-	-	-	-	-	-	12
BCCP Site Expansion	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total FY 2013-14 Adjustments	-	-	-	-	14,864	(1,105)	68,564	12	10,190	693	432	-	-	184	-	93,834
SB 13-200 Medicaid Expansion	-	-	-	-	-	21,849	204,525	-	-	-	2,035	-	-	430	-	228,839
SB 13-200 EBNE	-	-	-	-	7,785	2,727	-	-	15,066	1,774	-	-	-	-	-	27,352
MAGI Effects	-	-	-	-	14,357	(14,357)	-	-	-	-	-	-	-	-	-	-
HB 14-1045 Breast and Cervical Cancer Program	-	-	-	-	-	-	-	38	-	-	-	-	-	-	-	38
BCCP Site Expansion	-	-	-	-	-	-	-	3	-	-	-	-	-	-	-	3
HB 09-1353 - Removing 5 Year Bar on Legal Immigrants Implementation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SLS & DD Waitlist Reduction	-	-	523	-	-	-	-	-	-	-	-	-	-	-	-	523
Total FY 2014-15 Adjustments	-	-	523	-	22,142	10,219	204,525	41	15,066	1,774	2,035	-	-	430	-	256,755
SB 13-200 Medicaid Expansion	-	-	-	-	-	23,898	236,674	-	-	-	2,101	-	-	449	-	263,122
SB 13-200 EBNE	-	-	-	-	8,549	2,983	-	-	16,112	2,059	-	-	-	-	-	29,703
MAGI Effects	-	-	-	-	15,749	(15,749)	-	-	-	-	-	-	-	-	-	-
HB 14-1045 Breast and Cervical Cancer Program	-	-	-	-	-	-	-	42	-	-	-	-	-	-	-	42
BCCP Site Expansion	-	-	-	-	-	-	-	12	-	-	-	-	-	-	-	12
HB 09-1353 - Removing 5 Year Bar on Legal Immigrants Implementation	-	-	-	-	-	-	-	-	1,518	181	-	-	-	-	-	1,699
SLS & DD Waitlist Reduction	-	-	821	-	-	-	-	-	-	-	-	-	-	-	-	821
Total FY 2015-16 Adjustments	-	-	821	-	24,298	11,132	236,674	54	17,630	2,240	2,101	-	-	449	-	295,399
SB 13-200 Medicaid Expansion	-	-	-	-	-	25,882	267,595	-	-	-	2,161	-	-	469	-	296,107
SB 13-200 EBNE	-	-	-	-	9,355	3,231	-	-	17,125	2,390	-	-	-	-	-	32,101
MAGI Effects	-	-	-	-	17,183	(17,183)	-	-	-	-	-	-	-	-	-	-
HB 14-1045 Breast and Cervical Cancer Program	-	-	-	-	-	-	-	47	-	-	-	-	-	-	-	47
BCCP Site Expansion	-	-	-	-	-	-	-	12	-	-	-	-	-	-	-	12
HB 09-1353 - Removing 5 Year Bar on Legal Immigrants Implementation	-	-	-	-	-	-	-	-	2,320	280	-	-	-	-	-	2,600
SLS & DD Waitlist Reduction	-	-	821	-	-	-	-	-	-	-	-	-	-	-	-	821
Total FY 2016-17 Adjustments	-	-	821	-	26,538	11,930	267,595	59	19,445	2,670	2,161	-	-	469	-	331,688

Exhibit B - Medicaid Caseload

Prior to Adjustments - Not Official Department Request

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

Prior to Adjustments

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 1996-97 Actuals	32,080	4,429	46,090	-	33,250	-	-	-	110,586	-	9,261	5,476	-	4,610	4,316	250,098
FY 1997-98 Actuals	32,664	4,496	46,003	-	27,179	-	-	-	103,912	-	10,453	4,295	-	5,032	4,560	238,594
% Change from FY 1996-97	1.82%	1.51%	-0.19%	-	0	-	-	-	0	-	12.87%	-21.57%	-	9.15%	5.65%	-4.60%
FY 1998-99 Actuals	33,007	4,909	46,310	-	22,852	-	-	-	102,074	-	11,526	5,017	-	5,799	6,104	237,598
% Change from FY 1997-98	1.05%	9.19%	0.67%	-	0	-	-	-	0	-	10.26%	16.81%	-	15.24%	33.86%	-0.42%
FY 1999-00 Actuals	33,135	5,092	46,386	-	23,515	-	-	-	109,816	-	12,474	6,174	-	9,065	7,597	253,254
% Change from FY 1998-99	0.39%	3.73%	0.16%	-	0	-	-	-	0	-	8.22%	23.06%	-	56.32%	24.46%	6.59%
FY 2000-01 Actuals	33,649	5,157	46,046	-	27,081	-	-	-	123,221	-	13,076	6,561	-	12,451	8,157	275,399
% Change from FY 1999-00	1.55%	1.28%	-0.73%	-	0	-	-	-	0	-	4.83%	6.27%	-	37.35%	7.37%	8.74%
FY 2001-02 Actuals	33,916	5,184	46,349	-	33,347	-	-	-	143,909	-	13,121	7,131	-	4,028	8,428	295,413
% Change from FY 2000-01	0.79%	0.52%	0.66%	-	0	-	-	-	0	-	0.34%	8.69%	-	-67.65%	3.32%	7.27%
FY 2002-03 Actuals	34,704	5,431	46,647	-	40,798	-	-	47	169,311	-	13,967	7,823	-	4,084	8,988	331,800
% Change from FY 2001-02	2.32%	4.76%	0.64%	-	0	-	-	-	0	-	6.45%	9.70%	-	1.39%	6.64%	12.32%
FY 2003-04 Actuals	34,329	5,548	46,789	-	47,562	-	-	105	195,279	-	14,914	8,398	-	4,793	9,842	367,559
% Change from FY 2002-03	-1.08%	2.15%	0.30%	-	0	-	-	1	0	-	6.78%	7.35%	-	17.36%	9.50%	10.78%
FY 2004-05 Actuals	35,780	6,082	47,929	-	57,140	-	-	87	222,472	-	15,795	5,984	-	5,150	9,605	406,024
% Change from FY 2003-04	4.23%	9.63%	2.44%	-	0	-	-	0	0	-	5.91%	-28.74%	-	7.45%	-2.41%	10.46%
FY 2005-06 Actuals	36,207	6,042	47,855	-	58,885	-	-	188	214,158	-	16,460	5,119	-	6,212	11,092	402,218
% Change from FY 2004-05	1.19%	-0.66%	-0.15%	-	0	-	-	1	0	-	4.21%	-14.46%	-	20.62%	15.48%	-0.94%
FY 2006-07 Actuals	35,888	6,059	48,799	-	55,850	-	-	228	205,390	-	16,724	5,182	-	5,201	12,908	392,229
% Change from FY 2005-06	-0.88%	0.28%	1.97%	-	0	-	-	0	0	-	1.60%	1.23%	-	-16.27%	16.37%	-2.48%
FY 2007-08 Actuals	36,284	6,146	49,933	-	53,473	-	-	270	204,022	-	17,141	6,288	-	4,191	14,214	391,962
% Change from FY 2006-07	1.10%	1.44%	2.32%	-	0	-	-	0	0	-	2.49%	21.34%	-	-19.42%	10.12%	-0.07%
FY 2008-09 Actuals	37,619	6,447	51,355	-	61,874	-	-	317	235,129	-	18,033	6,976	-	3,987	15,075	436,812
% Change from FY 2007-08	3.68%	4.90%	2.85%	-	0	-	-	17.41%	0	-	5.20%	10.94%	-	-4.87%	6.06%	11.44%
FY 2009-10 Actuals	38,487	7,049	53,264	-	74,839	3,238	-	425	275,672	-	18,381	7,830	-	3,693	15,919	498,797
% Change from FY 2008-09	2.31%	9.34%	3.72%	-	0	-	-	34.07%	0	-	1.93%	12.24%	-	-7.37%	5.60%	14.19%
FY 2010-11 Actuals	38,879	7,767	56,285	-	81,114	27,167	-	531	302,410	-	18,393	7,868	-	3,213	17,090	560,717
% Change from FY 2009-10	1.02%	10.19%	5.67%	-	8.38%	739.01%	-	24.94%	9.70%	-	0.07%	0.49%	-	-13.00%	7.36%	12.41%
FY 2011-12 Actuals	39,740	8,383	59,434	52	93,224	35,461	1,134	597	334,633	-	18,034	7,630	-	2,770	18,871	619,963
% Change from FY 2010-11	2.21%	7.93%	5.59%	-	14.93%	30.53%	-	12.43%	10.66%	-	-1.95%	-3.02%	-	-13.79%	10.42%	10.57%
FY 2012-13 Actuals	40,827	9,051	61,920	888	99,392	41,545	10,634	623	359,843	8,236	17,777	8,024	344	2,684	21,206	682,994
% Change from FY 2011-12	2.74%	7.97%	4.18%	1607.69%	6.62%	17.16%	837.74%	4.36%	7.53%	-	-1.43%	5.16%	-	-3.10%	12.37%	10.17%
FY 2013-14 Actuals	41,836	9,853	64,424	2,560	109,816	48,187	18,679	547	387,172	26,322	17,835	13,160	1,057	2,297	23,378	767,123
% Change from FY 2012-13	2.47%	8.86%	4.04%	188.29%	10.49%	15.99%	75.65%	-12.20%	7.59%	219.60%	0.33%	64.01%	207.64%	-14.42%	10.24%	12.32%
FY 2014-15 Projection	41,932	10,838	66,125	3,700	133,525	54,344	19,250	327	424,031	50,530	18,579	15,124	1,767	2,378	27,261	869,711
% Change from FY 2013-14	0.23%	10.00%	2.64%	44.52%	21.59%	12.78%	3.06%	-40.18%	9.52%	91.97%	4.17%	14.92%	67.17%	3.53%	16.61%	27.34%
FY 2015-16 Projection	43,060	11,442	68,221	4,359	146,637	59,441	19,250	115	451,254	54,486	18,819	15,333	1,971	2,293	29,785	926,466
% Change from FY 2014-15	2.69%	5.57%	3.17%	17.81%	9.82%	9.38%	0.00%	-64.83%	6.42%	7.83%	1.29%	1.38%	11.54%	-3.57%	9.26%	6.53%
FY 2016-17 Projection	44,025	11,975	70,384	4,951	160,465	64,375	19,250	0	478,735	58,752	19,043	15,503	2,120	2,208	32,600	984,386
% Change from FY 2015-16	2.24%	4.66%	3.17%	13.58%	9.43%	8.30%	0.00%	-100.00%	6.09%	7.83%	1.19%	1.11%	7.56%	-3.71%	9.45%	6.25%
FY 2014-15 Appropriation	43,419	10,537	67,132	2,705	120,314	56,375	19,250	667	402,388	27,093	17,695	9,441	2,119	2,381	24,820	806,336
Difference between the Total FY 2014-15 Projection and Appropriation	(1,487)	301	(1,007)	995	13,211	(2,031)	0	(340)	21,643	23,437	884	5,683	(352)	(3)	2,441	63,375

[1] Medicaid Caseload forecast without adjustments.

Exhibit B - Medicaid Caseload Forecast

MEDICAID CASELOAD FY 2006-07 without RETROACTIVITY																		
FY 2006-07	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2006	36,264	5,927	48,080	-	58,380	-	-	202	215,937	-	16,499	5,074	-	6,703	12,145	405,211	-	-
August 2006	36,356	5,989	48,443	-	58,084	-	-	211	216,226	-	16,574	4,852	-	6,364	12,316	405,415	204	0.05%
September 2006	36,113	6,032	48,576	-	57,484	-	-	220	214,255	-	16,524	4,761	-	6,011	12,443	402,419	(2,996)	-0.74%
October 2006	36,088	6,067	48,747	-	58,063	-	-	226	209,565	-	16,576	4,950	-	5,761	12,536	398,579	(3,840)	-0.95%
November 2006	35,939	6,113	48,736	-	56,313	-	-	232	205,572	-	16,554	5,002	-	5,226	12,693	392,380	(6,199)	-1.56%
December 2006	36,195	6,141	48,498	-	55,325	-	-	236	202,812	-	16,595	5,070	-	4,864	12,879	388,615	(3,765)	-0.96%
January 2007	35,947	6,102	48,829	-	55,748	-	-	231	202,963	-	16,683	5,181	-	4,798	12,905	389,387	772	0.20%
February 2007	35,929	6,116	48,948	-	55,347	-	-	228	202,656	-	16,761	5,353	-	4,690	13,060	389,088	(299)	-0.08%
March 2007	35,664	6,064	49,044	-	54,842	-	-	228	201,549	-	16,849	5,422	-	4,514	13,213	387,389	(1,699)	-0.44%
April 2007	35,526	6,083	48,903	-	54,747	-	-	241	200,833	-	16,962	5,526	-	4,547	13,547	386,915	(474)	-0.12%
May 2007	35,186	6,028	49,337	-	53,287	-	-	236	196,757	-	17,007	5,437	-	4,501	13,493	381,269	(5,646)	-1.46%
June 2007	35,448	6,048	49,449	-	52,574	-	-	246	195,549	-	17,100	5,561	-	4,437	13,669	380,081	(1,188)	-0.31%
Year-to-Date Average	**35,888**	**6,059**	**48,799**	**-**	**55,850**	**-**	**-**	**228**	**205,390**	**-**	**16,724**	**5,182**	**-**	**5,201**	**12,908**	**392,229**		
MEDICAID CASELOAD FY 2007-08 without RETROACTIVITY																		
FY 2007-08	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2007	35,532	6,073	49,590	-	52,726	-	-	255	197,420	-	17,003	5,551	-	4,475	13,821	382,446	2,365	0.62%
August 2007	35,624	6,091	49,768	-	52,550	-	-	260	198,001	-	16,915	5,691	-	4,330	13,988	383,218	772	0.20%
September 2007	35,916	6,124	49,743	-	51,899	-	-	267	197,134	-	16,877	5,448	-	4,148	14,064	381,620	(1,598)	-0.42%
October 2007	36,104	6,141	49,853	-	53,700	-	-	273	201,710	-	16,968	5,479	-	4,136	14,105	388,469	6,849	1.79%
November 2007	36,059	6,127	49,889	-	53,464	-	-	261	201,378	-	16,995	5,759	-	4,069	14,144	388,145	(324)	-0.08%
December 2007	36,126	6,150	49,741	-	52,448	-	-	268	200,121	-	17,042	5,896	-	4,032	14,028	385,852	(2,293)	-0.59%
January 2008	36,329	6,158	49,785	-	52,759	-	-	268	201,816	-	17,050	6,233	-	4,007	14,066	388,471	2,619	0.68%
February 2008	36,418	6,128	49,891	-	53,099	-	-	272	203,657	-	17,117	6,827	-	4,026	14,212	391,647	3,176	0.82%
March 2008	36,702	6,145	49,989	-	53,672	-	-	282	206,695	-	17,208	7,035	-	4,130	14,333	396,191	4,544	1.16%
April 2008	36,771	6,188	50,237	-	54,432	-	-	280	210,620	-	17,358	7,142	-	4,178	14,479	401,685	5,494	1.39%
May 2008	36,897	6,203	50,358	-	55,124	-	-	280	213,554	-	17,537	7,191	-	4,371	14,628	406,143	4,458	1.11%
June 2008	36,932	6,227	50,351	-	55,797	-	-	270	216,154	-	17,620	7,200	-	4,389	14,700	409,640	3,497	0.86%
Year-to-Date Average	**36,284**	**6,146**	**49,933**	**-**	**53,473**	**-**	**-**	**270**	**204,022**	**-**	**17,141**	**6,288**	**-**	**4,191**	**14,214**	**391,961**		
MEDICAID CASELOAD FY 2008-09 without RETROACTIVITY																		
FY 2008-09	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**	**Monthly Growth**	**Monthly Growth Rate**
July 2008	36,961	6,249	50,565	-	56,554	-	-	277	218,619	-	17,588	7,286	-	4,258	14,768	413,125	3,485	0.85%
August 2008	37,127	6,317	50,671	-	57,289	-	-	283	221,736	-	17,761	7,270	-	4,136	14,821	417,411	4,286	1.04%
September 2008	37,273	6,369	50,864	-	57,893	-	-	275	223,167	-	17,736	7,027	-	4,052	14,898	419,554	2,143	0.51%
October 2008	37,441	6,386	51,201	-	58,425	-	-	282	225,486	-	17,864	6,932	-	4,005	14,933	422,955	3,401	0.81%
November 2008	37,591	6,399	51,406	-	59,021	-	-	290	228,186	-	17,977	6,773	-	3,889	14,980	426,512	3,557	0.84%
December 2008	37,530	6,361	51,298	-	60,184	-	-	304	230,447	-	18,033	6,689	-	3,884	15,053	429,783	3,271	0.77%
January 2009	37,814	6,367	51,452	-	61,641	-	-	314	234,744	-	18,022	6,847	-	3,954	15,194	436,349	6,566	1.53%
February 2009	37,769	6,438	51,494	-	62,753	-	-	331	237,345	-	18,144	6,910	-	3,885	15,205	440,274	3,925	0.90%
March 2009	37,942	6,539	51,640	-	64,720	-	-	339	242,805	-	18,265	6,959	-	3,988	15,293	448,490	8,216	1.87%
April 2009	37,947	6,597	51,695	-	67,086	-	-	355	249,444	-	18,328	6,995	-	3,984	15,268	457,699	9,209	2.05%
May 2009	37,989	6,654	51,862	-	67,753	-	-	373	252,943	-	18,327	6,973	-	3,919	15,240	462,033	4,334	0.95%
June 2009	38,044	6,691	52,107	-	69,167	-	-	383	256,630	-	18,348	7,045	-	3,892	15,249	467,556	5,523	1.20%
Year-to-Date Average	**37,619**	**6,447**	**51,355**	**-**	**61,874**	**-**	**-**	**317**	**235,129**	**-**	**18,033**	**6,976**	**-**	**3,987**	**15,075**	**436,812**		

Exhibit B - Medicaid Caseload Forecast

MEDICAID CASELOAD FY 2009-10 without RETROACTIVITY

FY 2009-10	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2009	38,058	6,774	52,315	-	70,356	-	-	393	259,609	-	18,285	7,745	-	3,930	15,434	472,899	5,343	1.14%
August 2009	38,306	6,863	52,573	-	71,467	-	-	395	263,415	-	18,325	7,849	-	3,835	15,522	478,550	5,651	1.19%
September 2009	38,346	6,945	52,710	-	72,192	-	-	402	266,381	-	18,200	7,775	-	3,724	15,513	482,188	3,638	0.76%
October 2009	38,480	6,985	52,847	-	73,474	-	-	406	270,514	-	18,169	7,713	-	3,650	15,638	487,876	5,688	1.18%
November 2009	38,387	6,986	52,982	-	73,957	-	-	418	272,453	-	17,992	7,674	-	3,644	15,743	490,236	2,360	0.48%
December 2009	38,410	7,025	53,000	-	75,120	-	-	411	275,867	-	18,371	7,627	-	3,632	15,846	495,309	5,073	1.03%
January 2010	38,452	7,047	53,255	-	76,403	-	-	416	279,000	-	18,400	7,796	-	3,610	15,954	500,333	5,024	1.01%
February 2010	38,432	7,049	53,298	-	77,214	-	-	431	279,898	-	18,467	7,779	-	3,550	16,076	502,194	1,861	0.37%
March 2010	38,597	7,152	53,629	-	79,286	-	-	449	283,625	-	18,486	7,996	-	3,768	16,212	509,200	7,006	1.40%
April 2010	38,727	7,212	53,904	-	80,192	-	-	452	285,746	-	18,552	8,054	-	3,831	16,308	512,978	3,778	0.74%
May 2010	38,754	7,228	54,164	-	75,804	18,253	-	455	285,779	-	18,651	8,039	-	3,615	16,285	527,027	14,049	2.74%
June 2010	38,900	7,326	54,493	-	72,608	20,607	-	466	285,778	-	18,678	7,903	-	3,522	16,495	526,776	(251)	-0.05%
Year-to-Date Average	**38,487**	**7,049**	**53,264**	**-**	**74,839**	**3,238**	**-**	**425**	**275,672**	**-**	**18,381**	**7,829**	**-**	**3,693**	**15,919**	**498,797**		

MEDICAID CASELOAD FY 2010-11 without RETROACTIVITY

FY 2010-11	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2010	39,382	7,395	54,740	-	73,769	21,446	-	471	287,674	-	18,628	7,909	-	3,492	16,539	531,445	4,669	0.89%
August 2010	38,648	7,492	55,032	-	75,863	24,193	-	493	290,871	-	18,455	8,014	-	3,378	16,634	539,073	7,628	1.44%
September 2010	38,774	7,562	55,223	-	76,255	25,071	-	503	291,592	-	18,451	7,971	-	3,231	16,652	541,285	2,212	0.41%
October 2010	38,901	7,602	55,508	-	77,291	26,016	-	505	294,155	-	18,464	7,985	-	3,080	16,794	546,301	5,016	0.93%
November 2010	39,009	7,682	55,804	-	78,278	26,924	-	511	296,482	-	18,597	7,891	-	3,049	16,941	551,168	4,867	0.89%
December 2010	38,769	7,721	55,937	-	79,773	27,596	-	526	299,499	-	18,510	7,764	-	3,023	17,002	556,120	4,952	0.90%
January 2011	38,813	7,781	56,417	-	82,824	27,188	-	532	304,042	-	18,386	7,806	-	3,116	17,210	564,115	7,995	1.44%
February 2011	38,823	7,870	56,671	-	83,547	28,323	-	535	307,032	-	18,200	7,677	-	3,161	17,249	569,088	4,973	0.88%
March 2011	38,939	7,966	57,103	-	85,574	28,968	-	556	312,300	-	18,244	7,881	-	3,271	17,390	578,192	9,104	1.60%
April 2011	38,861	7,987	57,385	-	85,763	29,451	-	569	312,603	-	18,280	7,864	-	3,274	17,399	579,436	1,244	0.22%
May 2011	38,981	8,051	57,608	-	86,596	30,102	-	587	315,116	-	18,279	7,830	-	3,255	17,546	583,951	4,515	0.78%
June 2011	39,154	8,089	57,986	-	87,827	30,724	-	589	317,551	-	18,221	7,828	-	3,229	17,727	588,925	4,974	0.85%
Year-to-Date Average	**38,921**	**7,767**	**56,285**	**-**	**81,113**	**27,167**	**-**	**531**	**302,410**	**-**	**18,393**	**7,868**	**-**	**3,213**	**17,090**	**560,759**	**5,179**	**0.94%**

MEDICAID CASELOAD FY 2011-12 without RETROACTIVITY

FY 2011-12	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2011	39,341	8,133	58,294	-	87,556	31,920	-	587	319,065	-	18,125	7,810	-	3,089	17,923	591,843	2,918	0.50%
August 2011	39,537	8,222	58,712	-	88,518	32,462	-	586	322,779	-	18,084	7,786	-	2,973	18,046	597,705	5,862	0.99%
September 2011	39,600	8,280	58,937	-	90,001	33,152	-	590	325,673	-	18,119	7,628	-	2,774	18,156	602,910	5,205	0.87%
October 2011	39,697	8,328	59,159	-	91,662	33,838	-	592	328,632	-	18,096	7,558	-	2,657	18,314	608,533	5,623	0.93%
November 2011	39,789	8,343	59,298	-	92,441	34,915	-	602	332,183	-	18,077	7,371	-	2,543	18,584	614,146	5,613	0.92%
December 2011	39,843	8,355	59,384	-	94,778	34,886	-	606	336,053	-	18,172	7,333	-	2,591	18,798	620,799	6,653	1.08%
January 2012	39,742	8,373	59,709	-	93,523	35,481	-	603	336,096	-	17,968	7,445	-	2,617	18,985	620,542	(257)	-0.04%
February 2012	39,800	8,401	59,635	-	94,868	35,962	-	604	339,523	-	17,863	7,594	-	2,636	19,220	626,106	5,564	0.90%
March 2012	39,849	8,445	59,847	51	97,318	37,141	-	604	341,274	-	17,930	7,734	-	2,852	19,466	632,511	6,405	1.02%
April 2012	39,837	8,507	59,970	133	94,317	37,902	-	596	341,546	-	17,944	7,705	-	2,846	19,396	630,699	(1,812)	-0.29%
May 2012	39,924	8,600	60,167	202	95,581	38,955	5,860	597	344,523	-	18,012	7,744	-	2,844	19,640	642,649	11,950	1.89%
June 2012	39,923	8,605	60,091	240	98,120	38,921	7,753	601	348,253	-	18,022	7,846	-	2,818	19,929	651,122	8,473	1.32%
Year-to-Date Average	**39,740**	**8,383**	**59,434**	**52**	**93,224**	**35,461**	**1,134**	**597**	**334,633**	**-**	**18,034**	**7,630**	**-**	**2,770**	**18,871**	**619,964**	**5,183**	**0.84%**

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

(1) Due to rounding, the average monthly totals may differ slightly from annual totals reported elsewhere.

Exhibit B - Medicaid Caseload Forecast

MEDICAID CASELOAD FY 2012-13 without RETROACTIVITY

FY 2012-13	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2012	40,117	8,689	60,389	338	93,088	38,961	9,652	607	348,510	-	17,959	7,824	-	2,764	20,117	649,015	(2,107)	-0.32%
August 2012	40,460	8,771	60,680	445	94,777	39,881	9,675	612	351,537	-	17,932	7,864	-	2,744	20,418	655,796	6,781	1.04%
September 2012	40,468	8,877	60,934	539	95,151	39,689	9,880	610	355,312	-	18,004	7,677	-	2,609	20,615	660,365	4,569	0.70%
October 2012	40,773	8,949	61,303	640	96,113	40,302	9,969	615	353,524	-	18,000	7,691	-	2,569	20,766	661,214	849	0.13%
November 2012	41,059	8,997	61,571	753	98,333	41,895	9,972	615	356,897	-	17,967	7,600	-	2,546	20,998	669,203	7,989	1.21%
December 2012	41,034	9,077	61,699	857	97,784	40,442	9,798	616	361,446	-	17,898	7,466	-	2,541	21,221	671,879	2,676	0.40%
January 2013	41,066	9,096	61,803	988	99,404	40,895	9,777	613	361,220	5,223	17,720	8,250	437	2,655	21,366	680,513	8,634	1.29%
February 2013	41,093	9,152	62,245	1,056	101,305	42,236	9,959	608	362,024	13,463	17,673	8,322	531	2,666	21,532	693,865	13,352	1.96%
March 2013	40,697	9,130	62,485	1,125	100,247	42,110	9,621	618	363,012	18,263	17,619	8,311	636	2,733	21,530	698,137	4,272	0.62%
April 2013	40,898	9,222	62,976	1,232	101,576	42,997	12,076	639	364,317	20,016	17,598	8,477	730	2,798	21,738	707,290	9,153	1.31%
May 2013	41,108	9,295	63,416	1,318	106,147	45,535	12,462	659	366,710	21,546	17,257	8,346	938	2,848	22,000	719,585	12,295	1.74%
June 2013	41,153	9,358	63,540	1,368	108,773	43,600	14,772	659	373,604	20,327	17,691	8,457	863	2,739	22,170	729,074	9,489	1.32%
Year-to-Date Average	**40,827**	**9,051**	**61,920**	**888**	**99,392**	**41,545**	**10,634**	**623**	**359,843**	**8,237**	**17,777**	**8,024**	**345**	**2,684**	**21,206**	**682,995**	**6,496**	**0.95%**

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

MEDICAID CASELOAD FY 2013-14 without RETROACTIVITY

FY 2013-14	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL	Monthly Growth	Monthly Growth Rate
July 2013	41,243	9,466	63,919	1,494	105,843	43,321	16,073	660	379,057	11,487	17,652	9,053	334	2,754	22,368	724,724	(4,350)	-0.60%
August 2013	41,540	9,538	64,281	1,616	106,672	45,336	17,388	648	382,925	8,984	17,659	9,219	186	2,562	22,539	731,093	6,369	0.88%
September 2013	41,696	9,641	64,309	1,692	110,929	43,247	20,951	645	394,462	4,348	17,619	9,233	105	2,511	22,690	744,078	12,985	1.78%
October 2013	41,861	9,709	64,151	2,200	111,274	37,094	19,168	639	382,709	11,153	17,675	13,079	549	2,392	22,299	735,952	(8,126)	-1.09%
November 2013	42,098	9,748	64,396	2,749	112,290	41,332	17,976	547	386,326	18,980	17,712	13,740	1,022	2,352	22,539	753,807	17,855	2.43%
December 2013	42,265	9,797	64,478	2,690	119,836	40,228	17,092	540	389,900	28,057	17,793	14,140	1,293	2,311	22,534	772,954	19,147	2.54%
January 2014	41,861	9,838	64,838	2,217	122,548	40,659	120,068	543	398,421	29,967	17,684	14,582	1,390	2,309	22,740	889,665	116,711	15.10%
February 2014	42,003	9,919	64,798	3,146	129,759	51,272	125,369	527	403,896	33,255	17,744	14,691	1,471	2,374	23,302	923,526	33,861	3.81%
March 2014	42,145	10,027	64,312	3,188	138,165	53,923	157,246	498	404,712	41,976	17,704	14,991	1,596	2,426	24,063	976,972	53,446	5.79%
April 2014	41,762	10,129	64,148	3,288	144,089	55,524	171,950	492	410,925	43,869	19,526	15,093	1,559	2,467	24,662	1,009,483	32,511	3.33%
May 2014	41,991	10,162	64,492	3,257	145,211	54,497	176,827	488	415,257	45,153	20,168	15,086	1,549	2,487	25,120	1,021,745	12,262	1.21%
June 2014	41,564	10,263	64,968	3,186	149,545	58,549	186,802	477	419,751	46,955	20,268	15,007	1,634	2,821	25,676	1,047,466	25,721	2.52%
Year-to-Date Average	**41,836**	**9,853**	**64,424**	**2,560**	**124,680**	**47,082**	**87,243**	**559**	**397,362**	**27,015**	**18,267**	**13,160**	**1,057**	**2,481**	**23,378**	**860,957**	**26,533**	**3.14%**

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

Exhibit C - History and Projections of Per Capita Costs

Per Capita Costs - Cash Based																
Fiscal Year	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
FY 1995-96	$11,340.29	$7,779.66	$5,966.69	-	$2,480.08	-	-	-	$1,185.25	-	$2,097.73	$5,622.41	-	$3,198.11	$1,525.64	$3,770.47
FY 1996-97	$13,421.54	$8,167.83	$6,928.39	-	$3,042.23	-	-	-	$1,180.98	-	$2,242.64	$6,573.60	-	$3,718.47	$1,504.85	$4,391.18
FY 1997-98	$13,133.89	$8,134.40	$6,854.18	-	$2,857.77	-	-	-	$1,294.26	-	$2,004.90	$6,346.56	-	$3,470.61	$1,351.80	$4,463.21
% Change from FY 1996-97	-2.14%	-0.41%	-1.07%	-	-6.06%	-	-	-	9.59%	-	-10.60%	-3.45%	-	-6.67%	-10.17%	1.64%
FY 1998-99	$14,044.48	$9,875.14	$7,786.31	-	$3,123.91	-	-	-	$1,463.55	-	$2,022.23	$6,262.47	-	$3,570.31	$1,013.03	$4,945.41
% Change from FY 1997-98	6.93%	21.40%	13.60%	-	9.31%	-	-	-	13.08%	-	0.86%	-1.32%	-	2.87%	-25.06%	10.80%
FY 1999-00	$15,040.64	$10,793.96	$8,772.23	-	$3,440.54	-	-	-	$1,544.54	-	$2,203.23	$5,430.89	-	$3,273.65	$917.32	$5,166.43
% Change from FY 1998-99	7.09%	9.30%	12.66%	-	10.14%	-	-	-	5.53%	-	8.95%	-13.28%	-	-8.31%	-9.45%	4.47%
FY 2000-01	$15,311.41	$11,851.80	$9,792.12	-	$3,277.51	-	-	-	$1,570.78	-	$2,351.36	$4,801.64	-	$2,966.03	$959.04	$5,143.57
% Change from FY 1999-00	1.80%	9.80%	11.63%	-	-4.74%	-	-	-	1.70%	-	6.72%	-11.59%	-	-9.40%	4.55%	-0.44%
FY 2001-02	$16,837.64	$11,821.86	$10,033.18	-	$3,125.56	-	-	-	$1,532.69	-	$2,530.78	$4,760.42	-	$9,774.69	$963.28	$5,202.27
% Change from FY 2000-01	9.97%	-0.25%	2.46%	-	-4.64%	-	-	-	-2.42%	-	7.63%	-0.86%	-	229.55%	0.44%	1.14%
FY 2002-03	$16,269.83	$11,909.35	$11,071.22	-	$3,425.30	-	-	$30,399.56	$1,346.59	-	$2,689.77	$5,435.44	-	$11,932.93	$882.68	$4,977.91
% Change from FY 2001-02	-3.37%	0.74%	10.35%	-	9.59%	-	-	-	-12.14%	-	6.28%	14.18%	-	22.08%	-8.37%	-4.31%
FY 2003-04	$17,945.57	$13,629.55	$11,928.04	-	$3,858.31	-	-	$25,417.70	$1,187.37	-	$3,037.79	$7,621.82	-	$11,504.23	$961.96	$5,010.73
% Change from FY 2002-03	10.30%	14.44%	7.74%	-	12.64%	-	-	-16.39%	-11.82%	-	12.94%	40.22%	-	-3.59%	8.98%	0.66%
FY 2004-05	$17,743.75	$13,289.25	$11,185.17	-	$3,358.68	-	-	$28,627.25	$1,361.10	-	$2,944.32	$7,040.94	-	$8,682.52	$1,137.98	$4,662.99
% Change from FY 2003-04	-1.12%	-2.50%	-6.23%	-	-12.95%	-	-	12.63%	14.63%	-	-3.08%	-7.62%	-	-24.53%	18.30%	-6.94%
FY 2005-06	$18,260.97	$14,352.34	$11,548.70	-	$3,390.82	-	-	$36,225.53	$1,476.94	-	$2,993.56	$8,031.97	-	$8,904.59	$1,204.47	$4,928.66
% Change from FY 2004-05	2.91%	8.00%	3.25%	-	0.96%	-	-	26.54%	8.51%	-	1.67%	14.08%	-	2.56%	5.84%	5.70%
FY 2006-07	$18,736.83	$14,870.06	$11,712.50	-	$3,664.68	-	-	$24,376.09	$1,608.92	-	$3,210.70	$9,371.52	-	$10,470.57	$1,313.15	$5,222.55
% Change from FY 2005-06	2.61%	3.61%	1.42%	-	8.08%	-	-	-32.71%	8.94%	-	7.25%	16.68%	-	17.59%	9.02%	5.96%
FY 2007-08	$19,419.11	$16,382.42	$13,078.77	-	$3,872.69	-	-	$26,305.08	$1,780.61	-	$3,739.87	$8,670.42	-	$12,797.32	$1,333.66	$5,681.77
% Change from FY 2006-07	3.64%	10.17%	11.67%	-	5.68%	-	-	7.91%	10.67%	-	16.48%	-7.48%	-	22.22%	1.56%	8.79%
FY 2008-09	$20,680.43	$17,762.70	$14,251.48	-	$3,858.15	-	-	$22,261.37	$1,836.99	-	$3,748.13	$8,702.15	-	$14,858.01	$1,254.95	$5,742.83
% Change from FY 2007-08	6.50%	8.43%	8.97%	-	-0.38%	-	-	-15.37%	3.17%	-	0.22%	0.37%	-	16.10%	-5.90%	1.07%
FY 2009-10	$19,455.97	$15,862.64	$13,373.23	-	$3,355.09	$689.29	-	$20,511.28	$1,632.88	-	$3,536.01	$8,401.86	-	$12,655.02	$1,213.77	$4,975.87
% Change from FY 2008-09	-5.92%	-10.70%	-6.16%	-	-13.04%	-	-	-7.86%	-11.11%	-	-5.66%	-3.45%	-	-14.83%	-3.28%	-13.36%
FY 2010-11	$20,358.36	$17,105.76	$14,635.16	-	$3,519.43	$2,316.20	-	$19,033.37	$1,711.49	-	$4,014.76	$8,894.53	-	$14,661.32	$1,428.00	$5,064.10
% Change from FY 2009-10	4.64%	7.84%	9.44%	-	4.90%	236.03%	-	-7.21%	4.81%	-	13.54%	5.86%	-	15.85%	17.65%	1.77%
FY 2011-12	$20,300.66	$16,955.03	$14,209.99	$8,877.60	$3,311.46	$2,423.80	$2,185.53	$17,216.60	$1,569.28	-	$3,783.82	$8,354.70	-	$15,148.44	$1,298.38	$4,717.85
% Change from FY 2010-11	-0.28%	-0.88%	-2.91%	-	-5.91%	4.65%	-	-9.55%	-8.31%	-	-5.75%	-6.07%	-	3.32%	-9.08%	-6.84%
FY 2012-13	$20,575.23	$16,956.24	$14,026.17	$13,583.69	$3,305.17	$2,332.34	$5,389.53	$15,345.22	$1,589.28	$1,829.27	$3,794.33	$9,068.38	$8,350.19	$16,302.95	$1,196.39	$4,634.75
% Change from FY 2011-12	1.35%	0.01%	-1.29%	53.01%	-0.19%	-3.77%	146.60%	-10.87%	1.27%	-	0.28%	8.54%	-	7.62%	-7.86%	-1.76%
FY 2013-14	$21,409.29	$17,530.57	$15,039.24	$11,481.79	$2,976.47	$2,399.40	$3,765.62	$15,885.67	$1,715.64	$1,457.36	$4,167.05	$9,324.58	$8,761.65	$15,522.95	$1,313.55	$4,514.26
% Change from FY 2012-13	4.05%	3.39%	7.22%	-15.47%	-9.95%	2.88%	-30.13%	3.52%	7.95%	-20.33%	9.82%	2.83%	4.93%	-4.78%	9.79%	-2.60%
FY 2014-15 Projection	$22,948.24	$17,533.77	$15,407.83	$12,597.97	$2,945.06	$2,413.13	$4,366.12	$16,563.02	$1,684.58	$1,372.93	$3,918.05	$9,890.91	$9,184.27	$16,712.35	$1,305.95	$4,406.53
% Change from FY 2013-14	7.19%	0.02%	2.45%	9.72%	-1.06%	0.57%	15.95%	4.26%	-1.81%	-5.79%	-5.98%	6.07%	4.82%	7.66%	-0.58%	-2.39%
FY 2015-16 Projection	$23,007.01	$17,437.75	$15,749.01	$12,802.72	$2,859.40	$2,343.45	$4,552.42	$16,639.94	$1,671.19	$1,366.83	$4,026.11	$9,970.99	$9,228.03	$17,322.08	$1,282.95	$4,384.72
% Change from FY 2014-15	0.26%	-0.55%	2.21%	1.63%	-2.91%	-2.89%	4.27%	0.46%	-0.79%	-0.44%	2.76%	0.81%	0.48%	3.65%	-1.76%	-0.49%
FY 2016-17 Projection	$23,314.30	$17,278.88	$15,985.93	$13,197.97	$2,689.65	$2,219.65	$4,604.27	$16,558.73	$1,611.43	$1,341.24	$4,025.27	$9,564.22	$9,013.35	$17,398.87	$1,259.98	$4,298.03
% Change from FY 2015-16	1.34%	-0.91%	1.50%	3.09%	-5.94%	-5.28%	1.14%	-0.49%	-3.58%	-1.87%	-0.02%	-4.08%	-2.33%	0.44%	-1.79%	-1.98%

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

See narrative for a description of events that alter trends.

Exhibit C - History and Projections of Per Capita Costs

Per Capita Costs - Adjusted for Payment Delays

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 1995-96	$11,340.29	$7,779.66	$5,966.69	-	$2,480.08	-	-	-	$1,185.25	-	$2,097.73	$5,622.41	-	$3,198.11	$1,525.64	$3,770.47
FY 1996-97	$13,421.54	$8,167.83	$6,928.39	-	$3,042.23	-	-	-	$1,180.98	-	$2,242.64	$6,573.60	-	$3,718.47	$1,504.85	$4,391.18
FY 1997-98	$13,133.89	$8,134.40	$6,854.18	-	$2,857.77	-	-	-	$1,294.26	-	$2,004.90	$6,346.56	-	$3,470.61	$1,351.80	$4,463.21
% Change from FY 1996-97	-2.14%	-0.41%	-1.07%	-	-6.06%	-	-	-	9.59%	-	-10.60%	-3.45%	-	-6.67%	-10.17%	1.64%
FY 1998-99	$14,044.48	$9,875.14	$7,786.31	-	$3,123.91	-	-	-	$1,463.55	-	$2,022.23	$6,262.47	-	$3,570.31	$1,013.03	$4,945.41
% Change from FY 1997-98	6.93%	21.40%	13.60%	-	9.31%	-	-	-	13.08%	-	0.86%	-1.32%	-	2.87%	-25.06%	10.80%
FY 1999-00	$15,040.64	$10,793.96	$8,772.23	-	$3,440.54	-	-	-	$1,544.54	-	$2,203.23	$5,430.89	-	$3,273.65	$917.32	$5,166.43
% Change from FY 1998-99	7.09%	9.30%	12.66%	-	10.14%	-	-	-	5.53%	-	8.95%	-13.28%	-	-8.31%	-9.45%	4.47%
FY 2000-01	$15,311.41	$11,851.80	$9,792.12	-	$3,277.51	-	-	-	$1,570.78	-	$2,351.36	$4,801.64	-	$2,966.03	$959.04	$5,143.57
% Change from FY 1999-00	1.80%	9.80%	11.63%	-	-4.74%	-	-	-	1.70%	-	6.72%	-11.59%	-	-9.40%	4.55%	-0.44%
FY 2001-02	$16,837.64	$11,821.86	$10,033.18	-	$3,125.56	-	-	-	$1,532.69	-	$2,530.78	$4,760.42	-	$9,774.69	$963.28	$5,202.27
% Change from FY 2000-01	9.97%	-0.25%	2.46%	-	-4.64%	-	-	-	-2.42%	-	7.63%	-0.86%	-	229.55%	0.44%	1.14%
FY 2002-03	$16,269.83	$11,909.35	$11,071.22	-	$3,425.30	-	-	$30,399.56	$1,346.59	-	$2,689.77	$5,435.44	-	$11,932.93	$882.68	$4,977.91
% Change from FY 2001-02	-3.37%	0.74%	10.35%	-	9.59%	-	-	-	-12.14%	-	6.28%	14.18%	-	22.08%	-8.37%	-4.31%
FY 2003-04	$17,945.57	$13,629.55	$11,928.04	-	$3,858.31	-	-	$25,417.70	$1,187.37	-	$3,037.79	$7,621.82	-	$11,504.23	$961.96	$5,010.73
% Change from FY 2002-03	10.30%	14.44%	7.74%	-	12.64%	-	-	-16.39%	-11.82%	-	12.94%	40.22%	-	-3.59%	8.98%	0.66%
FY 2004-05	$17,743.75	$13,289.25	$11,185.17	-	$3,358.68	-	-	$28,627.25	$1,361.10	-	$2,944.32	$7,040.94	-	$8,682.52	$1,137.98	$4,662.99
% Change from FY 2003-04	-1.12%	-2.50%	-6.23%	-	-12.95%	-	-	12.63%	14.63%	-	-3.08%	-7.62%	-	-24.53%	18.30%	-6.94%
FY 2005-06	$18,260.97	$14,352.34	$11,548.70	-	$3,390.82	-	-	$36,225.53	$1,476.94	-	$2,993.56	$8,031.97	-	$8,904.59	$1,204.47	$4,928.66
% Change from FY 2004-05	2.91%	8.00%	3.25%	-	0.96%	-	-	26.54%	8.51%	-	1.67%	14.08%	-	2.56%	5.84%	5.70%
FY 2006-07	$18,736.83	$14,870.06	$11,712.50	-	$3,664.68	-	-	$24,376.09	$1,608.92	-	$3,210.70	$9,371.52	-	$10,470.57	$1,313.15	$5,222.55
% Change from FY 2005-06	2.61%	3.61%	1.42%	-	8.08%	-	-	-32.71%	8.94%	-	7.25%	16.68%	-	17.59%	9.02%	5.96%
FY 2007-08	$19,419.11	$16,382.42	$13,078.77	-	$3,872.69	-	-	$26,305.08	$1,780.61	-	$3,739.87	$8,670.42	-	$12,797.32	$1,333.66	$5,681.77
% Change from FY 2006-07	3.64%	10.17%	11.67%	-	5.68%	-	-	7.91%	10.67%	-	16.48%	-7.48%	-	22.22%	1.56%	8.79%
FY 2008-09	$20,680.43	$17,762.70	$14,251.48	-	$3,858.15	-	-	$22,261.37	$1,836.99	-	$3,748.13	$8,702.15	-	$14,858.01	$1,254.95	$5,742.83
% Change from FY 2007-08	6.50%	8.43%	8.97%	-	-0.38%	-	-	-15.37%	3.17%	-	0.22%	0.37%	-	16.10%	-5.90%	1.07%
FY 2009-10 (DA)	$19,767.99	$16,303.29	$13,773.18	-	$3,484.92	$952.90	-	$21,192.52	$1,691.68	-	$3,669.73	$8,704.60	-	$13,125.32	$1,225.15	$5,116.67
% Change from FY 2008-09	-4.41%	-8.22%	-3.36%	-	-9.67%	-	-	-4.80%	-7.91%	-	-2.09%	0.03%	-	-11.66%	-2.37%	-10.90%
FY 2010-11 (DA)	$20,049.48	$16,705.85	$14,256.68	-	3,399.65	$2,284.78	-	$18,488.13	$1,657.89	-	$3,881.13	$8,593.25	-	$14,120.76	$1,417.39	$4,938.85
% Change from FY 2009-10 (DA)	1.42%	2.47%	3.51%	-	-2.45%	139.77%	-	-12.76%	-2.00%	-	5.76%	-1.28%	-	7.58%	15.69%	-3.48%
FY 2011-12	$20,300.66	$16,955.03	$14,209.99	$8,877.60	$3,311.46	$2,423.80	$2,185.53	$17,216.60	$1,569.28	-	$3,783.82	$8,354.70	-	$15,148.44	$1,298.38	$4,717.85
% Change from FY 2010-11 (DA)	1.25%	1.49%	-0.33%	-	-2.59%	6.08%	-	-6.88%	-5.34%	-	-2.51%	-2.78%	-	7.28%	-8.40%	-4.47%
FY 2012-13	$20,575.23	$16,956.24	$14,026.17	$13,583.69	$3,305.17	$2,332.34	$5,389.53	$15,345.22	$1,589.28	$1,829.27	$3,794.33	$9,068.38	$8,350.19	$16,302.95	$1,196.39	$4,634.75
% Change from FY 2011-12	1.35%	0.01%	-1.29%	53.01%	-0.19%	-3.77%	146.60%	-10.87%	1.27%	-	0.28%	8.54%	-	7.62%	-7.86%	-1.76%
FY 2013-14	$21,409.29	$17,530.57	$15,039.24	$11,481.79	$2,976.47	$2,399.40	$3,765.62	$15,885.67	$1,715.64	$1,457.36	$4,167.05	$9,324.58	$8,761.65	$15,522.95	$1,313.55	$4,514.26
% Change from FY 2012-13	4.05%	3.39%	7.22%	-15.47%	-9.95%	2.88%	-30.13%	3.52%	7.95%	-20.33%	9.82%	2.83%	4.93%	-4.78%	9.79%	-2.60%
FY 2014-15 Projection	$22,948.24	$17,533.77	$15,407.83	$12,597.97	$2,945.06	$2,413.13	$4,366.12	$16,563.02	$1,684.58	$1,372.93	$3,918.05	$9,890.91	$9,184.27	$16,712.35	$1,305.95	$4,406.53
% Change from FY 2013-14	7.19%	0.02%	2.45%	9.72%	-1.06%	0.57%	15.95%	4.26%	-1.81%	-5.79%	-5.98%	6.07%	4.82%	7.66%	-0.58%	-2.39%
FY 2015-16 Projection	$23,007.01	$17,437.75	$15,749.01	$12,802.72	$2,859.40	$2,343.45	$4,552.42	$16,639.94	$1,671.19	$1,366.83	$4,026.11	$9,970.99	$9,228.03	$17,322.08	$1,282.95	$4,384.72
% Change from FY 2014-15	0.26%	-0.55%	2.21%	1.63%	-2.91%	-2.89%	4.27%	0.46%	-0.79%	-0.44%	2.76%	0.81%	0.48%	3.65%	-1.76%	-0.49%
FY 2016-17 Projection	$23,314.30	$17,278.88	$15,985.93	$13,197.97	$2,689.65	$2,219.65	$4,604.27	$16,558.73	$1,611.43	$1,341.24	$4,025.27	$9,564.22	$9,013.35	$17,398.87	$1,259.98	$4,298.03
% Change from FY 2015-16	1.34%	-0.91%	1.50%	3.09%	-5.94%	-5.28%	1.14%	-0.49%	-3.58%	-1.87%	-0.02%	-4.08%	-2.33%	0.44%	-1.79%	-1.98%

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

See narrative for a description of events that alter trends.

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

Exhibit D - Cash Funds Report

Cash Funds Report

Cash Fund	FY 2014-15			FY 2015-16			FY 2016-17		
	Spending Authority	Request	Change	Base Spending Authority	Request	Change	Base Spending Authority	Request	Change
Cash Funds									
Certified Funds	$16,100,503	$14,008,763	($2,091,740)	$16,100,503	$14,101,350	($1,999,153)	$16,100,503	$14,165,693	($1,934,810)
Local Funds	$14,044	$29,000	$14,956	$14,044	$29,000	$14,956	$14,044	$29,000	$14,956
Hospital Provider Fee Cash Fund	$391,081,821	$428,151,624	$37,069,803	$396,351,802	$455,614,224	$59,262,422	$396,351,802	$497,246,771	$100,894,969
Medicaid Buy-In Fund	$1,492,745	$2,236,793	$744,048	$1,508,305	$2,643,141	$1,134,836	$1,508,305	$3,010,108	$1,501,803
Tobacco Tax Cash Fund	$2,230,500	$2,230,500	$0	$2,230,500	$2,230,500	$0	$2,230,500	$2,230,500	$0
Health Care Expansion Fund	$64,951,999	$64,951,999	$0	$64,951,999	$64,951,999	$0	$64,951,999	$64,951,999	$0
Breast and Cervical Cancer Prevention and Treatment Fund	$2,351,018	$2,100,925	($250,093)	$1,119,217	$964,199	($155,018)	$1,119,217	$334,971	($784,246)
Colorado Autism Treatment Fund	$513,757	$400,936	($112,821)	$521,390	$420,179	($101,211)	$521,390	$440,844	($80,546)
Coordinated Care for People with Disabilities Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Cash Fund	$45,345,190	$45,660,596	$315,406	$46,017,249	$47,077,833	$1,060,584	$46,017,249	$48,786,759	$2,769,510
Home Health Telemedicine Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Comprehensive Primary and Preventive Care Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Pediatric Specialty Hospital Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Tobacco Education Program Fund	$630,706	$640,520	$9,814	$640,077	$619,665	($20,412)	$640,077	$664,961	$24,884
Health Disparities Grant Program Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Old Age Pension Health and Medical Care Fund	$5,495,027	$5,495,027	$0	$5,495,027	$5,369,479	($125,548)	$5,495,027	$5,240,893	($254,134)
Prevention, Early Detection, and Treatment Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Department Recoveries	$48,043,559	$39,442,506	($8,601,053)	$48,043,559	$45,514,128	($2,529,431)	$48,043,559	$52,520,392	$4,476,833
ICF-IID Provider Fee	$200,460	$200,460	$0	$200,460	$200,460	$0	$200,460	$200,460	$0
Adult Dental Fund	$29,447,039	$27,516,319	($1,930,720)	$30,511,217	$28,944,365	($1,566,852)	$30,511,217	$30,434,252	($76,965)
Intergovernmental Transfer - Denver Health	$15,000,000	$15,000,000	$0	$15,000,000	$15,000,000	$0	$15,000,000	$15,000,000	$0
Nursing Facility Penalty Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Cash Funds	**$622,898,368**	**$648,065,968**	**$25,167,600**	**$628,705,349**	**$683,680,522**	**$54,975,173**	**$628,705,349**	**$735,257,603**	**$106,552,254**
Reappropriated Funds - Transfers from the Department of Public Health and Environment									
(9) Prevention Services Division; (A) Prevention Programs, (1) Programs and Administration	$0	$0	$0	$0	$0	$0	$0	$0	$0
(9) Prevention Services Division; (A) Prevention Programs, (3) Chronic Disease and Cancer Prevention Grants Program	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Reappropriated Funds	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

Note: Calculation of letternote changes for FY 2014-15 can be found on page ED-2. Request amounts shown above for FY 2014-15 and FY 2015-16 represent the total letternote amount that would appear in the Long Bill.

Exhibit D - Cash Funds Report

Cash Funds Spending Authority by Source of Authority
FY 2014-15

Spending Authority	FY 2014-15 Long Bill Appropriation (HB 14-1336)	HB 14-1045 "Continuation of BCCP"	HB 14-1357 "In-home Support Services in Medicaid Program"	SB 14-130 "Increase Personal Care Allowance Nursing Facility"	Total
Certified Funds	$16,100,503	$0	$0	$0	$16,100,503
Local Funds	$14,044	$0	$0	$0	$14,044
Hospital Provider Fee Cash Fund	$391,081,821	$0	$0	$0	$391,081,821
Medicaid Buy-In Fund	$1,492,745	$0	$0	$0	$1,492,745
Tobacco Tax Cash Fund	$2,230,500	$0	$0	$0	$2,230,500
Health Care Expansion Fund	$64,951,999	$0	$0	$0	$64,951,999
Breast and Cervical Cancer Prevention and Treatment Fund	$0	$2,351,018	$0	$0	$2,351,018
Colorado Autism Treatment Fund	$513,757	$0	$0	$0	$513,757
Coordinated Care for People with Disabilities Fund	$0	$0	$0	$0	$0
Nursing Facility Cash Fund	$45,345,190	$0	$0	$0	$45,345,190
Home Health Telemedicine Fund	$0	$0	$0	$0	$0
Comprehensive Primary and Preventive Care Fund	$0	$0	$0	$0	$0
Pediatric Specialty Hospital Fund	$0	$0	$0	$0	$0
Tobacco Education Program Fund	$630,706	$0	$0	$0	$630,706
Health Disparities Grant Program Fund	$0	$0	$0	$0	$0
Supplemental Old Age Pension Health and Medical Care Fund	$5,495,027	$0	$0	$0	$5,495,027
Prevention, Early Detection, and Treatment Fund	$0	$0	$0	$0	$0
Primary Care Fund	$0	$0	$0	$0	$0
Department Recoveries	$48,043,559	$0	$0	$0	$48,043,559
ICF-IID Provider Fee	$200,460	$0	$0	$0	$200,460
Adult Dental Fund	$29,447,039	$0	$0	$0	$29,447,039
Intergovernmental Transfer - Denver Health	$15,000,000	$0	$0	$0	$15,000,000
Nursing Facility Penalty Fund	$0	$0	$0	$0	$0
Total Cash Funds	**$620,547,350**	**$2,351,018**	**$0**	**$0**	**$622,898,368**

Exhibit D - Cash Funds Report

Revised Totals for Letternotes and Appropriation Clauses
FY 2014-15

FY 2014-15 Request	FY 2014-15 Long Bill Appropriation (HB 14-1336)	HB 14-1045 "Continuation of BCCP"	HB 14-1357 "In-home Support Services in Medicaid Program"	SB 14-130 "Increase Personal Care Allowance Nursing Facility"	Total
Certified Funds	**$14,008,763**	$0	$0	$0	$14,008,763
Local Funds	**$29,000**	$0	$0	$0	$29,000
Hospital Provider Fee Cash Fund	**$428,151,624**	$0	$0	$0	$428,151,624
Medicaid Buy-In Fund	**$2,236,793**	$0	$0	$0	$2,236,793
Tobacco Tax Cash Fund	$2,230,500	$0	$0	$0	$2,230,500
Health Care Expansion Fund	$64,951,999	$0	$0	$0	$64,951,999
Breast and Cervical Cancer Prevention and Treatment Fund	**($250,093)**	$2,351,018	$0	$0	$2,100,925
Colorado Autism Treatment Fund	**$400,936**	$0	$0	$0	$400,936
Coordinated Care for People with Disabilities Fund	$0	$0	$0	$0	$0
Nursing Facility Cash Fund	**$45,660,596**	$0	$0	$0	$45,660,596
Home Health Telemedicine Fund	$0	$0	$0	$0	$0
Comprehensive Primary and Preventive Care Fund	$0	$0	$0	$0	$0
Pediatric Specialty Hospital Fund	$0	$0	$0	$0	$0
Tobacco Education Program Fund	**$640,520**	$0	$0	$0	$640,520
Health Disparities Grant Program Fund	$0	$0	$0	$0	$0
Old Age Pension Health and Medical Care Fund	$5,495,027	$0	$0	$0	$5,495,027
Prevention, Early Detection, and Treatment Fund	$0	$0	$0	$0	$0
Primary Care Fund	$0	$0	$0	$0	$0
Department Recoveries	**$39,442,506**	$0	$0	$0	$39,442,506
ICF-IID Provider Fee	$200,460	$0	$0	$0	$200,460
Adult Dental Fund	**$27,516,319**	$0	$0	$0	$27,516,319
Intergovernmental Transfer - Denver Health	$15,000,000	$0	$0	$0	$15,000,000
Nursing Facility Penalty Fund	$0	$0	$0	$0	$0
Total Cash Funds	$645,714,950	$2,351,018	$0	$0	$648,065,968

Cells in **bold and underline** font indicate a requested change from the appropriation. The font in the "Total" columns are intentionally left unchanged. Please note, this table shows the total change required to the letternotes and appropriation clauses and include the incremental amounts from prior budget requests (in particular, the Department's February 2014 S-1 request).

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2014-15	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Acute Care	**$124,054,802**	**$92,590,742**	**$640,986,160**	**$44,429,269**	**$440,232,394**	**$146,077,167**	**$940,939,106**	**$6,094,937**	**$674,210,776**	**$68,946,135**	**$66,150,629**	**$148,281,621**	**$16,159,056**	**$46,926,357**	**$10,867,953**	**$3,466,947,104**
Community Based Long-Term Care																
Base CBLTC	$151,744,361	$31,471,019	$176,884,605	$812,514	$217,477	$0	$0	$0	$399,192	$0	$191,601	$37	$0	$0	$936,614	$362,657,420
Hospice	$29,229,660	$3,942,118	$7,211,296	$468,066	$186,201	$185,851	$2,470,125	$0	$155,310	$0	$0	$0	$0	$0	$28,727	$43,877,354
Private Duty Nursing	$3,586,574	$874,926	$42,203,627	$337,642	$14,942	$0	$51,582	$0	$4,023,717	$0	$12,095,766	$0	$0	$0	$15,434	$63,204,210
Subtotal CBLTC	**$184,560,595**	**$36,288,063**	**$226,299,528**	**$1,618,222**	**$418,620**	**$185,851**	**$2,521,707**	**$0**	**$4,578,219**	**$0**	**$12,287,367**	**$37**	**$0**	**$0**	**$980,775**	**$469,738,984**
Long-Term Care																
Class I Nursing Facilities	$455,045,653	$39,349,332	$84,293,329	$400,180	$129,910	$0	$0	$0	$0	$0	$0	$0	$0	$0	$809,595	$580,027,999
Class II Nursing Facilities	$482,475	$366,037	$3,365,675	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,214,187
PACE	$118,208,940	$13,909,912	$7,488,917	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$139,607,769
Subtotal Long-Term Care	**$573,737,068**	**$53,625,281**	**$95,147,921**	**$400,180**	**$129,910**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$809,595**	**$723,849,955**
Insurance																
Supplemental Medicare Insurance Benefit	$70,353,157	$4,408,138	$37,778,272	$0	$275,010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$22,924,438	$135,739,015
Heath Insurance Buy-In	$15,392	$26,934	$1,592,989	$0	$34,631	$0	$0	$0	$79,276	$0	$28,462	$11,543	$0	$0	$0	$1,789,227
Subtotal Insurance	**$70,368,549**	**$4,435,072**	**$39,371,261**	**$0**	**$309,641**	**$0**	**$0**	**$0**	**$79,276**	**$0**	**$28,462**	**$11,543**	**$0**	**$0**	**$22,924,438**	**$137,528,242**
Service Management																
Single Entry Points	$8,759,301	$2,383,238	$19,391,929	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$30,534,468
Disease Management	$36,040	$24,914	$162,186	$10,499	$249,019	$85,050	$266,023	$253	$301,651	$35,932	$34,092	$73,282	$1,214	$1,929	$18,728	$1,300,812
Prepaid Inpatient Health Plan	$749,167	$683,704	$5,541,852	$154,321	$17,109,631	$9,450,999	$33,302,313	$0	$60,526,274	$2,827,868	$2,266,232	$1,223,696	$68,343	$0	$5	$133,904,405
Subtotal Service Management	**$9,544,508**	**$3,091,856**	**$25,095,967**	**$164,820**	**$17,358,650**	**$9,536,049**	**$33,568,336**	**$253**	**$60,827,925**	**$2,863,800**	**$2,300,324**	**$1,296,978**	**$69,557**	**$1,929**	**$18,733**	**$165,739,685**
Medical Services Total	**$962,265,522**	**$190,031,014**	**$1,026,900,837**	**$46,612,491**	**$458,449,215**	**$155,799,067**	**$977,029,149**	**$6,095,190**	**$739,696,196**	**$71,809,935**	**$80,766,782**	**$149,590,179**	**$16,228,613**	**$46,928,286**	**$35,601,494**	**$4,963,803,970**
Caseload	41,932	10,838	66,648	3,700	155,667	64,563	223,775	368	439,097	52,304	20,614	15,124	1,767	2,808	27,261	1,126,466
Medical Services Per Capita	$22,948.24	$17,533.77	$15,407.83	$12,597.97	$2,945.06	$2,413.13	$4,366.12	$16,563.02	$1,684.58	$1,372.93	$3,918.05	$9,890.91	$9,184.27	$16,712.35	$1,305.95	$4,406.53
Financing	$174,943,947	$34,548,443	$186,694,920	$8,474,348	$83,348,009	$28,324,930	$177,628,036	$1,108,131	$134,479,901	$13,055,350	$14,683,743	$27,196,128	$2,950,431	$8,531,761	$6,472,502	$902,440,580
Grand Total Medical Services Premiums	**$1,137,209,469**	**$224,579,457**	**$1,213,595,757**	**$55,086,839**	**$541,797,224**	**$184,123,997**	**$1,154,657,185**	**$7,203,321**	**$874,176,097**	**$84,865,285**	**$95,450,525**	**$176,786,307**	**$19,179,044**	**$55,460,047**	**$42,073,996**	**$5,866,244,550**
Total Per Capita	$27,120.33	$20,721.49	$18,209.03	$14,888.33	$3,480.49	$2,851.85	$5,159.90	$19,574.24	$1,990.85	$1,622.54	$4,630.37	$11,689.12	$10,854.01	$19,750.73	$1,543.38	$5,207.65

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2015-16	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Acute Care	**$124,239,557**	**$97,143,908**	**$669,753,623**	**$53,419,480**	**$469,977,526**	**$154,785,190**	**$1,124,550,606**	**$2,811,897**	**$717,398,987**	**$74,595,915**	**$67,415,274**	**$151,547,920**	**$18,116,831**	**$47,495,218**	**$8,217,266**	**$3,781,469,198**
Community Based Long-Term Care																
Base CBLTC	$162,574,883	$33,772,187	$194,535,105	$870,687	$232,723	$0	$0	$0	$578,638	$0	$207,064	$40	$0	$0	$1,005,557	$393,776,884
Hospice	$30,042,918	$4,122,256	$7,399,325	$546,191	$192,115	$201,221	$2,798,150	$0	$164,269	$0	$0	$0	$0	$0	$31,088	$45,497,533
Private Duty Nursing	$4,267,587	$1,035,528	$50,123,038	$396,095	$17,112	$0	$59,627	$0	$4,739,204	$0	$14,226,831	$0	$0	$0	$18,172	$74,883,194
Subtotal CBLTC	**$196,885,388**	**$38,929,971**	**$252,057,468**	**$1,812,973**	**$441,950**	**$201,221**	**$2,857,777**	**$0**	**$5,482,111**	**$0**	**$14,433,895**	**$40**	**$0**	**$0**	**$1,054,817**	**$514,157,611**
Long-Term Care																
Class I Nursing Facilities	$463,567,112	$40,086,211	$85,871,856	$407,674	$132,343	$0	$0	$0	$0	$0	$0	$0	$0	$0	$824,756	$590,889,952
Class II Nursing Facilities	$539,407	$409,229	$3,762,825	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,711,461
PACE	$122,689,658	$14,889,608	$7,602,247	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$145,181,513
Subtotal Long-Term Care	**$586,796,177**	**$55,385,048**	**$97,236,928**	**$407,674**	**$132,343**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$824,756**	**$740,782,926**
Insurance																
Supplemental Medicare Insurance Benefit	$72,593,730	$4,757,204	$39,557,714	$0	$316,259	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,796,912	$143,021,819
Heath Insurance Buy-In	$20,772	$36,349	$2,149,838	$0	$46,737	$0	$0	$0	$106,988	$0	$38,411	$15,578	$0	$0	$0	$2,414,673
Subtotal Insurance	**$72,614,502**	**$4,793,553**	**$41,707,552**	**$0**	**$362,996**	**$0**	**$0**	**$0**	**$106,988**	**$0**	**$38,411**	**$15,578**	**$0**	**$0**	**$25,796,912**	**$145,436,492**
Service Management																
Single Entry Points	$9,397,854	$2,556,261	$20,805,601	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$32,759,716
Disease Management	$36,040	$24,914	$162,186	$10,499	$249,019	$85,050	$266,023	$253	$301,651	$0	$34,092	$73,282	$1,214	$1,929	$18,728	$1,264,880
Prepaid Inpatient Health Plan	$712,507	$689,044	$5,619,749	$156,427	$17,607,047	$10,312,803	$37,398,052	$0	$60,302,781	$2,938,736	$2,304,634	$1,248,366	$70,393	$0	$2,300,189	$141,660,728
Subtotal Service Management	**$10,146,401**	**$3,270,219**	**$26,587,536**	**$166,926**	**$17,856,066**	**$10,397,853**	**$37,664,075**	**$253**	**$60,604,432**	**$2,938,736**	**$2,338,726**	**$1,321,648**	**$71,607**	**$1,929**	**$2,318,917**	**$175,685,324**
Medical Services Total	**$990,682,025**	**$199,522,699**	**$1,087,343,107**	**$55,807,053**	**$488,770,881**	**$165,384,264**	**$1,165,072,458**	**$2,812,150**	**$783,592,518**	**$77,534,651**	**$84,226,306**	**$152,885,186**	**$18,188,438**	**$47,497,147**	**$38,212,668**	**$5,357,531,551**
Caseload	43,060	11,442	69,042	4,359	170,935	70,573	255,924	169	468,884	56,726	20,920	15,333	1,971	2,742	29,785	1,221,865
Medical Services Per Capita	$23,007.01	$17,437.75	$15,749.01	$12,802.72	$2,859.40	$2,343.45	$4,552.42	$16,639.94	$1,671.19	$1,366.83	$4,026.11	$9,970.99	$9,228.03	$17,322.08	$1,282.95	$4,384.72
Financing	$179,180,679	$36,086,869	$196,663,382	$10,093,598	$88,402,027	$29,912,388	$210,721,978	$508,622	$141,725,233	$14,023,381	$15,233,674	$27,651,730	$3,289,670	$8,590,618	$6,911,372	$968,995,221
Grand Total Medical Services Premiums	**$1,169,862,704**	**$235,609,568**	**$1,284,006,489**	**$65,900,651**	**$577,172,908**	**$195,296,652**	**$1,375,794,436**	**$3,320,772**	**$925,317,751**	**$91,558,032**	**$99,459,980**	**$180,536,916**	**$21,478,108**	**$56,087,765**	**$45,124,040**	**$6,326,526,772**
Total Per Capita	$27,168.20	$20,591.64	$18,597.47	$15,118.30	$3,376.56	$2,767.30	$5,375.79	$19,649.54	$1,973.45	$1,614.04	$4,754.30	$11,774.40	$10,897.06	$20,455.06	$1,514.99	$5,177.76

Exhibit E - Summary of Total Requested Expenditure by Service Group

FY 2016-17	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Acute Care	**$123,098,618**	**$99,124,639**	**$684,338,043**	**$62,743,677**	**$483,610,476**	**$157,794,346**	**$1,274,868,041**	**$976,876**	**$731,068,514**	**$79,365,127**	**$66,227,391**	**$146,897,845**	**$19,034,727**	**$46,574,890**	**$6,763,491**	**$3,982,486,701**
Community Based Long-Term Care																
Base CBLTC	$174,314,866	$36,310,270	$215,641,613	$933,858	$249,296	$0	$0	$0	$827,770	$0	$222,446	$44	$0	$0	$1,081,494	$429,581,658
Hospice	$30,881,832	$4,293,256	$7,593,945	$617,346	$197,481	$216,504	$3,120,941	$0	$173,682	$0	$0	$0	$0	$0	$33,860	$47,128,847
Private Duty Nursing	$4,996,141	$1,206,607	$58,691,607	$464,089	$19,592	$0	$68,916	$0	$5,546,324	$0	$16,450,618	$0	$0	$0	$21,391	$87,465,285
Subtotal CBLTC	**$210,192,839**	**$41,810,133**	**$281,927,165**	**$2,015,293**	**$466,369**	**$216,504**	**$3,189,857**	**$0**	**$6,547,776**	**$0**	**$16,673,064**	**$44**	**$0**	**$0**	**$1,136,745**	**$564,175,790**
Long-Term Care																
Class I Nursing Facilities	$468,104,088	$40,478,539	$86,712,292	$411,664	$133,638	$0	$0	$0	$0	$0	$0	$0	$0	$0	$832,828	$596,673,049
Class II Nursing Facilities	$571,232	$433,374	$3,984,832	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,989,438
PACE	$137,671,610	$16,444,814	$8,472,951	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$162,589,375
Subtotal Long-Term Care	**$606,346,930**	**$57,356,727**	**$99,170,075**	**$411,664**	**$133,638**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$832,828**	**$764,251,862**
Insurance																
Supplemental Medicare Insurance Benefit	$75,894,742	$5,098,736	$41,725,094	$0	$354,397	$0	$0	$0	$0	$0	$0	$0	$0	$0	$28,884,359	$151,957,328
Heath Insurance Buy-In	$27,628	$48,346	$2,859,406	$0	$62,163	$0	$0	$0	$142,300	$0	$51,088	$20,720	$0	$0	$0	$3,211,651
Subtotal Insurance	**$75,922,370**	**$5,147,082**	**$44,584,500**	**$0**	**$416,560**	**$0**	**$0**	**$0**	**$142,300**	**$0**	**$51,088**	**$20,720**	**$0**	**$0**	**$28,884,359**	**$155,168,979**
Service Management																
Single Entry Points	$10,082,958	$2,742,612	$22,322,329	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,147,899
Disease Management	$36,981	$26,106	$167,332	$11,932	$273,024	$92,329	$298,319	$89	$318,835	$0	$34,563	$74,104	$1,314	$1,874	$20,538	$1,357,340
Prepaid Inpatient Health Plan	$731,373	$707,287	$5,768,537	$160,569	$18,073,209	$11,267,005	$42,354,810	$0	$64,706,759	$3,016,542	$2,365,650	$1,281,419	$72,256	$0	$3,437,354	$153,942,770
Subtotal Service Management	**$10,851,312**	**$3,476,005**	**$28,258,198**	**$172,501**	**$18,346,233**	**$11,359,334**	**$42,653,129**	**$89**	**$65,025,594**	**$3,016,542**	**$2,400,213**	**$1,355,523**	**$73,570**	**$1,874**	**$3,457,892**	**$190,448,009**
Medical Services Total	**$1,026,412,069**	**$206,914,586**	**$1,138,277,981**	**$65,343,135**	**$502,973,276**	**$169,370,184**	**$1,320,711,027**	**$976,965**	**$802,784,184**	**$82,381,669**	**$85,351,756**	**$148,274,132**	**$19,108,297**	**$46,576,764**	**$41,075,315**	**$5,656,531,341**
Caseload	44,025	11,975	71,205	4,951	187,003	76,305	286,845	59	498,180	61,422	21,204	15,503	2,120	2,677	32,600	1,316,074
Medical Services Per Capita	$23,314.30	$17,278.88	$15,985.93	$13,197.97	$2,689.65	$2,219.65	$4,604.27	$16,558.73	$1,611.43	$1,341.24	$4,025.27	$9,564.22	$9,013.35	$17,398.87	$1,259.98	$4,298.03
Financing	$176,474,737	$35,575,573	$195,708,248	$11,234,681	$86,478,013	$29,120,428	$227,074,621	$167,973	$138,025,586	$14,164,178	$14,674,836	$25,493,308	$3,285,359	$8,008,111	$7,062,227	$972,547,879
Grand Total Medical Services Premiums	**$1,202,886,806**	**$242,490,159**	**$1,333,986,229**	**$76,577,816**	**$589,451,289**	**$198,490,612**	**$1,547,785,648**	**$1,144,938**	**$940,809,770**	**$96,545,847**	**$100,026,592**	**$173,767,440**	**$22,393,656**	**$54,584,875**	**$48,137,542**	**$6,629,079,220**
Total Per Capita	$27,322.81	$20,249.70	$18,734.45	$15,467.14	$3,152.10	$2,601.28	$5,395.90	$19,405.73	$1,888.49	$1,571.84	$4,717.35	$11,208.63	$10,563.05	$20,390.32	$1,476.61	$5,037.01

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills - FY 2014-15

Item	Long Bill and Special Bills	R-1 Request (November 2014)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Acute Care					
Base Acute Cost	$3,359,886,836	$3,350,552,936	($9,333,900)	Trends for Some Populations Changed Based on FY 2013-14 Full Year Actuals	Exhibit F
Bottom Line Impacts					
Breast and Cervical Cancer Program Claims Runout	$834,968	$0	($834,968)	Program Reauthorized	Exhibit F
SB 10-117: "OTC MEDS"	$0	$0	$0	Program Delayed	Exhibit F
Physicians to 100% of Medicare: 100% Federally Funded Portion	($9,575,251)	($6,027,427)	$3,547,824	Decreased Savings Utilization Expectations Based Upon Actuals	Exhibit F
Physicians to 100% of Medicare: GF and FF Portion Due to Rate Decreases Since 2009	($1,865,815)	($3,198,850)	($1,333,035)	Significantly Higher Volume of Code Utilization for Applicable Services	Exhibit F
Accountable Care Collaborative Savings	($44,211,123)	($42,240,749)	$1,970,374	Increased Savings Utilization Expectations Based Upon Actuals	Exhibit F
FY 2010-11 BRI-1: "Client Overutilization"	($394,665)	$0	$394,665	Savings Shifted to FY 2015-16 Due to Implementation Timing	Exhibit F
FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	$0	$0	$0		Exhibit F
Estimated Impact of Increasing PACE Enrollment	($3,253,223)	($4,995,171)	($1,741,948)	Increasing Enrollment in PACE Program	Exhibit F
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($1,441,287)	($731,697)	$709,590	Decreased Savings Utilization Expectations Based Upon Actuals	Exhibit F
Colorado Choice Transitions	$186,839	$345,145	$158,306	Decreased Savings Utilization Expectations Based Upon Actuals	Exhibit F
FY 2012-13 R-6: "Dental Efficiency"	$0	($464,900)	($464,900)	Savings Shifted From Prior Year Due to Implementation Timing	Exhibit F
FY 2012-13 R-6: "Augmentative Communication Devices"	($451,000)	($246,000)	$205,000	Savings Shifted to FY 2015-16 Due to Implementation Timing	Exhibit F
FY 2012-13 R-5: "ACC Gainsharing"	($1,401,004)	($1,401,004)	$0		Exhibit F
53 Pay Periods in FY 2013-14	($38,288,901)	($49,726,790)	($11,437,889)	Adjusted based upon actuals for extra pay period	Exhibit F
FY 2013-14 R-7: "Substance Abuse Disorder Benefit"	($1,485,982)	($1,485,982)	$0		Exhibit F
FY 2013-14 R-9: "Dental ASO for Children"	$0	($576,072)	($576,072)	Savings Shifted From Prior Year Due to Implementation Timing	Exhibit F
FY 2013-14 R-13: "2% Provider Rate Increase"	$4,523,183	$5,507,961	$984,778	Increased Costs due to Increased Utilization	Exhibit F
SB 13-200: "Medicaid Expansion Adjustment"	$53,348,482	($4,009,347)	($57,357,829)	Updated Assumptions Based Upon Actuals	Exhibit F
SB 13-242: "Adult Dental Benefit"	($30,741,961)	$82,118,666	$112,860,627	Updated Assumptions and Implementation Timing	Exhibit F
Preventive Services	$646,789	$107,372	($539,417)	Updated Assumptions Based Upon Actuals	Exhibit F
Fluoride Benefit Expansion for Children	$315,385	$578,206	$262,821	Updated Assumptions Based Upon Actuals	Exhibit F
CDASS Service Expansion into the Brain Injury Waiver	$0	($128,943)	($128,943)		Exhibit F
Clients move from Low Income Adults to Baby Care Adults	($6,395,649)	$0	$6,395,649	Accounted for in Exhibit J	Exhibit J
HB 14-1252: "Intellectual and Developmental Disabilities Services System Capacity"	($985,189)	($985,189)	$0		
FY 2014-15 R#7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($4,915,688)	($4,915,688)	$0		Exhibit F
FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents"	($168,363)	($168,363)	$0		Exhibit F
FY 2014-15 R#9: "Medicaid Community Living Initiative"	$364,073	$364,073	$0		Exhibit F
FY 2014-15 R#10: "Primary Care Specialty Collaboration"	$237,497	$237,497	$0		Exhibit F
FY 2014-15 R#11: "Community Provider Rate Increase"	$52,102,938	$52,102,938	$0		Exhibit F
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Extended Hours/After Hours Care 10% Rate Increase	$641,597	$641,597	$0		Exhibit F
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Incentives to Use Ambulatory Surgery Centers	$333,333	$333,333	$0		Exhibit F
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - High-Value Specialist Services to 80% of Medicare	$11,312,435	$11,312,435	$0		Exhibit F
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Mammography Reimbursement to 80% of Medicare	$94,841	$94,841	$0		Exhibit F
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Assistive Technology Reimbursement Rate to 80% of Medicare	$22,037	$22,037	$0		Exhibit F
FY 2014-15 BA-10 "Dental Provider Network Adequacy"	$5,000,000	$5,000,000	$0		Exhibit F
FY 2014-15 BA-10 Continuation of "1202 Provider Rate Increase"	$44,277,696	$44,277,696	$0		Exhibit F
FY 2014-15 BA-12 "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	$63,635	$63,635	$0		Exhibit F
JBC Action: "Matching Incentives to Ambulatory Surgery Center Facilities"	$500,000	$333,333	($166,667)	Delayed Implementation Shifted Costs Between Fiscal Years	Exhibit F
JBC Action: "Family Planning Rate Increase"	$1,817,275	$1,817,275	$0		Exhibit F
JBC Action: "Raising FQHC Rate Increase to APM"	$7,261,751	$7,261,751	$0		Exhibit F
JBC Action: "Full Denture Benefit"	$26,737,869	$24,509,713	($2,228,156)	Delayed Implementation Shifted Costs Between Fiscal Years	Exhibit F
EPSDT Personal Care	$0	$666,836	$666,836	Federal Requirement	Exhibit F
Total Acute Care	**$3,424,934,358**	**$3,466,947,104**	**$42,012,746**		
Community Based Long-Term Care					
Base CBLTC Cost	$473,728,615	$465,411,832	($8,316,783)		Exhibit G
Bottom Line Impacts					
Annualization of Adjustment of 53 Pay Periods	($5,223,933)	($5,933,553)	($709,620)	Adjusted based upon actuals for extra pay period	Exhibit G
Colorado Choice Transitions	$4,941,163	$1,787,479	($3,153,684)	Adjusted Client Enrollment Expectations	Exhibit G
CLLI Audit Recommendations	$669,816	$669,816	$0		Exhibit G
Annualization of 8.26% Rate Adjustment	$2,568,895	$2,568,895	$0		Exhibit G
Annualization of CDASS Service Expansion into the Brain Injury Waiver	$170,084	$277,249	$107,165		Exhibit G
Annualization of Alternative Therapies Waiver Chiropractic Rate Increase	$54,029	$54,029	$0		Exhibit G
Annualization of Persons Living with AIDS Waiver Consolidation into the Elderly, Blind and Disabled Waiver	$0	$0	$0		Exhibit G
HB 14-1252: "Intellectual and Developmental Disabilities Service System Capacity"	($236,826)	($236,826)	$0		Exhibit G
HB 14-1357: "In-Home Support Services in Medicaid Program"	$297,986	$297,986	$0		Exhibit G
Raising Cap on Home Modifications	$676,923	$676,923	$0		Exhibit G
FY 2014-15 R#7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($1,880,836)	($1,880,836)	$0		Exhibit G
FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents"	($116,274)	($116,274)	$0		Exhibit G
FY 2014-15 R#11: "Community Provider Rate Increase" Targeted - Pediatric Hospice Services 20%	$246,878	$246,878	$0		Exhibit G
FY 2014-15 R#11: "Community Provider Rate Increase" 2% Across the Board Increase	$6,431,610	$6,431,610	$0		Exhibit G
FY 2014-15 R#12: "Administrative Contract Reprocurement"	$1,753,499	$1,753,499	$0		Exhibit G
EPSDT Personal Care	$0	($321,140)	($321,140)	Federal Requirement	Exhibit G
CDASS Administrative FMS & Training Contract Competitive Reprocurement	$0	($1,948,583)	($1,948,583)	Lowered Administrative Costs for New Contract	Exhibit G
Total Community Based Long-Term Care	**$484,081,629**	**$469,738,984**	**($14,342,645)**		

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills - FY 2014-15

Item	Long Bill and Special Bills	R-1 Request (November 2014)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Long-Term Care and Insurance					
Class I Nursing Facilities					
Base Class I Nursing Facility Cost	$567,290,694	$583,208,697	$15,918,003		Exhibit H
Bottom Line Impacts					
Hospital Back Up Program	$6,783,601	$7,172,066	$388,465	Revised Forecast	Exhibit H
Recoveries from Department Overpayment Review	($1,658,080)	($1,600,000)	$58,080	Revised Forecast	Exhibit H
Savings from days incurred in FY 2013-14 and paid in FY 2014-15 under HB 13-1152	($672,693)	$0	$672,693	Annualized Out of Base	Exhibit H
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($9,659,675)	($8,163,270)	$1,496,405	Revised Forecast	Exhibit H
Colorado Choice Transitions	($5,563,503)	($4,117,244)	$1,446,259	Decreased Savings Utilization Expectations Based Upon Actuals	Exhibit H
SB 14-130: "Increase Personal Care Allowance Nursing Facility"	$1,057,300	$1,057,300	$0		Exhibit H
Payment for Audit Findings Concerning Nursing Facility Supplemental Payments	$0	$2,470,450	$2,470,450	New Information	
Total Class I Nursing Facilities	**$557,577,644**	**$580,027,999**	**$22,450,355**		
Class II Nursing Facilities					
Base Class II Nursing Facilities Cost	$4,227,768	$4,214,187	($13,581)	Revised Forecast	Exhibit H
Bottom Line Impacts					
Total Class II Nursing Facilities	**$4,227,768**	**$4,214,187**	**($13,581)**		
Program of All Inclusive Care for the Elderly (PACE)					
Base PACE Cost	$130,064,953	$139,607,769	$9,542,816	Revised Forecast	Exhibit H
Bottom Line Impacts					
Total Program of All-Inclusive Care for the Elderly	**$130,064,953**	**$139,607,769**	**$9,542,816**		
Supplemental Medicare Insurance Benefit (SMIB)					
Base SMIB Cost	$135,041,629	$135,739,015	$697,386	Medicare Part B Premium Remained Constant	Exhibit H
Bottom Line Impacts					
Total Supplemental Medicare Insurance Benefit	**$135,041,629**	**$135,739,015**	**$697,386**		
Health Insurance Buy-In Program (HIBI)					
Base HIBI Cost	$3,376,553	$1,365,261	($2,011,292)		Exhibit H
Bottom Line Impacts					
SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$525,525	$29,975	($495,550)	Delayed Program Implementation	Exhibit H
SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$1,287,596	$393,991	($893,605)	Delayed Program Implementation	Exhibit H
Total Health Insurance Buy-In Program	**$5,189,674**	**$1,789,227**	**($3,400,447)**		
Total Long-Term Care and Insurance	**$832,101,668**	**$861,378,197**	**$29,276,529**		
Service Management					
Single Entry Points (SEP)					
Single Entry Points (SEP) Base	$29,078,489	$29,304,678	$226,189		Exhibit I
Bottom Line Impacts					
FY 2014-15 R#11: "Community Provider Rate Increase" Targeted - Single Entry Point case Management 10% Rate Increase	$1,229,790	$1,229,790	$0		Exhibit I
Total Single Entry Points	**$30,308,279**	**$30,534,468**	**$226,189**		
Disease Management					
Base Disease Management	$506,957	$526,953	$19,996		Exhibit I
Bottom Line Impacts					
Smoking Quit line	$773,859	$773,859	$0		Exhibit I
Total Disease Management	**$1,280,816**	**$1,300,812**	**$19,996**		
Prepaid Inpatient Health Plan Administration					
PIHP Base	$119,120,223	$133,904,405	$14,784,182	Revised Forecast	Exhibit I
Bottom Line Impacts					
Total Prepaid Inpatient Health Plan Administration	**$119,120,223**	**$133,904,405**	**$14,784,182**		
Total Service Management	**$150,709,318**	**$165,739,685**	**$15,030,367**		
Grand Total Services	**$4,891,826,973**	**$4,963,803,970**	**$71,976,997**		

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills - FY 2014-15

Item	Long Bill and Special Bills	R-1 Request (November 2014)	Difference from Appropriation	Description of Difference from Appropriation	Department Source
Bottom Line Financing					
Upper Payment Limit Financing	$5,162,991	$5,065,793	($97,198)		Exhibit K
Department Recoveries Adjustment	$0	$0	$0		Exhibit A
Denver Health Outstationing	$14,066,357	$6,408,699	($7,657,658)		Exhibit A
Hospital Provider Fee Supplemental Payments	$683,597,029	$757,053,890	$73,456,861		Exhibit J
Nursing Facility Provider Fee Supplemental Payments	$86,274,152	$92,730,698	$6,456,546		Exhibit H
Physician Supplemental Payments	$11,240,250	$5,619,125	($5,621,125)		Exhibit A
Memorial Hospital High Volume Supplemental Payments	$2,185,018	$5,562,375	$3,377,357		Exhibit A
Health Care Expansion Fund Transfer Adjustment	$0	$0	$0		Exhibit A
Intergovernmental Transfer for Difficult to Discharge Clients	$30,000,000	$30,000,000	$0		Exhibit A
Cash Funds Financing(1)	$0	$0	$0		Exhibit A
Total Bottom Line Financing	**$832,525,797**	**$902,440,580**	**$69,914,783**		
Grand Total[(1)]	**$5,724,352,770**	**$5,866,244,550**	**$141,891,780**		
Total Acute Care	$3,424,934,358	$3,466,947,104	$42,012,746		
Total Community Based Long-Term Care	$484,081,629	$469,738,984	($14,342,645)		
Total Class I Nursing Facilities	$557,577,644	$580,027,999	$22,450,355		
Total Class II Nursing Facilities	$4,227,768	$4,214,187	($13,581)		
Total Program of All-Inclusive Care for the Elderly	$130,064,953	$139,607,769	$9,542,816		
Total Supplemental Medicare Insurance Benefit	$135,041,629	$135,739,015	$697,386		
Total Health Insurance Buy-In Program	$5,189,674	$1,789,227	($3,400,447)		
Total Single Entry Point	$30,308,279	$30,534,468	$226,189		
Total Disease Management	$1,280,816	$1,300,812	$19,996		
Total Prepaid Inpatient Health Plan Administration	$119,120,223	$133,904,405	$14,784,182		
Total Bottom Line Financing	$832,525,797	$902,440,580	$69,914,783		
Grand Total[(1)]	**$5,724,352,770**	**$5,866,244,550**	**$141,891,780**		
Footnotes					
(1) The Department Request is the sum of all the pieces in this document and comprises the summation of this Budget Request for Medical Services Premiums. This total matches the totals presented in Exhibit A of this Request.					

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills - FY 2015-16

Item	Base Spending Authority	R-1 Request (November 2014)	Difference	Description of Difference from Base Request
Acute Care				
Base Acute Cost	$3,316,374,819	$3,642,132,777	$325,757,958	Increasing Caseload and Per Capita Costs
Bottom Line Impacts				
Breast and Cervical Cancer Program Claims Runout	$834,968	$0	($834,968)	Program Reauthorized
SB 10-117: "OTC MEDS"	$0	$0	$0	Program Delayed
Physicians to 100% of Medicare: 100% Federally Funded Portion	($38,914,422)	($38,755,940)	$158,482	Decreased Savings Utilization Expectations Based Upon Actuals
Physicians to 100% of Medicare: GF and FF Portion Due to Rate Decreases Since 2009	($4,254,431)	($4,269,882)	($15,451)	Significantly Higher Volume of Code Utilization for Applicable Services
Accountable Care Collaborative Savings	($65,353,795)	($67,833,935)	($2,480,140)	Increased Savings Utilization Expectations Based Upon Actuals
FY 2010-11 BRI-1: "Client Overutilization"	($394,665)	$0	$394,665	Savings Shifted to FY 2015-16 Due to Implementation Timing
FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	$0	$0	$0	
Estimated Impact of Increasing PACE Enrollment	($5,950,351)	($7,734,047)	($1,783,696)	Increasing Enrollment in PACE Program
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($1,441,287)	($1,811,118)	($369,831)	Decreased Savings Utilization Expectations Based Upon Actuals
Colorado Choice Transitions	$389,908	$1,018,292	$628,384	Decreased Savings Utilization Expectations Based Upon Actuals
FY 2012-13 R-6: "Dental Efficiency"	$0	($1,859,599)	($1,859,599)	Savings Shifted From Prior Year Due to Implementation Timing
FY 2012-13 R-6: "Augmentative Communication Devices"	($492,000)	($492,000)	$0	
FY 2012-13 R-5: "ACC Gainsharing"	($1,401,004)	($1,401,004)	$0	
53 Pay Periods in FY 2013-14	($38,288,901)	($49,726,790)	($11,437,889)	Adjusted based upon actuals for extra pay period
FY 2013-14 R-7: "Substance Abuse Disorder Benefit"	($1,485,982)	($1,485,982)	$0	
FY 2013-14 R-9: "Dental ASO for Children"	$0	($576,072)	($576,072)	Savings Shifted From Prior Year Due to Implementation Timing
FY 2013-14 R-13: "2% Provider Rate Increase"	$4,523,183	$5,507,961	$984,778	Increased Costs due to Increased Utilization
SB 13-200: "Medicaid Expansion Adjustment"	($77,335,403)	($4,975,338)	$72,360,065	Updated Assumptions Based Upon Actuals
SB 13-242: "Adult Dental Benefit"	$53,348,482	$82,118,666	$28,770,184	Updated Assumptions and Implementation Timing
Preventive Services	$646,789	$107,372	($539,417)	Updated Assumptions Based Upon Actuals
Fluoride Benefit Expansion for Children	$0	$52,564	$52,564	Updated Assumptions Based Upon Actuals
CDASS Service Expansion into the Brain Injury Waiver	$79,103	($128,943)	($208,046)	
Clients move from Low Income Adults to Baby Care Adults	($6,395,649)	$0	$6,395,649	Accounted for in Exhibit J
HB 14-1252: "Intellectual and Developmental Disabilities Services System Capacity"	($978,215)	($978,215)	$0	
FY 2014-15 R#7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($4,915,688)	($4,915,688)	$0	
FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents"	($336,726)	($336,726)	$0	
FY 2014-15 R#9: "Medicaid Community Living Initiative"	$370,067	$370,067	$0	
FY 2014-15 R#10: "Primary Care Specialty Collaboration"	($173,987)	($173,987)	$0	
FY 2014-15 R#11: "Community Provider Rate Increase"	$100,808,404	$100,808,404	$0	
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Extended Hours/After Hours Care 10% Rate Increase	$699,924	$699,924	$0	
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Incentives to Use Ambulatory Surgery Centers	$500,000	$500,000	$0	
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - High-Value Specialist Services to 80% of Medicare	$12,340,838	$12,340,838	$0	
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Mammography Reimbursement to 80% of Medicare	$103,463	$103,463	$0	
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Assistive Technology Reimbursement Rate to 80% of Medicare	$24,040	$24,040	$0	
FY 2014-15 BA-10 "Dental Provider Network Adequacy"	$0	$0	$0	
FY 2014-15 BA-10 Continuation of "1202 Provider Rate Increase"	$92,983,162	$92,983,162	$0	
FY 2014-15 BA-12 "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	($8,318,999)	($8,318,999)	$0	
JBC Action: "Matching Incentives to Ambulatory Surgery Center Facilities"	$500,000	$500,000	$0	Delayed Implementation Shifted Costs Between Fiscal Years
JBC Action: "Family Planning Rate Increase"	$1,982,482	$1,982,482	$0	
JBC Action: "Raising FQHC Rate Increase to APM"	$7,921,910	$7,921,910	$0	
JBC Action: "Full Denture Benefit"	$26,737,869	$26,737,869	$0	Delayed Implementation Shifted Costs Between Fiscal Years
EPSDT Personal Care	$0	$1,333,672	$1,333,672	Federal Requirement
Total Acute Care	**$3,364,737,906**	**$3,781,469,198**	**$416,731,292**	
Community Based Long-Term Care				
Base CBLTC Cost	$500,052,999	$506,746,276	$6,693,277	
Bottom Line Impacts				
Annualization of Adjustment of 53 Pay Periods	($5,223,933)	($5,933,553)	($709,620)	Adjusted based upon actuals for extra pay period
Colorado Choice Transitions	$11,264,631	$5,322,651	($5,941,980)	Adjusted Client Enrollment Expectations
CLLI Audit Recommendations	$730,708	$730,708	$0	
Annualization of 8.26% Rate Adjustment	$2,568,895	$2,568,895	$0	
Annualization of CDASS Service Expansion into the Brain Injury Waiver	$170,084	$277,249	$107,165	
Annualization of Alternative Therapies Waiver Chiropractic Rate Increase	$54,029	$54,029	$0	
Annualization of Persons Living with AIDS Waiver Consolidation into the Elderly, Blind and Disabled Waiver	$0	$0	$0	
HB 14-1252: "Intellectual and Developmental Disabilities Service System Capacity"	($256,584)	($256,584)	$0	
HB 14-1357: "In-Home Support Services in Medicaid Program"	$1,191,942	$1,191,942	$0	
Raising Cap on Home Modifications	$1,353,846	$1,353,846	$0	
FY 2014-15 R#7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($1,880,836)	($1,880,836)	$0	
FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents"	($232,548)	($232,548)	$0	
FY 2014-15 R#11: "Community Provider Rate Increase" Targeted - Pediatric Hospice Services 20%	$269,321	$269,321	$0	
FY 2014-15 R#11: "Community Provider Rate Increase" 2% Across the Board Increase	$7,016,302	$7,016,302	$0	
FY 2014-15 R#12: "Administrative Contract Reprocurement"	$1,753,499	$1,753,499	$0	
EPSDT Personal Care	($642,280)	($642,280)	$0	Federal Requirement
CDASS Administrative FMS & Training Contract Competitive Reprocurement	($4,181,306)	($4,181,306)	$0	Lowered Administrative Costs for New Contract
Total Community Based Long-Term Care	**$514,008,769**	**$514,157,611**	**$148,842**	

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills - FY 2015-16

Item	Base Spending Authority	R-1 Request (November 2014)	Difference	Description of Difference from Base Request
Long-Term Care and Insurance				
Class I Nursing Facilities				
Base Class I Nursing Facility Cost	$597,504,474	$606,088,634	$8,584,160	
Bottom Line Impacts				
Hospital Back Up Program	$14,662,667	$14,960,571	$297,904	Revised Forecast
Recoveries from Department Overpayment Review	($3,376,348)	($3,258,080)	$118,268	Revised Forecast
Savings from days incurred in FY 2013-14 and paid in FY 2014-15 under HB 13-1152	($1,360,821)	($627,675)	$733,146	annualizing out
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($19,656,960)	($16,608,995)	$3,047,965	Policy Adjustment
Colorado Choice Transitions	($15,889,223)	($14,780,493)	$1,108,730	Revised Forecast
SB 14-130: "Increase Personal Care Allowance Nursing Facility"	$1,057,300	$2,645,540	$1,588,240	
Payment for Audit Findings Concerning Nursing Facility Supplemental Payments	$0	$2,470,450	$2,470,450	Audit Findings
Total Class I Nursing Facilities	**$572,941,089**	**$590,889,952**	**$17,948,863**	
Class II Nursing Facilities				
Base Class II Nursing Facilities	$4,311,644	$4,711,461	$399,817	Revised Forecast
Bottom Line Impacts				
Total Class II Nursing Facilities	**$4,311,644**	**$4,711,461**	**$399,817**	
Program of All Inclusive Care for the Elderly (PACE)				
Base PACE Cost	$145,543,632	$145,181,513	($362,119)	Revised Forecast
Bottom Line Impacts				
Total Program of All-Inclusive Care for the Elderly	**$145,543,632**	**$145,181,513**	**($362,119)**	
Supplemental Medicare Insurance Benefit (SMIB)				
Base SMIB	$143,785,430	$143,021,819	($763,611)	Revised Forecast
Bottom Line Impacts				
Total Supplemental Medicare Insurance Benefit	**$143,785,430**	**$143,021,819**	**($763,611)**	
Health Insurance Buy-In Program (HIBI)				
Base HIBI Cost	$3,863,864	$1,365,261	($2,498,603)	
Bottom Line Impacts				
SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$525,525	$74,195	($451,330)	
SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$1,287,596	$975,217	($312,379)	
Total Health Insurance Buy-In Program	**$5,676,985**	**$2,414,673**	**($3,262,312)**	
Total Long-Term Care and Insurance	**$872,258,780**	**$886,219,418**	**$13,960,638**	
Service Management				
Single Entry Points (SEP)				
FY 2012-13 Base Contracts	$30,431,479	$31,529,926	$1,098,447	Revised Forecast
Bottom Line Impacts				
FY 2014-15 R#11: "Community Provider Rate Increase" Targeted - Single Entry Point case Management 10% Rate Increase	$1,229,790	$1,229,790	$0	
Total Single Entry Points	**$31,661,269**	**$32,759,716**	**$1,098,447**	
Disease Management				
Base Disease Management	$599,398	$491,021	($108,377)	Revised Forecast
Bottom Line Impacts				
Smoking Quit line	$773,859	$773,859	$0	
Total Disease Management	**$1,373,257**	**$1,264,880**	**($108,377)**	
Prepaid Inpatient Health Plan Administration				
Estimated FY 2010-11 Base Expenditures	$137,142,617	$141,660,728	$4,518,111	Revised Forecast
Bottom Line Impacts				
Total Prepaid Inpatient Health Plan Administration	**$137,142,617**	**$141,660,728**	**$4,518,111**	
Total Service Management	**$170,177,143**	**$175,685,324**	**$5,508,181**	
Grand Total Services	**$4,921,182,598**	**$5,357,531,551**	**$436,348,953**	

Exhibit E - Comparison of Request to Long Bill Appropriation and Special Bills - FY 2015-16

Item	Base Spending Authority	R-1 Request (November 2014)	Difference	Description of Difference from Base Request
Bottom Line Financing				
Upper Payment Limit Financing	$7,623,824	$5,158,379	($2,465,445)	Revised Forecast
Department Recoveries Adjustment	$0	$0	$0	
Denver Health Outstationing	$6,964,536	$6,408,699	($555,837)	Revised Forecast
Hospital Provider Fee Supplemental Payments	$693,330,144	$820,149,821	$126,819,677	Revised Forecast
Nursing Facility Provider Fee Supplemental Payments	$95,428,177	$96,096,822	$668,645	Revised Forecast
Physician Supplemental Payments	$13,483,709	$5,619,125	($7,864,584)	Revised Forecast
Memorial Hospital High Volume Supplemental Payments	$555,237	$5,562,375	$5,007,138	Revised Forecast
Health Care Expansion Fund Transfer Adjustment	$0	$0	$0	
Intergovernmental Transfer for Difficult to Discharge Clients	$30,000,000	$30,000,000	$0	Revised Forecast
Cash Funds Financing[1]	$0	$0	$0	
Grand Total[2]	**$5,768,568,225**	**$6,326,526,772**	**$557,958,547**	
Total Acute Care	$3,364,737,906	$3,781,469,198	$416,731,292	
Total Community Based Long-Term Care	$514,008,769	$514,157,611	$148,842	
Total Class I Nursing Facilities	$572,941,089	$590,889,952	$17,948,863	
Total Class II Nursing Facilities	$4,311,644	$4,711,461	$399,817	
Total Program of All-Inclusive Care for the Elderly	$145,543,632	$145,181,513	($362,119)	
Total Supplemental Medicare Insurance Benefit	$143,785,430	$143,021,819	($763,611)	
Total Health Insurance Buy-In Program	$5,676,985	$2,414,673	($3,262,312)	
Total Single Entry Point	$31,661,269	$32,759,716	$1,098,447	
Total Disease Management	$1,373,257	$1,264,880	($108,377)	
Total Prepaid Inpatient Health Plan Administration	$137,142,617	$141,660,728	$4,518,111	
Total Bottom Line Financing	$847,385,627	$968,995,221	$121,609,594	
Rounding Adjustment	$0	$0	$0	
Grand Total[2]	**$5,768,568,225**	**$6,326,526,772**	**$557,958,547**	

Footnotes

(1) The Department has not received a FY 2015-16 appropriation as of this Budget Request. No annualizations are included.

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

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

Cash Based Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$112,419,226	$45,351,381	$387,591,606	$0	$198,695,066	$0	$0	$6,809,762	$312,707,761	$0	$44,927,120	$41,011,299	$0	$55,307,093	$2,067,371	$1,206,887,685
FY 2006-07	$83,410,163	$44,481,575	$383,750,038	$0	$203,830,016	$0	$0	$5,555,696	$327,210,370	$0	$49,460,226	$48,460,189	$0	$54,457,447	$2,748,118	$1,203,363,838
FY 2007-08	$91,223,938	$50,717,725	$450,621,054	$0	$205,933,059	$0	$0	$7,089,560	$360,156,073	$0	$58,954,606	$54,344,094	$0	$53,633,572	$3,330,605	$1,336,004,286
FY 2008-09	$102,239,226	$56,004,946	$492,622,774	$0	$237,359,354	$0	$0	$7,043,287	$428,647,150	$0	$61,714,145	$60,515,451	$0	$59,182,087	$3,886,476	$1,509,214,896
FY 2009-10 (DA)	$94,978,885	$54,197,977	$489,172,778	$0	$259,666,993	$3,085,476	$0	$9,006,411	$462,761,448	$0	$60,444,300	$68,066,557	$0	$48,429,084	$3,328,831	$1,553,138,739
FY 2010-11 (DA)	$97,388,620	$61,036,898	$529,213,760	$0	$274,229,762	$61,707,804	$0	$9,817,196	$497,319,012	$0	$62,802,717	$67,507,543	$0	$45,331,275	$5,066,688	$1,711,421,275
FY 2011-12	$94,396,992	$67,010,397	$555,792,836	$398,462	$301,175,002	$83,020,177	$2,393,150	$10,272,697	$512,975,400	$0	$59,325,794	$63,318,002	$0	$41,938,165	$5,407,941	$1,797,425,015
FY 2012-13	$100,206,400	$72,945,965	$556,997,760	$11,806,899	$316,984,870	$92,100,414	$55,270,434	$9,559,216	$552,331,119	$14,144,638	$56,920,356	$72,165,834	$2,846,306	$43,756,602	$6,305,490	$1,964,342,303
FY 2013-14	$111,926,692	$82,815,186	$616,667,268	$27,359,865	$357,971,947	$108,370,603	$319,962,742	$8,879,715	$635,883,491	$37,376,981	$63,491,746	$121,662,449	$9,212,035	$38,511,597	$8,917,128	$2,549,009,445
Estimated FY 2014-15	$124,054,802	$92,590,742	$640,986,160	$44,429,269	$440,232,394	$146,077,167	$940,939,106	$6,094,937	$674,210,776	$68,946,135	$66,150,629	$148,281,621	$16,159,056	$46,926,357	$10,867,953	$3,466,947,104
Estimated FY 2015-16	$124,239,557	$97,143,908	$669,753,623	$53,419,480	$469,977,526	$154,785,190	$1,124,550,606	$2,811,897	$717,398,987	$74,595,915	$67,415,274	$151,547,920	$18,116,831	$47,495,218	$8,217,266	$3,781,469,198
Estimated FY 2016-17	$123,098,618	$99,124,639	$684,338,043	$62,743,677	$483,610,476	$157,794,346	$1,274,868,041	$976,876	$731,068,514	$79,365,127	$66,227,391	$146,897,845	$19,034,727	$46,574,890	$6,763,491	$3,982,486,701

Percent Change in Cash Based Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	-25.80%	-1.92%	-0.99%	0.00%	2.58%	0.00%	0.00%	-18.42%	4.64%	0.00%	10.09%	18.16%	0.00%	-1.54%	32.93%	-0.29%
FY 2007-08	9.37%	14.02%	17.43%	0.00%	1.03%	0.00%	0.00%	27.61%	10.07%	0.00%	19.20%	12.14%	0.00%	-1.51%	21.20%	11.02%
FY 2008-09	12.07%	10.42%	9.32%	0.00%	15.26%	0.00%	0.00%	-0.65%	19.02%	0.00%	4.68%	11.36%	0.00%	10.35%	16.69%	12.96%
FY 2009-10 (DA)	-7.10%	-3.23%	-0.70%	0.00%	9.40%	0.00%	0.00%	27.87%	7.96%	0.00%	-2.06%	12.48%	0.00%	-18.17%	-14.35%	2.91%
FY 2010-11 (DA)	2.54%	12.62%	8.19%	0.00%	5.61%	1899.94%	0.00%	9.00%	7.47%	0.00%	3.90%	-0.82%	0.00%	-6.40%	52.21%	10.19%
FY 2011-12	-3.07%	9.79%	5.02%	0.00%	9.83%	34.54%	0.00%	4.64%	3.15%	0.00%	-5.54%	-6.21%	0.00%	-7.49%	6.74%	5.03%
FY 2012-13	6.15%	8.86%	0.22%	2863.12%	5.25%	10.94%	2209.53%	-6.95%	7.67%	0.00%	-4.05%	13.97%	0.00%	4.34%	16.60%	9.29%
FY 2013-14	11.70%	13.53%	10.71%	131.73%	12.93%	17.67%	478.90%	-7.11%	15.13%	164.25%	11.54%	68.59%	223.65%	-11.99%	41.42%	29.76%
Estimated FY 2014-15	10.84%	11.80%	3.94%	62.39%	22.98%	34.79%	194.08%	-31.36%	6.03%	84.46%	4.19%	21.88%	75.41%	21.85%	21.88%	36.01%
Estimated FY 2015-16	0.15%	4.92%	4.49%	20.23%	6.76%	5.96%	19.51%	-53.87%	6.41%	8.19%	1.91%	2.20%	12.12%	1.21%	-24.39%	9.07%
Estimated FY 2016-17	-0.92%	2.04%	2.18%	17.45%	2.90%	1.94%	13.37%	-65.26%	1.91%	6.39%	-1.76%	-3.07%	5.07%	-1.94%	-17.69%	5.32%

Per Capita Cost

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$3,104.90	$7,506.02	$8,099.29	$0.00	$3,374.29	$0.00	$0.00	$36,222.14	$1,460.17	$0.00	$2,729.47	$8,011.58	$0.00	$8,903.27	$186.38	$3,000.58
FY 2006-07	$2,324.18	$7,341.41	$7,863.89	$0.00	$3,649.60	$0.00	$0.00	$24,367.09	$1,593.12	$0.00	$2,957.44	$9,351.64	$0.00	$10,470.57	$212.90	$3,068.01
FY 2007-08	$2,514.16	$8,252.15	$9,024.51	$0.00	$3,851.16	$0.00	$0.00	$26,257.63	$1,765.28	$0.00	$3,439.39	$8,642.51	$0.00	$12,797.32	$234.32	$3,408.50
FY 2008-09	$2,717.76	$8,686.98	$9,592.50	$0.00	$3,836.17	$0.00	$0.00	$22,218.57	$1,823.03	$0.00	$3,422.29	$8,674.81	$0.00	$14,843.76	$257.81	$3,455.07
FY 2009-10 (DA)	$2,467.82	$7,688.75	$9,183.93	$0.00	$3,469.67	$952.90	$0.00	$21,191.56	$1,678.67	$0.00	$3,288.41	$8,693.05	$0.00	$13,113.75	$209.11	$3,113.77
FY 2010-11 (DA)	$2,504.92	$7,858.49	$9,402.39	$0.00	$3,380.79	$2,271.43	$0.00	$18,488.13	$1,644.52	$0.00	$3,414.49	$8,580.01	$0.00	$14,108.71	$296.47	$3,052.20
FY 2011-12	$2,375.36	$7,993.61	$9,351.43	$7,662.73	$3,230.66	$2,341.17	$2,110.36	$17,207.20	$1,532.95	$0.00	$3,289.66	$8,298.56	$0.00	$15,140.13	$286.57	$2,899.25
FY 2012-13	$2,454.41	$8,059.44	$8,995.44	$13,296.06	$3,189.24	$2,216.88	$5,197.52	$15,343.85	$1,534.92	$1,717.42	$3,201.91	$8,993.75	$8,284.18	$16,302.76	$297.34	$2,876.08
FY 2013-14	$2,675.37	$8,405.07	$9,572.01	$10,687.45	$2,871.13	$2,301.74	$3,667.49	$15,885.00	$1,600.26	$1,383.56	$3,475.76	$9,244.87	$8,715.26	$15,522.61	$381.43	$2,960.67
Estimated FY 2014-15	$2,958.48	$8,543.16	$9,617.49	$12,007.91	$2,828.04	$2,262.55	$4,204.84	$16,562.33	$1,535.45	$1,318.18	$3,209.01	$9,804.39	$9,144.91	$16,711.67	$398.66	$3,077.72
Estimated FY 2015-16	$2,885.27	$8,490.12	$9,700.67	$12,254.99	$2,749.45	$2,193.26	$4,394.08	$16,638.44	$1,530.01	$1,315.02	$3,222.53	$9,883.77	$9,191.70	$17,321.38	$275.89	$3,094.83
Estimated FY 2016-17	$2,796.11	$8,277.63	$9,610.81	$12,672.93	$2,586.11	$2,067.94	$4,444.45	$16,557.22	$1,467.48	$1,292.13	$3,123.34	$9,475.45	$8,978.64	$17,398.17	$207.47	$3,026.04

Percent Change in Per Capita Cost

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	-25.14%	-2.19%	-2.91%	0.00%	8.16%	0.00%	0.00%	-32.73%	9.11%	0.00%	8.35%	16.73%	0.00%	17.60%	14.23%	2.25%
FY 2007-08	8.17%	12.41%	14.76%	0.00%	5.52%	0.00%	0.00%	7.76%	10.81%	0.00%	16.30%	-7.58%	0.00%	22.22%	10.06%	11.10%
FY 2008-09	8.10%	5.27%	6.29%	0.00%	-0.39%	0.00%	0.00%	-15.38%	3.27%	0.00%	-0.50%	0.37%	0.00%	15.99%	10.02%	1.37%
FY 2009-10 (DA)	-9.20%	-11.49%	-4.26%	0.00%	-9.55%	0.00%	0.00%	-4.62%	-7.92%	0.00%	-3.91%	0.21%	0.00%	-11.65%	-18.89%	-9.88%
FY 2010-11 (DA)	1.50%	2.21%	2.38%	0.00%	-2.56%	138.37%	0.00%	-12.76%	-2.03%	0.00%	3.83%	-1.30%	0.00%	7.59%	41.78%	-1.98%
FY 2011-12	-5.17%	1.72%	-0.54%	0.00%	-4.44%	3.07%	0.00%	-6.93%	-6.78%	0.00%	-3.66%	-3.28%	0.00%	7.31%	-3.34%	-5.01%
FY 2012-13	3.33%	0.82%	-3.81%	73.52%	-1.28%	-5.31%	146.29%	-10.83%	0.13%	0.00%	-2.67%	8.38%	0.00%	7.68%	3.76%	-0.80%
FY 2013-14	9.00%	4.29%	6.41%	-19.62%	-9.97%	3.83%	-29.44%	3.53%	4.26%	-19.44%	8.55%	2.79%	5.20%	-4.79%	28.28%	2.94%
Estimated FY 2014-15	10.58%	1.64%	0.48%	12.36%	-1.50%	-1.70%	14.65%	4.26%	-4.05%	-4.73%	-7.67%	6.05%	4.93%	7.66%	4.52%	3.95%
Estimated FY 2015-16	-2.47%	-0.62%	0.86%	2.06%	-2.78%	-3.06%	4.50%	0.46%	-0.35%	-0.24%	0.42%	0.81%	0.51%	3.65%	-30.80%	0.56%
Estimated FY 2016-17	-3.09%	-2.50%	-0.93%	3.41%	-5.94%	-5.71%	1.15%	-0.49%	-4.09%	-1.74%	-3.08%	-4.13%	-2.32%	0.44%	-24.80%	-2.22%

Per Capita Trends

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Actual FY 2013-14 Per Capita	$2,675.37	$8,405.07	$9,572.01	$10,687.45	$2,871.13	$2,301.74	$3,667.49	$15,885.00	$1,600.26	$1,383.56	$3,475.76	$9,244.87	$8,715.26	$15,522.61	$381.43	$2,960.67
Average of FY 2007-08 through FY 2011-12	0.68%	2.02%	3.73%	0.00%	0.00%	28.29%	0.00%	-6.39%	-0.53%	0.00%	2.41%	-2.32%	0.00%	8.29%	7.93%	-0.88%
Average of FY 2008-09 through FY 2011-12	-1.19%	-0.57%	0.97%	0.00%	-4.24%	35.36%	0.00%	-9.92%	-3.37%	0.00%	-1.06%	-1.00%	0.00%	4.81%	7.39%	-3.88%
Average of FY 2009-10 through FY 2011-12	-4.29%	-2.52%	-0.81%	0.00%	-5.52%	47.15%	0.00%	-8.10%	-5.58%	0.00%	-1.25%	-1.46%	0.00%	1.08%	6.52%	-5.62%
Average of FY 2010-11 through FY 2011-12	-1.84%	1.97%	0.92%	0.00%	-3.50%	70.72%	0.00%	-9.85%	-4.41%	0.00%	0.09%	-2.29%	0.00%	7.45%	19.22%	-3.50%
Average of FY 2008-09 through FY 2012-13	-0.29%	-0.29%	0.01%	14.70%	-3.64%	27.23%	29.26%	-10.10%	-2.67%	0.00%	-1.38%	0.88%	0.00%	5.38%	6.67%	-3.26%
Average of FY 2009-10 through FY 2012-13	-2.39%	-1.69%	-1.56%	18.38%	-4.46%	34.03%	36.57%	-8.79%	-4.15%	0.00%	-1.60%	1.00%	0.00%	2.73%	5.83%	-4.42%
Average of FY 2010-11 through FY 2012-13	-0.11%	1.58%	-0.66%	24.51%	-2.76%	45.38%	48.76%	-10.17%	-2.89%	0.00%	-0.83%	1.27%	0.00%	7.53%	14.07%	-2.60%
Average of FY 2011-12 through FY 2012-13	-0.92%	1.27%	-2.18%	36.76%	-2.86%	-1.12%	73.15%	-8.88%	-3.33%	0.00%	-3.17%	2.55%	0.00%	7.50%	0.21%	-2.91%
Average of FY 2009-10 through FY 2013-14	-0.11%	-0.49%	0.04%	10.78%	-5.56%	27.99%	23.37%	-6.32%	-2.47%	-3.89%	0.43%	1.36%	1.04%	1.23%	10.32%	-2.95%
Average of FY 2010-11 through FY 2013-14	2.17%	2.26%	1.11%	13.48%	-4.56%	34.99%	29.21%	-6.75%	-1.11%	-4.86%	1.51%	1.65%	1.30%	4.45%	17.62%	-1.21%
Average of FY 2011-12 through FY 2013-14	2.39%	2.28%	0.69%	17.97%	-5.23%	0.53%	38.95%	-4.74%	-0.80%	-6.48%	0.74%	2.63%	1.73%	3.40%	9.57%	-0.96%
Average of FY 2012-13 through FY 2013-14	6.17%	2.56%	1.30%	26.95%	-5.63%	-0.74%	58.43%	-3.65%	2.20%	-9.72%	2.94%	5.59%	2.60%	1.45%	16.02%	1.07%

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

Current Year Projection

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Percentage Selected to Modify Per Capita[1]	0.36%	0.35%	0.80%	5.00%	-7.50%	-9.34%	10.00%	0.00%	-6.00%	-6.00%	-8.00%	0.00%	0.00%	2.95%	2.67%	
Estimated FY 2014-15 Base Per Capita	$2,685.00	$8,434.49	$9,648.59	$11,221.82	$2,655.80	$2,086.76	$4,034.24	$15,885.00	$1,504.24	$1,300.55	$3,197.70	$9,244.87	$8,715.26	$15,980.53	$391.61	$2,974.39
Estimated FY 2014-15 Eligibles	41,932	10,838	66,648	3,700	155,667	64,563	223,775	368	439,097	52,304	20,614	15,124	1,767	2,808	27,261	1,126,466
Estimated FY 2014-15 Base Expenditures	$112,587,420	$91,413,003	$643,059,226	$41,520,734	$413,420,419	$134,727,486	$902,762,056	$5,845,680	$660,507,271	$68,023,967	$65,917,388	$139,819,414	$15,399,864	$44,873,328	$10,675,680	$3,350,552,936
Bottom Line Impacts																
SB 10-117: "OTC MEDS"	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physicians to 100% of Medicare: 100% Federally Funded Portion	($54,431)	($131,442)	($875,826)	($59,871)	($1,069,034)	($306,211)	($844,926)	$0	($1,885,431)	($96,264)	($149,967)	($441,684)	($31,530)	($80,726)	($84)	($6,027,427)
Physicians to 100% of Medicare: GF and FF Portion Due to Rate Decreases Since 2009	($28,886)	($69,758)	($464,815)	($31,775)	($567,353)	($162,511)	($448,415)	$0	($1,000,628)	($51,089)	($79,590)	($234,408)	($16,734)	($42,843)	($45)	($3,198,850)
Accountable Care Collaborative Savings	($9,957)	($388,502)	($17,852,824)	($35,480)	($4,057,368)	($2,374,714)	($11,272,149)	$0	($5,362,523)	($505,881)	($25,888)	($336,470)	($18,993)	$0	$0	($42,240,749)
FY 2010-11 BRI-1: "Client Overutilization"	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Impact of Increasing PACE Enrollment	($2,424,482)	($1,282,614)	($1,288,075)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($4,995,171)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($32,130)	($23,772)	($177,015)	($7,854)	($102,756)	($31,108)	($91,846)	($2,549)	($182,531)	($10,729)	($18,225)	($34,923)	($2,644)	($11,055)	($2,560)	($731,697)
Colorado Choice Transitions	$51,109	$17,055	$233,070	$2,607	$1,683	$396	$2,642	$0	$14,669	$571	$20,534	$144	$5	$0	$660	$345,145
FY 2012-13 R-6: "Dental Efficiency"	$0	$0	($20,630)	($578)	($28,988)	($8,555)	($22,196)	$0	($329,727)	($27,051)	($24,642)	($2,376)	($129)	($221)	($7)	($464,900)
FY 2012-13 R-6: "Augmentative Communication Devices"	($42,701)	($13,576)	($120,021)	($2,357)	($12,603)	($3,489)	($12,481)	$0	($28,205)	$0	($9,794)	($662)	($26)	$0	($85)	($246,000)
FY 2012-13 R-5: "ACC Gainsharing"	($61,518)	($45,517)	($338,937)	($15,038)	($196,751)	($59,563)	($175,860)	($4,881)	($349,499)	($20,543)	($34,897)	($66,869)	($5,063)	($21,167)	($4,901)	($1,401,004)
53 Pay Periods in FY 2013-14	($837,853)	($2,237,311)	($15,433,344)	($556,345)	($8,218,963)	($2,554,659)	($7,782,962)	$0	($9,238,084)	($283,101)	($2,060,674)	($510,318)	($10,982)	$0	($2,194)	($49,726,790)
FY 2013-14 R-7: "Substance Abuse Disorder Benefit"	($65,251)	($48,278)	($359,495)	($15,950)	($208,685)	($63,176)	($186,527)	($5,177)	($370,697)	($21,789)	($37,013)	($70,925)	($5,370)	($22,451)	($5,198)	($1,485,982)
FY 2013-14 R-9: "Dental ASO for Children"	$0	$0	$0	$0	$0	$0	$0	$0	($494,031)	($58,848)	($23,193)	$0	$0	$0	$0	($576,072)
FY 2013-14 R-13: "2% Provider Rate Increase"	$241,855	$178,949	$1,332,509	$59,120	$773,514	$234,170	$691,383	$19,188	$1,374,032	$80,765	$137,194	$262,891	$19,906	$83,217	$19,268	$5,507,961
SB 13-200: "Medicaid Expansion Adjustment"	$0	$0	$0	$0	($2,022,158)	$0	$0	$0	($1,987,189)	$0	$0	$0	$0	$0	$0	($4,009,347)
SB 13-242: "Adult Dental Benefit"	$5,892,379	$1,522,980	$9,365,526	$519,932	$21,874,675	$9,072,537	$31,445,364	$51,712	$0	$0	$0	$2,125,258	$248,303	$0	$0	$82,118,666
Preventive Services	$1,369	$2,671	$20,165	$420	$0	$18,147	$4,998	$6,287	$3,428	$0	$40,192	$3,578	$6,117	$0	$0	$107,372
Fluoride Benefit Expansion for Children	$0	$0	$0	$0	$0	$0	$0	$0	$495,861	$59,066	$23,279	$0	$0	$0	$0	$578,206
CDASS Service Expansion into the Brain Injury Waiver	($61,335)	($4,017)	($55,939)	($200)	($335)	($579)	($100)	$0	($1,879)	$0	($4,939)	($21)	$0	$0	($99)	($128,943)
HB 14-1252: "Intellectual and Developmental Disabilities Services System Capacity"	($145,886)	($48,681)	($665,280)	($7,442)	($4,805)	($1,130)	($7,542)	$0	($41,872)	($1,629)	($58,612)	($412)	($14)	$0	($1,884)	($985,189)
FY 2014-15 R#7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($727,909)	($242,897)	($3,319,472)	($37,134)	($23,975)	($5,639)	($37,632)	$0	($208,924)	($8,130)	($292,451)	($2,055)	($70)	$0	($9,400)	($4,915,688)
FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents"	($24,933)	($8,319)	($113,692)	($1,272)	($821)	($193)	($1,289)	$0	($7,156)	($278)	($10,016)	($70)	($2)	$0	($322)	($168,363)
FY 2014-15 R#9: "Medicaid Community Living Initiative"	$285,255	$24,699	$52,909	$251	$82	$0	$369	$0	$0	$0	$0	$0	$0	$0	$508	$364,073
FY 2014-15 R#10: "Primary Care Specialty Collaboration"	$2,145	$5,179	$34,510	$2,359	$42,123	$12,066	$33,292	$0	$74,291	$3,793	$5,909	$17,404	$1,242	$3,181	$3	$237,497
FY 2014-15 R#11: "Community Provider Rate Increase"	$2,287,833	$1,692,781	$12,604,966	$559,248	$7,317,113	$2,215,146	$6,540,187	$181,506	$12,997,754	$764,003	$1,297,801	$2,486,837	$188,298	$787,195	$182,270	$52,102,938
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Extended Hours/After Hours Care 10% Rate Increase	$5,796	$13,991	$93,228	$6,373	$113,795	$32,595	$89,939	$0	$200,697	$10,247	$15,963	$47,016	$3,356	$8,592	$9	$641,597
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Incentives to Use Ambulatory Surgery Centers	$3,418	$7,280	$52,902	$3,845	$69,844	$23,843	$67,318	$0	$79,542	$7,405	$5,632	$9,844	$775	$1,670	$15	$333,333
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - High-Value Specialist Services to 80% of Medicare	$288,614	$365,633	$2,382,190	$233,319	$1,253,947	$347,570	$1,945,777	$0	$2,262,519	$103,884	$128,999	$1,187,380	$105,346	$707,257	$0	$11,312,435
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Mammography Reimbursement to 80% of Medicare	$7,013	$1,812	$11,146	$619	$26,032	$10,797	$37,422	$0	$0	$0	$0	$0	$0	$0	$0	$94,841
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Assistive Technology Reimbursement Rate to 80% of Medicare	$3,683	$1,216	$10,752	$211	$1,129	$313	$1,118	$0	$2,526	$143	$877	$59	$2	$0	$8	$22,037
FY 2014-15 BA-10 "Dental Provider Network Adequacy"	$237,899	$73,596	$1,965,039	$1,637,318	$0	$421,225	$539,714	$0	$124,018	$1,191	$0	$0	$0	$0	$0	$5,000,000
FY 2014-15 BA-10 Continuation of "1202 Provider Rate Increase"	$399,853	$965,574	$6,433,850	$439,817	$7,853,159	$2,249,439	$6,206,853	$0	$13,850,446	$707,161	$1,101,664	$3,244,624	$231,622	$593,017	$617	$44,277,696
FY 2014-15 BA-12 "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	$26,349	$4,554	$19,014	$877	$1,986	$655	$321	$0	$28	$1	$8	$59	$2	$0	$9,781	$63,635
JBC Action: "Matching Incentives to Ambulatory Surgery Center Facilities"	$3,418	$7,280	$52,902	$3,845	$69,844	$23,843	$67,318	$0	$79,542	$7,405	$5,632	$9,844	$775	$1,670	$15	$333,333
JBC Action: "Family Planning Rate Increase"	$61,065	$49,581	$348,783	$22,520	$224,231	$73,074	$489,641	$3,171	$358,246	$36,895	$35,752	$75,835	$8,353	$24,338	$5,790	$1,817,275
JBC Action: "Raising FQHC Rate Increase to APM"	$58,173	$79,261	$491,037	$14,671	$1,007,345	$344,213	$1,120,394	$0	$3,266,844	$212,623	$106,569	$502,711	$36,647	$21,155	$108	$7,261,751
JBC Action: "Full Denture Benefit"	$6,127,428	$708,331	$3,007,342	$164,215	$2,696,068	$1,840,679	$9,776,925	$0	$0	$0	$0	$188,725	$0	$0	$0	$24,509,713
EPSDT Personal Care	$0	$0	$500,459	$8,264	$0	$0	$0	$0	$131,456	$13,538	$13,119	$0	$0	$0	$0	$666,836
Total Bottom Line Impacts	$11,467,382	$1,177,739	($2,073,066)	$2,908,535	$26,811,975	$11,349,681	$38,177,050	$249,257	$13,703,505	$922,168	$233,241	$8,462,207	$759,192	$2,053,029	$192,273	$116,394,168
Estimated FY 2014-15 Expenditures	**$124,054,802**	**$92,590,742**	**$640,986,160**	**$44,429,269**	**$440,232,394**	**$146,077,167**	**$940,939,106**	**$6,094,937**	**$674,210,776**	**$68,946,135**	**$66,150,629**	**$148,281,621**	**$16,159,056**	**$46,926,357**	**$10,867,953**	**$3,466,947,104**
Estimated FY 2014-15 Per Capita	$2,958.48	$8,543.16	$9,617.49	$12,007.91	$2,828.04	$2,262.55	$4,204.84	$16,562.33	$1,535.45	$1,318.18	$3,209.01	$9,804.39	$9,144.91	$16,711.67	$398.66	$3,077.72
% Change over FY 2013-14 Per Capita	10.58%	1.64%	0.48%	12.36%	-1.50%	-1.70%	14.65%	4.26%	-4.05%	-4.73%	-7.67%	6.05%	4.93%	7.66%	4.52%	3.95%

Request Year Projection

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Percentage Selected to Modify Per Capita[2]	0.86%	0.58%	1.30%	5.00%	-2.78%	-2.78%	5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.95%	2.67%	
Estimated FY 2015-16 Base Per Capita	$2,983.92	$8,592.71	$9,742.52	$12,608.31	$2,749.42	$2,199.65	$4,415.08	$16,562.33	$1,535.45	$1,318.18	$3,209.01	$9,804.39	$9,144.91	$17,204.66	$409.30	$3,111.57
Estimated FY 2015-16 Eligibles	43,060	11,442	69,042	4,359	170,935	70,573	255,924	169	468,884	56,726	20,920	15,333	1,971	2,742	29,785	1,221,865
Estimated FY 2015-16 Base Expenditure	$128,487,595	$98,317,788	$672,643,066	$54,959,623	$469,972,108	$155,235,899	$1,129,925,446	$2,799,034	$719,947,938	$74,775,079	$67,132,489	$150,330,712	$18,024,618	$47,175,178	$12,191,001	$3,801,917,574
Bottom Line Impacts																
SB 10-117: "OTC MEDS"	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physicians to 100% of Medicare: 100% Federally Funded Portion	($295,558)	($713,719)	($4,755,675)	($325,097)	($5,804,778)	($1,662,706)	($4,587,887)	$0	($10,237,762)	($522,708)	($814,311)	($2,398,312)	($171,207)	($438,337)	($456)	($32,728,513)
Physicians to 100% of Medicare: GF and FF Portion Due to Rate Decreases Since 2009	($9,673)	($23,356)	($155,628)	($10,639)	($189,960)	($54,412)	($150,137)	$0	($335,028)	($17,105)	($26,648)	($78,484)	($5,603)	($14,344)	($15)	($1,071,032)
Accountable Care Collaborative Savings	($110,930)	($259,555)	($2,116,902)	($24,355)	($2,741,256)	($1,071,306)	($8,504,363)	$0	($7,366,058)	($457,535)	($35,881)	($194,359)	($10,959)	$0	($2,699,727)	($25,593,186)
FY 2010-11 BRI-1: "Client Overutilization"	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2011-12 BA-9: "Limit Physical and Occupational Therapy"	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Impact of Increasing PACE Enrollment	($1,341,682)	($805,779)	($591,415)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($2,738,876)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($63,226)	($35,069)	($261,138)	($11,586)	($151,589)	($45,891)	($135,494)	($3,760)	($269,276)	($26,887)	($51,520)	($3,901)	($16,308)	($3,776)	($1,079,421)	
Colorado Choice Transitions	$100,792	$33,262	$454,564	$5,085	$3,283	$772	$5,153	$0	$28,610	$0	$40,048	$281	$10	$0	$1,287	$673,147
FY 2012-13 R-6: "Dental Efficiency"	$0	$0	($61,891)	($1,735)	($86,965)	($25,666)	($66,589)	$0	($989,181)	($81,152)	($73,922)	($7,127)	($388)	($62)	($21)	($1,394,699)
FY 2012-13 R-6: "Augmentative Communication Devices"	($42,701)	($13,576)	($120,021)	($2,357)	($12,603)	($3,489)	($12,481)	$0	($28,205)	$0	($9,794)	($662)	($26)	$0	($85)	($246,000)
SB 13-200: "Medicaid Expansion Adjustment"	$0	$0	$0	$0	($532,760)	$0	$0	$0	($433,231)	$0	$0	$0	$0	$0	$0	($965,991)
Fluoride Benefit Expansion for Children	$0	$0	$0	$0	$0	$0	$0	$0	$45,096	$5,456	$2,012	$0	$0	$0	$0	$52,564
HB 14-1252: "Intellectual and Developmental Disabilities Services System Capacity"	$1,046	$345	$4,709	$53	$34	$8	$53	$0	$296	$12	$415	$3	$0	$0	$0	$6,974
FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents"	($24,933)	($8,319)	($113,692)	($1,272)	($821)	($193)	($1,289)	$0	($7,156)	($278)	($10,016)	($70)	($2)	$0	($322)	($168,363)
FY 2014-15 R#9: "Medicaid Community Living Initiative"	$4,697	$407	$871	$4	$1	$0	$6	$0	$0	$0	$0	$0	$0	$0	$8	$5,994
FY 2014-15 R#10: "Primary Care Specialty Collaboration"	($3,716)	($8,973)	($59,791)	($4,087)	($72,981)	($20,905)	($57,682)	$0	($128,716)	($6,572)	($10,238)	($30,153)	($2,153)	($5,511)	($6)	($411,484)
FY 2014-15 R#11: "Community Provider Rate Increase"	$207,984	$153,889	$1,145,906	$50,841	$665,192	$201,377	$594,563	$16,501	$1,181,614	$69,455	$117,982	$226,076	$17,118	$71,563	$16,570	$4,736,631
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Extended Hours/After Hours Care 10% Rate Increase	$528	$1,272	$8,475	$579	$10,345	$2,963	$8,176	$0	$18,245	$932	$1,451	$4,274	$305	$781	$1	$58,327
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Incentives to Use Ambulatory Surgery Centers	$1,710	$3,640	$26,451	$1,923	$34,922	$11,921	$33,659	$0	$39,771	$3,702	$2,816	$4,922	$387	$835	$8	$166,667
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - High-Value Specialist Services to 80% of Medicare	$26,237	$33,239	$216,563	$21,211	$113,995	$31,597	$176,889	$0	$205,684	$9,444	$11,727	$107,944	$9,577	$64,296	$0	$1,028,403
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Mammography Reimbursement to 80% of Medicare	$593	$158	$952	$60	$2,357	$973	$3,529	$0	$0	$0	$0	$0	$0	$0	$0	$8,622
FY 2014-15 R#11:" Community Provider Rate Increase" Targeted - Assistive Technology Reimbursement Rate to 80% of Medicare	$336	$111	$977	$19	$102	$28	$101	$0	$230	$13	$80	$5	$0	$0	$1	$2,003
FY 2014-15 BA-10 "Dental Provider Network Adequacy"	($237,899)	($73,596)	($1,965,039)	($1,637,318)	$0	($421,225)	($539,714)	$0	$0	$0	($124,018)	($1,191)	$0	$0	$0	($5,000,000)
FY 2014-15 BA#10 Continuation of "1202 Provider Rate Increase"	$439,836	$1,062,132	$7,077,235	$483,799	$8,638,475	$2,474,383	$6,827,539	$0	$15,235,491	$777,877	$1,211,830	$3,569,087	$254,784	$652,319	$679	$48,705,466
FY 2014-15 BA-12 "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	($3,471,098)	($599,905)	($2,504,700)	($115,485)	($261,593)	($86,232)	($42,295)	$0	($3,691)	($100)	($1,057)	($7,818)	($231)	$0	($1,288,429)	($8,382,634)
JBC Action: "Matching Incentives to Ambulatory Surgery Center Facilities"	$1,710	$3,640	$26,451	$1,923	$34,922	$11,921	$33,659	$0	$39,771	$3,702	$2,816	$4,922	$387	$835	$8	$166,667
JBC Action: "Family Planning Rate Increase"	$5,584	$4,272	$29,229	$2,388	$20,422	$6,746	$49,099	$122	$31,284	$3,249	$2,917	$6,532	$783	$2,050	$530	$165,207
JBC Action: "Raising FQHC Rate Increase to APM"	$5,287	$7,206	$44,640	$1,334	$91,577	$31,292	$101,854	$0	$296,986	$19,329	$9,688	$45,701	$3,332	$1,923	$10	$660,159
JBC Action: "Full Denture Benefit"	$557,038	$64,394	$273,395	$14,929	$245,097	$167,335	$888,811	$0	$0	$0	$0	$17,157	$0	$0	$0	$2,228,156
EPSDT Personal Care	$0	$0	$506,031	$9,640	$0	$0	$0	$0	$126,275	$13,115	$11,775	$0	$0	$0	$0	$666,836
Total Bottom Line Impacts	($4,248,038)	($1,173,880)	($2,889,443)	($1,540,143)	$5,418	($450,709)	($5,374,840)	$12,863	($2,548,951)	($179,164)	$282,785	$1,217,208	$92,213	$320,040	($3,973,735)	($20,448,376)
Estimated FY 2015-16 Expenditure	**$124,239,557**	**$97,143,908**	**$669,753,623**	**$53,419,480**	**$469,977,526**	**$154,785,190**	**$1,124,550,606**	**$2,811,897**	**$717,398,987**	**$74,595,915**	**$67,415,274**	**$151,547,920**	**$18,116,831**	**$47,495,218**	**$8,217,266**	**$3,781,469,198**
Estimated FY 2015-16 Per Capita	$2,885.27	$8,490.12	$9,700.67	$12,254.99	$2,749.45	$2,193.26	$4,394.08	$16,638.44	$1,530.01	$1,315.02	$3,222.53	$9,883.77	$9,191.70	$17,321.38	$275.89	$3,094.83
% Change over FY 2014-15 Per Capita	-2.47%	-0.62%	0.86%	2.06%	-2.78%	-3.06%	4.50%	0.46%	-0.35%	-0.24%	0.42%	0.81%	0.51%	3.65%	-30.80%	0.56%

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

Out Year Projection																
ACUTE CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Percentage Selected to Modify Per Capita[5]	0.86%	0.58%	1.30%	5.00%	-2.78%	-2.78%	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.95%	2.67%	
Estimated FY 2016-17 Base Per Capita	$2,910.08	$8,539.36	$9,826.78	$12,867.74	$2,673.02	$2,132.29	$4,503.93	$16,638.44	$1,530.01	$1,315.02	$3,222.53	$9,883.77	$9,191.70	$17,832.36	$283.26	$3,107.95
Estimated FY 2016-17 Eligibles	44,025	11,975	71,205	4,951	187,003	76,305	286,845	59	498,180	61,422	21,204	15,503	2,120	2,677	32,600	1,316,074
Estimated FY 2016-17 Base Expenditure	$128,116,272	$102,258,836	$699,715,870	$63,708,181	$499,862,759	$162,704,388	$1,291,929,801	$981,668	$762,220,382	$80,771,158	$68,330,526	$153,228,086	$19,486,404	$47,737,228	$9,234,276	$4,090,285,835
Bottom Line Impacts																
SB 10-117: "OTC MEDS"	($1,473)	($3,930)	($27,112)	($977)	($14,439)	($4,488)	($13,673)	$0	($16,229)	($497)	($3,620)	($896)	($19)	$0	($4)	($87,357)
Accountable Care Collaborative Savings	($6,209)	($55,738)	($454,585)	($1,364)	($153,454)	($437,261)	($4,895,145)	$0	($3,759,468)	($25,612)	($2,009)	($10,881)	($613)	$0	($1,259,815)	($11,062,154)
FY 2010-11 BRI-1: "Client Overutilization"	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2011-12 BA-9: Limit Physical and Occupational Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Impact of Increasing PACE Enrollment	($1,074,027)	($657,736)	($495,515)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($2,227,278)
Annualization of SB 10-167: "Colorado False Claims Act - HIBI"	($60,397)	($44,687)	($332,756)	($14,763)	($193,163)	($58,477)	($172,653)	($4,792)	($343,125)	($20,169)	($34,260)	($65,650)	($4,971)	($20,781)	($4,812)	($1,375,456)
Colorado Choice Transitions	$145,473	$48,543	$663,403	$7,421	$4,792	$1,127	$7,521	$0	$41,754	$1,625	$58,447	$411	$14	$0	$1,879	$982,410
SB 13-200: "Medicaid Expansion Adjustment"	$0	$0	$0	$0	($533,659)	$0	$0	$0	($409,234)	$0	$0	$0	$0	$0	$0	($942,893)
FY 2014-15 BA#10 Continuation of "1202 Provider Rate Increase"	($769,715)	($1,858,731)	($12,385,161)	($846,648)	($15,117,331)	($4,330,171)	($11,948,193)	$0	($26,662,109)	($1,361,284)	($2,120,703)	($6,245,902)	($445,872)	($1,141,557)	($1,188)	($85,234,565)
FY 2014-15 BA-12 "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	($3,251,306)	($561,918)	($2,346,101)	($108,173)	($245,029)	($80,772)	($39,617)	$0	($3,457)	($94)	($990)	($7,323)	($216)	$0	($1,206,845)	($7,851,841)
Total Bottom Line Impacts	($5,017,654)	($3,134,197)	($15,377,827)	($964,504)	($16,252,283)	($4,910,042)	($17,061,760)	($4,792)	($31,151,868)	($1,406,031)	($2,103,135)	($6,330,241)	($451,677)	($1,162,338)	($2,470,785)	($107,799,134)
Estimated FY 2016-17 Expenditure	**$123,098,618**	**$99,124,639**	**$684,338,043**	**$62,743,677**	**$483,610,476**	**$157,794,346**	**$1,274,868,041**	**$976,876**	**$731,068,514**	**$79,365,127**	**$66,227,391**	**$146,897,845**	**$19,034,727**	**$46,574,890**	**$6,763,491**	**$3,982,486,701**
Estimated FY 2016-17 Per Capita	$2,796.11	$8,277.63	$9,610.81	$12,672.93	$2,586.11	$2,067.94	$4,444.45	$16,557.22	$1,467.48	$1,292.13	$3,123.34	$9,475.45	$8,978.64	$17,398.17	$207.47	$3,026.04
% Change over FY 2015-16 Per Capita	-3.09%	-2.50%	-0.93%	3.41%	-5.94%	-5.71%	1.15%	-0.49%	-4.09%	-1.74%	-3.08%	-4.13%	-2.32%	0.44%	-24.80%	-2.22%

Footnotes

(1) Percentage selected to modify Per Capita amounts for Estimated FY 2014-15:
Where applicable, percentage selections have been bolded for clarification.

OAP-A	The Department believes the higher than anticipate growth in FY 2013-14 is due to a level shift in per-capita costs of Home Health expenditure within this population. Thus the Department selected a lower trend to modify per-capita.	**MAGI Parents/ Caretakers 69% to 133% FPL**	Per-capita for this population was roughly 80% that of the MAGI Parents/Caretakers to 68% FPL in FY 2013-14, the Department is maintaining this ratio to modify per-capita costs.
OAP-B	Similar to OAP-A, the Department believes the increase in per-capita costs in FY 2013-14 are due to a level shift related to Home Health expenditure. The Department has maintained the previous trend selection to modify per-capita costs.	**MAGI Adults**	The Department is anticipating strong pent-up demand for services from this population, thus an aggressive trend has been selected to modify per-capita.
AND/AB	Similar to OAP-A and OAP-B, the Department believes the increase in per-capita costs in FY 2013-14 are due to a level shift related to Home Health expenditure. The Department has lowered the previous trend to modify per-capita costs.	**BCCP**	See Narrative
Disabled Buy-in	With little history to predict expenditure for this category, the Department is anticipating a 5.00% growth rate to modify per-capita as caseload growth put strong downward pressure in FY 2013-14 that is not expected to continue.	**Eligible Children (AFDC-C/BC)**	The Department assumes strong caseload growth, EBNE effects, coupled with effective primary care utilization will put strong downward pressure on per-capita costs.
MAGI Parents/ Caretakers to 68% FPL	The Department has selected an aggressive downward trend as significant per-capita decreases seen in FY 2013-14 are expected to continue due to strong caseload growth expected for this category. Similarly, many new clients have been eligible for services for some time now without receiving services so their per-capita is expected to be far lower than the standard population.	**SB 11-008 Eligible Children**	The Department assumes a near doubling of caseload growth expected in 2014-15 will put strong downward pressure on per-capita costs.
Foster Care	Strong caseload growth and a number of prescription drug patent expirations contribute to the strong downward trend selected.	**MAGI Pregnant Adults**	The Department does not expect the strong per-capita growth within this category to continue.
SB 11-250 Eligible Preenant Adults	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.	**Non-Citizens Emergency Services**	The Department has lowered the per-capita growth trend for this population given actual per-capita decreases in FY 2013-14.
Partial Dual Eligibles	The Department has lowered the per-capita growth trend for this population give lower than expected growth in FY 2013-14.		

(2) Percentage selected to modify Per Capita amounts for Estimated FY 2015-16:
Where applicable, percentage selections have been italicized for clarification.

OAP-A	The Department believes the higher than anticipate growth in FY 2013-14 is due to a level shift in per-capita costs of Home Health expenditure within this population. Thus the Department selected a lower trend to modify per-capita.	**MAGI Parents/ Caretakers 69% to 133% FPL**	Per-capita for this population was roughly 80% that of the MAGI Parents/Caretakers to 68% FPL in FY 2013-14, the Department is maintaining this ratio to modify per-capita costs.
OAP-B	Similar to OAP-A, the Department believes the increase in per-capita costs in FY 2013-14 are due to a level shift related to Home Health expenditure. The Department has maintained the previous trend selection to modify per-capita costs.	**MAGI Adults**	The Department is anticipating strong pent-up demand for services from this population, thus an aggressive trend has been selected to modify per-capita.
AND/AB	Similar to OAP-A and OAP-B, the Department believes the increase in per-capita costs in FY 2013-14 are due to a level shift related to Home Health expenditure. The Department has lowered the previous trend to modify per-capita costs.	**BCCP**	See Narrative
Disabled Buy-in	With little history to predict expenditure for this category, the Department is anticipating a 5.00% growth rate to modify per-capita as caseload growth put strong downward pressure in FY 2013-14 that is not expected to continue.	**Eligible Children (AFDC-C/BC)**	After the aggressive downward trend selected to modify FY 2014-15 per-capita, the Department anticipates costs to stabilize for this population.
MAGI Parents/ Caretakers to 68% FPL	The Department has selected an aggressive downward trend as significant per-capita decreases seen in FY 2013-14 are expected to continue due to strong caseload growth expected for this category. Similarly, many new clients have been eligible for services for some time now without receiving services so their per-capita is expected to be far lower than the standard population.	**SB 11-008 Eligible Children**	Similar to Eligible Children, the Department anticipates costs will stabilize for this population after the aggressive downward trend in FY 2014-15.
Foster Care	Strong caseload growth and a number of prescription drug patent expirations contribute to the strong downward trend selected.	**MAGI Pregnant Adults**	The Department does not expect the strong per-capita growth within this category to continue.
SB 11-250 Eligible Preenant Adults	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.	**Non-Citizens Emergency Services**	The Department has lowered the per-capita growth trend for this population given actual per-capita decreases in FY 2013-14.
Partial Dual Eligibles	The Department has lowered the per-capita growth trend for this population give lower than expected growth in FY 2013-14.		

(3) Percentage selected to modify Per Capita amounts for Estimated FY 2016-17:
Where applicable, percentage selections have been italicized for clarification.

OAP-A	The Department believes the higher than anticipate growth in FY 2013-14 is due to a level shift in per-capita costs of Home Health expenditure within this population. Thus the Department selected a lower trend to modify per-capita.	**MAGI Parents/ Caretakers 69% to 133% FPL**	Per-capita for this population was roughly 80% that of the MAGI Parents/Caretakers to 68% FPL in FY 2013-14, the Department is maintaining this ratio to modify per-capita costs.
OAP-B	Similar to OAP-A, the Department believes the increase in per-capita costs in FY 2013-14 are due to a level shift related to Home Health expenditure. The Department has maintained the previous trend selection to modify per-capita costs.	**MAGI Adults**	The Department is anticipating strong pent-up demand for services from this population, thus an aggressive trend has been selected to modify per-capita.
AND/AB	Similar to OAP-A and OAP-B, the Department believes the increase in per-capita costs in FY 2013-14 are due to a level shift related to Home Health expenditure. The Department has lowered the previous trend to modify per-capita costs.	**BCCP**	See Narrative
Disabled Buy-in	With little history to predict expenditure for this category, the Department is anticipating a 5.00% growth rate to modify per-capita as caseload growth put strong downward pressure in FY 2013-14 that is not expected to continue.	**Eligible Children (AFDC-C/BC)**	After the aggressive downward trend selected to modify FY 2014-15 per-capita, the Department anticipates costs to stabilize for this population.
MAGI Parents/ Caretakers to 68% FPL	The Department has selected an aggressive downward trend as significant per-capita decreases seen in FY 2013-14 are expected to continue due to strong caseload growth expected for this category. Similarly, many new clients have been eligible for services for some time now without receiving services so their per-capita is expected to be far lower than the standard population.	**SB 11-008 Eligible Children**	Similar to Eligible Children, the Department anticipates costs will stabilize for this population after the aggressive downward trend in FY 2014-15.
Foster Care	Strong caseload growth and a number of prescription drug patent expirations contribute to the strong downward trend selected.	**MAGI Pregnant Adults**	The Department does not expect the strong per-capita growth within this category to continue.
SB 11-250 Eligible Preenant Adults	The trend for this category is tied to MAGI Pregnant Adults, the Department assumes similar utilization within these populations.	**Non-Citizens Emergency Services**	The Department has lowered the per-capita growth trend for this population given actual per-capita decreases in FY 2013-14.
Partial Dual Eligibles	The Department has lowered the per-capita growth trend for this population give lower than expected growth in FY 2013-14.		

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

Breast and Cervical Cancer Program Costs					
Month	**Total[(1)]**	**Caseload**	**Monthly Per Capita**	**Rolling 3-Month Per Capita**	**Percent Change**
October 2010	$731,130	505	$1,447.78	-	-
November 2010	$838,350	511	$1,640.61	-	-
December 2010	$641,895	526	$1,220.33	$4,308.72	-
January 2011	$858,219	532	$1,613.19	$4,474.13	3.84%
February 2011	$860,735	535	$1,608.85	$4,442.37	-0.71%
March 2011	$758,865	556	$1,364.87	$4,586.91	3.25%
April 2011	$842,553	569	$1,480.76	$4,454.48	-2.89%
May 2011	$977,078	587	$1,664.53	$4,510.16	1.25%
June 2011	$796,240	589	$1,351.85	$4,497.14	-0.29%
July 2011	$905,622	587	$1,542.80	$4,559.18	1.38%
August 2011	$1,098,058	586	$1,873.82	$4,768.47	4.59%
September 2011	$806,654	590	$1,367.21	$4,783.83	0.32%
October 2011	$840,959	592	$1,420.54	$4,661.57	-2.56%
November 2011	$777,937	602	$1,292.25	$4,080.00	-12.48%
December 2011	$948,163	606	$1,564.63	$4,277.42	4.84%
January 2012	$759,376	603	$1,259.33	$4,116.21	-3.77%
February 2012	$807,113	604	$1,336.28	$4,160.24	1.07%
March 2012	$896,406	604	$1,484.12	$4,079.73	-1.94%
April 2012	$931,643	596	$1,563.16	$4,383.56	7.45%
May 2012	$713,371	597	$1,194.93	$4,242.21	-3.22%
June 2012	$787,309	601	$1,310.00	$4,068.09	-4.10%
July 2012	$886,933	607	$1,461.17	$3,966.10	-2.51%
August 2012	$852,135	612	$1,392.38	$4,163.55	4.98%
September 2012	$632,389	610	$1,036.70	$3,890.25	-6.56%
October 2012	$935,272	615	$1,520.77	$3,949.85	1.53%
November 2012	$712,236	615	$1,158.11	$3,715.58	-5.93%
December 2012	$832,382	616	$1,351.27	$4,030.15	8.47%
January 2013	$782,163	613	$1,275.96	$3,785.34	-6.07%
February 2013	$690,923	608	$1,136.39	$3,763.62	-0.57%
March 2013	$766,740	618	$1,240.68	$3,653.03	-2.94%
April 2013	$919,733	639	$1,439.33	$3,816.40	4.47%
May 2013	$768,143	659	$1,165.62	$3,845.63	0.77%
June 2013	$810,981	659	$1,230.62	$3,835.57	-0.26%
July 2013	$1,122,185	660	$1,700.28	$4,096.52	6.80%
August 2013	$1,175,748	648	$1,814.43	$4,745.33	15.84%
September 2013	$1,002,170	645	$1,553.75	$5,068.46	6.81%
October 2013	$962,474	639	$1,506.22	$4,874.40	-3.83%
November 2013	$926,244	547	$1,693.32	$4,753.29	-2.48%
December 2013	$1,187,201	540	$2,198.52	$5,398.06	13.56%
January 2014	$611,981	543	$1,127.04	$5,018.88	-7.02%
February 2014	$366,871	527	$696.15	$4,021.71	-19.87%
March 2014	$320,858	498	$644.29	$2,467.48	-38.65%
April 2014	$288,153	492	$585.68	$1,926.12	-21.94%
May 2014	$180,838	488	$370.57	$1,600.54	-16.90%
June 2014	$288,405	477	$604.62	$1,560.87	-2.48%
FY 2013-14 Totals	$8,879,715	559	$15,885.00		
FY 2014-15 Totals[(2)]	$6,094,937	368	$16,562.33		**4.26%**
FY 2015-16 Totals[(3)]	$2,811,897	169	$16,638.44		**0.46%**
FY 2016-17 Totals[(3)]	$976,876	59	$16,557.22		**-0.49%**

Footnotes

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

(2) The FY 2014-15 Totals are calculated on page EF-2 and include bottom line impacts. Caseload totals are taken from Exhibit B.

(3) Per capita growth in FY 2014-15 follows the assumptions from the fiscal note, which states per capita stays constant.

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

Breast and Cervical Cancer Program Fund Splits								
FY 2014-15 Fund Splits	**Per Capita**	**Allocation**	**Caseload**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Breast and Cervical Cancer Program Clients[(1)]	$16,562.33	100.00%	368	$6,094,937	$0	$2,100,925	$0	$3,994,012
Total	**$16,562.33**	**100.00%**	**368**	**$6,094,937**	**$0**	**$2,100,925**	**$0**	**$3,994,012**
FY 2015-16 Fund Splits	**Per Capita**	**Allocation**	**Caseload**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Breast and Cervical Cancer Program Clients[(1)]	$16,638.44	100.00%	169	$2,811,897	$0	$964,199	$0	$1,847,698
Total	**$16,638.44**	**100.00%**	**169**	**$2,811,897**	**$0**	**$964,199**	**$0**	**$1,847,698**
FY 2016-17 Fund Splits	**Per Capita**	**Allocation**	**Caseload**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
Breast and Cervical Cancer Program Clients[(1)]	$16,557.22	100.00%	59	$976,876	$0	$334,971	$0	$641,905
Total	**$16,557.22**	**100.00%**	**59**	**$976,876**	**$0**	**$334,971**	**$0**	**$641,905**
(1) 25.5-5-308 (9) (g), C.R.S. (2014). 100% of the State share is from the Breast and Cervical Cancer Prevention and Treatment Fund, 65.71% federal financial participation beginning October 1, 2014.								

Exhibit F - ACUTE CARE - Adult Dental - Projection and Fund Splits

Adult Dental Benefit Expenditure

ADULT DENTAL BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2006-07	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2007-08	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2008-09	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2009-10 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2010-11 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2011-12	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2012-13	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2013-14	$201,003	$77,570	$499,282	$0	$2,343,854	$520,871	$2,554,317	$0	$0	$0	$0	$151,160	$9,840	$0	$0	$6,357,897
Estimated FY 2014-15	$10,563,834	$2,234,971	$11,271,694	$645,807	$28,827,887	$9,054,303	$48,420,630	$0	$0	$0	$0	$1,797,465	$169,685	$0	$0	$112,986,276
Estimated FY 2015-16	$11,498,584	$2,437,693	$12,101,671	$813,803	$31,020,235	$9,789,258	$59,034,744	$0	$0	$0	$0	$1,839,484	$189,275	$0	$0	$128,724,747
Estimated FY 2016-17	$11,857,693	$2,566,123	$12,643,159	$970,495	$32,992,939	$10,289,729	$67,821,631	$0	$0	$0	$0	$1,859,895	$203,584	$0	$0	$141,205,248

Percent Change in Adult Dental Benefit Expenditure

ADULT DENTAL BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2007-08	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2008-09	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2009-10 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2010-11 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2011-12	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2012-13	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2013-14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2014-15	5155.56%	2781.23%	2157.58%	0.00%	1129.94%	1638.30%	1795.64%	0.00%	0.00%	0.00%	0.00%	1089.11%	1624.44%	0.00%	0.00%	1677.10%
Estimated FY 2015-16	8.85%	9.07%	7.36%	26.01%	7.60%	8.12%	21.92%	0.00%	0.00%	0.00%	0.00%	2.34%	11.54%	0.00%	0.00%	13.93%
Estimated FY 2016-17	3.12%	5.27%	4.47%	19.25%	6.36%	5.11%	14.88%	0.00%	0.00%	0.00%	0.00%	1.11%	7.56%	0.00%	0.00%	9.70%

Per Capita Cost

ADULT DENTAL BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2006-07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2007-08	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2008-09	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2009-10 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2010-11 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2011-12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2012-13	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2013-14	$4.80	$7.87	$7.75	$0.00	$18.80	$11.06	$29.28	$0.00	$0.00	$0.00	$0.00	$11.49	$9.31	$0.00	$0.00	$7.38
Estimated FY 2014-15	$251.93	$206.22	$169.12	$174.54	$185.19	$140.24	$216.38	$0.00	$0.00	$0.00	$0.00	$118.85	$96.03	$0.00	$0.00	$100.30
Estimated FY 2015-16	$267.04	$213.05	$175.28	$186.69	$181.47	$138.71	$230.67	$0.00	$0.00	$0.00	$0.00	$119.97	$96.03	$0.00	$0.00	$105.35
Estimated FY 2016-17	$269.34	$214.29	$177.56	$196.02	$176.43	$134.85	$236.44	$0.00	$0.00	$0.00	$0.00	$119.97	$96.03	$0.00	$0.00	$107.29

Percent Change in Per Capita Cost

ADULT DENTAL BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2007-08	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2008-09	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2009-10 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2010-11 (DA)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2011-12	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2012-13	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FY 2013-14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2014-15	5143.53%	2519.37%	2082.25%	0.00%	885.10%	1167.64%	639.05%	0.00%	0.00%	0.00%	0.00%	934.70%	931.54%	0.00%	0.00%	1258.24%
Estimated FY 2015-16	6.00%	3.31%	3.64%	6.96%	-2.01%	-1.09%	6.61%	0.00%	0.00%	0.00%	0.00%	0.94%	0.00%	0.00%	0.00%	5.03%
Estimated FY 2016-17	0.86%	0.58%	1.30%	4.99%	-2.78%	-2.78%	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.84%

Exhibit F - ACUTE CARE - Adult Dental - Projection and Fund Splits

Previous Fiscal Year

ADULT DENTAL BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2013-14 Total Dental Expenditure	$1,724,207	$535,633	$3,064,480	$134,995	$7,673,356	$1,951,352	$5,224,127	$0	$0	$0	$0	$515,132	$37,738	$3,698	$0	$20,864,718
Estimated FY 2013-14 Emergency and Co-Occurring Dental Expenditure	$1,523,204	$458,063	$2,565,198	$134,995	$5,329,502	$1,430,481	$2,669,810	$0	$0	$0	$0	$363,972	$27,898	$3,698	$0	$14,506,821
Estimated FY 2013-14 Adult Dental Benefit Expenditure	$201,003	$77,570	$499,282	$0	$2,343,854	$520,871	$2,554,317	$0	$0	$0	$0	$151,160	$9,840	$0	$0	$6,357,897
FY 2013-14 Caseload	41,836	9,853	64,424	2,560	124,680	47,082	87,243	559	397,362	27,015	18,267	13,160	1,057	2,481	23,378	860,957
FY 2013-14 Total Dental Per Capita	$41.21	$54.36	$47.57	$52.73	$61.54	$41.45	$59.88	$0.00	$0.00	$0.00	$0.00	$39.14	$35.70	$1.49	$0.00	$24.23
Estimated FY 2013-14 Emergency and Co-Occurring Dental Per Capita	$36.41	$46.49	$39.82	$52.73	$42.75	$30.38	$30.60	$0.00	$0.00	$0.00	$0.00	$27.66	$26.39	$1.49	$0.00	$16.85
Estimated FY 2013-14 Adult Dental Benefit Per Capita	$4.80	$7.87	$7.75	$0.00	$18.80	$11.06	$29.28	$0.00	$0.00	$0.00	$0.00	$11.49	$9.31	$0.00	$0.00	$7.38

Current Year Projection

ADULT DENTAL BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Total Dental Per Capita Trend Factor	231.83%	231.83%	231.83%	231.83%	231.83%	231.83%	231.83%	0.00%	0.00%	0.00%	0.00%	231.83%	231.83%	2.95%	0.00%	
Estimated FY 2014-15 Total Dental Per Capita	$136.75	$180.38	$157.85	$174.98	$204.21	$137.55	$198.70	$0.00	$0.00	$0.00	$0.00	$129.88	$118.46	$1.53	$0.00	
Emergency and Co-Occurring Dental Per Capita Trend Factor	-15.00%	-15.00%	-15.00%	-15.00%	-15.00%	-15.00%	-15.00%	0.00%	0.00%	0.00%	0.00%	-15.00%	-15.00%	2.95%	0.00%	
Estimated FY 2014-15 Emergency and Co-Occurring Dental Per Capita	$30.95	$39.52	$33.85	$44.82	$36.34	$25.82	$26.01	$0.00	$0.00	$0.00	$0.00	$23.51	$22.43	$1.53	$0.00	
Estimated FY 2014-15 Eligible Caseload	41,932	10,838	66,648	3,700	155,667	64,563	223,775	368	439,097	52,304	20,614	15,124	1,767	2,808	27,261	1,126,466
Estimated FY 2014-15 Total Dental Expenditure	$5,734,201	$1,954,958	$10,520,387	$647,426	$31,788,758	$8,880,641	$44,464,093	$0	$0	$0	$0	$1,964,305	$209,319	$4,296	$0	$106,168,384
Estimated FY 2014-15 Emergency and Co-Occurring Dental Expenditure	$1,297,795	$428,318	$2,256,035	$165,834	$5,656,939	$1,667,017	$5,820,388	$0	$0	$0	$0	$355,565	$39,634	$4,296	$0	$17,691,821
Bottom Line Impacts																
JBC Action: "Full Denture Benefit"	$6,127,428	$708,331	$3,007,342	$164,215	$2,696,068	$1,840,679	$9,776,925	$0	$0	$0	$0	$188,725	$0	$0	$0	$24,509,713
Total Bottom Line Impacts	$6,127,428	$708,331	$3,007,342	$164,215	$2,696,068	$1,840,679	$9,776,925	$0	$0	$0	$0	$188,725	$0	$0	$0	$24,509,713
Estimated FY 2014-15 Adult Dental Benefit Expenditure	$10,563,834	$2,234,971	$11,271,694	$645,807	$28,827,887	$9,054,303	$48,420,630	$0	$0	$0	$0	$1,797,465	$169,685	$0	$0	$112,986,276
% Change over Estimated FY 2013-14 Adult Dental Benefit Expenditure	5155.56%	2781.23%	2157.58%	0.00%	1129.94%	1638.30%	1795.64%	0.00%	0.00%	0.00%	0.00%	1089.11%	1624.44%	0.00%	0.00%	1677.10%
Estimated FY 2014-15 Adult Dental Benefit Per Capita	$251.93	$206.22	$169.12	$174.54	$185.19	$140.24	$216.38	$0.00	$0.00	$0.00	$0.00	$118.85	$96.03	$0.00	$0.00	$100.30
% Change over Estimated FY 2013-14 Adult Dental Benefit Per Capita	5148.54%	2520.33%	2082.19%	0.00%	885.05%	1167.99%	639.00%	0.00%	0.00%	0.00%	0.00%	934.38%	931.47%	0.00%	0.00%	1259.08%

Request Year Projection

ADULT DENTAL BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Total Dental Pre Capita Trend Factor	0.86%	0.58%	1.30%	5.00%	-2.78%	-2.78%	5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.95%	0.00%	
Estimated FY 2015-16 Total Dental Per Capita	$275.77	$235.08	$195.02	$214.64	$205.48	$154.41	$245.41	$0.00	$0.00	$0.00	$0.00	$135.31	$111.73	$1.58	$0.00	
Emergency and Co-Occurring Dental Per Capita Trend Factor	-30.00%	-30.00%	-30.00%	-30.00%	-30.00%	-30.00%	-30.00%	0.00%	0.00%	0.00%	0.00%	-30.00%	-30.00%	2.95%	0.00%	
Estimated FY 2015-16 Emergency and Co-Occurring Dental Per Capita	$21.67	$27.66	$23.70	$31.37	$25.44	$18.07	$18.21	$0.00	$0.00	$0.00	$0.00	$16.46	$15.70	$1.58	$0.00	
Estimated FY 2015-16 Caseload	43,060	11,442	69,042	4,359	170,935	70,573	255,924	169	468,884	56,726	20,920	15,333	1,971	2,742	29,785	1,221,865
Estimated FY 2015-16 Total Dental Expenditure	$11,874,656	$2,689,785	$13,464,571	$935,616	$35,123,724	$10,897,177	$62,806,309	$0	$0	$0	$0	$2,074,708	$220,220	$4,332	$0	$140,091,098
Estimated FY 2015-16 Emergency and Co-Occurring Dental Expenditure	$933,110	$316,486	$1,636,295	$136,742	$4,348,586	$1,275,254	$4,660,376	$0	$0	$0	$0	$252,381	$30,945	$4,332	$0	$13,594,507
Bottom Line Impacts																
JBC Action: "Full Denture Benefit"	$557,038	$64,394	$273,395	$14,929	$245,097	$167,335	$888,811	$0	$0	$0	$0	$17,157	$0	$0	$0	$2,228,156
Total Bottom Line Impacts	$557,038	$64,394	$273,395	$14,929	$245,097	$167,335	$888,811	$0	$0	$0	$0	$17,157	$0	$0	$0	$2,228,156
Estimated FY 2015-16 Adult Dental Benefit Expenditure	$11,498,584	$2,437,693	$12,101,671	$813,803	$31,020,235	$9,789,258	$59,034,744	$0	$0	$0	$0	$1,839,484	$189,275	$0	$0	$128,724,747
% Change over Estimated FY 2014-15 Adult Dental Benefit Expenditure	8.85%	9.07%	7.36%	26.01%	7.60%	8.12%	21.92%	0.00%	0.00%	0.00%	0.00%	2.34%	11.54%	0.00%	0.00%	13.93%
Estimated FY 2015-16 Adult Dental Benefit Per Capita	$267.04	$213.05	$175.28	$186.69	$181.47	$138.71	$230.67	$0.00	$0.00	$0.00	$0.00	$119.97	$96.03	$0.00	$0.00	$105.35
% Change over Estimated FY 2014-15 Adult Dental Benefit Per Capita	6.00%	3.31%	3.64%	6.96%	-2.01%	-1.09%	6.60%	0.00%	0.00%	0.00%	0.00%	0.94%	0.00%	0.00%	0.00%	5.03%

Out Year Projection

ADULT DENTAL BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Total Dental Per Capita Trend Factor	0.86%	0.58%	1.30%	5.00%	-2.78%	-2.78%	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.95%	0.00%	
Estimated FY 2016-17 Total Dental Per Capita	$289.93	$240.57	$200.08	$225.82	$200.60	$152.02	$253.74	$0.00	$0.00	$0.00	$0.00	$135.61	$110.95	$1.63	$0.00	
Emergency and Co-Occurring Dental Per Capita Trend Factor	-5.00%	-5.00%	-5.00%	-5.00%	-5.00%	-5.00%	-5.00%	0.00%	0.00%	0.00%	0.00%	-5.00%	-5.00%	2.95%	0.00%	
Estimated FY 2016-17 Emergency and Co-Occurring Dental Per Capita	$20.59	$26.28	$22.52	$29.80	$24.17	$17.17	$17.30	$0.00	$0.00	$0.00	$0.00	$15.64	$14.92	$1.63	$0.00	
Estimated FY 2016-17 Caseload	44,025	11,975	71,205	4,951	187,003	76,305	286,845	59	498,180	61,422	21,204	15,503	2,120	2,677	32,600	1,316,074
Estimated FY 2016-17 Total Dental Expenditure	$12,764,168	$2,880,826	$14,246,696	$1,118,035	$37,512,802	$11,599,886	$72,784,050	$0	$0	$0	$0	$2,102,362	$235,214	$4,364	$0	$155,248,403
Estimated FY 2016-17 Emergency and Co-Occurring Dental Expenditure	$906,475	$314,703	$1,603,537	$147,540	$4,519,863	$1,310,157	$4,962,419	$0	$0	$0	$0	$242,467	$31,630	$4,364	$0	$14,043,155
Bottom Line Impacts																
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2016-17 Adult Dental Benefit Expenditure	$11,857,693	$2,566,123	$12,643,159	$970,495	$32,992,939	$10,289,729	$67,821,631	$0	$0	$0	$0	$1,859,895	$203,584	$0	$0	$141,205,248
% Change over Estimated FY 2015-16 Adult Dental Benefit Expenditure	3.12%	5.27%	4.47%	19.25%	6.36%	5.11%	14.88%	0.00%	0.00%	0.00%	0.00%	1.11%	7.56%	0.00%	0.00%	9.70%
Estimated FY 2016-17 Adult Dental Benefit Per Capita	$269.34	$214.29	$177.56	$196.02	$176.43	$134.85	$236.44	$0.00	$0.00	$0.00	$0.00	$119.97	$96.03	$0.00	$0.00	$107.29
% Change over Estimated FY 2015-16 Adult Dental Benefit Per Capita	0.86%	0.58%	1.30%	5.00%	-2.78%	-2.78%	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.84%

Adult Dental Benefit Cash Fund - Fund Splits

FY 2014-15

Eligibility Category	Caseload	Per Capita	FMAP	Total Funds [1]	General Fund	Adult Dental Fund	Federal Funds
Adults 65 and Older(OAP-A)	41,932	$251.93	50.76%	$10,563,834	$0	$5,201,632	$5,362,202
Disabled Adults 60 to 64 (OAP-B)	10,838	$206.22	50.76%	$2,234,971	$0	$1,100,500	$1,134,471
Disabled Individuals to 59 (AND/AB)	66,648	$169.12	50.76%	$11,271,694	$0	$5,550,182	$5,721,512
MAGI Parents/ Caretakers to 60% FPL	155,667	$185.19	50.76%	$28,827,887	$0	$14,194,852	$14,633,035
MAGI Pregnant Adults	15,124	$118.85	50.76%	$1,797,465	$0	$885,072	$912,393
SB 11-250 Eligible Pregnant Adults	1,767	$96.03	65.53%	$169,685	$0	$58,490	$111,195
Total	**291,976**	**$187.91**		**$54,865,536**	**$0**	**$26,990,728**	**$27,874,808**

FY 2015-16

Eligibility Category	Caseload	Per Capita	FMAP	Total Funds [1]	General Fund	Adult Dental Fund	Federal Funds
Adults 65 and Older(OAP-A)	43,060	$267.04	51.01%	$11,498,584	$0	$5,633,156	$5,865,428
Disabled Adults 60 to 64 (OAP-B)	11,442	$213.05	51.01%	$2,437,693	$0	$1,194,226	$1,243,467
Disabled Individuals to 59 (AND/AB)	69,042	$175.28	51.01%	$12,101,671	$0	$5,928,609	$6,173,062
MAGI Parents/ Caretakers to 60% FPL	170,935	$181.47	51.01%	$31,020,235	$0	$15,196,813	$15,823,422
MAGI Pregnant Adults	15,333	$119.97	51.01%	$1,839,484	$0	$901,163	$938,321
SB 11-250 Eligible Pregnant Adults	1,971	$96.03	52.24%	$189,275	$0	$90,398	$98,877
Total	**311,783**	**$189.51**		**$59,086,942**	**$0**	**$28,944,365**	**$30,142,577**

FY 2016-17

Eligibility Category	Caseload	Per Capita	FMAP	Total Funds [1]	General Fund	Adult Dental Fund	Federal Funds
Adults 65 and Older(OAP-A)	44,025	$269.34	51.01%	$11,857,693	$0	$5,809,084	$6,048,609
Disabled Adults 60 to 64 (OAP-B)	11,975	$214.29	51.01%	$2,566,123	$0	$1,257,144	$1,308,979
Disabled Individuals to 59 (AND/AB)	71,205	$177.56	51.01%	$12,643,159	$0	$6,193,884	$6,449,275
MAGI Parents/ Caretakers to 60% FPL	187,003	$176.43	51.01%	$32,992,939	$0	$16,163,241	$16,829,698
MAGI Pregnant Adults	15,503	$119.97	51.01%	$1,859,895	$0	$911,163	$948,732
SB 11-250 Eligible Pregnant Adults	2,120	$96.03	51.01%	$203,584	$0	$99,736	$103,848
Total	**331,831**	**$187.21**		**$62,123,393**	**$0**	**$30,434,252**	**$31,689,141**

(1) Figures may not sum due to rounding.

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

Cash Based Actuals

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2003-04	$6,372,432	$1,298,597	$25,500,975	$0	$1,057,440	$0	$0	$3,389	$1,296,760	$0	$5,340,219	$29,882	$0	$0	$0	$40,899,694
FY 2004-05	$6,629,621	$1,760,042	$28,042,949	$0	$1,378,076	$0	$0	$3,654	$1,795,300	$0	$6,321,954	$22,953	$0	$0	$0	$45,954,548
FY 2005-06	$4,033,428	$1,685,933	$24,178,645	$0	$1,633,973	$0	$0	$326	$1,935,729	$0	$7,189,609	$22,633	$0	$0	$0	$40,680,277
FY 2006-07	$479,529	$1,222,769	$19,965,507	$0	$2,110,260	$0	$0	$183	$2,688,319	$0	$7,814,333	$13,828	$0	$0	$0	$34,294,729
FY 2007-08	$476,587	$1,416,439	$22,587,953	$0	$2,583,540	$0	$0	$7,201	$3,116,761	$0	$8,901,950	$23,191	$0	$0	$0	$39,113,622
FY 2008-09	$574,003	$1,594,319	$22,596,632	$0	$3,589,477	$0	$0	$13,539	$3,477,458	$0	$8,956,851	$50,359	$0	$0	$0	$40,852,638
FY 2009-10 (DA)	$624,336	$1,845,804	$23,477,770	$0	$4,244,208	$66,514	$0	$31,055	$3,652,240	$0	$8,663,502	$61,246	$0	$0	$0	$42,666,675
FY 2010-11 (DA)	$528,892	$2,236,572	$27,074,670	$0	$4,769,442	$469,727	$0	$41,477	$3,795,327	$0	$8,465,862	$77,588	$0	$0	$0	$47,459,557
FY 2011-12	$332,196	$2,736,142	$29,681,347	$3,181	$5,332,883	$1,369,338	$51,852	$45,428	$4,356,981	$0	$8,441,242	$76,112	$0	$0	$0	$52,426,702
FY 2012-13	$227,134	$1,750,998	$19,898,570	$84,657	$3,831,667	$1,085,249	$1,625,465	$45,947	$3,866,964	$0	$5,970,754	$34,100	$0	$0	$0	$38,421,504
FY 2013-14	$282,005	$1,757,115	$20,280,399	$245,383	$5,504,911	$1,214,763	$6,440,111	$27,008	$5,079,647	$0	$5,561,277	$127,504	$0	$0	$0	$46,520,123

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	-39.16%	-4.21%	-13.78%	0.00%	18.57%	0.00%	0.00%	-91.07%	7.82%	0.00%	13.72%	-1.39%	0.00%	0.00%	0.00%	-11.48%
FY 2006-07	-88.11%	-27.47%	-17.43%	0.00%	29.15%	0.00%	0.00%	-44.00%	38.88%	0.00%	8.69%	-38.90%	0.00%	0.00%	0.00%	-15.70%
FY 2007-08	-0.61%	15.84%	13.13%	0.00%	22.43%	0.00%	0.00%	3839.28%	15.94%	0.00%	13.92%	67.71%	0.00%	0.00%	0.00%	14.05%
FY 2008-09	20.44%	12.56%	0.04%	0.00%	38.94%	0.00%	0.00%	88.02%	11.57%	0.00%	0.62%	117.15%	0.00%	0.00%	0.00%	4.45%
FY 2009-10 (DA)	8.77%	15.77%	3.90%	0.00%	18.24%	0.00%	0.00%	129.37%	5.03%	0.00%	-3.28%	21.62%	0.00%	0.00%	0.00%	4.44%
FY 2010-11 (DA)	-15.29%	21.17%	15.32%	0.00%	12.38%	606.21%	0.00%	33.56%	3.92%	0.00%	-2.28%	26.68%	0.00%	0.00%	0.00%	11.23%
FY 2011-12	-37.19%	22.34%	9.63%	0.00%	11.81%	191.52%	0.00%	9.53%	14.80%	0.00%	-0.29%	-1.90%	0.00%	0.00%	0.00%	10.47%
FY 2012-13	-31.63%	-36.00%	-32.96%	2561.41%	-28.15%	-20.75%	3034.82%	1.14%	-11.25%	0.00%	-29.27%	-55.20%	0.00%	0.00%	0.00%	-26.71%
FY 2013-14	24.16%	0.35%	1.92%	189.86%	43.67%	11.93%	296.20%	-41.22%	31.36%	0.00%	-6.86%	273.92%	0.00%	0.00%	0.00%	21.08%

Per Capita Cost

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2004-05	$185.29	$289.39	$585.09	$0.00	$24.12	$0.00	$0.00	$42.01	$8.07	$0.00	$400.25	$3.84	$0.00	$0.00	$0.00	$113.18
FY 2005-06	$111.40	$279.04	$505.25	$0.00	$27.75	$0.00	$0.00	$1.74	$9.04	$0.00	$436.79	$4.42	$0.00	$0.00	$0.00	$101.14
FY 2006-07	$13.36	$201.81	$409.14	$0.00	$37.78	$0.00	$0.00	$0.80	$13.09	$0.00	$467.25	$2.67	$0.00	$0.00	$0.00	$87.44
FY 2007-08	$13.13	$230.47	$452.37	$0.00	$48.31	$0.00	$0.00	$26.67	$15.28	$0.00	$519.34	$3.69	$0.00	$0.00	$0.00	$99.79
FY 2008-09	$15.26	$247.30	$440.01	$0.00	$58.01	$0.00	$0.00	$42.71	$14.79	$0.00	$496.69	$7.22	$0.00	$0.00	$0.00	$93.52
FY 2009-10 (DA)	$16.22	$261.85	$440.78	$0.00	$56.71	$20.54	$0.00	$73.07	$13.25	$0.00	$471.33	$7.82	$0.00	$0.00	$0.00	$85.54
FY 2010-11 (DA)	$13.60	$287.96	$481.03	$0.00	$58.80	$17.29	$0.00	$78.11	$12.55	$0.00	$460.28	$9.86	$0.00	$0.00	$0.00	$84.64
FY 2011-12	$8.36	$326.39	$499.40	$61.17	$57.21	$38.62	$45.72	$76.09	$13.02	$0.00	$468.07	$9.98	$0.00	$0.00	$0.00	$84.56
FY 2012-13	$5.56	$193.46	$321.36	$95.33	$38.55	$26.12	$152.86	$73.75	$10.75	$0.00	$335.87	$4.25	$0.00	$0.00	$0.00	$56.25
FY 2013-14	$6.74	$178.33	$314.80	$95.85	$44.15	$25.80	$73.82	$48.31	$12.78	$0.00	$304.44	$9.69	$0.00	$0.00	$0.00	$54.03

Percent Change in Per Capita Cost

ACUTE CARE Gross Antipsychotic Drugs Expenditure (For Information Only)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	-39.88%	-3.58%	-13.65%	0.00%	15.05%	0.00%	0.00%	-95.86%	12.02%	0.00%	9.13%	15.10%	0.00%	0.00%	0.00%	-10.64%
FY 2006-07	-88.01%	-27.68%	-19.02%	0.00%	36.14%	0.00%	0.00%	-54.02%	44.80%	0.00%	6.97%	-39.59%	0.00%	0.00%	0.00%	-13.55%
FY 2007-08	-1.72%	14.20%	10.57%	0.00%	27.87%	0.00%	0.00%	3233.75%	16.73%	0.00%	11.15%	38.20%	0.00%	0.00%	0.00%	14.12%
FY 2008-09	16.22%	7.30%	-2.73%	0.00%	20.08%	0.00%	0.00%	60.14%	-3.21%	0.00%	-4.36%	95.66%	0.00%	0.00%	0.00%	-6.28%
FY 2009-10 (DA)	6.29%	5.88%	0.17%	0.00%	-2.24%	0.00%	0.00%	71.08%	-10.41%	0.00%	-5.11%	8.31%	0.00%	0.00%	0.00%	-8.53%
FY 2010-11 (DA)	-16.15%	9.97%	9.13%	0.00%	3.69%	-15.82%	0.00%	6.90%	-5.28%	0.00%	-2.34%	26.09%	0.00%	0.00%	0.00%	-1.05%
FY 2011-12	-38.53%	13.35%	3.82%	0.00%	-2.70%	123.37%	0.00%	-2.59%	3.75%	0.00%	1.69%	1.22%	0.00%	0.00%	0.00%	-0.09%
FY 2012-13	-33.49%	-40.73%	-35.65%	55.84%	-32.62%	-32.37%	234.34%	-3.08%	-17.43%	0.00%	-28.24%	-57.41%	0.00%	0.00%	0.00%	-33.48%
FY 2013-14	21.22%	-7.82%	-2.04%	0.55%	14.53%	-1.23%	-51.71%	-34.49%	18.88%	0.00%	-9.36%	128.00%	0.00%	0.00%	0.00%	-3.95%

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

Cash Based Actuals

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2004-05	$4,938,612	$1,311,110	$20,890,071	$0	$1,026,572	$0	$0	$2,722	$1,337,375	$0	$4,709,421	$17,098	$0	$0	$0	$34,232,981
FY 2005-06	$2,687,488	$1,123,343	$16,110,320	$0	$1,088,722	$0	$0	$217	$1,289,783	$0	$4,790,463	$15,081	$0	$0	$0	$27,105,417
FY 2006-07	$331,389	$845,022	$13,797,610	$0	$1,458,343	$0	$0	$126	$1,857,823	$0	$5,400,269	$9,556	$0	$0	$0	$23,700,138
FY 2007-08	$354,695	$1,054,171	$16,810,867	$0	$1,922,775	$0	$0	$5,359	$2,319,619	$0	$6,625,191	$17,260	$0	$0	$0	$29,109,937
FY 2008-09	$348,451	$967,839	$13,717,389	$0	$2,179,008	$0	$0	$8,219	$2,111,007	$0	$5,437,298	$30,571	$0	$0	$0	$24,799,782
FY 2009-10 (DA)	$337,362	$997,385	$12,686,278	$0	$2,293,370	$35,941	$0	$16,781	$1,973,498	$0	$4,681,347	$33,094	$0	$0	$0	$23,055,056
FY 2010-11 (DA)	$276,098	$1,167,559	$14,133,811	$0	$2,489,795	$245,212	$0	$21,652	$1,981,277	$0	$4,419,440	$40,503	$0	$0	$0	$24,775,347
FY 2011-12	$170,868	$1,407,362	$15,266,894	$1,636	$2,743,021	$704,332	$26,671	$23,366	$2,241,056	$0	$4,341,836	$39,149	$0	$0	$0	$26,966,191
FY 2012-13	$99,799	$769,359	$8,743,092	$37,197	$1,683,569	$476,840	$714,202	$20,188	$1,699,078	$0	$2,623,448	$14,983	$0	$0	$0	$16,881,755
FY 2013-14	$155,296	$967,616	$11,168,104	$135,129	$3,031,470	$668,951	$3,546,470	$14,873	$2,797,283	$0	$3,062,510	$70,214	$0	$0	$0	$25,617,916

Percent Change in Cash Based Actuals

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	-45.58%	-14.32%	-22.88%	0.00%	6.05%	0.00%	0.00%	-92.03%	-3.56%	0.00%	1.72%	-11.80%	0.00%	0.00%	0.00%	-20.82%
FY 2006-07	-87.67%	-24.78%	-14.36%	0.00%	33.95%	0.00%	0.00%	-41.94%	44.04%	0.00%	12.73%	-36.64%	0.00%	0.00%	0.00%	-12.56%
FY 2007-08	7.03%	24.75%	21.84%	0.00%	31.85%	0.00%	0.00%	4153.17%	24.86%	0.00%	22.68%	80.62%	0.00%	0.00%	0.00%	22.83%
FY 2008-09	-1.76%	-8.19%	-18.40%	0.00%	13.33%	0.00%	0.00%	53.37%	-8.99%	0.00%	-17.93%	77.12%	0.00%	0.00%	0.00%	-14.81%
FY 2009-10 (DA)	-3.18%	3.05%	-7.52%	0.00%	5.25%	0.00%	0.00%	104.17%	-6.51%	0.00%	-13.90%	8.25%	0.00%	0.00%	0.00%	-7.04%
FY 2010-11 (DA)	-18.16%	17.06%	11.41%	0.00%	8.56%	582.26%	0.00%	29.03%	0.39%	0.00%	-5.59%	22.39%	0.00%	0.00%	0.00%	7.46%
FY 2011-12	-38.11%	20.54%	8.02%	0.00%	10.17%	187.23%	0.00%	7.92%	13.11%	0.00%	-1.76%	-3.34%	0.00%	0.00%	0.00%	8.84%
FY 2012-13	-41.59%	-45.33%	-42.73%	2173.66%	-38.62%	-32.30%	2577.82%	-13.60%	-24.18%	0.00%	-39.58%	-61.73%	0.00%	0.00%	0.00%	-37.40%
FY 2013-14	55.61%	25.77%	27.74%	263.28%	80.06%	40.29%	396.56%	-26.33%	64.64%	0.00%	16.74%	368.62%	0.00%	0.00%	0.00%	51.75%

Per Capita Cost

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2004-05	$138.03	$215.57	$435.85	$0.00	$17.97	$0.00	$0.00	$31.29	$6.01	$0.00	$298.16	$2.86	$0.00	$0.00	$0.00	$84.31
FY 2005-06	$74.23	$185.92	$336.65	$0.00	$18.49	$0.00	$0.00	$1.15	$6.02	$0.00	$291.04	$2.95	$0.00	$0.00	$0.00	$67.39
FY 2006-07	$9.23	$139.47	$282.74	$0.00	$26.11	$0.00	$0.00	$0.55	$9.05	$0.00	$322.91	$1.84	$0.00	$0.00	$0.00	$60.42
FY 2007-08	$9.78	$171.52	$336.67	$0.00	$35.96	$0.00	$0.00	$19.85	$11.37	$0.00	$386.51	$2.74	$0.00	$0.00	$0.00	$74.27
FY 2008-09	$9.26	$150.12	$267.11	$0.00	$35.22	$0.00	$0.00	$25.93	$8.98	$0.00	$301.52	$4.38	$0.00	$0.00	$0.00	$56.77
FY 2009-10 (DA)	$8.77	$141.49	$238.18	$0.00	$30.64	$11.10	$0.00	$39.48	$7.16	$0.00	$254.68	$4.23	$0.00	$0.00	$0.00	$46.22
FY 2010-11 (DA)	$7.10	$150.32	$251.11	$0.00	$30.70	$9.03	$0.00	$40.78	$6.55	$0.00	$240.28	$5.15	$0.00	$0.00	$0.00	$44.19
FY 2011-12	$4.30	$167.88	$256.87	$31.46	$29.42	$19.86	$23.52	$39.14	$6.70	$0.00	$240.76	$5.13	$0.00	$0.00	$0.00	$43.50
FY 2012-13	$2.44	$85.00	$141.20	$41.89	$16.94	$11.48	$67.16	$32.40	$4.72	$0.00	$147.58	$1.87	$0.00	$0.00	$0.00	$24.72
FY 2013-14	$3.71	$98.21	$173.35	$52.78	$24.31	$14.21	$40.65	$26.61	$7.04	$0.00	$167.65	$5.34	$0.00	$0.00	$0.00	$29.76

Percent Change in Per Capita Cost

ACUTE CARE Net Antipsychotic Drugs Expenditure (With Estimated Drug Rebate)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	-46.22%	-13.75%	-22.76%	0.00%	2.89%	0.00%	0.00%	-96.32%	0.17%	0.00%	-2.39%	3.15%	0.00%	0.00%	0.00%	-20.07%
FY 2006-07	-87.57%	-24.98%	-16.01%	0.00%	41.21%	0.00%	0.00%	-52.17%	50.33%	0.00%	10.95%	-37.63%	0.00%	0.00%	0.00%	-10.34%
FY 2007-08	5.96%	22.98%	19.07%	0.00%	37.73%	0.00%	0.00%	3509.09%	25.64%	0.00%	19.70%	48.91%	0.00%	0.00%	0.00%	22.92%
FY 2008-09	-5.32%	-12.48%	-20.66%	0.00%	-2.06%	0.00%	0.00%	30.63%	-21.02%	0.00%	-21.99%	59.85%	0.00%	0.00%	0.00%	-23.56%
FY 2009-10 (DA)	-5.29%	-5.75%	-10.83%	0.00%	-13.00%	0.00%	0.00%	52.26%	-20.27%	0.00%	-15.53%	-3.42%	0.00%	0.00%	0.00%	-18.58%
FY 2010-11 (DA)	-19.04%	6.24%	5.43%	0.00%	0.20%	-18.65%	0.00%	3.29%	-8.52%	0.00%	-5.65%	21.75%	0.00%	0.00%	0.00%	-4.39%
FY 2011-12	-39.44%	11.68%	2.29%	0.00%	-4.17%	119.93%	0.00%	-4.02%	2.29%	0.00%	0.20%	-0.39%	0.00%	0.00%	0.00%	-1.56%
FY 2012-13	-43.26%	-49.37%	-45.03%	33.15%	-42.42%	-42.20%	185.54%	-17.22%	-29.55%	0.00%	-38.70%	-63.55%	0.00%	0.00%	0.00%	-43.17%
FY 2013-14	52.05%	15.54%	22.77%	26.00%	43.51%	23.78%	-39.47%	-17.87%	49.15%	0.00%	13.60%	185.56%	0.00%	0.00%	0.00%	20.39%

Exhibit F - ACUTE CARE - Pharmacy Rebates

Estimated Increase in Rebates Attributable to the Affordable Care Act

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	Percentage Change[2]
FY 2010-11[1]	$2,623,793	$2,663,517	$2,986,818	$2,724,952	$10,999,080	-
FY 2011-12[1]	$3,079,979	$3,164,919	$3,074,020	$3,278,629	$12,597,547	14.53%
FY 2012-13[1]	$2,844,435	$2,078,580	$3,217,760	$1,876,367	$10,017,142	-20.48%
FY 2013-14[1]	$3,311,683	$3,403,012	$3,305,275	$3,525,277	$13,545,247	35.22%
FY 2014-15[2]	$3,894,881	$4,002,295	$3,887,345	$4,146,090	$15,930,611	17.61%
FY 2015-16[2]	$4,580,783	$4,707,112	$4,571,920	$4,876,230	$18,736,045	17.61%
FY 2016-17[2]	$5,387,474	$5,536,050	$5,377,051	$5,734,951	$22,035,526	17.61%

(1) Historical actuals have been restated as the Department has transitioned from an accrual-based reconciliation to cash-based reconciliation process in FY 2011-12 to prevent overstatement of federal funds only rebate revenue actually received by the state.

(2) The estimated FY 2014-15, FY 2015-16 and FY 2016-17 growth rate is held constant for the request and out years and is equal to the percentage growth from FY 2012-13 to FY 2013-14.

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

Total Expenditure [2]

Fiscal Year	Total Reported Expenditures	General Fund	Cash Funds [1]	Federal Funds (90% FMAP) [2]	Change	% Change
FY 2000-01	$1,954,562	$195,456	$0	$1,759,106	($1,518,369)	-38.38%
FY 2001-02	$4,555,016	$455,502	$0	$4,099,514	$2,600,454	133.05%
FY 2002-03	$6,066,468	$606,647	$0	$5,459,821	$1,511,452	33.18%
FY 2003-04	$5,369,643	$536,964	$0	$4,832,679	($696,825)	-11.49%
FY 2004-05	$7,008,093	$700,809	$0	$6,307,284	$1,638,451	30.51%
FY 2005-06	$7,121,173	$712,117	$0	$6,409,056	$113,079	1.61%
FY 2006-07	$7,302,900	$730,290	$0	$6,572,610	$181,728	2.55%
FY 2007-08	$9,682,728	$968,273	$0	$8,714,455	$2,379,827	32.59%
FY 2008-09	$13,069,942	$1,306,994	$0	$11,762,948	$3,387,215	34.98%
FY 2009-10	$11,628,243	$1,162,825	$0	$10,465,418	($1,441,700)	-11.03%
FY 2010-11	$11,529,927	$1,152,993	$0	$10,376,934	($98,316)	-0.85%
FY 2011-12	$9,616,143	$942,711	$18,903	$8,654,529	($1,913,784)	-16.60%
FY 2012-13	$7,948,469	$775,555	$19,292	$7,153,622	($1,667,674)	-17.34%
FY 2013-14	$9,987,817	$979,489	$19,292	$8,989,036	$2,039,349	25.66%
FY 2014-15 Estimate[3]	$12,453,015	$1,460,469	$29,160	$10,963,386	$2,465,198	24.68%
FY 2015-16 Estimate[3]	$13,179,026	$1,544,801	$30,026	$11,604,199	$726,011	5.83%
FY 2016-17 Estimate[3]	$13,947,363	$1,661,487	$5,153	$12,280,723	$768,337	5.83%

[1] SB 11-177 extended and expanded the Teen Pregnancy and Dropout Prevention program. The Department receives local funds to provide services for the program. The cash fund expenditures in FY 2011-12, FY 2012-13, FY 2013-14, FY 2014-15, FY 2015-16, and FY 2016-17 represent the contributions -- actual and anticipated -- of this program.

[2] Due to recent audit findings, 23% of total expenditure will not be able to be claimed at the enhanced (90%) federal match, it must be claimed at the standard match rate.

[3] The FY 2014-15 estimate for total reported expenditures is the average of annual total reported expenditures for FY 2010-11 though FY 2013-14, also accounting for the increase in family planning reimbursement rates beginning July 1, 2014. Estimates for FY 2015-16 and FY 2016-17 are the result of the application of the average growth rate for FY 2010-11 and FY 2012-13 to the previous year's estimated total reported expenditure.

Breakdown of Total Expenditure

Fiscal Year	Total Reported Expenditures	Fee-for-Service Expenditure	Managed Care Expenditure	Drug Rebates	Total Expenditure Net of Rebates	Percent Change Net of Rebates
FY 2000-01	$2,438,198	$2,438,198	$0	($483,635)	$1,954,562	-
FY 2001-02	$5,111,123	$2,763,372	$2,347,751	($556,107)	$4,555,016	133.05%
FY 2002-03	$6,538,073	$3,094,894	$3,443,179	($471,606)	$6,066,468	33.18%
FY 2003-04	$6,061,856	$4,058,413	$2,003,442	($692,213)	$5,369,643	-11.49%
FY 2004-05	$8,019,717	$6,902,883	$1,116,833	($1,011,623)	$7,008,093	30.51%
FY 2005-06	$8,260,397	$7,013,966	$1,246,431	($1,139,224)	$7,121,173	1.61%
FY 2006-07	$8,343,188	$7,431,084	$912,103	($1,040,287)	$7,302,900	2.55%
FY 2007-08	$9,902,250	$9,139,367	$762,883	($219,523)	$9,682,728	32.59%
FY 2008-09	$13,893,561	$13,472,771	$420,790	($823,619)	$13,069,942	34.98%
FY 2009-10	$12,619,883	$12,533,203	$86,680	($991,641)	$11,628,243	-11.03%
FY 2010-11	$13,895,800	$12,375,826	$1,519,974	($2,365,873)	$11,529,927	-0.85%
FY 2011-12	$11,795,916	$10,329,972	$1,465,944	($2,179,772)	$9,616,143	-16.60%
FY 2012-13	$11,806,126	$10,594,615	$1,211,511	($3,857,657)	$7,948,469	-17.34%
FY 2013-14	$13,703,377	$12,637,553	$1,065,824	($3,715,560)	$9,987,817	25.66%

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

Total Expenditure Fund Splits

Fiscal Year	Total Reported Expenditures[1]	General Fund	Cash Funds	Federal Funds	FMAP
FY 2014-15 Estimate [4]	$11,830,364	$1,155,334	$27,702	$10,647,328	90.00%
	$622,651	$305,135	$1,458	$316,058	50.76%
FY 2015-16 Estimate [4]	$12,520,075	$1,223,482	$28,525	$11,268,068	90.00%
	$658,951	$321,319	$1,501	$336,131	51.01%
FY 2016-17 Estimate [4]	$13,249,995	$1,320,104	$4,895	$11,924,996	90.00%
	$697,368	$341,383	$258	$355,727	51.01%

[4] Approximately 5% of total family planning expenditure is ineligible for a 90% match.

Exhibit F - ACUTE CARE - Indian Health Services

Total Expenditure for Indian Health Service			
Fiscal Year	**Total Reported Expenditures: 100% FF**	**Change**	**% Change**
FY 2001-02	$100,299	$100,299	-
FY 2002-03	$511,451	$411,152	409.93%
FY 2003-04	$813,791	$302,340	59.11%
FY 2004-05	$922,761	$108,970	13.39%
FY 2005-06	$840,371	($82,390)	-8.93%
FY 2006-07	$899,521	$59,150	7.04%
FY 2007-08	$1,061,989	$162,468	18.06%
FY 2008-09	$1,534,327	$472,338	44.48%
FY 2009-10	$1,536,532	$2,205	0.14%
FY 2010-11	$1,672,353	$135,821	8.84%
FY 2011-12	$1,434,711	($237,642)	-14.21%
FY 2012-13	$1,238,524	($196,187)	-13.67%
FY 2013-14	$1,450,187	$211,663	17.09%
FY 2014-15 Estimated Total[(1)]	$1,513,089	$274,565	4.34%
FY 2015-16 Estimated Total[(1)]	$1,578,720	$65,631	4.34%
FY 2016-17 Estimated Total[(1)]	$1,647,198	$68,478	4.34%

[(1)] The trend for FY 2014-15, FY 2015-16, and FY 2016-17 is half the average percent growth from FY 2007-08 through FY 2013-14.

Exhibit F - ACUTE CARE - Expenditure by Half-Year

FY 2013-14 July-December COFRS Total Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Physician Services & EPSDT	$2,126,380	$5,391,702	$36,200,872	$2,878,789	$42,656,116	$11,477,217	$8,768,648	$0	$74,357,192	$0	$6,047,201	$15,420,192	$0	$3,584,186	$2,621	$208,911,115
Emergency Transportation	$66,504	$200,380	$1,240,531	$44,246	$859,994	$179,231	$476,798	$0	$907,106	$0	$108,429	$165,861	$0	$36,487	$0	$4,285,568
Non-emergency Medical Transportation	$878,622	$492,614	$2,058,121	$33,069	$210,709	$46,398	$146,096	$0	$402,699	$0	$60,028	$22,412	$0	$288	$0	$4,351,057
Dental Services	$735,057	$228,184	$2,996,748	$93,421	$3,003,799	$860,293	$576,406	$0	$54,735,487	$0	$2,776,140	$222,842	$0	$1,510	$0	$66,229,886
Family Planning	$117	$146	$9,907	$256	$136,589	$45,235	$7,042	$0	$104,861	$0	$43,774	$17,024	$0	$0	$0	$364,951
Health Maintenance Organizations	$2,998,630	$4,238,163	$21,963,468	$209,563	$11,372,325	$3,876,839	$5,794	$0	$21,174,857	$0	$400,679	$1,093,389	$0	$0	$1,013	$67,334,719
Inpatient Hospitals	$6,178,058	$7,853,987	$54,302,484	$5,754,817	$32,505,371	$6,842,546	$10,750,120	$0	$42,596,739	$0	$2,534,222	$20,274,757	$0	$17,071,224	($11,971)	$206,652,353
Outpatient Hospitals	$1,936,308	$4,164,759	$31,523,907	$2,575,497	$39,123,092	$11,349,198	$10,883,542	$0	$45,645,423	$0	$3,100,785	$4,658,903	$0	$931,629	$0	$155,893,042
Lab & X-Ray	$266,509	$641,424	$3,873,295	$221,903	$8,787,987	$2,354,173	$1,585,800	$0	$3,665,006	$0	$629,608	$2,412,401	$0	$77,972	$0	$24,516,078
Durable Medical Equipment	$9,734,717	$3,220,923	$28,562,773	$563,023	$2,682,293	$841,403	$974,402	$0	$6,207,880	$0	$2,360,864	$139,748	$0	$0	$17,075	$55,305,102
Prescription Drugs	$3,611,551	$9,645,371	$66,667,184	$2,502,929	$32,079,199	$10,369,827	$10,168,489	$0	$37,340,325	$0	$9,044,408	$1,758,137	$0	$0	$111	$183,187,529
Drug Rebate	($1,535,519)	($4,100,912)	($28,344,816)	($1,064,168)	($13,639,079)	($4,408,928)	($4,323,325)	$0	($15,875,946)	$0	($3,845,401)	($747,505)	$0	$0	($47)	($77,885,647)
Rural Health Centers	$33,922	$127,596	$627,077	$29,424	$1,197,446	$416,216	$148,739	$0	$3,210,610	$0	$163,823	$158,014	$0	$3,782	$0	$6,116,648
Federally Qualified Health Centers	$464,276	$646,657	$4,282,377	$138,410	$8,575,367	$2,379,716	$2,638,073	$0	$29,747,989	$0	$937,379	$3,783,919	$0	$200,299	$0	$53,794,461
Co-Insurance (Title XVIII-Medicare)	$3,545,667	$605,785	$2,644,569	$57,508	$142,797	$184,805	$3,313	$0	$3,349	$0	$1,674	$5,324	$0	$0	$1,357,221	$8,552,012
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$6,376,022	$0	$0	$0	$0	$0	$0	$0	$6,376,022
Administrative Service Organizations - Services	$547,749	$1,593,095	$9,974,042	$1,519,050	$5,351,996	$1,071,156	$40,512	$0	$2,960,862	$0	$507,529	$4,255,426	$0	$0	$836	$27,822,253
Other Medical Services	$339	$277	$2,137	$102	$1,169	$328	$306	$43	$2,048	$0	$221	$314	$0	$141	$21	$7,446
Home Health	$15,236,201	$4,991,385	$70,874,888	$663,624	$456,228	$154,283	$185,007	$0	$3,214,315	$0	$6,181,653	$44,090	$0	$0	$149,592	$102,151,267
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$46,825,087	$39,941,537	$309,459,564	$16,221,461	$175,503,400	$48,039,936	$43,035,761	$6,376,065	$310,400,800	$0	$31,053,016	$53,685,247	$0	$21,907,517	$1,516,472	$1,103,965,862
Caseload	41,784	9,650	64,256	2,074	111,141	41,760	18,108	613	385,897	13,835	17,685	11,411	582	2,480	22,495	743,768
Half -Year Per Capita	$1,120.65	$4,139.09	$4,816.07	$7,823.23	$1,579.11	$1,150.39	$2,376.62	$10,398.58	$804.36	$0.00	$1,755.90	$4,704.83	$0.00	$8,832.49	$67.41	$1,484.29

FY 2013-14 January-June COFRS Total Actuals

ACUTE CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Physician Services & EPSDT	$1,916,978	$4,372,320	$28,859,113	$1,568,706	$36,756,120	$11,269,427	$53,995,917	$0	$65,700,450	$7,150,906	$5,092,978	$17,389,902	$2,342,191	$2,412,483	$3,620	$238,831,111
Emergency Transportation	$56,263	$186,579	$1,051,750	$30,363	$828,412	$198,192	$2,052,310	$0	$921,636	$101,343	$109,302	$252,061	$13,119	$38,162	$793	$5,840,284
Non-emergency Medical Transportation	$1,922,846	$1,189,194	$4,656,743	$71,918	$577,149	$87,631	$738,322	$0	$908,429	$15,344	$126,620	$85,917	$158	$883	$2,733	$10,383,886
Dental Services	$1,059,795	$330,062	$3,517,797	$89,207	$6,149,996	$1,841,242	$6,432,666	$0	$49,384,193	$8,541,901	$2,651,760	$527,343	$40,847	$5,041	$2,203	$80,574,054
Family Planning	$55	$2	$11,550	$263	$187,434	$75,350	$101,498	$0	$128,645	$16,551	$44,146	$23,664	$4,468	$0	$0	$593,625
Health Maintenance Organizations	$2,679,213	$3,933,838	$20,287,796	$204,054	$12,957,332	$3,331,297	$984,249	$0	$21,293,892	$669,190	$441,456	$1,716,070	$57,645	$0	($30)	$68,556,003
Inpatient Hospitals	$6,036,371	$7,605,652	$46,421,040	$4,110,367	$20,513,889	$7,853,367	$71,521,048	$0	$53,066,877	$4,392,433	$2,920,082	$29,929,945	$4,454,216	$12,832,957	$693	$271,658,938
Outpatient Hospitals	$2,136,710	$4,509,718	$31,509,388	$2,006,329	$44,096,213	$17,059,686	$69,326,331	$0	$49,129,190	$8,822,676	$3,609,771	$7,070,590	$922,940	$1,058,695	$18,275	$241,276,512
Lab & X-Ray	$294,719	$666,820	$4,170,019	$190,813	$10,276,315	$3,242,963	$11,082,355	$0	$4,242,334	$761,171	$733,879	$3,931,920	$498,413	$76,587	$389	$40,168,697
Durable Medical Equipment	$10,258,949	$3,383,054	$29,819,078	$583,403	$3,447,960	$855,896	$5,096,618	$0	$7,512,085	$776,900	$2,403,335	$182,076	$12,827	$191	$24,202	$64,356,573
Prescription Drugs	$4,024,328	$10,744,651	$73,986,564	$2,567,396	$42,825,368	$12,912,380	$60,762,527	$0	$46,852,135	$2,580,080	$9,735,805	$2,892,707	$100,082	$0	$19,884	$270,003,909
Drug Rebate	($1,754,638)	($4,684,766)	($32,260,248)	($1,120,540)	($18,635,895)	($5,622,939)	($26,239,520)	$0	($20,366,939)	($1,145,777)	($4,246,641)	($1,255,528)	($44,052)	$0	($8,569)	($117,386,051)
Rural Health Centers	$42,343	$142,027	$633,397	$19,899	$1,645,263	$511,612	$1,403,590	$0	$3,396,603	$393,261	$174,783	$311,510	$28,873	$6,020	$68	$8,709,248
Federally Qualified Health Centers	$561,943	$751,624	$4,380,200	$120,401	$9,195,618	$3,692,682	$17,127,255	$0	$27,883,720	$3,750,977	$942,663	$5,084,626	$646,513	$172,897	$1,908	$74,313,028
Co-Insurance (Title XVIII-Medicare)	$19,189,244	$3,323,456	$13,760,657	$698,899	$1,570,580	$379,994	$273,710	$0	$20,823	$658	$5,247	$45,885	$1,510	$0	$7,081,704	$46,352,367
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$2,503,625	$0	$0	$0	$0	$0	$0	$0	$2,503,625
Administrative Service Organizations - Services	$914,084	$1,066,604	$5,914,612	($920,928)	$9,510,255	$2,555,467	$848,065	$0	$9,722,778	$202,815	$1,420,827	($255,506)	$129,215	$0	$2,022	$31,110,310
Other Medical Services	$510	$409	$3,024	$125	$1,776	$575	$2,462	$25	$3,099	$322	$327	$617	$76	$163	$35	$13,545
Home Health	$15,761,893	$5,352,406	$70,485,224	$917,729	$564,764	$85,845	$1,417,577	$0	$5,682,739	$346,230	$6,272,390	$43,403	$2,994	$0	$250,726	$107,183,919
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total	$65,101,605	$42,873,649	$307,207,704	$11,138,404	$182,468,547	$60,330,667	$276,926,981	$2,503,650	$325,482,691	$37,376,981	$32,438,730	$67,977,203	$9,212,035	$16,604,080	$7,400,656	$1,445,043,583
Caseload	41,888	10,056	64,593	3,047	138,220	52,404	156,377	504	408,827	40,196	18,849	14,908	1,533	2,481	24,261	978,143
Half -Year Per Capita	$1,554.20	$4,263.35	$4,756.08	$3,655.53	$1,320.14	$1,151.26	$1,770.89	$4,965.92	$796.14	$929.87	$1,720.98	$4,559.68	$6,008.50	$6,693.39	$305.05	$1,477.33

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

Cash Based Actuals

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$73,871,969	$9,613,615	$55,885,763	$0	$38,653	$0	$0	$0	$3,201	$0	$1,113	$0	$0	$0	$32,605	$139,446,919
FY 2006-07	$88,671,456	$11,964,141	$65,079,570	$0	$47,107	$0	$0	$0	$264	$0	$7,029	$0	$0	$0	$269,817	$166,039,384
FY 2007-08	$98,761,506	$14,013,387	$75,665,199	$0	$44,160	$0	$0	$0	$3,477	$0	$24,363	$0	$0	$0	$669,883	$189,181,976
FY 2008-09	$103,189,236	$16,600,418	$99,120,846	$0	$16,756	$0	$0	$0	$50	$0	$88,666	$0	$0	$0	$242,445	$219,258,416
FY 2009-10 (DA)	$108,935,302	$17,849,185	$105,282,774	$0	$19,344	$0	$0	$0	$0	$0	$105,173	$0	$0	$0	$194,576	$232,386,355
FY 2010-11 (DA)	$111,149,465	$20,210,586	$120,507,011	$0	$32,094	$12,129	$0	$0	$3,327	$0	$86,754	$0	$0	$0	$142,108	$252,143,475
FY 2011-12	$117,679,185	$23,268,051	$130,652,872	$0	$8,548	$20,511	$0	$0	$7,404	$0	$111,354	$0	$0	$0	$260,261	$272,008,186
FY 2012-13	$125,361,271	$24,829,149	$142,882,126	$47,542	$16,956	$39,770	$7,746	$0	$17,013	$0	$69,174	$0	$0	$0	$221,261	$293,492,008
FY 2013-14	$144,155,003	$29,761,079	$162,371,250	$771,736	$205,171	$30,048	$339,106	$0	$264,157	$0	$169,103	$35	$0	$0	$888,063	$338,954,751
Estimated FY 2014-15	$151,744,361	$31,471,019	$176,884,605	$812,514	$217,477	$0	$0	$0	$399,192	$0	$191,601	$37	$0	$0	$936,614	$362,657,420
Estimated FY 2015-16	$162,574,883	$33,772,187	$194,535,105	$870,687	$232,723	$0	$0	$0	$578,638	$0	$207,064	$40	$0	$0	$1,005,557	$393,776,884
Estimated FY 2016-17	$174,314,866	$36,310,270	$215,641,613	$933,858	$249,296	$0	$0	$0	$827,770	$0	$222,446	$44	$0	$0	$1,081,494	$429,581,658

Percent Change in Cash Based Actuals

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	20.03%	24.45%	16.45%	0.00%	21.87%	0.00%	0.00%	0.00%	-91.75%	0.00%	531.54%	0.00%	0.00%	0.00%	727.53%	19.07%
FY 2007-08	11.38%	17.13%	16.27%	0.00%	-6.26%	0.00%	0.00%	0.00%	1217.17%	0.00%	246.61%	0.00%	0.00%	0.00%	148.27%	13.94%
FY 2008-09	4.48%	18.46%	31.00%	0.00%	-62.06%	0.00%	0.00%	0.00%	-98.57%	0.00%	263.94%	0.00%	0.00%	0.00%	-63.81%	15.90%
FY 2009-10 (DA)	5.57%	7.52%	6.22%	0.00%	15.45%	0.00%	0.00%	0.00%	-100.00%	0.00%	18.62%	0.00%	0.00%	0.00%	-19.74%	5.99%
FY 2010-11 (DA)	2.03%	13.23%	14.46%	0.00%	65.91%	100.00%	0.00%	0.00%	100.00%	0.00%	-17.51%	0.00%	0.00%	0.00%	-26.97%	8.50%
FY 2011-12	5.87%	15.13%	8.42%	0.00%	-73.37%	69.11%	0.00%	0.00%	122.52%	0.00%	28.36%	0.00%	0.00%	0.00%	83.14%	7.88%
FY 2012-13	6.53%	6.71%	9.36%	100.00%	98.36%	93.90%	100.00%	0.00%	129.78%	0.00%	-37.88%	0.00%	0.00%	0.00%	-14.98%	7.90%
FY 2013-14	14.99%	19.86%	13.64%	1523.27%	1110.02%	-24.45%	4277.82%	0.00%	1452.68%	0.00%	144.46%	100.00%	0.00%	0.00%	301.36%	15.49%
Estimated FY 2014-15	5.26%	5.75%	8.94%	5.28%	6.00%	-100.00%	-100.00%	0.00%	51.12%	0.00%	13.30%	5.71%	0.00%	0.00%	5.47%	6.99%
Estimated FY 2015-16	7.14%	7.31%	9.98%	7.16%	7.01%	0.00%	0.00%	0.00%	44.95%	0.00%	8.07%	8.11%	0.00%	0.00%	7.36%	8.58%
Estimated FY 2016-17	7.22%	7.52%	10.85%	7.26%	7.12%	0.00%	0.00%	0.00%	43.05%	0.00%	7.43%	11.14%	0.00%	0.00%	7.55%	9.09%

Per Capita Cost

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$2,040.27	$1,591.13	$1,167.81	$0.00	$0.66	$0.00	$0.00	$0.00	$0.01	$0.00	$0.07	$0.00	$0.00	$0.00	$2.94	$346.69
FY 2006-07	$2,470.78	$1,974.61	$1,333.63	$0.00	$0.84	$0.00	$0.00	$0.00	$0.00	$0.00	$0.42	$0.00	$0.00	$0.00	$20.90	$423.32
FY 2007-08	$2,721.90	$2,280.08	$1,515.33	$0.00	$0.83	$0.00	$0.00	$0.00	$0.02	$0.00	$1.42	$0.00	$0.00	$0.00	$47.13	$482.65
FY 2008-09	$2,743.01	$2,574.91	$1,930.11	$0.00	$0.27	$0.00	$0.00	$0.00	$0.00	$0.00	$4.92	$0.00	$0.00	$0.00	$16.08	$501.95
FY 2009-10 (DA)	$2,830.44	$2,532.16	$1,976.62	$0.00	$0.26	$0.00	$0.00	$0.00	$0.00	$0.00	$5.72	$0.00	$0.00	$0.00	$12.22	$465.89
FY 2010-11 (DA)	$2,858.86	$2,602.11	$2,141.01	$0.00	$0.40	$0.45	$0.00	$0.00	$0.01	$0.00	$4.72	$0.00	$0.00	$0.00	$8.32	$449.68
FY 2011-12	$2,961.23	$2,775.62	$2,198.29	$0.00	$0.09	$0.58	$0.00	$0.00	$0.02	$0.00	$6.17	$0.00	$0.00	$0.00	$13.79	$438.75
FY 2012-13	$3,070.55	$2,743.25	$2,307.53	$53.54	$0.17	$0.96	$0.73	$0.00	$0.05	$0.00	$3.89	$0.00	$0.00	$0.00	$10.43	$429.71
FY 2013-14	$3,445.72	$3,020.51	$2,520.35	$301.46	$1.65	$0.64	$3.89	$0.00	$0.66	$0.00	$9.26	$0.00	$0.00	$0.00	$37.99	$393.70
Estimated FY 2014-15	$3,618.82	$2,903.77	$2,654.01	$219.60	$1.40	$0.00	$0.00	$0.00	$0.91	$0.00	$9.29	$0.00	$0.00	$0.00	$34.36	$321.94
Estimated FY 2015-16	$3,775.54	$2,951.60	$2,817.63	$199.74	$1.36	$0.00	$0.00	$0.00	$1.23	$0.00	$9.90	$0.00	$0.00	$0.00	$33.76	$322.28
Estimated FY 2016-17	$3,959.45	$3,032.17	$3,028.46	$188.62	$1.33	$0.00	$0.00	$0.00	$1.66	$0.00	$10.49	$0.00	$0.00	$0.00	$33.17	$326.41

Percent Change in Per Capita Cost

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	21.10%	24.10%	14.20%	0.00%	27.27%	0.00%	0.00%	0.00%	-100.00%	0.00%	500.00%	0.00%	0.00%	0.00%	610.88%	22.10%
FY 2007-08	10.16%	15.47%	13.62%	0.00%	-1.19%	0.00%	0.00%	0.00%	100.00%	0.00%	238.10%	0.00%	0.00%	0.00%	125.50%	14.02%
FY 2008-09	0.78%	12.93%	27.37%	0.00%	-67.47%	0.00%	0.00%	0.00%	-100.00%	0.00%	246.48%	0.00%	0.00%	0.00%	-65.88%	4.00%
FY 2009-10 (DA)	3.19%	-1.66%	2.41%	0.00%	-3.70%	0.00%	0.00%	0.00%	0.00%	0.00%	16.26%	0.00%	0.00%	0.00%	-24.00%	-7.18%
FY 2010-11 (DA)	1.00%	2.76%	8.32%	0.00%	53.85%	100.00%	0.00%	0.00%	100.00%	0.00%	-17.48%	0.00%	0.00%	0.00%	-31.91%	-3.48%
FY 2011-12	3.58%	6.67%	2.68%	0.00%	-77.50%	28.89%	0.00%	0.00%	100.00%	0.00%	30.72%	0.00%	0.00%	0.00%	65.75%	-2.43%
FY 2012-13	3.69%	-1.17%	4.97%	100.00%	88.89%	65.52%	100.00%	0.00%	150.00%	0.00%	-36.95%	0.00%	0.00%	0.00%	-24.37%	-2.06%
FY 2013-14	12.22%	10.11%	9.22%	463.06%	870.59%	-33.33%	432.88%	0.00%	1220.00%	0.00%	138.05%	0.00%	0.00%	0.00%	264.24%	-8.38%
Estimated FY 2014-15	5.02%	-3.86%	5.30%	-27.15%	-15.15%	-100.00%	-100.00%	0.00%	37.88%	0.00%	0.32%	0.00%	0.00%	0.00%	-9.56%	-18.23%
Estimated FY 2015-16	4.33%	1.65%	6.17%	-9.04%	-2.86%	0.00%	0.00%	0.00%	35.16%	0.00%	6.57%	0.00%	0.00%	0.00%	-1.75%	0.11%
Estimated FY 2016-17	4.87%	2.73%	7.48%	-5.57%	-2.21%	0.00%	0.00%	0.00%	34.96%	0.00%	5.96%	0.00%	0.00%	0.00%	-1.75%	1.28%

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

Current Year Projections by Eligibility Category

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Elderly, Blind and Disabled Wavier	$145,358,156	$25,597,671	$122,265,401	$766,187	$196,840	$0	$0	$0	$1,723	$0	$157,185	$0	$0	$0	$780,650	$295,123,813
Community Mental Health Supports Waiver	$5,116,089	$4,295,874	$24,086,978	$35,259	$4,422	$0	$0	$0	$0	$0	$686	$37	$0	$0	$134,017	$33,673,362
Disabled Children's Waiver	$0	$0	$11,663,971	$25	$0	$0	$0	$0	$364,723	$0	$0	$0	$0	$0	$0	$12,028,719
Persons Living with AIDS Waiver	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Consumer Directed Attendant Support-State Plan	$511,111	$90,007	$429,913	$2,694	$692	$0	$0	$0	$6	$0	$553	$0	$0	$0	$2,745	$1,037,721
Brain Injury Waiver	$481,167	$1,462,246	$14,528,617	$5,619	$14,090	$0	$0	$0	$0	$0	$0	$0	$0	$0	$19,202	$16,510,941
Children with Autism Waiver	$1	$0	$781,004	$2,730	$0	$0	$0	$0	$14,221	$0	$16,293	$0	$0	$0	$0	$814,249
Children with Life Limiting Illness Waiver	$0	$0	$1,133,965	$0	$0	$0	$0	$0	$18,519	$0	$16,884	$0	$0	$0	$0	$1,169,368
Spinal Cord Injury Adult Waiver	$277,837	$25,221	$1,994,756	$0	$1,433	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,299,247
Estimated FY 2014-15 Total Expenditure	$151,744,361	$31,471,019	$176,884,605	$812,514	$217,477	$0	$0	$0	$399,192	$0	$191,601	$37	$0	$0	$936,614	$362,657,420
Estimated FY 2014-15 Per Capita	$3,618.82	$2,903.77	$2,654.01	$219.60	$1.40	$0.00	$0.00	$0.00	$0.91	$0.00	$9.29	$0.00	$0.00	$0.00	$34.36	$321.94
% Change over FY 2013-14 Per Capita	5.02%	-3.86%	5.30%	-27.15%	-15.15%	-100.00%	-100.00%	0.00%	37.88%	0.00%	0.32%	0.00%	0.00%	0.00%	-9.56%	-18.23%

Request Year Projections by Eligibility Category

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Elderly, Blind and Disabled Wavier	$155,750,010	$27,427,683	$131,006,321	$820,962	$210,912	$0	$0	$0	$1,846	$0	$168,423	$0	$0	$0	$836,459	$316,222,616
Community Mental Health Supports Waiver	$5,587,218	$4,691,471	$26,305,094	$38,506	$4,830	$0	$0	$0	$0	$0	$749	$40	$0	$0	$146,359	$36,774,267
Disabled Children's Waiver	$0	$0	$17,256,579	$37	$0	$0	$0	$0	$539,599	$0	$0	$0	$0	$0	$0	$17,796,215
Persons Living with AIDS Waiver	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Consumer Directed Attendant Support-State Plan	$446,647	$78,655	$375,690	$2,354	$605	$0	$0	$0	$5	$0	$483	$0	$0	$0	$2,399	$906,838
Brain Injury Waiver	$509,660	$1,548,838	$15,388,986	$5,952	$14,925	$0	$0	$0	$0	$0	$0	$0	$0	$0	$20,340	$17,488,701
Children with Autism Waiver	$0	$0	$822,665	$2,876	$0	$0	$0	$0	$14,980	$0	$17,163	$0	$0	$0	$0	$857,684
Children with Life Limiting Illness Waiver	$0	$0	$1,359,804	$0	$0	$0	$0	$0	$22,208	$0	$20,246	$0	$0	$0	$0	$1,402,258
Spinal Cord Injury Adult Waiver	$281,348	$25,540	$2,019,966	$0	$1,451	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,328,305
Estimated FY 2015-16 Total Expenditure	$162,574,883	$33,772,187	$194,535,105	$870,687	$232,723	$0	$0	$0	$578,638	$0	$207,064	$40	$0	$0	$1,005,557	$393,776,884
Estimated FY 2015-16 Per Capita	$3,775.54	$2,951.60	$2,817.63	$199.74	$1.36	$0.00	$0.00	$0.00	$1.23	$0.00	$9.90	$0.00	$0.00	$0.00	$33.76	$322.28
% Change over FY 2014-15 Per Capita	4.33%	1.65%	6.17%	-9.04%	-2.86%	0.00%	0.00%	0.00%	35.16%	0.00%	6.57%	0.00%	0.00%	0.00%	-1.75%	0.11%

Out Year Projections by Eligibility Category

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Elderly, Blind and Disabled Wavier	$166,957,375	$29,401,308	$140,433,196	$880,037	$226,089	$0	$0	$0	$1,979	$0	$180,542	$0	$0	$0	$896,649	$338,977,174
Community Mental Health Supports Waiver	$6,149,590	$5,163,684	$28,952,792	$42,382	$5,316	$0	$0	$0	$0	$0	$824	$44	$0	$0	$161,090	$40,475,723
Disabled Children's Waiver	$0	$0	$25,111,524	$54	$0	$0	$0	$0	$785,216	$0	$0	$0	$0	$0	$0	$25,896,795
Persons Living with AIDS Waiver	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Consumer Directed Attendant Support-State Plan	$382,841	$67,418	$322,020	$2,018	$518	$0	$0	$0	$5	$0	$414	$0	$0	$0	$2,056	$777,290
Brain Injury Waiver	$543,712	$1,652,321	$16,417,166	$6,350	$15,922	$0	$0	$0	$0	$0	$0	$0	$0	$0	$21,699	$18,657,169
Children with Autism Waiver	$0	$0	$863,124	$3,018	$0	$0	$0	$0	$15,717	$0	$18,007	$0	$0	$0	$0	$899,865
Children with Life Limiting Illness Waiver	$0	$0	$1,521,825	$0	$0	$0	$0	$0	$24,854	$0	$22,659	$0	$0	$0	$0	$1,569,337
Spinal Cord Injury Adult Waiver	$281,347	$25,540	$2,019,966	$0	$1,451	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,328,305
Estimated FY 2016-17 Total Expenditure	$174,314,866	$36,310,270	$215,641,613	$933,858	$249,296	$0	$0	$0	$827,770	$0	$222,446	$44	$0	$0	$1,081,494	$429,581,658
Estimated FY 2016-17 Per Capita	$3,959.45	$3,032.17	$3,028.46	$188.62	$1.33	$0.00	$0.00	$0.00	$1.66	$0.00	$10.49	$0.00	$0.00	$0.00	$33.17	$326.41
% Change over FY 2015-16 Per Capita	4.87%	2.73%	7.48%	-5.57%	-2.21%	0.00%	0.00%	0.00%	34.96%	0.00%	5.96%	0.00%	0.00%	0.00%	-1.75%	1.28%

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

Cash Based Actuals by Waiver

COMMUNITY BASED LONG-TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Spinal Cord Injury Adult Waiver	TOTAL
FY 2003-04	$94,741,923	$15,030,947	$358,891	$562,218	$3,064,733	$8,992,797	$0	$0	$0	$122,751,508
FY 2004-05	$94,216,182	$13,019,463	$481,927	$458,451	$5,912,371	$9,225,591	$0	$0	$0	$123,313,985
FY 2005-06	$107,276,565	$14,984,173	$661,823	$472,783	$7,237,889	$8,813,686	$0	$0	$0	$139,446,919
FY 2006-07	$123,673,036	$17,246,320	$904,883	$503,530	$12,580,285	$11,112,528	$18,801	$0	$0	$166,039,384
FY 2007-08	$141,231,844	$20,409,887	$1,353,847	$595,406	$14,109,819	$10,785,587	$695,586	$0	$0	$189,181,976
FY 2008-09	$176,481,671	$22,958,866	$1,747,683	$592,744	$4,125,973	$12,028,236	$1,293,932	$29,312	$0	$219,258,416
FY 2009-10	$190,095,902	$23,040,614	$1,841,013	$598,542	$3,516,917	$11,596,421	$1,594,735	$102,210	$0	$232,386,355
FY 2010-11	$208,526,316	$24,587,535	$1,887,201	$550,397	$2,961,259	$12,182,916	$1,328,577	$119,273	$0	$252,143,475
FY 2011-12	$225,185,711	$25,934,255	$3,130,073	$516,036	$3,461,683	$12,587,131	$1,022,387	$170,910	$0	$272,008,186
FY 2012-13	$242,494,560	$28,309,412	$5,350,385	$480,928	$2,661,977	$12,849,682	$885,424	$207,131	$252,509	$293,492,008
FY 2013-14	$279,523,188	$31,919,229	$8,101,781	$135,733	$2,331,237	$14,184,077	$764,302	$221,632	$1,773,572	$338,954,751
Estimated FY 2014-15	$295,123,813	$33,673,362	$12,028,719	$0	$1,037,721	$16,510,941	$814,249	$1,169,368	$2,299,247	$362,657,420
Estimated FY 2015-16	$316,222,616	$36,774,267	$17,796,215	$0	$906,838	$17,488,701	$857,684	$1,402,258	$2,328,305	$393,776,884
Estimated FY 2016-17	$338,977,174	$40,475,723	$25,896,795	$0	$777,290	$18,657,169	$899,865	$1,569,337	$2,328,305	$429,581,658

Percent Change in Cash Based Actuals

COMMUNITY BASED LONG-TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Spinal Cord Injury Adult Waiver	TOTAL
FY 2004-05	-0.55%	-13.38%	34.28%	-18.46%	92.92%	2.59%	0.00%	0.00%	0.00%	0.46%
FY 2005-06	13.86%	15.09%	37.33%	3.13%	22.42%	-4.46%	0.00%	0.00%	0.00%	13.08%
FY 2006-07	15.28%	15.10%	36.73%	6.50%	73.81%	26.08%	100.00%	0.00%	0.00%	19.07%
FY 2007-08	14.20%	18.34%	49.62%	18.25%	12.16%	-2.94%	3599.64%	0.00%	0.00%	13.94%
FY 2008-09	24.96%	12.49%	29.09%	-0.45%	-70.76%	11.52%	86.02%	100.00%	0.00%	15.90%
FY 2009-10	7.71%	0.36%	5.34%	0.98%	-14.76%	-3.59%	23.25%	248.70%	0.00%	5.99%
FY 2010-11	9.70%	6.71%	2.51%	-8.04%	-15.80%	5.06%	-16.69%	16.69%	0.00%	8.50%
FY 2011-12	7.99%	5.48%	65.86%	-6.24%	16.90%	3.32%	-23.05%	43.29%	0.00%	7.88%
FY 2012-13	7.69%	9.16%	70.93%	-6.80%	-23.10%	2.09%	-13.40%	21.19%	100.00%	7.90%
FY 2013-14	15.27%	12.75%	51.42%	-71.78%	-12.42%	10.38%	-13.68%	7.00%	602.38%	15.49%
Estimated FY 2014-15	5.58%	5.50%	48.47%	-100.00%	-55.49%	16.40%	6.53%	427.62%	29.64%	6.99%
Estimated FY 2015-16	7.15%	9.21%	47.95%	0.00%	-12.61%	5.92%	5.33%	19.92%	1.26%	8.58%
Estimated FY 2016-17	7.20%	10.07%	45.52%	0.00%	-14.29%	6.68%	4.92%	11.91%	0.00%	9.09%

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

HCBS Waiver Enrollment[3]

COMMUNITY BASED LONG-TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Spinal Cord Injury Adult Waiver	TOTAL
FY 2007-08	15,790	1,775	1,253	34	0	201	48	6	0	19,107
FY 2008-09	16,680	1,923	1,267	34	0	210	68	56	0	20,238
FY 2009-10	17,587	2,060	1,250	37	41	211	67	98	0	21,351
FY 2010-11	18,539	2,187	1,177	38	39	217	64	130	0	22,391
FY 2011-12	19,652	2,351	1,121	40	36	221	63	167	0	23,651
FY 2012-13	20,981	2,666	1,134	45	33	247	64	190	8	25,368
FY 2013-14	21,396	2,884	1,029	26	31	296	55	169	51	25,937
Estimated FY 2014-15	22,812	3,135	1,064	0	24	323	58	175	66	27,657
Estimated FY 2015-16	23,918	3,408	1,098	0	21	346	61	182	67	29,101
Estimated FY 2016-17	24,961	3,704	1,126	0	18	371	64	189	67	30,500

Percent Change in Enrollment

COMMUNITY BASED LONG-TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Spinal Cord Injury Adult Waiver	TOTAL
FY 2008-09	5.64%	8.34%	1.12%	0.00%	0.00%	4.48%	41.67%	833.33%	0.00%	5.92%
FY 2009-10	5.44%	7.12%	-1.34%	8.82%	100.00%	0.48%	-1.47%	75.00%	0.00%	5.50%
FY 2010-11	5.41%	6.17%	-5.84%	2.70%	-4.88%	2.84%	-4.48%	32.65%	0.00%	4.87%
FY 2011-12	6.00%	7.50%	-4.76%	5.26%	-7.69%	1.84%	-1.56%	28.46%	0.00%	5.63%
FY 2012-13	6.76%	13.40%	1.16%	12.50%	-8.33%	11.76%	1.59%	13.77%	100.00%	7.26%
FY 2013-14	1.98%	8.18%	-9.26%	-42.22%	-6.06%	19.84%	-14.06%	-11.05%	537.50%	2.24%
Estimated FY 2014-15	6.62%	8.70%	3.40%	-100.00%	-22.58%	9.12%	5.45%	3.55%	29.41%	6.63%
Estimated FY 2015-16	4.85%	8.71%	3.20%	0.00%	-12.50%	7.12%	5.17%	4.00%	1.52%	5.22%
Estimated FY 2016-17	4.36%	8.69%	2.55%	0.00%	-14.29%	7.23%	4.92%	3.85%	0.00%	4.81%

Per Enrollee Cost

COMMUNITY BASED LONG-TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Spinal Cord Injury Adult Waiver	TOTAL
FY 2007-08	$8,944.39	$11,498.53	$1,080.48	$17,511.93	$0.00	$53,659.64	$14,491.37	$0.00	$0.00	$9,901.19
FY 2008-09	$10,580.44	$11,939.09	$1,379.39	$17,433.64	$0.00	$57,277.31	$19,028.42	$523.42	$0.00	$10,834.00
FY 2009-10	$10,808.89	$11,184.76	$1,472.81	$16,176.82	$85,778.47	$54,959.34	$23,802.01	$1,042.96	$0.00	$10,884.10
FY 2010-11	$11,247.98	$11,242.59	$1,603.40	$14,484.14	$75,929.72	$56,142.47	$20,759.02	$917.48	$0.00	$11,260.93
FY 2011-12	$11,458.67	$11,031.16	$2,792.21	$12,900.90	$96,157.86	$56,955.34	$16,228.37	$1,023.41	$0.00	$11,500.92
FY 2012-13	$11,557.82	$10,618.68	$4,718.15	$10,687.29	$80,665.97	$52,023.00	$13,834.75	$1,090.16	$31,563.63	$11,569.38
FY 2013-14	$13,064.27	$11,067.69	$7,873.45	$5,220.50	$75,201.19	$47,919.18	$13,896.40	$1,311.43	$34,775.92	$13,068.39
Estimated FY 2014-15	$12,937.22	$10,741.10	$11,305.19	$0.00	$43,238.38	$51,117.46	$14,038.78	$6,682.10	$34,837.08	$13,112.68
Estimated FY 2015-16	$13,221.11	$10,790.57	$16,207.85	$0.00	$43,182.76	$50,545.38	$14,060.39	$7,704.71	$34,750.82	$13,531.39
Estimated FY 2016-17	$13,580.27	$10,927.57	$22,998.93	$0.00	$43,182.78	$50,288.87	$14,060.39	$8,303.37	$34,750.82	$14,084.64

Percent Change in Per Enrollee Cost

COMMUNITY BASED LONG-TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Spinal Cord Injury Adult Waiver	TOTAL
FY 2008-09	18.29%	3.83%	27.66%	-0.45%	0.00%	6.74%	31.31%	100.00%	0.00%	9.42%
FY 2009-10	2.16%	-6.32%	6.77%	-7.21%	100.00%	-4.05%	25.09%	99.26%	0.00%	0.46%
FY 2010-11	4.06%	0.52%	8.87%	-10.46%	-11.48%	2.15%	-12.78%	-12.03%	0.00%	3.46%
FY 2011-12	1.87%	-1.88%	74.14%	-10.93%	26.64%	1.45%	-21.82%	11.55%	0.00%	2.13%
FY 2012-13	0.87%	-3.74%	68.98%	-17.16%	-16.11%	-8.66%	-14.75%	6.52%	100.00%	0.60%
FY 2013-14	13.03%	4.23%	66.88%	-51.15%	-6.77%	-7.89%	0.45%	20.30%	10.18%	12.96%
Estimated FY 2014-15	-0.97%	-2.95%	43.59%	-100.00%	-42.50%	6.67%	1.02%	409.53%	0.18%	0.34%
Estimated FY 2015-16	2.19%	0.46%	43.37%	0.00%	-0.13%	-1.12%	0.15%	15.30%	-0.25%	3.19%
Estimated FY 2016-17	2.72%	1.27%	41.90%	0.00%	0.00%	-0.51%	0.00%	7.77%	0.00%	4.09%

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

Current Year Projection

COMMUNITY BASED LONG-TERM CARE	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Spinal Cord Injury Adult Waiver	TOTAL
FY 2013-14 Average HCBS Waiver Enrollment	21,396	2,884	1,029	26	31	296	55	169	51	25,937
Enrollment Trend Selected[1]	6.62%	8.70%	3.40%	-100.00%	-22.58%	9.29%	5.45%	3.81%	29.41%	6.63%
Bottom Line Impacts										
Total Bottom Line Impacts	-	-	-	-	-	-	-	-	-	-
FY 2014-15 Estimated Enrollment	**22,812**	**3,135**	**1,064**	**0**	**24**	**323**	**58**	**175**	**66**	**27,657**
FY 2013-14 Cost per Enrollee	$13,064.27	$11,067.69	$7,873.45	$5,220.50	$75,201.19	$47,919.18	$13,896.40	$1,311.43	$34,775.92	$13,068.39
Percentage Selected to Modify Per Enrollee [2]	-1.74%	-4.21%	41.90%	-100.00%	0.00%	-1.71%	0.00%	9.19%	0.00%	
FY 2014-15 Estimate Cost Per Enrollee	**$12,836.95**	**$10,601.74**	**$11,172.43**	**$0.00**	**$75,201.19**	**$47,099.76**	**$13,896.40**	**$1,431.95**	**$34,775.92**	
Estimated FY 2014-15 Base Expenditure	**$292,836,503**	**$33,236,455**	**$11,887,466**	**$0**	**$1,804,829**	**$15,213,222**	**$805,991**	**$250,591**	**$2,295,211**	**$358,330,268**
Bottom Line Impacts										
HB 14-1252: "Intellectual and Developmental Disabilities Service System Capacity"	($236,826)	$0	$0	$0	$0	$0	$0	$0	$0	($236,826)
HB 14-1357: "In-Home Support Services in Medicaid Program"	$253,290	$0	$44,696	$0	$0	$0	$0	$0	$0	$297,986
Annualization of Adjustment of 53 Pay Periods	($4,895,554)	($558,760)	($141,825)	$0	($40,809)	($248,299)	($13,379)	($3,880)	($31,047)	($5,933,553)
Colorado Choice Transitions	$1,528,110	$178,395	$0	$0	$0	$80,974	$0	$0	$0	$1,787,479
CLLI Audit Recommendations	$0	$0	$0	$0	$0	$0	$0	$669,816	$0	$669,816
Annualization of 8.26% Rate Adjustment	$2,097,435	$252,460	$59,680	$0	$16,355	$118,193	$7,134	$1,758	$15,880	$2,568,895
Annualization of CDASS Service Expansion into the Brain Injury Waiver	$0	$0	$0	$0	($789,466)	$1,066,715	$0	$0	$0	$277,249
Annualization of Alternative Therapies Waiver Chiropractic Rate Increase	$0	$0	$0	$0	$0	$0	$0	$0	$54,029	$54,029
Raising Cap on Home Modifications	$615,170	$0	$24,972	$0	$0	$31,959	$0	$0	$4,822	$676,923
FY 2014-15 R#7: "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase"	($1,880,836)	$0	$0	$0	$0	$0	$0	$0	$0	($1,880,836)
FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents"	($116,274)	$0	$0	$0	$0	$0	$0	$0	$0	($116,274)
FY 2014-15 R#11: "Community Provider Rate Increase" Targeted - Pediatric Hospice Services 20%	$0	$0	$0	$0	$0	$0	$0	$246,878	$0	$246,878
FY 2014-15 R#11: "Community Provider Rate Increase" 2% Across the Board Increase	$5,306,481	$605,662	$153,730	$0	$44,235	$269,141	$14,503	$4,205	$33,653	$6,431,610
FY 2014-15 R#12: "Administrative Contract Reprocurement"	$1,486,605	$169,675	$0	$0	$12,392	$75,399	$0	$0	$9,428	$1,753,499
EPSDT Personal Care	($277,719)	($29,787)	$0	$0	$0	($13,634)	$0	$0	$0	($321,140)
CDASS Administrative FMS & Training Contract Competitive Reprocurement	($1,592,572)	($180,738)	$0	$0	($9,815)	($82,729)	$0	$0	($82,729)	($1,948,583)
Total Bottom Line Impacts	**$2,287,310**	**$436,907**	**$141,253**	**$0**	**($767,108)**	**$1,297,719**	**$8,258**	**$918,777**	**$4,036**	**$4,327,152**
Estimated FY 2014-15 Expenditure	**$295,123,813**	**$33,673,362**	**$12,028,719**	**$0**	**$1,037,721**	**$16,510,941**	**$814,249**	**$1,169,368**	**$2,299,247**	**$362,657,420**
Estimated FY 2014-15 Per Enrollee	$12,937.22	$10,741.10	$11,305.19	$0.00	$43,238.38	$51,117.46	$14,038.78	$6,682.10	$34,837.08	$13,112.68
% Change over FY 2013-14 Per Enrollee	-0.97%	-2.95%	43.59%	-100.00%	-42.50%	6.67%	1.02%	409.53%	0.18%	0.34%

Request Year Projection

Per Capita Trends	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Spinal Cord Injury Adult Waiver	TOTAL
Estimated FY 2014-15 Average HCBS Waiver Enrollment	22,812	3,135	1,064	0	24	323	58	175	66	27,657
Enrollment Trend Selected[1]	4.85%	8.70%	3.23%	0.00%	-12.50%	7.13%	5.45%	3.81%	1.52%	5.22%
Bottom Line Impacts										
Total Bottom Line Impacts	-	-	-	-	-	-	-	-	-	-
FY 2015-16 Estimated Enrollment	**23,918**	**3,408**	**1,098**	**0**	**21**	**346**	**61**	**182**	**67**	**29,101**
FY 2014-15 Cost per Enrollee	$12,937.22	$10,741.10	$11,305.19	$0.00	$43,238.38	$51,117.46	$14,038.78	$6,682.10	$34,837.08	$13,112.68
Percentage Selected to Modify Per Enrollee [2]	1.37%	0.00%	41.90%	0.00%	0.00%	-1.71%	0.00%	8.42%	0.00%	
FY 2015-16 Estimate Cost Per Enrollee	**$13,114.46**	**$10,741.10**	**$16,042.06**	**$0.00**	**$43,238.38**	**$50,243.35**	**$14,038.78**	**$7,244.73**	**$34,837.08**	
Estimated FY 2015-16 Base Expenditure	**$313,671,654**	**$36,605,669**	**$17,614,182**	**$0**	**$908,006**	**$17,384,199**	**$856,366**	**$1,318,541**	**$2,334,084**	**$390,692,701**
Bottom Line Impacts										
Annualization of HB 14-1252: "Intellectual and Developmental Disabilities Service System Capacity"	($19,758)	$0	$0	$0	$0	$0	$0	$0	$0	($19,758)
Annualization of HB 14-1357: "In-Home Support Services in Medicaid Program"	$759,868	$0	$134,088	$0	$0	$0	$0	$0	$0	$893,956
Colorado Choice Transitions	$3,022,207	$352,820	$0	$0	$0	$160,145	$0	$0	$0	$3,535,172
Annualization of CLLI Audit Recommendations	$0	$0	$0	$0	$0	$0	$0	$60,892	$0	$60,892
Annualization of Raising Cap on Home Modifications	$604,926	$0	$33,970	$0	$0	$33,526	$0	$0	$4,501	$676,923
Annualization of FY 2014-15 R#8: "Developmental Disabilities New Full Program Equivalents"	($116,274)	$0	$0	$0	$0	$0	$0	$0	$0	($116,274)
Annualization of FY 2014-15 R#11: "Community Provider Rate Increase" Targeted - Pediatric Hospice Services 20%	$0	$0	$0	$0	$0	$0	$0	$22,443	$0	$22,443
Annualization of FY 2014-15 R#11: "Community Provider Rate Increase" 2% Across the Board Increase	$482,410	$55,060	$13,975	$0	$4,021	$24,467	$1,318	$382	$3,059	$584,692
Annualization of FY 2014-15 R#12: "Administrative Contract Reprocurement"	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Annualization of EPSDT Personal Care	($276,762)	($30,089)	$0	$0	$0	($14,289)	$0	$0	$0	($321,140)
Annualization CDASS Administrative FMS & Training Contract Competitive Reprocurement	($1,905,655)	($209,193)	$0	$0	($5,189)	($99,347)	$0	$0	($13,339)	($2,232,723)
Total Bottom Line Impacts	**$2,550,962**	**$168,598**	**$182,033**	**$0**	**($1,168)**	**$104,502**	**$1,318**	**$83,717**	**($5,779)**	**$3,084,183**
Estimated FY 2015-16 Total Expenditure	**$316,222,616**	**$36,774,267**	**$17,796,215**	**$0**	**$906,838**	**$17,488,701**	**$857,684**	**$1,402,258**	**$2,328,305**	**$393,776,884**
Estimated FY 2015-16 Per Enrollee	$13,221.11	$10,790.57	$16,207.85	$0.00	$43,182.76	$50,545.38	$14,060.39	$7,704.71	$34,750.82	$13,531.39
% Change over FY 2014-15 Per Enrollee	2.19%	0.46%	43.37%	0.00%	-0.13%	-1.12%	0.15%	15.30%	-0.25%	3.19%

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

Out Year Projection

Per Capita Trends	Elderly, Blind and Disabled Wavier	Community Mental Health Supports Waiver	Disabled Children's Waiver	Persons Living with AIDS Waiver	Consumer Directed Attendant Support-State Plan	Brain Injury Waiver	Children with Autism Waiver	Children with Life Limiting Illness Waiver	Spinal Cord Injury Adult Waiver	TOTAL
Estimated FY 2015-16 Average HCBS Waiver Enrollment	23,918	3,408	1,098	0	21	346	61	182	67	29,101
Enrollment Trend Selected[1]	4.36%	8.70%	2.57%	0.00%	-14.29%	7.36%	5.45%	3.81%	0.00%	4.81%
Bottom Line Impacts										
FY 2016-17 Estimated Enrollment	**24,961**	**3,704**	**1,126**	**0**	**18**	**371**	**64**	**189**	**67**	**30,500**
FY 2015-16 Cost per Enrollee	$13,221.11	$10,790.57	$16,207.85	$0.00	$43,182.76	$50,545.38	$14,060.39	$7,704.71	$34,750.82	$13,531.39
Percentage Selected to Modify Per Enrollee[2]	1.37%	0.00%	41.90%	0.00%	0.00%	-1.71%	0.00%	7.77%	0.00%	
FY 2016-17 Estimate Cost Per Enrollee	**$13,402.24**	**$10,790.57**	**$22,998.93**	**$0.00**	**$43,182.76**	**$49,681.05**	**$14,060.39**	**$8,303.37**	**$34,750.82**	
Estimated FY 2016-17 Base Expenditure	$334,533,313	$39,968,271	$25,896,795	$0	$777,290	$18,431,670	$899,865	$1,569,337	$2,328,305	$424,404,846
Bottom Line Impacts										
Colorado Choice Transitions	$4,443,861	$507,452	$0	$0	$0	$225,499	$0	$0	$0	$5,176,812
Total Bottom Line Impacts	**$4,443,861**	**$507,452**	**$0**	**$0**	**$0**	**$225,499**	**$0**	**$0**	**$0**	**$5,176,812**
Estimated FY 2016-17 Total Expenditure	**$338,977,174**	**$40,475,723**	**$25,896,795**	**$0**	**$777,290**	**$18,657,169**	**$899,865**	**$1,569,337**	**$2,328,305**	**$429,581,658**
Estimated FY 2016-17 Per Enrollee	$13,580.27	$10,927.57	$22,998.93	$0.00	$43,182.78	$50,288.87	$14,060.39	$8,303.37	$34,750.82	$14,084.64
% Change over FY 2015-16 Per Enrollee	2.72%	1.27%	41.90%	0.00%	0.00%	-0.51%	0.00%	7.77%	0.00%	4.09%

Footnotes:

(1) Percentage selected to modify enrollment for FY 2014-15 through FY 2016-17

Elderly, Blind and Disabled Wavier	6.62%, 4.85%, 4.36%	Persons Living with AIDS Waiver	-100.00%, 0.00%, 0.00%	Children with Autism Waiver	5.45%, 5.45%, 5.45%
Community Mental Health Supports Waiver	8.70%, 8.70%, 8.70%	Consumer Directed Attendant Support-State Plan	-22.58%, -12.50%, -14.29%	Children with Life Limiting Illness Waiver	3.81%, 3.81%, 3.81%
Disabled Children's Waiver	3.40%, 3.23%, 2.57%	Brain Injury Waiver	9.29%, 7.13%, 7.36%	Spinal Cord Injury Adult Waiver	29.41%, 1.52%, 0.00%

(2) Percentage selected to modify per enrollee costs for FY 2014-15 through FY 2016-17

Elderly, Blind and Disabled Wavier	-1.74%, 1.37%, 1.37%	Persons Living with AIDS Waiver	-100.00%, 0.00%, 0.00%	Children with Autism Waiver	0.00%, 0.00%, 0.00%
Community Mental Health Supports Waiver	-4.21%, 0.00%, 0.00%	Consumer Directed Attendant Support-State Plan	0.00%, 0.00%, 0.00%	Children with Life Limiting Illness Waiver	9.19%, 8.42%, 7.77%
Disabled Children's Waiver	41.90%, 41.90%, 41.90%	Brain Injury Waiver	-1.71%, -1.71%, -1.71%	Spinal Cord Injury Adult Waiver	0.00%, 0.00%, 0.00%

(3) Presented information regarding the enrolled clients in each waiver is derived from client tables that contain data beginning in FY 2007-08. The Department chose to use this information to present the number of clients enrolled in each waiver as it is a static monthly report showing the exact number of clients enrolled in each waiver. The Department believes this to be a more accurate representation of enrollment

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

FY 2013-14 July - December COFRS Total Actuals

Community Based Long-Term Care	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
HCBS - Elderly, Blind, and Disabled	$66,507,361	$11,595,711	$56,351,817	$201,392	$28,384	$11,213	$2,934	$0	$1,244	$0	$59,295	$0	$0	$0	$166,179	$134,925,528
HCBS - Mental Illness	$2,305,129	$1,950,852	$11,282,352	$1,151	$200	$40	$1,904	$0	$0	$0	$117	$35	$0	$0	$20,987	$15,562,767
HCBS - Disabled Children	$0	$0	$3,891,150	$0	$0	$0	$0	$0	$5,814	$0	$0	$0	$0	$0	$0	$3,896,964
HCBS - Persons Living with AIDS	$15,368	$1,249	$182,888	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$199,505
HCBS - Consumer Directed Attendant Support	$463,582	$80,827	$392,794	$1,404	$198	$78	$20	$0	$9	$0	$413	$0	$0	$0	$1,158	$940,482
HCBS - Brain Injury	$185,894	$521,249	$6,040,508	$1,450	$8,603	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,064	$6,773,767
HCBS - Children with Autism	$0	$0	$374,205	$187	$0	$0	$0	$0	$3,792	$0	$0	$0	$0	$0	$0	$378,184
HCBS - Pediatric Hospice	$0	$0	$108,128	$0	$0	$0	$0	$0	$443	$0	$1,040	$0	$0	$0	$0	$109,611
HCBS - Spinal Cord Injury	$99,640	$4,529	$772,606	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$876,775
Total	$69,576,974	$14,154,417	$79,396,446	$205,583	$37,385	$11,331	$4,858	$0	$11,302	$0	$60,865	$35	$0	$0	$204,388	$163,663,584
Caseload	41,784	9,650	64,256	2,074	111,141	41,760	18,108	613	385,897	13,835	17,685	11,411	582	2,480	22,495	743,768
Half -Year Per Capita	$1,665.16	$1,466.80	$1,235.63	$99.15	$0.34	$0.27	$0.27	$0.00	$0.03	$0.00	$3.44	$0.00	$0.00	$0.00	$9.09	$220.05

FY 2013-14 January - June COFRS Total Actuals

Community Based Long-Term Care	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
HCBS - Elderly, Blind, and Disabled	$71,022,413	$12,623,376	$59,328,881	$523,531	$157,855	$18,547	$260,816	$0	$386	$0	$89,425	$0	$0	$0	$572,428	$144,597,660
HCBS - Mental Illness	$2,536,236	$2,114,342	$11,511,204	$32,215	$3,985	($0)	$52,114	$0	$0	$0	$532	($0)	$0	$0	$105,834	$16,356,462
HCBS - Disabled Children	$0	$0	$3,964,960	$17	$0	$0	$0	$0	$239,840	$0	$0	$0	$0	$0	$0	$4,204,817
HCBS - Persons Living with AIDS	($5,547)	($436)	($57,789)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($63,772)
HCBS - Consumer Directed Attendant Support	$683,423	$121,161	$571,989	$4,642	$1,355	$170	$2,180	$0	$5	$0	$827	$0	$0	$0	$5,002	$1,390,755
HCBS - Brain Injury	$226,928	$733,302	$6,424,490	$3,371	$3,486	$0	$18,321	$0	$0	$0	$0	$0	$0	$0	$411	$7,410,310
HCBS - Children with Autism	$0	$0	$358,891	$2,376	$0	$0	$0	$0	$9,557	$0	$15,294	$0	$0	$0	$0	$386,118
HCBS - Pediatric Hospice	$0	$0	$106,794	$0	$0	$0	$0	$0	$3,067	$0	$2,160	$0	$0	$0	$0	$112,021
HCBS - Spinal Cord Injury	$114,576	$14,917	$765,382	$0	$1,105	$0	$817	$0	$0	$0	$0	$0	$0	$0	$0	$896,797
Total	$74,578,029	$15,606,662	$82,974,804	$566,153	$167,786	$18,717	$334,248	$0	$252,855	$0	$108,238	($0)	$0	$0	$683,675	$175,291,167
Caseload	41,888	10,056	64,593	3,047	138,220	52,404	156,377	504	408,827	40,196	18,849	14,908	1,533	2,481	24,261	978,143
Half -Year Per Capita	$1,780.43	$1,551.92	$1,284.59	$185.81	$1.21	$0.36	$2.14	$0.00	$0.62	$0.00	$5.74	($0.00)	$0.00	$0.00	$28.18	$179.21

Hospice Calculations for FY 2014-15, FY 2015-16, FY 2016-17

FY 2014-15 Calculation

Nursing Facility Room and Board

Service Expenditure:	Core Components	Reference
Estimate of FY 2014-15 Per Diem Rate	$158.55	Footnote 1
Estimate of Patient Days	216,764	Footnote 2
Total Estimated Costs for FY 2014-15 Days of Service	$34,367,932	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	88.67%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$30,474,045	
Estimated Expenditure for FY 2013-14 Dates of Service	$3,767,272	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2014-15 Prior to Adjustments	**$34,241,317**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2013-14 and paid in FY 2014-15 under HB 13-1152	($57,397)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($457,448)	Footnote 6
Total Bottom Line Adjustments:	**($514,845)**	
Total Estimated Nursing Facility Room and Board FY 2014-15 General Fund Expenditure	**$33,726,472**	
Percentage Change in Core Component Expenditure Over Prior Year	-2.53%	

Hospice Services

Service Expenditure:	Core Components	Reference
Hospice Routine Home Care	$8,172,032	Footnote 7
Hospice General Inpatient	$1,744,848	Footnote 7
Other Services	$54,756	Footnote 7
Estimated Hospice Services Expenditure in FY 2014-15 Prior to Adjustments	**$9,971,636**	
Bottom Line Adjustments:		
JBC Action: Hospice 2% Rate Increase	$179,246	
Total Bottom Line Adjustments:	**$179,246**	
Total Estimated Hospice Services FY 2014-15 General Fund Expenditure	**$10,150,882**	
Percentage Change in Expenditure Over Prior Year	3.25%	
Total Estimated FY 2014-15 Expenditure	**$43,877,354**	

Exhibit G - COMMUNITY BASED LONG TERM CARE - Hospice

FY 2015-16 Calculation		
Nursing Facility Room and Board		
Service Expenditure:	**Core Components**	**Reference**
Estimate of FY 2015-16 Per Diem Rate	$163.31	Footnote 1
Estimate of Patient Days	219,699	Footnote 2
Total Estimated Costs for FY 2015-16 Days of Service	$35,879,044	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	88.67%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$31,813,948	
Estimated Expenditure for FY 2014-15 Dates of Service	$3,893,887	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2015-16 Prior to Adjustments	**$35,707,835**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2014-15 and paid in FY 2015-16 under HB 13-1152	($58,450)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($477,277)	Footnote 6
Total Bottom Line Adjustments:	**($535,727)**	
Total Estimated Nursing Facility Room and Board FY 2015-16 General Fund Expenditure	**$35,172,108**	
Percentage Change in Core Component Expenditure Over Prior Year	4.29%	
Hospice Services		
Service Expenditure:	**Core Components**	**Reference**
Hospice Routine Home Care	$8,475,738	Footnote 7
Hospice General Inpatient	$1,798,729	Footnote 7
Other Services	$34,663	Footnote 7
Estimated Hospice Services Expenditure in FY 2015-16 Prior to Adjustments	**$10,309,130**	
Bottom Line Adjustments:		
Annualization of JBC Action: Hospice 2% Rate Increase	$16,295	
Total Bottom Line Adjustments:	**$16,295**	
Total Estimated Hospice Services FY 2015-16 General Fund Expenditure	**$10,325,425**	
Percentage Change in Expenditure Over Prior Year	1.72%	
Total Estimated FY 2015-16 Expenditure	**$45,497,533**	

Exhibit G - COMMUNITY BASED LONG TERM CARE - Hospice

FY 2016-17 Calculation		
Nursing Facility Room and Board		
Service Expenditure:	**Core Components**	**Reference**
Estimate of FY 2016-17 Per Diem Rate	$168.21	Footnote 1
Estimate of Patient Days	221,226	Footnote 2
Total Estimated Costs for FY 2016-17 Days of Service	$37,212,425	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	88.67%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$32,996,257	
Estimated Expenditure for FY 2016-17 Dates of Service	$4,065,096	Footnote 5
Estimated Nursing Facility Room and Board Expenditure in FY 2016-17 Prior to Adjustments	**$37,061,353**	
Bottom Line Adjustments:		
Savings from days incurred in FY 2015-16 and paid in FY 2016-17 under HB 13-1152	($60,985)	Footnote 6
HB 13-1152 1.5% permanent rate reduction Effective July 1, 2013	($494,326)	Footnote 6
Total Bottom Line Adjustments:	**($555,311)**	
Total Estimated Nursing Facility Room and Board FY 2016-17 General Fund Expenditure	**$36,506,042**	
Percentage Change in Core Component Expenditure Over Prior Year	3.79%	
Hospice Services		
Service Expenditure:	**Core Components**	**Reference**
Hospice Routine Home Care	$8,748,252	Footnote 7
Hospice General Inpatient	$1,852,610	Footnote 7
Other Services	$21,943	Footnote 7
Estimated Hospice Services Expenditure in FY 2016-17 Prior to Adjustments	**$10,622,805**	
Bottom Line Adjustments:		
Total Bottom Line Adjustments:	**$0**	
Total Estimated Hospice Services FY 2016-17 General Fund Expenditure	**$10,622,805**	
Percentage Change in Expenditure Over Prior Year	2.88%	
Total Estimated FY 2016-17 Expenditure	**$47,128,847**	

Hospice Nursing Facility Room and Board FY 2014-15 , FY 2015-16 and FY 2016-17 Footnotes:

(1) Fiscal year per diems are the quotient of annual IBNR-adjusted expenditure and patient days, by first-date-of-service. Estimates for FY 2014-15, FY 2015-16, and FY 2016-17 are computed by applying rate reductions where appropriate and projecting the maximum-allowable-growth (3%) in general fund expenditure. See footnote (4) for a detailed discussion of incurred-but-not-reported analysis. Rate reduction in FY 2014-15, FY 2015-16, and FY 2016-17 due to HB 13-1152; see footnote (6) for further detail.

Year	Per Diem After Reductions	Maximum Allowable Growth in General Fund Portion	Rate Reduction	Paid Rate Before Reductions	Percentage Change in Core Rate Before Reductions
FY 2007-08	$132.36			$132.36	
FY 2008-09	$148.16			$148.16	11.94%
FY 2009-10	$138.14	3.00%	0.50%	$138.83	-6.30%
FY 2010-11	$137.05	1.90%	2.50%	$140.56	1.25%
FY 2011-12	$140.21	3.00%	1.50%	$142.35	1.27%
FY 2012-13	$144.63	3.00%	1.50%	$146.83	3.15%
FY 2013-14	$151.62	3.00%	1.50%	$153.93	4.84%
Estimated FY 2014-15	$156.17	3.00%	1.50%	$158.55	3.00%
Estimated FY 2015-16	$160.86	3.00%	1.50%	$163.31	3.00%
Estimated FY 2016-17	$165.69	3.00%	1.50%	$168.21	3.00%

(2) The patient days estimates for FY 2014-15, FY 2015-16 and FY 2016-17 are estimated using incurred-but-not-reported (IBNR) adjusted data from FY 2007-08 to FY 2013-14.

Fiscal Year	Patient Days	Percentage Change	Full Time Equivalent Clients	Percentage Change
FY 2007-08	206,269		564	
FY 2008-09	234,364	13.62%	642	13.83%
FY 2009-10	235,640	0.54%	646	0.62%
FY 2010-11	226,854	-3.73%	622	-3.72%
FY 2011-12	237,158	4.54%	648	4.18%
FY 2012-13	237,884	0.31%	652	0.62%
FY 2013-14	219,301	-7.81%	601	-7.82%
Estimated FY 2014-15	216,764	-1.16%	594	-1.16%
Estimated FY 2015-16	219,699	1.35%	600	1.01%
Estimated FY 2016-17	221,226	0.70%	606	1.00%

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

Exhibit G - COMMUNITY BASED LONG TERM CARE - Hospice Footnotes

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

Estimate of Claims Incurred and Paid in the Same Fiscal Year

Month Incurred	Additional Months Until End of Fiscal Year	Estimated Percent Complete at End of Fiscal Year (IBNR Factor)
July	11	99.91%
August	10	99.80%
September	9	99.68%
October	8	99.45%
November	7	99.09%
December	6	98.62%
January	5	97.99%
February	4	96.99%
March	3	95.26%
April	2	92.41%
May	1	84.58%
June	-	0.23%
Average		88.67%

(5) As calculated in the table below, the estimated FY 2014-15 expenditure for core components with FY 2013-14 dates of service is the estimated FY 2013-14 core components per diem rate multiplied by the estimated number of patient days. This calculation is then multiplied by one minus the calculated IBNR rate.

Calculation of Expenditure From Claims in Previous Fiscal Year	FY 2013-14	Source
IBNR Factor	88.67%	Footnote (4)
Estimated Patient Days from previous fiscal year	219,301	Footnote (2)
Estimated Per Diem Rate for Core Components for previous fiscal year	$151.62	Footnote (1)
Estimated claims expenditure for core components from previous fiscal year to be paid in the current fiscal year	$3,767,272	As described in Footnote (5) narrative

Exhibit G - COMMUNITY BASED LONG TERM CARE - Hospice Footnotes

(6) HB 10-1324 imposed a rate reduction of 1.5% effective March 1, 2010 and effective until June 30, 2011. HB 10-1379 imposed a rate reduction of 1% in addition to the rate reduction of HB 10-1324 for the period of July 1, 2010 to June 30, 2011. SB 11-215 imposed a rate reduction of 1.5% effective July 1, 2011 for FY 2011-12 that was extended for FY 2012-13 by HB 12-1340. HB 13-1152 extended the 1.5% rate reduction indefinitely, effective July 1, 2013. The rate reductions apply to all days incurred under the effective periods of each bill. As not all days will be reported in the fiscal year in which they are incurred, the impact of the rate cuts extends over multiple fiscal years. The tables below show the incremental impact of HB 13-1152. These figures may vary from previous submissions of the Department's requests due to revised forecasts for rates and patient days. Because HB 13-1152 made the 1.5% rate reduction permanent, potential rate reductions of 1.5% for FY 2014-15, FY 2015-16, and FY 2016-17 are accounted for here.

HB 13-1152	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
Estimated FY 2013-14 Rates	1.50%	$153.93	$151.62	($2.31)
Estimated FY 2013-14 Patient Days				219,301
Estimated FY 2013-14 Days Paid in FY 2013-14				194,454
Total FY 2013-14 Impact				**($449,189)**
Estimated FY 2013-14 Days Paid in FY 2014-15				24,847
FY 2014-15 Impact from Carryover from FY 2013-14				($57,397)
Estimated FY 2014-15 Rates	1.50%	$158.55	$156.17	($2.38)
Estimated FY 2014-15 Patient Days				216,764
Estimated FY 2014-15 Days Paid in FY 2014-15				192,205
FY 2014-15 Impact from FY 2014-15				($457,448)
Total FY 2014-15 Impact				**($514,845)**
Estimated FY 2014-15 Days Paid in FY 2015-16				24,559
FY 2015-16 Impact from Carryover from FY 2014-15				($58,450)
Estimated FY 2015-16 Rates	1.50%	$163.31	$160.86	($2.45)
Estimated FY 2015-16 Patient Days				219,699
Estimated FY 2015-16 Days Paid in FY 2015-16				194,807
FY 2015-16 Impact from FY 2015-16				($477,277)
Total FY 2015-16 Impact				**($535,727)**
Estimated FY 2015-16 Days Paid in FY 2016-17				24,892
FY 2016-17 Impact from Carryover from FY 2015-16				($60,985)
Estimated FY 2016-17 Rates	1.50%	$168.21	$165.69	($2.52)
Estimated FY 2016-17 Patient Days				221,226
Estimated FY 2016-17 Days Paid in FY 2016-17				196,161
FY 2016-17 Impact from FY 2016-17				($494,326)
Total FY 2016-17 Impact				**($555,311)**

(7) Hospice Services refers here to the following categories of service: hospice routine home care, hospice general inpatient, continuous home care, hospice inpatient respite, hospice physician visit, and hearing, vision, dental, and other PETI services. Hospice routine home care expenditure is forecast by linearly estimating FY 2014-15, FY 2015-16, and FY 2016-17 usage and rate using data from FY 2007-08 through FY 2013-14 . Hospice general inpatient expenditure estimates are produced by applying a linear time trend to annual expenditure for FY 2007-08 through FY 2013-14. Estimates for the remaining service categories are the result of aggregating all remaining expenditure and applying the average annual percentage growth rate from FY 2008-09 through FY 2013-14 to observed expenditure in FY 2013-14. The aforementioned average annual growth rate is applied to the estimate for FY 2014-15 to derive the estimate for FY 2015-16 and again to the estimate for FY 2015-16 expenditure in order to estimate FY 2016-17 expenditure.

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

Cash Based Actuals

Hospice	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$21,266,594	$2,111,240	$4,880,020	$0	$111,898	$0	$0	$0	$128,732	$0	$0	$0	$0	$0	$8,603	$28,507,087
FY 2006-07	$23,913,110	$1,986,641	$5,611,231	$0	$46,496	$0	$0	$0	$141,295	$0	$0	$0	$0	$0	$88,575	$31,787,348
FY 2007-08	$25,148,153	$2,134,632	$5,123,646	$0	$77,203	$0	$0	$0	$86,351	$0	$0	$0	$0	$0	$240,791	$32,810,776
FY 2008-09	$31,767,623	$2,005,681	$5,941,975	$0	$45,064	$0	$0	$0	$77,422	$0	$3,390	$2,017	$0	$0	$59,700	$39,902,873
FY 2009-10 (DA)	$34,017,386	$3,025,452	$6,115,615	$0	$203,862	$0	$0	$0	$231,678	$0	$34,952	$0	$0	$1,279	$6,603	$43,636,826
FY 2010-11 (DA)	$30,229,237	$2,102,622	$6,889,023	$0	$228,537	$39,141	$0	$0	$60,107	$0	$3,517	$0	$0	$0	($4,548)	$39,547,635
FY 2011-12	$32,103,872	$2,846,601	$6,969,248	$15,185	$114,106	$67,245	$4,370	$0	$116,333	$0	$1,215	$1,787	$0	$0	$86,846	$42,326,808
FY 2012-13	$33,427,166	$2,868,294	$6,505,178	$140,227	$168,345	$92,875	$117,103	$0	$37,390	$0	$0	$0	$0	$0	$40,522	$43,397,100
FY 2013-14	$31,935,985	$3,814,200	$7,418,711	$344,667	$158,722	$144,242	$1,024,926	$0	$149,582	$0	$0	$0	$0	$0	$26,219	$45,017,254
Estimated FY 2014-15	$29,229,660	$3,942,118	$7,211,296	$468,066	$186,201	$185,851	$2,470,125	$0	$155,310	$0	$0	$0	$0	$0	$28,727	$43,877,354
Estimated FY 2015-16	$30,042,918	$4,122,256	$7,399,325	$546,191	$192,115	$201,221	$2,798,150	$0	$164,269	$0	$0	$0	$0	$0	$31,088	$45,497,533
Estimated FY 2016-17	$30,881,832	$4,293,256	$7,593,945	$617,346	$197,481	$216,504	$3,120,941	$0	$173,682	$0	$0	$0	$0	$0	$33,860	$47,128,847

Percent Change in Cash Based Actuals

Hospice	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	12.44%	-5.90%	14.98%	0.00%	-58.45%	0.00%	0.00%	0.00%	9.76%	0.00%	0.00%	0.00%	0.00%	0.00%	929.58%	11.51%
FY 2007-08	5.16%	7.45%	-8.69%	0.00%	66.04%	0.00%	0.00%	0.00%	-38.89%	0.00%	0.00%	0.00%	0.00%	0.00%	171.85%	3.22%
FY 2008-09	26.32%	-6.04%	15.97%	0.00%	-41.63%	0.00%	0.00%	0.00%	-10.34%	0.00%	0.00%	0.00%	0.00%	0.00%	-75.21%	21.62%
FY 2009-10 (DA)	7.08%	50.84%	2.92%	0.00%	352.38%	0.00%	0.00%	0.00%	199.24%	0.00%	930.97%	-100.00%	0.00%	0.00%	-88.94%	9.36%
FY 2010-11 (DA)	-11.14%	-30.50%	12.65%	0.00%	12.10%	0.00%	0.00%	0.00%	-74.06%	0.00%	-89.94%	0.00%	0.00%	-100.00%	-168.88%	-9.37%
FY 2011-12	6.20%	35.38%	1.16%	0.00%	-50.07%	71.80%	0.00%	0.00%	93.54%	0.00%	-65.45%	0.00%	0.00%	0.00%	-2009.39%	7.03%
FY 2012-13	4.12%	0.76%	-6.66%	823.46%	47.53%	38.11%	2579.70%	0.00%	-67.86%	0.00%	-100.00%	-100.00%	0.00%	0.00%	-53.34%	2.53%
FY 2013-14	-4.46%	32.98%	14.04%	145.79%	-5.72%	55.31%	775.23%	0.00%	300.06%	0.00%	0.00%	0.00%	0.00%	0.00%	-35.30%	3.73%
Estimated FY 2014-15	-8.47%	3.35%	-2.80%	35.80%	17.31%	28.85%	141.01%	0.00%	3.83%	0.00%	0.00%	0.00%	0.00%	0.00%	9.57%	-2.53%
Estimated FY 2015-16	2.78%	4.57%	2.61%	16.69%	3.18%	8.27%	13.28%	0.00%	5.77%	0.00%	0.00%	0.00%	0.00%	0.00%	8.22%	3.69%
Estimated FY 2016-17	2.79%	4.15%	2.63%	13.03%	2.79%	7.60%	11.54%	0.00%	5.73%	0.00%	0.00%	0.00%	0.00%	0.00%	8.92%	3.59%

Per Capita Cost

Hospice	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$587.36	$349.43	$101.98	$0.00	$1.90	$0.00	$0.00	$0.00	$0.60	$0.00	$0.00	$0.00	$0.00	$0.00	$0.78	$70.87
FY 2006-07	$666.33	$327.88	$114.99	$0.00	$0.83	$0.00	$0.00	$0.00	$0.69	$0.00	$0.00	$0.00	$0.00	$0.00	$6.86	$81.04
FY 2007-08	$693.09	$347.32	$102.61	$0.00	$1.44	$0.00	$0.00	$0.00	$0.42	$0.00	$0.00	$0.00	$0.00	$0.00	$16.94	$83.71
FY 2008-09	$844.46	$311.10	$115.70	$0.00	$0.73	$0.00	$0.00	$0.00	$0.33	$0.00	$0.19	$0.29	$0.00	$0.00	$3.96	$91.35
FY 2009-10 (DA)	$883.87	$429.20	$114.82	$0.00	$2.72	$0.00	$0.00	$0.00	$0.84	$0.00	$1.90	$0.00	$0.00	$0.35	$0.41	$87.48
FY 2010-11 (DA)	$777.52	$270.71	$122.40	$0.00	$2.82	$1.44	$0.00	$0.00	$0.20	$0.00	$0.19	$0.00	$0.00	$0.00	($0.27)	$70.53
FY 2011-12	$807.85	$339.57	$117.26	$292.02	$1.22	$1.90	$3.85	$0.00	$0.35	$0.00	$0.07	$0.23	$0.00	$0.00	$4.60	$68.27
FY 2012-13	$818.75	$316.90	$105.06	$157.91	$1.69	$2.24	$11.01	$0.00	$0.10	$0.00	$0.00	$0.00	$0.00	$0.00	$1.91	$63.54
FY 2013-14	$763.36	$387.11	$115.15	$134.64	$1.27	$3.06	$11.75	$0.00	$0.38	$0.00	$0.00	$0.00	$0.00	$0.00	$1.12	$52.29
Estimated FY 2014-15	$697.07	$363.73	$108.20	$126.50	$1.20	$2.88	$11.04	$0.00	$0.35	$0.00	$0.00	$0.00	$0.00	$0.00	$1.05	$38.95
Estimated FY 2015-16	$697.70	$360.27	$107.17	$125.30	$1.12	$2.85	$10.93	$0.00	$0.35	$0.00	$0.00	$0.00	$0.00	$0.00	$1.04	$37.24
Estimated FY 2016-17	$701.46	$358.52	$106.65	$124.69	$1.06	$2.84	$10.88	$0.00	$0.35	$0.00	$0.00	$0.00	$0.00	$0.00	$1.04	$35.81

Percent Change in Per Capita Cost

Hospice	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	13.44%	-6.17%	12.76%	0.00%	-56.32%	0.00%	0.00%	0.00%	15.00%	0.00%	0.00%	0.00%	0.00%	0.00%	779.49%	14.35%
FY 2007-08	4.02%	5.93%	-10.77%	0.00%	73.49%	0.00%	0.00%	0.00%	-39.13%	0.00%	0.00%	0.00%	0.00%	0.00%	146.94%	3.29%
FY 2008-09	21.84%	-10.43%	12.76%	0.00%	-49.31%	0.00%	0.00%	0.00%	-21.43%	0.00%	0.00%	0.00%	0.00%	0.00%	-76.62%	9.13%
FY 2009-10 (DA)	4.67%	37.96%	-0.76%	0.00%	272.60%	0.00%	0.00%	0.00%	154.55%	0.00%	900.00%	-100.00%	0.00%	0.00%	-89.65%	-4.24%
FY 2010-11 (DA)	-12.03%	-36.93%	6.60%	0.00%	3.68%	0.00%	0.00%	0.00%	-76.19%	0.00%	-90.00%	0.00%	0.00%	-100.00%	-165.85%	-19.38%
FY 2011-12	3.90%	25.44%	-4.20%	0.00%	-56.74%	31.94%	0.00%	0.00%	75.00%	0.00%	-63.16%	0.00%	0.00%	0.00%	-1803.70%	-3.20%
FY 2012-13	1.35%	-6.68%	-10.40%	-45.92%	38.52%	17.89%	185.97%	0.00%	-71.43%	0.00%	-100.00%	-100.00%	0.00%	0.00%	-58.48%	-6.93%
FY 2013-14	-6.77%	22.16%	9.60%	-14.74%	-24.85%	36.61%	6.72%	0.00%	280.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-41.36%	-17.71%
Estimated FY 2014-15	-8.68%	-6.04%	-6.04%	-6.05%	-5.51%	-5.88%	-6.04%	0.00%	-7.89%	0.00%	0.00%	0.00%	0.00%	0.00%	-6.25%	-25.51%
Estimated FY 2015-16	0.09%	-0.95%	-0.95%	-0.95%	-6.67%	-1.04%	-1.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.95%	-4.39%
Estimated FY 2016-17	0.54%	-0.49%	-0.49%	-0.49%	-5.36%	-0.35%	-0.46%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-3.84%

Exhibit G - COMMUNITY BASED LONG TERM CARE - Private Duty Nursing

Cash Based Actuals

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Baby Care Program-Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$157,164	$405,549	$10,536,627	$0	$0	$0	$0	$0	$397,273	$0	$4,120,147	$0	$0	$0	$0	$15,616,760
FY 2006-07	$354,877	$155,949	$12,205,855	$0	$0	$0	$0	$0	$562,535	$0	$3,983,279	$0	$0	$0	$37,261	$17,299,756
FY 2007-08	$313,936	$207,166	$13,885,052	$0	$0	$0	$0	$0	$500,847	$0	$4,832,273	$0	$0	$0	$9,988	$19,749,262
FY 2008-09	$725,106	$186,844	$14,728,104	$0	$0	$0	$0	$0	$250,793	$0	$5,460,562	$0	$0	$0	$0	$21,351,408
FY 2009-10 (DA)	$1,035,252	$240,541	$15,137,079	$0	$0	$0	$0	$0	$604,720	$0	$6,648,963	$0	$0	$0	$0	$23,666,555
FY 2010-11 (DA)	$1,319,815	$0	$17,252,161	$0	$0	$0	$0	$0	$502,792	$0	$8,251,188	$0	$0	$0	$0	$27,325,957
FY 2011-12	$1,832,636	$135,105	$20,720,340	$0	$0	$0	$0	$0	$601,939	$0	$7,854,133	$0	$0	$0	$0	$31,144,153
FY 2012-13	$2,364,123	$557,116	$24,342,047	$18,478	$0	$0	$0	$0	$1,069,272	$5,806	$8,490,119	$0	$0	$0	$0	$36,846,961
FY 2013-14	$3,039,698	$734,755	$35,345,893	$280,781	$0	$0	$43,544	$0	$3,373,711	$400	$10,310,507	$0	$0	$0	$25,614	$53,154,903
Estimated FY 2014-15	$3,586,574	$874,926	$42,203,627	$337,642	$14,942	$0	$51,582	$0	$4,023,717	$0	$12,095,766	$0	$0	$0	$15,434	$63,204,210
Estimated FY 2015-16	$4,267,587	$1,035,528	$50,123,038	$396,095	$17,112	$0	$59,627	$0	$4,739,204	$0	$14,226,831	$0	$0	$0	$18,172	$74,883,194
Estimated FY 2016-17	$4,996,141	$1,206,607	$58,691,607	$464,089	$19,592	$0	$68,916	$0	$5,546,324	$0	$16,450,618	$0	$0	$0	$21,391	$87,465,285

Percent Change in Cash Based Actuals

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Baby Care Program-Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	125.80%	-61.55%	15.84%	0.00%	0.00%	0.00%	0.00%	0.00%	41.60%	0.00%	-3.32%	0.00%	0.00%	0.00%	100.00%	10.78%
FY 2007-08	-11.54%	32.84%	13.76%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.97%	0.00%	21.31%	0.00%	0.00%	0.00%	-73.19%	14.16%
FY 2008-09	130.97%	-9.81%	6.07%	0.00%	0.00%	0.00%	0.00%	0.00%	-49.93%	0.00%	13.00%	0.00%	0.00%	0.00%	-100.00%	8.11%
FY 2009-10 (DA)	42.77%	28.74%	2.78%	0.00%	0.00%	0.00%	0.00%	0.00%	141.12%	0.00%	21.76%	0.00%	0.00%	0.00%	0.00%	10.84%
FY 2010-11 (DA)	27.49%	-100.00%	13.97%	0.00%	0.00%	0.00%	0.00%	0.00%	-16.86%	0.00%	24.10%	0.00%	0.00%	0.00%	0.00%	15.46%
FY 2011-12	38.86%	100.00%	20.10%	0.00%	0.00%	0.00%	0.00%	0.00%	19.72%	0.00%	-4.81%	0.00%	0.00%	0.00%	0.00%	13.97%
FY 2012-13	29.00%	312.36%	17.48%	100.00%	0.00%	0.00%	0.00%	0.00%	77.64%	100.00%	8.10%	0.00%	0.00%	0.00%	0.00%	18.31%
FY 2013-14	28.58%	31.89%	45.21%	1419.54%	0.00%	0.00%	100.00%	0.00%	215.51%	-93.11%	21.44%	0.00%	0.00%	0.00%	100.00%	44.26%
Estimated FY 2014-15	17.99%	19.08%	19.40%	20.25%	100.00%	0.00%	18.46%	0.00%	19.27%	-100.00%	17.31%	0.00%	0.00%	0.00%	-39.74%	18.91%
Estimated FY 2015-16	18.99%	18.36%	18.76%	17.31%	14.52%	0.00%	15.60%	0.00%	17.78%	0.00%	17.62%	0.00%	0.00%	0.00%	17.74%	18.48%
Estimated FY 2016-17	17.07%	16.52%	17.10%	17.17%	14.49%	0.00%	15.58%	0.00%	17.03%	0.00%	15.63%	0.00%	0.00%	0.00%	17.71%	16.80%

Per Capita Cost

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Baby Care Program-Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$4.34	$67.12	$220.18	$0.00	$0.00	$0.00	$0.00	$0.00	$1.86	$0.00	$250.31	$0.00	$0.00	$0.00	$0.00	$38.83
FY 2006-07	$9.89	$25.74	$250.13	$0.00	$0.00	$0.00	$0.00	$0.00	$2.74	$0.00	$238.18	$0.00	$0.00	$0.00	$2.89	$44.11
FY 2007-08	$8.65	$33.71	$278.07	$0.00	$0.00	$0.00	$0.00	$0.00	$2.45	$0.00	$281.91	$0.00	$0.00	$0.00	$0.70	$50.39
FY 2008-09	$19.27	$28.98	$286.79	$0.00	$0.00	$0.00	$0.00	$0.00	$1.07	$0.00	$302.81	$0.00	$0.00	$0.00	$0.00	$48.88
FY 2009-10 (DA)	$26.90	$34.12	$284.19	$0.00	$0.00	$0.00	$0.00	$0.00	$2.19	$0.00	$361.73	$0.00	$0.00	$0.00	$0.00	$47.45
FY 2010-11 (DA)	$33.95	$0.00	$306.51	$0.00	$0.00	$0.00	$0.00	$0.00	$1.66	$0.00	$448.60	$0.00	$0.00	$0.00	$0.00	$48.73
FY 2011-12	$46.12	$16.12	$348.63	$0.00	$0.00	$0.00	$0.00	$0.00	$1.80	$0.00	$435.52	$0.00	$0.00	$0.00	$0.00	$50.24
FY 2012-13	$57.91	$61.55	$393.12	$20.81	$0.00	$0.00	$0.00	$0.00	$2.97	$0.70	$477.59	$0.00	$0.00	$0.00	$0.00	$53.95
FY 2013-14	$72.66	$74.57	$548.64	$109.68	$0.00	$0.00	$0.50	$0.00	$8.49	$0.01	$564.43	$0.00	$0.00	$0.00	$1.10	$61.74
Estimated FY 2014-15	$85.53	$80.73	$633.23	$91.25	$0.10	$0.00	$0.23	$0.00	$9.16	$0.00	$586.77	$0.00	$0.00	$0.00	$0.57	$56.11
Estimated FY 2015-16	$99.11	$90.50	$725.98	$90.87	$0.10	$0.00	$0.23	$0.00	$10.11	$0.00	$680.06	$0.00	$0.00	$0.00	$0.61	$61.29
Estimated FY 2016-17	$113.48	$100.76	$824.26	$93.74	$0.10	$0.00	$0.24	$0.00	$11.13	$0.00	$775.83	$0.00	$0.00	$0.00	$0.66	$66.46

Percent Change in Per Capita Cost

COMMUNITY BASED LONG-TERM CARE	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Baby Care Program-Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	127.88%	-61.65%	13.60%	0.00%	0.00%	0.00%	0.00%	0.00%	47.31%	0.00%	-4.85%	0.00%	0.00%	0.00%	100.00%	13.60%
FY 2007-08	-12.54%	30.96%	11.17%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.58%	0.00%	18.36%	0.00%	0.00%	0.00%	-75.78%	14.24%
FY 2008-09	122.77%	-14.03%	3.14%	0.00%	0.00%	0.00%	0.00%	0.00%	-56.33%	0.00%	7.41%	0.00%	0.00%	0.00%	-100.00%	-3.00%
FY 2009-10 (DA)	39.60%	17.74%	-0.91%	0.00%	0.00%	0.00%	0.00%	0.00%	104.67%	0.00%	19.46%	0.00%	0.00%	0.00%	0.00%	-2.93%
FY 2010-11 (DA)	26.21%	-100.00%	7.85%	0.00%	0.00%	0.00%	0.00%	0.00%	-24.20%	0.00%	24.02%	0.00%	0.00%	0.00%	0.00%	2.70%
FY 2011-12	35.85%	100.00%	13.74%	0.00%	0.00%	0.00%	0.00%	0.00%	8.43%	0.00%	-2.92%	0.00%	0.00%	0.00%	0.00%	3.10%
FY 2012-13	25.56%	281.82%	12.76%	100.00%	0.00%	0.00%	0.00%	0.00%	65.00%	100.00%	9.66%	0.00%	0.00%	0.00%	0.00%	7.38%
FY 2013-14	25.47%	21.15%	39.56%	427.05%	0.00%	0.00%	100.00%	0.00%	185.86%	-98.57%	18.18%	0.00%	0.00%	0.00%	100.00%	14.44%
Estimated FY 2014-15	17.71%	8.26%	15.42%	-16.80%	100.00%	0.00%	-54.00%	0.00%	7.89%	-100.00%	3.96%	0.00%	0.00%	0.00%	-48.18%	-9.12%
Estimated FY 2015-16	15.88%	12.10%	14.65%	-0.42%	0.00%	0.00%	0.00%	0.00%	10.37%	0.00%	15.90%	0.00%	0.00%	0.00%	7.02%	9.23%
Estimated FY 2016-17	14.50%	11.34%	13.54%	3.16%	0.00%	0.00%	4.35%	0.00%	10.09%	0.00%	14.08%	0.00%	0.00%	0.00%	8.20%	8.44%

Exhibit G - COMMUNITY BASED LONG TERM CARE - Private Duty Nursing

Current Year Projection																	
COMMUNITY BASED LONG-TERM CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**Baby Care Program-Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Registered Nurse Services																
FY 2013-14 Hours	55,272	10,566	665,900	5,325	0	0	334	0	62,085	0	98,684	0	0	0	286	898,452
Estimated Growth Rate	18.00%	18.00%	18.00%	18.00%	0.00%	0.00%	18.00%	0.00%	18.00%	0.00%	18.00%	0.00%	0.00%	0.00%	18.00%	18.00%
Estimated FY 2014-15 Hours	65,221	12,468	785,762	6,284	0	0	394	0	73,260	0	116,447	0	0	0	337	1,060,173
FY 2013-14 Rate	$39.57	$39.57	$39.57	$39.57	$39.57	$39.57	$39.57	$39.57	$39.57	$39.57	$39.57	$39.57	$39.57	$39.57	$39.57	$39.57
Estimated Growth Rate	3.19%	3.19%	3.19%	3.19%	3.19%	3.19%	3.19%	3.19%	3.19%	3.19%	3.19%	3.19%	3.19%	3.19%	3.19%	3.19%
Estimated FY 2014-15 Rate	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83
Estimated FY 2014-15 Expenditure	**$2,662,973**	**$509,068**	**$32,082,663**	**$256,576**	**$0**	**$0**	**$16,087**	**$0**	**$2,991,206**	**$0**	**$4,754,531**	**$0**	**$0**	**$0**	**$13,760**	**$43,286,864**
Registered Nurse Services Group , Licensed Practical Nurse Services, and Blended Services																
FY 2013-14 Hours	27,697	10,703	295,210	2,297	421	0	1,000	0	28,742	0	201,747	0	0	0	48	567,865
Estimated Growth Rate	14.48%	14.48%	14.48%	14.50%	14.49%	0.00%	14.50%	0.00%	14.48%	0.00%	14.48%	0.00%	0.00%	0.00%	12.50%	14.48%
Estimated FY 2014-15 Hours	31,708	12,253	337,956	2,630	482	0	1,145	0	32,904	0	230,960	0	0	0	54	650,092
FY 2013-14 Rate	$29.75	$29.75	$29.75	$29.75	$29.75	$29.75	$29.75	$29.75	$29.75	$29.75	$29.75	$29.75	$29.75	$29.75	$29.75	$29.75
Estimated Growth Rate	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%	4.20%
Estimated FY 2014-15 Rate	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00
Estimated FY 2014-15 Expenditure	**$982,948**	**$379,843**	**$10,476,636**	**$81,530**	**$14,942**	**$0**	**$35,495**	**$0**	**$1,020,024**	**$0**	**$7,159,760**	**$0**	**$0**	**$0**	**$1,674**	**$20,152,852**
LPN-Group Services																
FY 2013-14 Hours	0	0	10,219	0	0	0	0	0	1,574	0	15,789	0	0	0	0	27,582
Estimated Growth Rate	0.00%	0.00%	6.44%	0.00%	0.00%	0.00%	0.00%	0.00%	6.42%	0.00%	6.44%	0.00%	0.00%	0.00%	0.00%	6.44%
Estimated FY 2014-15 Hours	0	0	10,877	0	0	0	0	0	1,675	0	16,806	0	0	0	0	29,358
FY 2013-14 Rate	$22.91	$22.91	$22.91	$22.91	$22.91	$22.91	$22.91	$22.91	$22.91	$22.91	$22.91	$22.91	$22.91	$22.91	$22.91	$22.91
Estimated Growth Rate	2.49%	2.49%	2.49%	2.49%	2.49%	2.49%	2.49%	2.49%	2.49%	2.49%	2.49%	2.49%	2.49%	2.49%	2.49%	2.49%
Estimated FY 2014-15 Rate	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48
Estimated FY 2014-15 Expenditure	**$0**	**$0**	**$255,392**	**$0**	**$0**	**$0**	**$0**	**$0**	**$39,329**	**$0**	**$394,605**	**$0**	**$0**	**$0**	**$0**	**$689,326**
Totals																
Bottom Line Impacts																
Annualization of Adjustment for 53-week payment cycle in FY 2013-14	($59,347)	($13,985)	($611,064)	($464)	$0	$0	$0	$0	($26,842)	$0	($213,130)	$0	$0	$0	$0	($924,832)
Total Bottom Line Impacts	**($59,347)**	**($13,985)**	**($611,064)**	**($464)**	**$0**	**$0**	**$0**	**$0**	**($26,842)**	**$0**	**($213,130)**	**$0**	**$0**	**$0**	**$0**	**($924,832)**
Total FY 2014-15 Estimated Expenditure	**$3,586,574**	**$874,926**	**$42,203,627**	**$337,642**	**$14,942**	**$0**	**$51,582**	**$0**	**$4,023,717**	**$0**	**$12,095,766**	**$0**	**$0**	**$0**	**$15,434**	**$63,204,210**
% Change over Total FY 2013-14 Expenditure	17.99%	19.08%	19.40%	20.25%	0.00%	0.00%	18.46%	0.00%	19.27%	-100.00%	17.31%	0.00%	0.00%	0.00%	-39.74%	18.91%

Exhibit G - COMMUNITY BASED LONG TERM CARE - Private Duty Nursing

Request Year Projection																	
COMMUNITY BASED LONG-TERM CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**Baby Care Program-Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Registered Nurse Services																
Estimated FY 2014-15 Hours	65,221	12,468	785,762	6,284	0	0	394	0	73,260	0	116,447	0	0	0	337	1,060,173
Estimated Growth Rate	18.00%	18.00%	18.00%	18.00%	0.00%	0.00%	18.00%	0.00%	18.00%	0.00%	18.00%	0.00%	0.00%	0.00%	18.00%	18.00%
Estimated FY 2015-16 Hours	76,961	14,712	927,199	7,415	0	0	465	0	86,447	0	137,407	0	0	0	398	1,251,004
Estimated FY 2014-15 Rate	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2015-16 Rate	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83
Estimated FY 2015-16 Expenditure	**$3,142,318**	**$600,691**	**$37,857,535**	**$302,754**	**$0**	**$0**	**$18,986**	**$0**	**$3,529,631**	**$0**	**$5,610,328**	**$0**	**$0**	**$0**	**$16,250**	**$51,078,493**
Registered Nurse Services Group , Licensed Practical Nurse Services, and Blended Services																
Estimated FY 2014-15 Hours	31,708	12,253	337,956	2,630	482	0	1,145	0	32,904	0	230,960	0	0	0	54	650,092
Estimated Growth Rate	14.48%	14.48%	14.48%	14.49%	14.52%	0.00%	14.50%	0.00%	14.48%	0.00%	14.48%	0.00%	0.00%	0.00%	14.81%	14.48%
Estimated FY 2015-16 Hours	36,299	14,027	386,892	3,011	552	0	1,311	0	37,668	0	264,403	0	0	0	62	744,225
Estimated FY 2014-15 Rate	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2015-16 Rate	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00
Estimated FY 2015-16 Expenditure	**$1,125,269**	**$434,837**	**$11,993,652**	**$93,341**	**$17,112**	**$0**	**$40,641**	**$0**	**$1,167,708**	**$0**	**$8,196,493**	**$0**	**$0**	**$0**	**$1,922**	**$23,070,975**
LPN-Group Services																
Estimated FY 2014-15 Hours	0	0	10,877	0	0	0	0	0	1,675	0	16,806	0	0	0	0	29,358
Estimated Growth Rate	0.00%	0.00%	6.44%	0.00%	0.00%	0.00%	0.00%	0.00%	6.45%	0.00%	6.44%	0.00%	0.00%	0.00%	0.00%	6.44%
Estimated FY 2015-16 Hours	0	0	11,578	0	0	0	0	0	1,783	0	17,888	0	0	0	0	31,249
Estimated FY 2014-15 Rate	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2015-16 Rate	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48
Estimated FY 2015-16 Expenditure	**$0**	**$0**	**$271,851**	**$0**	**$0**	**$0**	**$0**	**$0**	**$41,865**	**$0**	**$420,010**	**$0**	**$0**	**$0**	**$0**	**$733,726**
Totals																
Total FY 2015-16 Estimated Expenditure	**$4,267,587**	**$1,035,528**	**$50,123,038**	**$396,095**	**$17,112**	**$0**	**$59,627**	**$0**	**$4,739,204**	**$0**	**$14,226,831**	**$0**	**$0**	**$0**	**$18,172**	**$74,883,194**
% Change over Total Estimated FY 2014-15 Expenditure	18.99%	18.36%	18.76%	17.31%	14.52%	0.00%	15.60%	0.00%	17.78%	0.00%	17.62%	0.00%	0.00%	0.00%	17.74%	18.48%

Exhibit G - COMMUNITY BASED LONG TERM CARE - Private Duty Nursing

Out Year Projection																
COMMUNITY BASED LONG-TERM CARE	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**Baby Care Program-Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Registered Nurse Services																
Estimated FY 2015-16 Hours	76,961	14,712	927,199	7,415	0	0	465	0	86,447	0	137,407	0	0	0	398	1,251,004
Estimated Growth Rate	18.00%	18.00%	18.00%	18.00%	0.00%	0.00%	18.00%	0.00%	18.00%	0.00%	18.00%	0.00%	0.00%	0.00%	18.00%	18.00%
Estimated FY 2016-17 Hours	90,814	17,360	1,094,095	8,750	0	0	549	0	102,007	0	162,140	0	0	0	470	1,476,185
Estimated FY 2015-16 Rate	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2016-17 Rate	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83	$40.83
Estimated FY 2016-17 Expenditure	**$3,707,936**	**$708,809**	**$44,671,898**	**$357,263**	**$0**	**$0**	**$22,416**	**$0**	**$4,164,946**	**$0**	**$6,620,176**	**$0**	**$0**	**$0**	**$19,190**	**$60,272,634**
Registered Nurse Services Group , Licensed Practical Nurse Services, and Blended Services																
Estimated FY 2015-16 Hours	36,299	14,027	386,892	3,011	552	0	1,311	0	37,668	0	264,403	0	0	0	62	744,225
Estimated Growth Rate	14.48%	14.48%	14.48%	14.45%	14.49%	0.00%	14.42%	0.00%	14.48%	0.00%	14.48%	0.00%	0.00%	0.00%	14.52%	14.48%
Estimated FY 2016-17 Hours	41,555	16,058	442,915	3,446	632	0	1,500	0	43,123	0	302,689	0	0	0	71	851,989
Estimated FY 2015-16 Rate	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2016-17 Rate	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00	$31.00
Estimated FY 2016-17 Expenditure	**$1,288,205**	**$497,798**	**$13,730,365**	**$106,826**	**$19,592**	**$0**	**$46,500**	**$0**	**$1,336,813**	**$0**	**$9,383,359**	**$0**	**$0**	**$0**	**$2,201**	**$26,411,659**
LPN-Group Services																
Estimated FY 2015-16 Hours	0	0	11,578	0	0	0	0	0	1,783	0	17,888	0	0	0	0	31,249
Estimated Growth Rate	0.00%	0.00%	6.43%	0.00%	0.00%	0.00%	0.00%	0.00%	6.45%	0.00%	6.45%	0.00%	0.00%	0.00%	0.00%	6.44%
Estimated FY 2016-17 Hours	0	0	12,323	0	0	0	0	0	1,898	0	19,041	0	0	0	0	33,262
Estimated FY 2015-16 Rate	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48
Estimated Growth Rate	0.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2016-17 Rate	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48	$23.48
Estimated FY 2016-17 Expenditure	**$0**	**$0**	**$289,344**	**$0**	**$0**	**$0**	**$0**	**$0**	**$44,565**	**$0**	**$447,083**	**$0**	**$0**	**$0**	**$0**	**$780,992**
Totals																
Total FY 2016-17 Estimated Expenditure	**$4,996,141**	**$1,206,607**	**$58,691,607**	**$464,089**	**$19,592**	**$0**	**$68,916**	**$0**	**$5,546,324**	**$0**	**$16,450,618**	**$0**	**$0**	**$0**	**$21,391**	**$87,465,285**
% Change over Total Estimated FY 2015-16 Expenditure	17.07%	16.52%	17.10%	17.17%	14.49%	0.00%	15.58%	0.00%	17.03%	0.00%	15.63%	0.00%	0.00%	0.00%	17.71%	16.80%

Exhibit G - COMMUNITY BASED LONG TERM CARE - Colorado Choice Transitions Budget Impacts

FY 2014-15 Colorado Choice Transitions Budget Impact

Row	Item	Total	DDD/Dual Diagnosis Transitions	EBD/BI/CMHS Transitions	Calculation	Notes
A	Estimated Average Monthly Enrollment	55	9	46		55 Expected - 17% are DIDD
B	Estimated Demonstration Service Per Capita Annual Cost	$6,000.51	$11,418.86	$4,940.40		
C	**Estimated Demonstration Service Total Cost**	**$330,028**	**$102,770**	**$227,258**	**Row A * Row B**	**Demo Expenses for all clients hit MSP**
D	Estimated Qualified Service Per Capita Annual Cost	$20,223.75	$63,835.55	$11,691.01		All Expenditure hits MSP, even DIDD waivers while in CCT.
E	**Estimated Qualified Service Total Cost**	**$1,112,306**	**$574,520**	**$537,786**	**Row A * Row D**	**DIDD Waiver Expenditure hits LBG 5 after 365 days in CCT program for DIDD clients.**
F	Estimated Long-Term Home Health Per Capita Annual Cost	$6,275.36	$6,275.37	$6,275.37		Bottom line impact in Acute Care - include all clients
G	**Estimated Long-Term Home Health Total Cost**	**$345,145**	**$56,478**	**$288,667**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$1,787,479**	**$733,768**	**$1,053,711**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$360,584**	**$169,323**	**$191,261**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions [(1)]	15	3	12		Cumulative
K	Estimated HCBS Service Per Capita Annual Cost	$23,626.73	$63,835.55	$13,574.51		New waiver expenditure for clients successfully transitioned into a HCBS waiver - hits both MSP and DIDD
L	**Estimated Non CCT HCBS Service Costs Total (MSP)**	**$162,894**		**$162,894**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DD)**	**$191,507**	**$191,507**		**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per Capita Annual Cost		($61,451.40)	($61,451.40)		All from MSP
O	Estimated ICF/IID Per Capita Annual Cost		($196,173.50)			Trended FY 2011-12 ICF/IID Per Capita Cost; from FY 2011-12 LTSS data book
P	**Estimated Nursing Facility Total Cost Avoided**	**($4,117,244)**	**($553,063)**	**($3,564,181)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from SNF (1/3 expected from ICF/IID)**
Q	**Estimated ICF/IID Total Cost Avoided**	**($588,521)**	**($588,521)**		**(Row A *25%) * Row O**	**Assume 25% DIDD from Regional Center**
R	**Total Cost Avoidance**	**($4,705,765)**	**($1,141,584)**	**($3,564,181)**	**Row P + Row Q**	
S	**Estimated Total Budget Impact**	**($2,563,885)**	**($216,309)**	**($2,347,576)**	**Row H + Row R**	
T	*Estimated Rebalancing Fund Balance*	*$360,584*	*$169,323*	*$191,261*	*Row I*	*Off budget balance - non appropriated line item*

(1) A completed transition means the client has received one year worth of demonstration services.

FY 2015-16 Colorado Choice Transitions Budget Impact

Row	Item	Total	DDD/Dual Diagnosis Transitions	EBD/BI/CMHS Transitions	Calculation	Notes
A	Estimated Average Monthly Enrollment	105	18	87		105 Expected - 17% are DIDD
B	Estimated Demonstration Service Per Capita Annual Cost	$6,181.70	$11,665.51	$5,047.11		
C	**Estimated Demonstration Service Total Cost**	**$649,078**	**$209,979**	**$439,099**	**Row A * Row B**	**Demo Expenses for all clients hit MSP**
D	Estimated Qualified Service Per Capita Annual Cost	$21,075.69	$65,214.40	$11,943.54		All Expenditure hits MSP, even DIDD waivers while in CCT.
E	**Estimated Qualified Service Total Cost**	**$2,212,947**	**$1,173,859**	**$1,039,088**	**Row A * Row D**	**DIDD Waiver Expenditure hits LBG 5 after 365 days in CCT program for DIDD clients.**
F	Estimated Long-Term Home Health Per Capita Annual Cost	$6,410.92	$6,410.92	$6,410.92		Bottom line impact in Acute Care - include all clients
G	**Estimated Long-Term Home Health Total Cost**	**$673,147**	**$115,397**	**$557,750**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$3,535,172**	**$1,499,235**	**$2,035,937**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$715,507**	**$345,960**	**$369,547**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions [(1)]	70	12	58		Cumulative
K	Estimated HCBS Service Per Capita Annual Cost	$22,670.01	$65,214.40	$13,867.72		New waiver expenditure for clients successfully transitioned into a HCBS waiver - hits both MSP and DIDD
L	**Estimated Non CCT HCBS Service Costs Total (MSP)**	**$804,328**		**$804,328**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DD)**	**$782,573**	**$782,573**		**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per Capita Annual Cost		($63,471.72)	($63,471.72)		All from MSP
O	Estimated ICF-IID Per Capita Annual Cost		($200,763.96)			Trended FY 2011-12 ICF/IID Per Capita Cost; from FY 2011-12 LTSS data book
P	**Estimated Nursing Facility Total Cost Avoided**	**($10,663,249)**	**($1,459,850)**	**($9,203,399)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from SNF (4/17 expected from ICF/IID)**
Q	**Estimated ICF-IID Total Cost Avoided**	**($1,606,112)**	**($1,606,112)**		**(Row A *25%) * Row O**	**Assume 25% DIDD from Regional Center**
R	**Total Cost Avoidance**	**($12,269,361)**	**($3,065,962)**	**($9,203,399)**	**Row P + Row Q**	
S	**Estimated Total Budget Impact**	**($7,147,288)**	**($784,154)**	**($6,363,134)**	**Row H + Row R**	
T	*Estimated Rebalancing Fund Balance*	*$715,507*	*$345,960*	*$369,547*	*Row I*	*Off budget balance - non appropriated line item*

(1) A completed transition means the client has received one year worth of demonstration services.

Exhibit G - COMMUNITY BASED LONG TERM CARE - Colorado Choice Transitions Budget Impacts

FY 2016-17 Colorado Choice Transitions Budget Impact						
Row	**Item**	**Total**	**DDD/Dual Diagnosis Transitions**	**EBD/BI/CMHS Transitions**	**Calculation**	**Notes**
A	Estimated Average Monthly Enrollment	150	26	124		150 Expected - 17% are DIDD
B	Estimated Demonstration Service Per Capita Annual Cost	$6,328.10	$11,917.49	$5,156.13		
C	**Estimated Demonstration Service Total Cost**	**$949,215**	**$309,855**	**$639,360**	**Row A * Row B**	**Demo Expenses for all clients hit MSP**
D	Estimated Qualified Service Per Capita Annual Cost	$21,634.58	$66,623.03	$12,201.52		All Expenditure hits MSP, even DIDD waivers while in CCT.
E	**Estimated Qualified Service Total Cost**	**$3,245,187**	**$1,732,199**	**$1,512,988**	**Row A * Row D**	**DIDD Waiver Expenditure hits LBG 5 after 365 days in CCT program for DIDD clients.**
F	Estimated Long-Term Home Health Per Capita Annual Cost	$6,549.40	$6,549.40	$6,549.40		Bottom line impact in Acute Care - include all clients
G	**Estimated Long-Term Home Health Total Cost**	**$982,410**	**$170,284**	**$812,126**	**Row A * Row F**	**This does not get additional 25% Federal Match for the Rebalancing Fund**
H	**Estimated Total Expenditures For CCT**	**$5,176,812**	**$2,212,338**	**$2,964,474**	**Row C + Row E + Row G**	**Total MSP Impact**
I	**Estimated Rebalancing Fund Total**	**$1,048,601**	**$510,514**	**$538,087**	**(Row C + Row E) * 25%**	**Off budget balance - non appropriated line item**
J	Estimated Number of Completed Transitions [(1)]	175	30	145		Cumulative
K	Estimated HCBS Service Per Capita Annual Cost	$23,159.68	$66,623.03	$14,167.26		New waiver expenditure for clients successfully transitioned into a HCBS waiver - hits both MSP and DIDD
L	**Estimated Non CCT HCBS Service Costs Total (MSP)**	**$2,054,253**		**$2,054,253**	**Row J * Row K**	**MSP impact**
M	**Estimated Non CCT HCBS Service Costs Total (DD)**	**$1,998,691**	**$1,998,691**		**Row J * Row K**	**DIDD impact**
N	Estimated Nursing Facility Per Capita Annual Cost		($65,192.65)	($65,192.65)		All from MSP
O	Estimated ICF-IID Per Capita Annual Cost		($205,461.84)			Trended FY 2011-12 ICF/IID Per Capita Cost; from FY 2011-12 LTSS data book
P	**Estimated Nursing Facility Total Cost Avoided**	**($20,274,914)**	**($2,738,091)**	**($17,536,823)**	**Row A * Row N; DIDD: (Row A * 75%) * Row N**	**Assume 75% DIDD from SNF (8/31 expected from ICF/IID)**
Q	**Estimated ICF-IID Total Cost Avoided**	**($2,876,466)**	**($2,876,466)**		**(Row A *25%) * Row O**	**Assume 25% DIDD from Regional Center**
R	**Total Cost Avoidance**	**($23,151,380)**	**($5,614,557)**	**($17,536,823)**	**Row P + Row Q**	
S	**Estimated Total Budget Impact**	**($13,921,624)**	**($1,403,528)**	**($12,518,096)**	**Row H + Row R**	
T	*Estimated Rebalancing Fund Balance*	*$1,048,601*	*$510,514*	*$538,087*	*Row I*	*Off budget balance - non appropriated line item*

(1) A completed transition means the client has received one year worth of demonstration services.

Exhibit H - Long Term Care and Insurance Summary

FY 2014-15 Long-Term Care and Insurance Request																
FY 2014-15	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Class I Nursing Facilities	$455,045,653	$39,349,332	$84,293,329	$400,180	$129,910	$0	$0	$0	$0	$0	$0	$0	$0	$0	$809,595	$580,027,999
Class II Nursing Facilities	$482,475	$366,037	$3,365,675	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,214,187
Program for All-Inclusive Care for the Elderly	$118,208,940	$13,909,912	$7,488,917	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$139,607,769
Subtotal Long-Term Care	**$573,737,068**	**$53,625,281**	**$95,147,921**	**$400,180**	**$129,910**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$809,595**	**$723,849,955**
Supplemental Medicare Insurance Benefit	$70,353,157	$4,408,138	$37,778,272	$0	$275,010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$22,924,438	$135,739,015
Health Insurance Buy-In	$15,392	$26,934	$1,592,989	$0	$34,631	$0	$0	$0	$79,276	$0	$28,462	$11,543	$0	$0	$0	$1,789,227
Subtotal Insurance	**$70,368,549**	**$4,435,072**	**$39,371,261**	**$0**	**$309,641**	**$0**	**$0**	**$0**	**$79,276**	**$0**	**$28,462**	**$11,543**	**$0**	**$0**	**$22,924,438**	**$137,528,242**
Total Long-Term Care and Insurance	**$644,105,617**	**$58,060,353**	**$134,519,182**	**$400,180**	**$439,551**	**$0**	**$0**	**$0**	**$79,276**	**$0**	**$28,462**	**$11,543**	**$0**	**$0**	**$23,734,033**	**$861,378,197**
Class I Nursing Facility Supplemental Payments	$72,749,421	$6,290,888	$13,476,210	$63,978	$20,769	$0	$0	$0	$0	$0	$0	$0	$0	$0	$129,432	$92,730,698
Total Long-Term Care and Insurance Including Financing	**$716,855,038**	**$64,351,241**	**$147,995,392**	**$464,158**	**$460,320**	**$0**	**$0**	**$0**	**$79,276**	**$0**	**$28,462**	**$11,543**	**$0**	**$0**	**$23,863,465**	**$954,108,895**

FY 2015-16 Long-Term Care and Insurance Request																
FY 2015-16	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Class I Nursing Facilities	$463,567,112	$40,086,211	$85,871,856	$407,674	$132,343	$0	$0	$0	$0	$0	$0	$0	$0	$0	$824,756	$590,889,952
Class II Nursing Facilities	$539,407	$409,229	$3,762,825	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,711,461
Program for All-Inclusive Care for the Elderly	$122,689,658	$14,889,608	$7,602,247	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$145,181,513
Subtotal Long-Term Care	**$586,796,177**	**$55,385,048**	**$97,236,928**	**$407,674**	**$132,343**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$824,756**	**$740,782,926**
Supplemental Medicare Insurance Benefit	$72,593,730	$4,757,204	$39,557,714	$0	$316,259	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,796,912	$143,021,819
Health Insurance Buy-In	$20,772	$36,349	$2,149,838	$0	$46,737	$0	$0	$0	$106,988	$0	$38,411	$15,578	$0	$0	$0	$2,414,673
Subtotal Insurance	**$72,614,502**	**$4,793,553**	**$41,707,552**	**$0**	**$362,996**	**$0**	**$0**	**$0**	**$106,988**	**$0**	**$38,411**	**$15,578**	**$0**	**$0**	**$25,796,912**	**$145,436,492**
Total Long-Term Care and Insurance	**$659,410,679**	**$60,178,601**	**$138,944,480**	**$407,674**	**$495,339**	**$0**	**$0**	**$0**	**$106,988**	**$0**	**$38,411**	**$15,578**	**$0**	**$0**	**$26,621,668**	**$886,219,418**
Class I Nursing Facility Supplemental Payments	$75,390,225	$6,519,247	$13,965,396	$66,300	$21,523	$0	$0	$0	$0	$0	$0	$0	$0	$0	$134,131	$96,096,822
Total Long-Term Care and Insurance Including Financing	**$734,800,904**	**$66,697,848**	**$152,909,876**	**$473,974**	**$516,862**	**$0**	**$0**	**$0**	**$106,988**	**$0**	**$38,411**	**$15,578**	**$0**	**$0**	**$26,755,799**	**$982,316,240**

FY 2016-17 Long-Term Care and Insurance Request																
FY 2016-17	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Class I Nursing Facilities	$468,104,088	$40,478,539	$86,712,292	$411,664	$133,638	$0	$0	$0	$0	$0	$0	$0	$0	$0	$832,828	$596,673,049
Class II Nursing Facilities	$571,232	$433,374	$3,984,832	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,989,438
Program for All-Inclusive Care for the Elderly	$137,671,610	$16,444,814	$8,472,951	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$162,589,375
Subtotal Long-Term Care	**$606,346,930**	**$57,356,727**	**$99,170,075**	**$411,664**	**$133,638**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$832,828**	**$764,251,862**
Supplemental Medicare Insurance Benefit	$75,894,742	$5,098,736	$41,725,094	$0	$354,397	$0	$0	$0	$0	$0	$0	$0	$0	$0	$28,884,359	$151,957,328
Health Insurance Buy-In	$27,628	$48,346	$2,859,406	$0	$62,163	$0	$0	$0	$142,300	$0	$51,088	$20,720	$0	$0	$0	$3,211,651
Subtotal Insurance	**$75,922,370**	**$5,147,082**	**$44,584,500**	**$0**	**$416,560**	**$0**	**$0**	**$0**	**$142,300**	**$0**	**$51,088**	**$20,720**	**$0**	**$0**	**$28,884,359**	**$155,168,979**
Total Long-Term Care and Insurance	**$682,269,300**	**$62,503,809**	**$143,754,575**	**$411,664**	**$550,198**	**$0**	**$0**	**$0**	**$142,300**	**$0**	**$51,088**	**$20,720**	**$0**	**$0**	**$29,717,187**	**$919,420,841**
Class I Nursing Facility Supplemental Payments	$78,126,890	$6,755,896	$14,472,340	$68,707	$22,304	$0	$0	$0	$0	$0	$0	$0	$0	$0	$139,000	$99,585,137
Total Long-Term Care and Insurance Including Financing	**$760,396,190**	**$69,259,705**	**$158,226,915**	**$480,371**	**$572,502**	**$0**	**$0**	**$0**	**$142,300**	**$0**	**$51,088**	**$20,720**	**$0**	**$0**	**$29,856,187**	**$1,019,005,978**

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES

Class I Nursing Home Calculations for FY 2014-15, FY 2015-16 and FY 2016-17

FY 2014-15 Calculation

Service Expenditure:	Core Components	Reference
Estimate of FY 2014-15 General Fund Portion of Per Diem Rate	$204.69	Footnote 1
Estimate of FY 2014-15 Patient Payment (per day)	($36.33)	Footnote 1
Estimated FY 2014-15 Medicaid Reimbursement (per day)	**$168.36**	
Estimate of Patient Days (without Hospital Back Up)	3,474,682	Footnote 2
Total Estimated Costs for FY 2014-15 Days of Service	$584,997,411	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.86%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$543,228,596	
Estimated Expenditure for FY 2013-14 Dates of Service	$39,980,101	Footnote 5
Estimated Expenditure in FY 2014-15 Prior to Adjustments	**$583,208,697**	
Bottom Line Adjustments:		
Hospital Back Up Program	$7,172,066	Footnote 6
Recoveries from Department Overpayment Review	($1,600,000)	Footnote 7
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($8,163,270)	Footnote 8
Colorado Choice Transitions	($4,117,244)	Exhibit G
SB 14-130: "Increase Personal Care Allowance Nursing Facility"	$1,057,300	Footnote 9
Payment for Audit Findings Concerning Nursing Facility Supplemental Payments	$2,470,450	Footnote 10
Total Bottom Line Adjustments:	**($3,180,698)**	
Total Estimated FY 2014-15 General Fund Expenditure	**$580,027,999**	
Percentage Change in Core Component Expenditure Over Prior Year	3.15%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$45,483,952	Page EH-9
Prior Year Rate Reconciliation	$4,304,753	Page EH-9
Rate Cut Backfill	$0	Page EH-9
Cognitive Performance Scale	$767,427	Page EH-9
PASRR - Resident	$1,884,606	Page EH-9
PASRR - Facility	$539,519	Page EH-9
Medicaid Supplemental Payment	$33,000,199	Page EH-9
Pay for Performance	$6,750,242	Page EH-9
Total Estimated Supplemental Payments	**$92,730,698**	
Total Estimated FY 2014-15 Expenditure	**$672,758,697**	

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES

Class I Nursing Home Calculations for FY 2014-15, FY 2015-16 and FY 2016-17

FY 2015-16 Calculation

Service Expenditure:	**Core Components**	**Reference**
Estimate of FY 2015-16 General Fund Portion of Per Diem Rate	$210.29	Footnote 1
Estimate of FY 2015-16 Patient Payment (per day)	($36.88)	Footnote 1
Estimated FY 2015-16 Medicaid Reimbursement (per day)	**$173.41**	
Estimate of Patient Days (without Hospital Back Up)	3,484,719	Footnote 2
Total Estimated Costs for FY 2015-16 Days of Service	$604,285,075	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.86%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$561,139,121	
Estimated Expenditure for FY 2014-15 Dates of Service	$41,768,815	Footnote 5
Estimated Expenditure in FY 2015-16 Prior to Adjustments	**$602,907,936**	
Bottom Line Adjustments:		
Hospital Back Up Program	$7,788,505	Footnote 6
Recoveries from Department Overpayment Review	($1,658,080)	Footnote 7
Savings from days incurred in FY 2013-14 and paid in FY 2014-15 under HB 13-1152	($627,675)	Footnote 8
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($8,445,725)	Footnote 8
Colorado Choice Transitions	($10,663,249)	Exhibit G
SB 14-130: "Increase Personal Care Allowance Nursing Facility"	$1,588,240	Footnote 9
Total Bottom Line Adjustments:	**($12,017,984)**	
Total Estimated FY 2015-16 Expenditure	**$590,889,952**	
Percentage Change in Core Component Expenditure Over Prior Year	1.87%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$39,492,725	Page EH-9
Prior Year Rate Reconciliation	$8,879,183	Page EH-9
Rate Cut Backfill	$0	Page EH-9
Cognitive Performance Scale	$1,016,231	Page EH-9
PASRR - Resident	$3,400,026	Page EH-9
PASRR - Facility	$505,191	Page EH-9
Medicaid Supplemental Payment	$35,152,212	Page EH-9
Pay for Performance	$7,651,254	Page EH-9
Total Estimated Supplemental Payments	**$96,096,822**	
Total Estimated FY 2015-16 Expenditure	**$686,986,774**	

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES

Class I Nursing Home Calculations for FY 2014-15, FY 2015-16 and FY 2016-17
FY 2016-17 Calculation

Service Expenditure:	Core Components	Reference
Estimate of FY 2016-17 General Fund Portion of Per Diem Rate	$216.04	Footnote 1
Estimate of FY 2016-17 Patient Payment (per day)	($37.43)	Footnote 1
Estimated FY 2016-17 Medicaid Reimbursement (per day)	**$178.61**	
Estimate of Patient Days (without Hospital Back Up)	3,475,233	Footnote 2
Total Estimated Costs for FY 2016-17 Days of Service	$620,711,442	Footnote 3
Estimated Percentage of Claims Paid in Current Year with Current Year Dates of Service	92.86%	Footnote 4
Estimated Expenditure for Claims Paid in Current Year with Current Year Dates of Service	$576,392,645	
Estimated Expenditure for FY 2015-16 Dates of Service	$43,145,954	Footnote 5
Estimated Expenditure in FY 2016-17 Prior to Adjustments	**$619,538,599**	
Bottom Line Adjustments:		
Hospital Back Up Program	$8,457,927	Footnote 6
Recoveries from Department Overpayment Review	($1,718,268)	Footnote 7
Savings from days incurred in FY 2014-15 and paid in FY 2015-16 under HB 13-1152	($649,391)	Footnote 8
HB 13-1152 1.5% permanent rate reduction effective July 1, 2013	($8,680,904)	Footnote 8
Colorado Choice Transitions	($20,274,914)	Exhibit G
Total Bottom Line Adjustments:	**($22,865,550)**	
Total Estimated FY 2016-17 Expenditure	**$596,673,049**	
Percentage Change in Core Component Expenditure Over Prior Year	0.98%	
Supplemental Payments from Nursing Facility Provider Fund:		
Growth Beyond General Fund Cap	$40,926,310	Page EH-9
Prior Year Rate Reconciliation	$9,201,497	Page EH-9
Rate Cut Backfill	$0	Page EH-9
Cognitive Performance Scale	$1,053,120	Page EH-9
PASRR - Resident	$3,523,447	Page EH-9
PASRR - Facility	$523,530	Page EH-9
Medicaid Supplemental Payment	$36,428,238	Page EH-9
Pay for Performance	$7,928,995	Page EH-9
Total Estimated Supplemental Payments	**$99,585,137**	
Total Estimated FY 2016-17 Expenditure	**$696,258,186**	

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES
Footnotes and Assumptions

Class I Nursing Home Calculations for FY 2014-15 , FY 2015-16 and FY 2016-17 Footnotes:

(1) Per HB 08-1114 and SB 09-263, the Department implemented significant changes in the reimbursement rate methodology for nursing facilities. Beginning in FY 2008-09, instead of reimbursement based on an overall per diem rate, facilities are reimbursed based on a per diem rate for core components as well as supplemental per diem rates for eligible facilities. The core components include fair rental value; direct and indirect health care; and administrative and general costs. Supplemental payments are made for providers who have residents with moderate to severe mental health conditions, cognitive dementia, or acquired brain injury; and to providers who meet performance standards. In addition, supplemental payments are made for growth above the General Fund growth cap and as a provider fee offset. The following table includes the historical per diem reimbursement rates and the estimated and projected per diem rates for FY 2002-03 through FY 2016-17. The Core Per Diem less patient payment represents the General Fund portion of nursing facility reimbursement. It is to this figure that the General Fund Growth cap outlined in statute is applied.

Year	Per Diem	Patient Payment	Final Paid Rate	Rate Reduction	Per Diem Before Rate Reduction
FY 2002-03	$131.06	$24.75	$106.31	-	$131.06
FY 2003-04	$143.49	$24.93	$118.56	-	$143.49
FY 2004-05	$150.15	$25.89	$124.26	-	$150.15
FY 2005-06	$157.34	$27.52	$129.82	-	$157.34
FY 2006-07	$166.30	$30.25	$136.05	-	$166.30
FY 2007-08	$169.28	$31.20	$138.08	-	$169.28
FY 2008-09	$190.34	$33.10	$157.24	-	$190.34
FY 2009-10	$178.91	$33.57	$145.34	0.50%	$179.81
FY 2010-11	$173.57	$33.22	$140.35	2.50%	$178.02
FY 2011-12	$183.73	$34.19	$149.54	1.50%	$186.53
FY 2012-13	$189.08	$35.24	$153.84	1.50%	$191.96
FY 2013-14	$196.75	$35.75	$161.00	1.50%	$199.75
Estimated FY 2014-15	$202.16	$36.33	$165.83	1.50%	$204.69
Estimated FY 2015-16	$207.68	$36.88	$170.80	1.50%	$210.29
Estimated FY 2016-17	$213.35	$37.43	$175.92	1.50%	$216.04

(2) The patient days estimate is a trended value using incurred but not reported (IBNR) adjusted data. Values for prior years differ slightly from prior Budget Requests due to the inclusion of claims paid between those Requests and this Request. Hospital Back Up days are removed from this calculation. Because FY 2015-16 is a leap year, estimated patient days for FY 2015-16 are inflated to account for an additional calendar day; this adds approximately 9,300 days to the projection.

Fiscal Year	Patient Days	Percentage Change	Full Time Equivalent Clients	Percentage Change
FY 2000-01	3,712,731	-	10,172	-
FY 2001-02	3,618,218	-2.55%	9,913	-2.55%
FY 2002-03	3,538,295	-2.21%	9,694	-2.21%
FY 2003-04	3,502,849	-1.00%	9,571	-1.27%
FY 2004-05	3,519,234	0.47%	9,642	0.74%
FY 2005-06	3,529,589	0.29%	9,670	0.29%
FY 2006-07	3,546,807	0.49%	9,717	0.49%
FY 2007-08	3,435,003	-3.15%	9,385	-3.42%
FY 2008-09	3,427,547	-0.22%	9,391	0.06%
FY 2009-10	3,452,652	0.73%	9,459	0.72%
FY 2010-11	3,527,750	2.18%	9,665	2.18%
FY 2011-12	3,502,556	-0.71%	9,570	-0.98%
FY 2012-13	3,470,526	-0.91%	9,508	-0.65%
FY 2013-14	3,477,863	0.21%	9,528	0.21%
Estimated FY 2014-15	3,474,682	-0.09%	9,520	-0.08%
Estimated FY 2015-16	3,484,719	0.29%	9,521	0.01%
Estimated FY 2016-17	3,475,233	-0.27%	9,521	0.00%

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

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

Estimate of Claims Incurred and Paid in the Same Fiscal Year

Month Incurred	Additional Months Until End of Fiscal Year	Estimated Percent Complete at End of Fiscal Year (IBNR Factor)
July	11	99.89%
August	10	99.85%
September	9	99.78%
October	8	99.68%
November	7	99.53%
December	6	99.27%
January	5	98.89%
February	4	98.27%
March	3	97.02%
April	2	94.80%
May	1	90.30%
June	-	36.99%
Average		92.86%

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

(5) As calculated in the table below, the estimated FY 2013-14 expenditure for core components with FY 2012-13 dates of service is the estimated FY 2012-13 core components per diem rate, less the estimated per diem patient payment rate, multiplied by the estimated number of patient days. This calculation is then multiplied by one minus the calculated IBNR rate.

Calculation of Expenditure From Claims in Previous Fiscal Year	FY 2013-14	Source
IBNR Factor	92.86%	Footnote (4)
Estimated Patient Days from previous fiscal year	3,477,863	Footnote (2)
Estimated Per Diem Rate for Core Components for previous fiscal year	$196.75	Footnote (1)
Less: Estimated Patient Payment Rate for previous fiscal year	$35.75	Footnote (1)
Estimated claims expenditure for core components from previous fiscal year to be paid in the current fiscal year	$39,980,101	As described in Footnote (5) narrative

(6) Hospital Back Up and out of state placements are programs where the Department pays a much higher per diem for specialized clients which can be several times the statewide average Nursing Facilities Medicaid reimbursement rate. This is an intermediate level of care in between the hospital and a skilled nursing facility. Types of clients treated under this program include ventilator, wound care, medically complex and traumatic brain injury with severe behaviors. This group is difficult to budget for due to the fluctuation in client base. FY 2007-08 expenditure was lower than previous years due to a facility which was placed under a "Denial of Payment for New Admissions" status for failure to comply with certain standards, although this has since been rectified. In FY 2008-09, expenditure rose sharply due to an increase in billed patient days. In FY 2009-10 no facilities were accepting new clients. In FY 2010-11 one new client was added to the program. In FY 2013-14, there was a spike in enrollment. The Department is unsure if this enrollment trend will continue in the future. Currently, the Department is working to evaluate the efficacy and design of the HBU program. As the Department continues through this process, client admission into the program will be evaluated on a case by case basis.

Fiscal Year	Hospital Back Up	Percent Difference
FY 2003-04	$4,907,936	-
FY 2004-05	$5,731,131	16.77%
FY 2005-06	$5,033,659	-12.17%
FY 2006-07	$5,615,794	11.56%
FY 2007-08	$5,309,178	-5.46%
FY 2008-09	$6,920,964	30.36%
FY 2009-10	$4,376,832	-36.76%
FY 2010-11	$4,731,471	8.10%
FY 2011-12	$3,549,186	-24.99%
FY 2012-13	$4,284,618	20.72%
FY 2013-14	$6,604,416	54.14%
Estimated FY 2014-15	$7,172,066	8.60%
Estimated FY 2015-16	$7,788,505	8.60%
Estimated FY 2016-17	$8,457,927	8.60%

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

(7) Overpayment review recoveries are amounts that the Department recovers from nursing homes. The Department contracted with a contingency based contractor to do a five year historical audit of all the facilities, and the contract expired at the end of FY 2005-06. The Department continues to do internal audits of nursing facilities, and estimates that, on average, each audit recovers approximately $19,458.

Fiscal Year	Overpayment Recoveries	Percent Difference
FY 2010-11	$1,797,766	-
FY 2011-12	$2,063,191	14.76%
FY 2012-13	$1,751,203	-15.12%
FY 2013-14	$1,363,500	-22.14%
Estimated FY 2014-15	$1,600,000	17.35%
Estimated FY 2015-16	$1,658,080	3.63%
Estimated FY 2016-17	$1,718,268	3.63%

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES
Footnotes and Assumptions

(8) HB 10-1324 imposed a rate reduction of 1.5% effective March 1, 2010 and effective until June 30, 2011. HB 10-1379 imposed a rate reduction of 1% in addition to the rate reduction of HB 10-1324 for the period of July 1, 2010 to June 30, 2011. SB 11-215 imposed a rate reduction of 1.5% effective July 1, 2011 for FY 2011-12 that was extended for FY 2012-13 by HB 12-1340. HB 13-1152 extended the 1.5% rate reduction indefinitely, effective July 1, 2013. The rate reductions apply to all days incurred under the effective periods of each bill. As not all days will be reported in the fiscal year in which they are incurred, the impact of the rate cuts extends over multiple fiscal years. The tables below show the incremental impact of the two bills. These figures may vary from previous submissions of the Department's requests due to revised forecasts for rates and patient days.

HB 13-1152	Rate Reduction	Per Diem before Reduction	Per Diem After Reduction	Per Diem Impact of Reduction
Estimated FY 2014-15 Rates	1.50%	$204.69	$202.16	($2.53)
Estimated FY 2014-15 Patient Days				3,474,682
Estimated FY 2014-15 Days Paid in FY 2014-15				3,226,589
Total FY 2014-15 Impact				**($8,163,270)**
Estimated FY 2014-15 Days Paid in FY 2015-16				248,093
FY 2015-16 Impact from Carryover from FY 2014-15				($627,675)
Estimated FY 2015-16 Rates	1.50%	$210.29	$207.68	($2.61)
Estimated FY 2015-16 Patient Days				3,484,719
Estimated FY 2015-16 Days Paid in FY 2015-16				3,235,910
FY 2015-16 Impact from FY 2015-16				($8,445,725)
Total FY 2015-16 Impact				**($9,073,400)**
Estimated FY 2015-16 Days Paid in FY 2016-17				248,809
FY 2016-17 Impact from Carryover from FY 2015-16				($649,391)
Estimated FY 2016-17 Rates	1.50%	$216.04	$213.35	($2.69)
Estimated FY 2016-17 Patient Days				3,475,233
Estimated FY 2016-17 Days Paid in FY 2016-17				3,227,102
FY 2016-17 Impact from FY 2016-17				($8,680,904)
Total FY 2016-17 Impact				**($9,330,295)**

(9) SB 14-130 raises the basic minimum amount payable for personal needs to any recipient admitted to a nursing facility or intermediate care facility for intellectuals with disabilities from $50.00 to $75.00, monthly.

(10) A July 2014 audit review on the nursing facility supplemental payments from July 1, 2009 to June 30, 2012, resulted in the finding that the state incorrectly calculated prospective payment amounts, resulting in overpayments to facilities. The federal share of the overpayments totaled $2,470,450, which must be reimbursed to the federal government and is a General Fund only payment.

Exhibit H - LONG TERM CARE - CLASS I NURSING FACILITIES
Supplemental Payments

Class I Nursing Facilities Supplemental Payments											
Year	Provider Fee Per Non Medicare Day Paid by Low Medicaid Volume Facilities	Provider Fee Per Non Medicare Day Paid by High Medicaid Volume Facilities	Growth Beyond General Fund Cap	Prior Year Rate Reconciliation	Rate Cut Backfill	Cognitive Performance Scale	PASRR - Resident(1)	PASRR - Facility(1)	Medicaid Supplemental Payment	Pay for Performance	Total Effective Add-on/ Supplemental
FY 2009-10	$5.90	$0.28	$31,277,211	$0	$2,995,689	$958,621	$2,713,717	$418,432	$12,830,094	$2,525,948	**$53,719,712**
FY 2010-11	$7.62	$1.17	$48,220,038	$6,575,460	$0	$81,245	$198,782	$49,344	$17,743,388	$1,174,416	**$74,042,673**
FY 2011-12	$12.35	$1.90	$43,446,400	$5,277,654	$0	$807,125	$2,773,147	$641,003	$29,614,476	$4,227,680	**$86,787,485**
FY 2012-13	$12.67	$1.95	$34,456,677	$7,746,924	$0	$886,643	$2,966,460	$440,770	$30,669,660	$6,675,579	**$83,842,713**
FY 2013-14	$12.96	$1.99	$40,051,460	$5,697,344	$0	$630,925	$2,796,344	$686,768	$32,429,057	$6,067,966	**$88,359,864**
Projected FY 2014-15	$13.30	$2.04	$45,483,952	$4,304,753	$0	$767,427	$1,884,606	$539,519	$33,000,199	$6,750,242	**$92,730,698**
Projected FY 2015-16	$13.78	$2.11	$39,492,725	$8,879,183	$0	$1,016,231	$3,400,026	$505,191	$35,152,212	$7,651,254	**$96,096,822**
Projected FY 2016-17	$14.28	$2.19	$40,926,310	$9,201,497	$0	$1,053,120	$3,523,447	$523,530	$36,428,238	$7,928,995	**$99,585,137**
Class I Nursing Facilities Supplemental Payments - Percent Change											
Year	Provider Fee Per Non Medicare Day Paid by Low Medicaid Volume Facilities	Provider Fee Per Non Medicare Day Paid by High Medicaid Volume Facilities	Growth Beyond General Fund Cap	Prior Year Rate Reconciliation	Rate Cut Backfill	Cognitive Performance Scale	PASRR - Resident(1)	PASRR - Facility(1)	Medicaid Supplemental Payment	Pay for Performance	Total Effective Add-on/ Supplemental
FY 2010-11	29.24%	317.86%	54.17%	-	-100.00%	-91.52%	-92.67%	-88.21%	38.30%	-53.51%	**37.83%**
FY 2011-12	61.97%	62.4%	-9.90%	-19.74%	-	893.45%	1295.07%	1199.05%	66.90%	259.98%	**17.21%**
FY 2012-13	2.59%	2.6%	-20.69%	46.79%	-	9.85%	6.97%	-31.24%	3.56%	57.90%	**-3.39%**
FY 2013-14	2.29%	2.1%	16.24%	-26.46%	-	-28.84%	-5.73%	55.81%	5.74%	-9.10%	**5.39%**
Projected FY 2014-15	2.62%	2.5%	13.56%	-24.44%	-	21.64%	-32.60%	-21.44%	1.76%	11.24%	**4.95%**
Projected FY 2014-15	3.61%	3.4%	-13.17%	106.26%	-	32.42%	80.41%	-6.36%	6.52%	13.35%	**3.63%**
Projected FY 2015-16	3.63%	3.8%	3.63%	3.63%	-	3.63%	3.63%	3.63%	3.63%	3.63%	**3.63%**

(1)PASRR: Preadmission Screening and Resident Review

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

Cash Based Actuals

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$370,539,529	$22,631,623	$63,039,217	$0	($10,541)	$0	$0	$0	$1,810	$0	$0	$0	$0	$0	$318,690	$456,520,328
FY 2006-07	$384,275,629	$24,171,304	$68,903,820	$0	$1,596	$0	$0	$0	$0	$0	$0	$0	$0	$0	$951,138	$478,303,487
FY 2007-08	$389,399,454	$25,395,243	$69,952,848	$0	$6,325	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,814,628	$486,568,498
FY 2008-09	$423,682,370	$29,953,087	$77,004,135	$0	$22,194	$0	$0	$0	$0	$0	$0	$0	$0	$0	$256,886	$530,918,672
FY 2009-10 (DA)	$393,028,828	$28,956,277	$73,847,716	$0	$5,285	$0	$0	$0	$0	$0	$0	$0	$0	$0	$62,685	$495,900,792
FY 2010-11 (DA)	$390,609,241	$31,625,232	$76,509,001	$0	$7,615	$0	$0	$0	$0	$0	$0	$0	$0	$0	$564,302	$499,315,391
FY 2011-12	$411,201,009	$33,559,826	$76,088,316	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$395,618	$521,244,769
FY 2012-13	$418,131,480	$35,559,417	$78,452,737	$0	$0	$0	$12,430	$0	$0	$0	$0	$0	$0	$0	$249,186	$532,405,250
FY 2013-14	$440,587,143	$38,148,380	$81,720,674	$387,966	$125,945	$0	$570,397	$0	$0	$0	$0	$0	$0	$0	$784,886	$562,325,391
Estimated FY 2014-15	$455,045,653	$39,349,332	$84,293,329	$400,180	$129,910	$0	$0	$0	$0	$0	$0	$0	$0	$0	$809,595	$580,027,999
Estimated FY 2015-16	$463,567,112	$40,086,211	$85,871,856	$407,674	$132,343	$0	$0	$0	$0	$0	$0	$0	$0	$0	$824,756	$590,889,952
Estimated FY 2016-17	$468,104,088	$40,478,539	$86,712,292	$411,664	$133,638	$0	$0	$0	$0	$0	$0	$0	$0	$0	$832,828	$596,673,049

Percent Change in Cash Based Actuals

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	3.71%	6.80%	9.30%	0.00%	-115.14%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	198.45%	4.77%
FY 2007-08	1.33%	5.06%	1.52%	0.00%	296.31%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	90.78%	1.73%
FY 2008-09	8.80%	17.95%	10.08%	0.00%	250.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-85.84%	9.11%
FY 2009-10 (DA)	-7.24%	-3.33%	-4.10%	0.00%	-76.19%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-75.60%	-6.60%
FY 2010-11 (DA)	-0.62%	9.22%	3.60%	0.00%	44.08%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	800.21%	0.69%
FY 2011-12	5.27%	6.12%	-0.55%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-29.89%	4.39%
FY 2012-13	1.69%	5.96%	3.11%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-37.01%	2.14%
FY 2013-14	5.37%	7.28%	4.17%	0.00%	0.00%	0.00%	4488.87%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	214.98%	5.62%
Estimated FY 2014-15	3.28%	3.15%	3.15%	3.15%	3.15%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.15%	3.15%
Estimated FY 2015-16	1.87%	1.87%	1.87%	1.87%	1.87%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.87%	1.87%
Estimated FY 2016-17	0.98%	0.98%	0.98%	0.98%	0.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.98%	0.98%

Per Capita Cost

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$10,233.92	$3,745.72	$1,317.30	$0.00	($0.18)	$0.00	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$0.00	$28.73	$1,135.01
FY 2006-07	$10,707.64	$3,989.32	$1,411.99	$0.00	$0.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$73.69	$1,219.45
FY 2007-08	$10,731.99	$4,132.00	$1,400.93	$0.00	$0.12	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$127.66	$1,241.37
FY 2008-09	$11,262.46	$4,646.05	$1,499.45	$0.00	$0.36	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.04	$1,215.44
FY 2009-10 (DA)	$10,211.99	$4,107.86	$1,386.45	$0.00	$0.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.94	$994.19
FY 2010-11 (DA)	$10,046.79	$4,071.74	$1,359.31	$0.00	$0.09	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$33.02	$890.49
FY 2011-12	$10,347.28	$4,003.32	$1,280.22	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$20.96	$840.77
FY 2012-13	$10,241.54	$3,928.78	$1,267.00	$0.00	$0.00	$0.00	$1.17	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$11.75	$779.52
FY 2013-14	$10,531.29	$3,871.75	$1,268.48	$151.55	$1.01	$0.00	$6.54	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$33.57	$653.14
Estimated FY 2014-15	$10,851.99	$3,630.68	$1,264.75	$108.16	$0.83	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$29.70	$514.91
Estimated FY 2015-16	$10,765.61	$3,503.43	$1,243.76	$93.52	$0.77	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$27.69	$483.60
Estimated FY 2016-17	$10,632.69	$3,380.25	$1,217.78	$83.15	$0.71	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$25.55	$453.37

Percent Change in Per Capita Cost

CLASS I NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	4.63%	6.50%	7.19%	0.00%	-116.67%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	156.49%	7.44%
FY 2007-08	0.23%	3.58%	-0.78%	0.00%	300.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	73.24%	1.80%
FY 2008-09	4.94%	12.44%	7.03%	0.00%	200.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-86.65%	-2.09%
FY 2009-10 (DA)	-9.33%	-11.58%	-7.54%	0.00%	-80.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-76.88%	-18.20%
FY 2010-11 (DA)	-1.62%	-0.88%	-1.96%	0.00%	28.57%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	738.07%	-10.43%
FY 2011-12	2.99%	-1.68%	-5.82%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-36.52%	-5.58%
FY 2012-13	-1.02%	-1.86%	-1.03%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-43.94%	-7.28%
FY 2013-14	2.83%	-1.45%	0.12%	100.00%	100.00%	0.00%	458.97%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	185.70%	-16.21%
Estimated FY 2014-15	3.05%	-6.23%	-0.29%	-28.63%	-17.82%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-11.53%	-21.16%
Estimated FY 2015-16	-0.80%	-3.50%	-1.66%	-13.54%	-7.23%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-6.77%	-6.08%
Estimated FY 2016-17	-1.23%	-3.52%	-2.09%	-11.09%	-7.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-7.73%	-6.25%

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

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

Cash Based Actuals

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$69,154	$0	$1,367,696	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,436,850
FY 2006-07	$106,064	$27,660	$2,100,702	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,710	$2,270,136
FY 2007-08	$74,970	$191,024	$1,924,394	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$45,248	$2,235,636
FY 2008-09	$0	$335,754	$1,935,960	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,271,714
FY 2009-10 (DA)	($38,446)	$264,098	$989,694	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,215,347
FY 2010-11 (DA)	($84,407)	$729,155	$2,518,445	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,163,194
FY 2011-12	$0	$583,751	$1,915,323	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,499,074
FY 2012-13	$180,939	$825,327	$4,101,296	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,107,562
FY 2013-14	$393,954	$298,879	$2,748,163	$0	$0	$0	$43,770	$0	$0	$0	$0	$0	$0	$0	$0	$3,484,766
Estimated FY 2014-15	$482,475	$366,037	$3,365,675	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,214,187
Estimated FY 2015-16	$539,407	$409,229	$3,762,825	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,711,461
Estimated FY 2016-17	$571,232	$433,374	$3,984,832	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,989,438

Percent Change in Cash Based Actuals

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	53.37%	-	53.59%	-	-	-	-	-	-	-	-	-	-	-	-	57.99%
FY 2007-08	-29.32%	590.61%	-8.39%	-	-	-	-	-	-	-	-	-	-	-	26.71%	-1.52%
FY 2008-09	-100.00%	75.77%	0.60%	-	-	-	-	-	-	-	-	-	-	-	-100.00%	1.61%
FY 2009-10 (DA)	-	-21.34%	-48.88%	-	-	-	-	-	-	-	-	-	-	-	-	-46.50%
FY 2010-11 (DA)	119.55%	176.09%	154.47%	-	-	-	-	-	-	-	-	-	-	-	-	160.27%
FY 2011-12	-100.00%	-19.94%	-23.95%	-	-	-	-	-	-	-	-	-	-	-	-	-21.00%
FY 2012-13	-	41.38%	114.13%	-	-	-	-	-	-	-	-	-	-	-	-	104.38%
FY 2013-14	117.73%	-63.79%	-32.99%	-	-	-	-	-	-	-	-	-	-	-	-	-31.77%
Estimated FY 2014-15	22.47%	22.47%	22.47%	-	-	-	-100.00%	-	-	-	-	-	-	-	-	20.93%
Estimated FY 2015-16	11.80%	11.80%	11.80%	-	-	-	-	-	-	-	-	-	-	-	-	11.80%
Estimated FY 2016-17	5.90%	5.90%	5.90%	-	-	-	-	-	-	-	-	-	-	-	-	5.90%

Per Capita Cost

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$1.91	$0.00	$28.58	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.57
FY 2006-07	$2.96	$4.57	$43.05	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.77	$5.79
FY 2007-08	$2.07	$31.08	$38.54	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.18	$5.70
FY 2008-09	$0.00	$52.08	$37.70	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.20
FY 2009-10 (DA)	($1.00)	$37.47	$18.58	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$2.44
FY 2010-11 (DA)	($2.17)	$93.88	$44.74	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.64
FY 2011-12	$0.00	$69.64	$32.23	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.03
FY 2012-13	$4.43	$91.19	$66.24	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.48
FY 2013-14	$9.42	$30.33	$42.66	$0.00	$0.00	$0.00	$0.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$4.05
Estimated FY 2014-15	$11.51	$33.77	$50.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.74
Estimated FY 2015-16	$12.53	$35.77	$54.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.86
Estimated FY 2016-17	$12.98	$36.19	$55.96	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.79

Percent Change in Per Capita Cost

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	54.97%	-	50.63%	-	-	-	-	-	-	-	-	-	-	-	-	62.18%
FY 2007-08	-30.07%	580.09%	-10.48%	-	-	-	-	-	-	-	-	-	-	-	14.80%	-1.55%
FY 2008-09	-100.00%	67.57%	-2.18%	-	-	-	-	-	-	-	-	-	-	-	-100.00%	-8.77%
FY 2009-10 (DA)	-	-28.05%	-50.72%	-	-	-	-	-	-	-	-	-	-	-	-	-53.08%
FY 2010-11 (DA)	117.00%	150.55%	140.80%	-	-	-	-	-	-	-	-	-	-	-	-	131.15%
FY 2011-12	-100.00%	-25.82%	-27.96%	-	-	-	-	-	-	-	-	-	-	-	-	-28.55%
FY 2012-13	-	30.94%	105.52%	-	-	-	-	-	-	-	-	-	-	-	-	85.61%
FY 2013-14	112.64%	-66.74%	-35.60%	-	-	-	-	-	-	-	-	-	-	-	-	-45.86%
Estimated FY 2014-15	22.19%	11.34%	18.38%	-	-	-	-100.00%	-	-	-	-	-	-	-	-	-7.65%
Estimated FY 2015-16	8.86%	5.92%	7.92%	-	-	-	-	-	-	-	-	-	-	-	-	3.21%
Estimated FY 2016-17	3.59%	1.17%	2.68%	-	-	-	-	-	-	-	-	-	-	-	-	-1.81%

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

CLASS II NURSING FACILITIES	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Current Year Projection																
FY 2013-14 Expenditure	$393,954	$298,879	$2,748,163	$0	$0	$0	$43,770	$0	$0	$0	$0	$0	$0	$0	$0	$3,484,766
Percentage Selected to Modify Expenditure(1)	22.47%	22.47%	22.47%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	20.93%
Estimated FY 2014-15 Base Expenditure	$482,475	$366,037	$3,365,675	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,214,187
Bottom Line Impacts																
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2014-15 Total Expenditure	**$482,475**	**$366,037**	**$3,365,675**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,214,187**
Estimated FY 2014-15 Per Capita	$11.51	$33.77	$50.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.74
% Change over FY 2013-14 Per Capita	22.19%	11.34%	18.38%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-7.65%
Request Year Projection																
FY 2014-15 Expenditure	$482,475	$366,037	$3,365,675	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,214,187
Percentage Selected to Modify Expenditure(1)	11.80%	11.80%	11.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.80%
Estimated FY 2015-16 Base Expenditure	$539,407	$409,229	$3,762,825	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,711,461
Bottom Line Impacts																
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2015-16 Total Expenditure	**$539,407**	**$409,229**	**$3,762,825**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,711,461**
Estimated FY 2015-16 Per Capita	$12.25	$34.17	$52.84	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.58
% Change over FY 2014-15 Per Capita	6.43%	1.18%	4.63%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-4.28%
Out Year Projection																
FY 2015-16 Expenditure	$539,407	$409,229	$3,762,825	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,711,461
Percentage Selected to Modify Expenditure(1)	5.90%	5.90%	5.90%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.90%
Estimated FY 2016-17 Base Expenditure	$571,232	$433,374	$3,984,832	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$4,989,438
Bottom Line Impacts																
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2016-17 Total Expenditure	**$571,232**	**$433,374**	**$3,984,832**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$4,989,438**
Estimated FY 2016-17 Per Capita	$12.98	$36.19	$55.96	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.79
% Change over FY 2015-16 Per Capita	5.96%	5.91%	5.90%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.87%

Footnotes

(1) The percentages selected to trend expenditure for FY 2014-15, FY 2015-16, and FY 2016-17 are 22.47%, 11.80%, and 5.90% respectively. These trends are equal to the percentage change in per diem rates as determined by audited costs by the Department's rate contractor with reduced growth over time.
Despite the drop in expenditure in the most recent year, the per diem rate for FY 2014-15 is known at this time and has increased over the previous per diem rate. FY 2015-16 and FY 2016-17 have been calculated with positive growth that decreases over time.

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

Cash Based Actuals

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$35,666,638	$2,962,484	$1,841,368	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$40,470,490
FY 2006-07	$37,878,793	$3,182,900	$1,810,588	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$42,872,281
FY 2007-08	$44,272,143	$3,549,809	$1,596,904	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$49,418,856
FY 2008-09	$54,470,714	$4,395,937	$2,183,184	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$61,049,835
FY 2009-10 (DA)	$61,924,560	$4,986,130	$2,345,339	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$69,256,029
FY 2010-11 (DA)	$73,232,307	$7,892,082	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$84,414,277
FY 2011-12	$73,671,387	$8,052,921	$3,756,277	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$85,480,585
FY 2012-13	$84,386,436	$8,794,508	$4,165,414	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$97,346,358
FY 2013-14	$85,832,165	$10,249,500	$4,393,152	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$100,474,817
Estimated FY 2014-15	$118,208,940	$13,909,912	$7,488,917	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$139,607,769
Estimated FY 2015-16	$122,689,658	$14,889,608	$7,602,247	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$145,181,513
Estimated FY 2016-17	$137,671,610	$16,444,814	$8,472,951	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$162,589,375

Percent Change in Cash Based Actuals

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	6.20%	7.44%	-1.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.93%
FY 2007-08	16.88%	11.53%	-11.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.27%
FY 2008-09	23.04%	23.84%	36.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	23.54%
FY 2009-10 (DA)	13.68%	13.43%	7.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.44%
FY 2010-11 (DA)	18.26%	58.28%	40.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	21.89%
FY 2011-12	0.60%	2.04%	14.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.26%
FY 2012-13	14.54%	9.21%	10.89%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.88%
FY 2013-14	1.71%	16.54%	5.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.21%
Estimated FY 2014-15	37.72%	35.71%	70.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	38.95%
Estimated FY 2015-16	3.79%	7.04%	1.51%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.99%
Estimated FY 2016-17	12.21%	10.44%	11.45%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.99%

Per Capita Cost

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$985.08	$490.32	$38.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$100.62
FY 2006-07	$1,055.47	$525.32	$37.10	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$109.30
FY 2007-08	$1,220.16	$577.58	$31.98	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$126.08
FY 2008-09	$1,447.96	$681.86	$42.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$139.76
FY 2009-10 (DA)	$1,608.97	$707.35	$44.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$138.85
FY 2010-11 (DA)	$1,883.60	$1,016.10	$58.45	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$150.55
FY 2011-12	$1,853.83	$960.63	$63.20	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$137.88
FY 2012-13	$2,066.93	$971.66	$67.27	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$142.53
FY 2012-13	$2,051.63	$1,040.24	$68.19	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$116.70
Estimated FY 2014-15	$2,819.06	$1,283.44	$112.37	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$123.93
Estimated FY 2015-16	$2,849.27	$1,301.31	$110.11	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$118.82
Estimated FY 2016-17	$3,127.12	$1,373.26	$118.99	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$123.54

Percent Change in Per Capita Cost

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	7.15%	7.14%	-3.59%	-	-	-	-	-	-	-	-	-	-	-	-	8.63%
FY 2007-08	15.60%	9.95%	-13.80%	-	-	-	-	-	-	-	-	-	-	-	-	15.35%
FY 2008-09	18.67%	18.05%	32.93%	-	-	-	-	-	-	-	-	-	-	-	-	10.85%
FY 2009-10 (DA)	11.12%	3.74%	3.58%	-	-	-	-	-	-	-	-	-	-	-	-	-0.65%
FY 2010-11 (DA)	17.07%	43.65%	32.75%	-	-	-	-	-	-	-	-	-	-	-	-	8.43%
FY 2011-12	-1.58%	-5.46%	8.13%	-	-	-	-	-	-	-	-	-	-	-	-	-8.42%
FY 2012-13	11.50%	1.15%	6.44%	-	-	-	-	-	-	-	-	-	-	-	-	3.37%
FY 2013-14	-0.74%	7.06%	1.37%	-	-	-	-	-	-	-	-	-	-	-	-	-18.12%
Estimated FY 2014-15	37.41%	23.38%	64.79%	-	-	-	-	-	-	-	-	-	-	-	-	6.20%
Estimated FY 2015-16	1.07%	1.39%	-2.01%	-	-	-	-	-	-	-	-	-	-	-	-	-4.12%
Estimated FY 2016-17	9.75%	5.53%	8.06%	-	-	-	-	-	-	-	-	-	-	-	-	3.97%

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

PACE Enrollment and Cost Per Enrollee																
PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
PACE Average Monthly Paid Enrollment[1]																
FY 2006-07	1,020	69	40	-	-	-	-	-	-	-	-	-	-	-	-	1,129
FY 2007-08	1,121	82	37	-	-	-	-	-	-	-	-	-	-	-	-	1,240
FY 2008-09	1,273	100	49	-	-	-	-	-	-	-	-	-	-	-	-	1,422
FY 2009-10 (DA)	1,439	120	60	-	-	-	-	-	-	-	-	-	-	-	-	1,619
FY 2010-11 (DA)	1,600	171	75	-	-	-	-	-	-	-	-	-	-	-	-	1,846
FY 2011-12	1,754	204	96	-	-	-	-	-	-	-	-	-	-	-	-	2,054
FY 2012-13	2,047	238	117	-	-	-	-	-	-	-	-	-	-	-	-	2,402
FY 2013-14	1,924	232	101	-	-	-	-	-	-	-	-	-	-	-	-	2,257
Estimated FY 2014-15	2,361	293	148	-	-	-	-	-	-	-	-	-	-	-	-	2,802
Estimated FY 2015-16	2,600	331	169	-	-	-	-	-	-	-	-	-	-	-	-	3,100
Estimated FY 2016-17	2,881	361	186	-	-	-	-	-	-	-	-	-	-	-	-	3,428
Percent Changes in Enrollment																
FY 2007-08	9.90%	18.84%	-7.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.83%
FY 2008-09	13.56%	21.95%	32.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	14.68%
FY 2009-10 (DA)	13.04%	20.00%	22.45%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.85%
FY 2010-11 (DA)	11.19%	42.50%	25.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	14.02%
FY 2011-12	9.62%	19.30%	28.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.27%
FY 2012-13	16.70%	16.67%	21.88%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.94%
FY 2013-14	-6.01%	-2.52%	-13.68%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-6.04%
Estimated FY 2014-15	22.71%	26.29%	46.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	24.15%
Estimated FY 2015-16	10.12%	12.97%	14.19%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.64%
Estimated FY 2016-17	10.81%	9.06%	10.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.58%
Average Cost Per Enrollee[3]																
FY 2006-07	$37,136.07	$46,128.99	$45,264.70	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37,973.68
FY 2007-08	$39,493.44	$43,290.35	$43,159.57	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$39,853.92
FY 2008-09	$42,789.25	$43,959.37	$44,554.78	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,932.37
FY 2009-10 (DA)	$43,033.05	$41,551.08	$39,088.98	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42,777.04
FY 2010-11 (DA)	$45,770.19	$46,152.53	$43,865.17	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45,728.21
FY 2011-12	$42,001.93	$39,475.10	$39,127.89	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$41,616.64
FY 2012-13	$41,224.44	$36,951.71	$35,601.83	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$40,527.21
FY 2013-14	$44,611.31	$44,178.88	$43,496.55	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$44,516.98
Estimated FY 2014-15	$46,598.09	$44,421.04	$44,421.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$46,255.45
Estimated FY 2015-16	$47,188.33	$44,983.71	$44,983.71	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$46,832.75
Estimated FY 2016-17	$47,786.05	$45,553.50	$45,553.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$47,429.81
Percent Changes in Cost Per Enrollee																
FY 2007-08	6.35%	-6.15%	-4.65%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.95%
FY 2008-09	8.35%	1.55%	3.23%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.72%
FY 2009-10 (DA)	0.57%	-5.48%	-12.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.36%
FY 2010-11 (DA)	6.36%	11.07%	12.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.90%
FY 2011-12	-8.23%	-14.47%	-10.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-8.99%
FY 2012-13	-1.85%	-6.39%	-9.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.62%
FY 2013-14	8.22%	19.56%	22.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.84%
Estimated FY 2014-15	4.45%	0.55%	2.13%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.91%
Estimated FY 2015-16	1.27%	1.27%	1.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.25%
Estimated FY 2016-17	1.27%	1.27%	1.27%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.27%

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

Current Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2013-14 Average Monthly Paid Enrollment	1,924	232	101	-	-	-	-	-	-	-	-	-	-	-	-	2,257
Trend Factor[4]	22.71%	26.29%	46.53%	-	-	-	-	-	-	-	-	-	-	-	-	24.15%
Estimated FY 2014-15 Monthly Paid Enrollment	2,361	293	148	-	-	-	-	-	-	-	-	-	-	-	-	2,802
FY 2014-15 Estimated Cost Per Enrollee	$46,598.09	$44,421.04	$44,421.04	-	-	-	-	-	-	-	-	-	-	-	-	$46,255.45
Bottom Line Impacts																
Estimated Impact of FY 2013-14 Enrollment Issues	$8,190,850	$894,547	$914,603	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10,000,000
Total Bottom Line Impacts	$8,190,850	$894,547	$914,603	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10,000,000
Estimated FY 2014-15 Expenditure	**$118,208,940**	**$13,909,912**	**$7,488,917**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$139,607,769**
Estimated FY 2014-15 Per Capita	$2,819.06	$1,283.44	$112.37	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$123.93
% Change over FY 2013-14 Per Capita	37.41%	23.38%	64.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.20%

Request Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Estimated FY 2014-15 Monthly Paid Enrollment	2,361	293	148	-	-	-	-	-	-	-	-	-	-	-	-	2,802
Trend Factor	10.12%	12.97%	14.19%	-	-	-	-	-	-	-	-	-	-	-	-	10.64%
Estimated FY 2015-16 Monthly Paid Enrollment	2,600	331	169	-	-	-	-	-	-	-	-	-	-	-	-	3,100
FY 2015-16 Estimated Cost Per Enrollee	$47,188.33	$44,983.71	$44,983.71	-	-	-	-	-	-	-	-	-	-	-	-	$46,832.75
Bottom Line Impacts																
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2015-16 Expenditure	**$122,689,658**	**$14,889,608**	**$7,602,247**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$145,181,513**
Estimated FY 2015-16 Per Capita	$2,849.27	$1,301.31	$110.11	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$118.82
% Change over FY 2014-15 Per Capita	1.07%	1.39%	-2.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-4.12%

Out Year Projection

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2014-15 Estimated Monthly Paid Enrollment	2,600	331	169	-	-	-	-	-	-	-	-	-	-	-	-	3,100
Trend Factor	10.81%	9.06%	10.06%	-	-	-	-	-	-	-	-	-	-	-	-	10.58%
FY 2015-16 Estimated Monthly Paid Enrollment	2,881	361	186	-	-	-	-	-	-	-	-	-	-	-	-	3,428
FY 2015-16 Estimated Cost Per Enrollee	$47,786.05	$45,553.50	$45,553.50	-	-	-	-	-	-	-	-	-	-	-	-	$47,429.81
Bottom Line Impacts																
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2015-16 Expenditure	**$137,671,610**	**$16,444,814**	**$8,472,951**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$162,589,375**
Estimated FY 2016-17 Per Capita	$3,127.12	$1,373.26	$118.99	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$123.54
% Change over FY 2015-16 Per Capita	9.75%	5.53%	8.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	3.97%

Footnotes

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

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

(3) Per-enrollee costs for FY 2014-15 are a weighted average of FY 2014-15 rates by forecasted FY 2014-15 provider distribution and FY 2013-14 third-party-liability status. FY 2015-16 per-enrollee costs are estimated using the average growth in per-enrollee cost between FY 2007-08 and FY 2012-13 applied to FY 2014-15 estimates. FY 2016-17 per-enrollee costs are estimated by application of the same growth rate to estimated FY 2015-16 per-enrollee costs.

(4) Monthly Paid Enrollment figures for FY 2014-15, FY 2015-16, and FY 2016-17 are estimated via linear regression of historical enrollment by provider and eligibility type.

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

Cash Based Actuals

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$37,744,128	$2,201,019	$19,784,933	$0	$123,754	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10,921,770	$70,775,604
FY 2006-07	$44,106,993	$2,572,065	$23,120,257	$0	$144,616	$0	$0	$0	$0	$0	$0	$0	$0	$0	$12,762,950	$82,706,881
FY 2007-08	$43,978,504	$2,564,572	$23,052,905	$0	$144,195	$0	$0	$0	$0	$0	$0	$0	$0	$0	$12,725,770	$82,465,946
FY 2008-09	$49,992,538	$2,915,276	$26,205,375	$0	$163,913	$0	$0	$0	$0	$0	$0	$0	$0	$0	$14,466,011	$93,743,114
FY 2009-10 (DA)	$54,965,748	$3,205,285	$28,812,261	$0	$180,219	$0	$0	$0	$0	$0	$0	$0	$0	$0	$15,905,077	$103,068,590
FY 2010-11 (DA)	$63,751,826	$3,717,638	$33,417,798	$0	$209,027	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,447,446	$119,543,734
FY 2011-12	$63,201,668	$3,688,256	$33,153,682	$46,299	$207,374	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,301,648	$118,598,927
FY 2012-13	$63,920,416	$3,727,469	$33,506,170	$0	$209,579	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,496,230	$119,859,864
FY 2013-14	$68,884,741	$4,016,960	$36,108,399	$0	$225,857	$0	$0	$0	$0	$0	$0	$0	$0	$0	$19,932,724	$129,168,681
Estimated FY 2014-15	$70,353,157	$4,408,138	$37,778,272	$0	$275,010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$22,924,438	$135,739,015
Estimated FY 2015-16	$72,593,730	$4,757,204	$39,557,714	$0	$316,259	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,796,912	$143,021,819
Estimated FY 2016-17	$75,894,742	$5,098,736	$41,725,094	$0	$354,397	$0	$0	$0	$0	$0	$0	$0	$0	$0	$28,884,359	$151,957,328

Percent Change in Cash Based Actuals

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	16.86%	16.86%	16.86%	0.00%	16.86%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	16.86%	16.86%
FY 2007-08	-0.29%	-0.29%	-0.29%	0.00%	-0.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.29%	-0.29%
FY 2008-09	13.67%	13.67%	13.67%	0.00%	13.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.67%	13.67%
FY 2009-10 (DA)	9.95%	9.95%	9.95%	0.00%	9.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.95%	9.95%
FY 2010-11 (DA)	15.98%	15.98%	15.98%	0.00%	15.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.98%	15.98%
FY 2011-12	-0.86%	-0.79%	-0.79%	0.00%	-0.79%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.79%	-0.79%
FY 2012-13	1.14%	1.06%	1.06%	-100.00%	1.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.06%	1.06%
FY 2013-14	7.77%	7.77%	7.77%	0.00%	7.77%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.77%	7.77%
Estimated FY 2014-15	2.13%	9.74%	4.62%	0.00%	21.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	15.01%	5.09%
Estimated FY 2015-16	3.18%	7.92%	4.71%	0.00%	15.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	12.53%	5.37%
Estimated FY 2016-17	4.55%	7.18%	5.48%	0.00%	12.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.97%	6.25%

Per Capita Cost

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$1,042.45	$364.29	$413.44	$0.00	$2.10	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$984.65	$175.96
FY 2006-07	$1,229.02	$424.50	$473.79	$0.00	$2.59	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$988.76	$210.86
FY 2007-08	$1,212.06	$417.27	$461.68	$0.00	$2.70	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$895.30	$210.39
FY 2008-09	$1,328.92	$452.19	$510.28	$0.00	$2.65	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$959.60	$214.61
FY 2009-10 (DA)	$1,428.16	$454.71	$540.93	$0.00	$2.41	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$999.13	$206.63
FY 2010-11 (DA)	$1,639.75	$478.65	$593.72	$0.00	$2.58	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,079.43	$213.20
FY 2011-12	$1,590.38	$439.97	$557.82	$890.37	$2.22	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$969.83	$191.30
FY 2012-13	$1,565.64	$411.83	$541.12	$0.00	$2.11	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$872.22	$175.49
FY 2013-14	$1,646.54	$407.69	$560.48	$0.00	$1.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$852.63	$150.03
Estimated FY 2014-15	$1,677.79	$406.73	$566.83	$0.00	$1.77	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$840.92	$120.50
Estimated FY 2015-16	$1,685.87	$415.77	$572.95	$0.00	$1.85	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$866.10	$117.05
Estimated FY 2016-17	$1,723.90	$425.78	$585.99	$0.00	$1.90	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$886.02	$115.46

Percent Change in Per Capita Cost

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	17.90%	16.53%	14.60%	0.00%	23.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.42%	19.83%
FY 2007-08	-1.38%	-1.70%	-2.56%	0.00%	4.25%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-9.45%	-0.22%
FY 2008-09	9.64%	8.37%	10.53%	0.00%	-1.85%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.18%	2.01%
FY 2009-10 (DA)	7.47%	0.56%	6.01%	0.00%	-9.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.12%	-3.72%
FY 2010-11 (DA)	14.82%	5.26%	9.76%	0.00%	7.05%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.04%	3.18%
FY 2011-12	-3.01%	-8.08%	-6.05%	0.00%	-13.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.15%	-10.27%
FY 2012-13	-1.56%	-6.40%	-2.99%	-100.00%	-4.95%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.06%	-8.26%
FY 2013-14	5.17%	-1.01%	3.58%	0.00%	-14.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.25%	-14.51%
Estimated FY 2014-15	1.90%	-0.24%	1.13%	0.00%	-2.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.37%	-19.68%
Estimated FY 2015-16	0.48%	2.22%	1.08%	0.00%	4.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.99%	-2.86%
Estimated FY 2016-17	2.26%	2.41%	2.28%	0.00%	2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.30%	-1.36%

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

SUPPLEMENTAL MEDICARE INSURANCE BENEFIT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Current Year Projection																
FY 2013-14 Expenditure	**$68,884,741**	**$4,016,960**	**$36,108,399**	**$0**	**$225,857**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$19,932,724**	**$129,168,681**
FY 2013-14 First Half Expenditure	$33,766,129	$1,969,045	$17,699,723	$0	$110,711	$0	$0	$0	$0	$0	$0	$0	$0	$0	$9,770,682	$63,316,291
FY 2013-14 Second Half Expenditure	$35,118,612	$2,047,915	$18,408,676	$0	$115,146	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10,162,042	$65,852,390
Estimated FY 2014-15 First Half Caseload Trend	0.11%	5.00%	1.73%	22.27%	12.43%	18.56%	78.25%	-17.08%	5.25%	46.81%	6.42%	7.46%	33.59%	6.59%	8.30%	15.42%
Estimated FY 2014-15 First Half Expenditure	$35,157,242	$2,150,311	$18,727,146	$0	$129,459	$0	$0	$0	$0	$0	$0	$0	$0	$0	$11,005,491	$67,169,649
Estimated FY 2014-15 Second Half Caseload Trend	0.11%	5.00%	1.73%	22.27%	12.43%	18.56%	78.25%	-17.08%	5.25%	46.81%	6.42%	7.46%	33.59%	6.59%	8.30%	15.42%
Estimated Increase in Medicare Part B Premium	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2014-15 Second Half Expenditure	$35,195,915	$2,257,827	$19,051,126	$0	$145,551	$0	$0	$0	$0	$0	$0	$0	$0	$0	$11,918,947	$68,569,366
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2014-15 Total Expenditure[2]	**$70,353,157**	**$4,408,138**	**$37,778,272**	**$0**	**$275,010**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$22,924,438**	**$135,739,015**
Estimated FY 2014-15 Per Capita	$1,677.79	$406.73	$566.83	$0.00	$1.77	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$840.92	$120.50
% Change over FY 2013-14 Per Capita	1.90%	-0.24%	1.13%	0.00%	-2.21%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.37%	-19.68%
Request Year Projection																
Estimated FY 2014-15 Expenditure	$70,353,157	$4,408,138	$37,778,272	$0	$275,010	$0	$0	$0	$0	$0	$0	$0	$0	$0	$22,924,438	$135,739,015
Estimated FY 2014-15 First Half Expenditure	$35,157,242	$2,150,311	$18,727,146	$0	$129,459	$0	$0	$0	$0	$0	$0	$0	$0	$0	$11,005,491	$67,169,649
Estimated FY 2014-15 Second Half Expenditure	$35,195,915	$2,257,827	$19,051,126	$0	$145,551	$0	$0	$0	$0	$0	$0	$0	$0	$0	$11,918,947	$68,569,366
Estimated FY 2015-16 First Half Caseload Trend	1.35%	2.79%	1.80%	8.91%	4.90%	4.65%	7.18%	-27.04%	3.39%	4.23%	0.74%	0.69%	5.77%	-1.18%	4.63%	4.23%
Estimated FY 2015-16 First Half Expenditure	$35,671,060	$2,320,820	$19,394,046	$0	$152,683	$0	$0	$0	$0	$0	$0	$0	$0	$0	$12,470,794	$70,009,403
Estimated FY 2015-16 Second Half Caseload Trend	1.35%	2.79%	1.80%	8.91%	4.90%	4.65%	7.18%	-27.04%	3.39%	4.23%	0.74%	0.69%	5.77%	-1.18%	4.63%	4.23%
Estimated Increase in Medicare Part B Premium (Effective January 1, 2016)[1]	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%
Estimated FY 2015-16 Second Half Expenditure	$36,922,670	$2,436,384	$20,163,668	$0	$163,576	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,326,118	$73,012,416
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2015-16 Total Expenditure[2]	**$72,593,730**	**$4,757,204**	**$39,557,714**	**$0**	**$316,259**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$25,796,912**	**$143,021,819**
Estimated FY 2015-16 Per Capita	$1,685.87	$415.77	$572.95	$0.00	$1.85	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$866.10	$117.05
% Change over FY 2014-15 Per Capita	0.48%	2.22%	1.08%	0.00%	4.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.99%	-2.86%
Out Year Projection																
Estimated FY 2015-16 Expenditure	$72,593,730	$4,757,204	$39,557,714	$0	$316,259	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,796,912	$143,021,819
Estimated FY 2015-16 First Half Expenditure	$35,671,060	$2,320,820	$19,394,046	$0	$152,683	$0	$0	$0	$0	$0	$0	$0	$0	$0	$12,470,794	$70,009,403
Estimated FY 2015-16 Second Half Expenditure	$36,922,670	$2,436,384	$20,163,668	$0	$163,576	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,326,118	$73,012,416
Estimated FY 2016-17 First Half Caseload Trend	1.12%	2.33%	1.57%	6.79%	4.70%	4.06%	6.04%	-32.54%	3.12%	4.14%	0.68%	0.55%	3.78%	-1.19%	4.73%	3.86%
Estimated FY 2016-17 First Half Expenditure	$37,336,204	$2,493,152	$20,480,238	$0	$171,264	$0	$0	$0	$0	$0	$0	$0	$0	$0	$13,956,443	$74,437,301
Estimated FY 2016-17 Second Half Caseload Trend	1.12%	2.33%	1.57%	6.79%	4.70%	4.06%	6.04%	-32.54%	3.12%	0.00%	0.68%	0.55%	3.78%	-1.19%	4.73%	3.86%
Estimated Increase in Medicare Part B Premium (Effective January 1, 2017)[1]	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%	2.13%
Estimated FY 2016-17 Second Half Expenditure	$38,558,538	$2,605,584	$21,244,856	$0	$183,133	$0	$0	$0	$0	$0	$0	$0	$0	$0	$14,927,916	$77,520,027
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2016-17 Total Expenditure[2]	**$75,894,742**	**$5,098,736**	**$41,725,094**	**$0**	**$354,397**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$28,884,359**	**$151,957,328**
Estimated FY 2016-17 Per Capita	$1,723.90	$425.78	$585.99	$0.00	$1.90	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$886.02	$115.46
% Change over Estimated FY 2015-16 Per Capita	2.26%	2.41%	2.28%	0.00%	2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.30%	-1.36%

Footnotes

(1)The Part B premium remained at $104.90 effective January 1, 2014. The January 1, 2015 and January 1, 2016 rates have not yet been issued by CMS. The most recent projections from CMS's Office of the Actuary is the basis for the CY 2015 growth rate. The projected growth in premium from the Kaiser Family Foundation issue brief, published January 13, 2014, is assumed for CY 2016 and CY 2017.

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

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

Cash Based Actuals

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$212,695	$18,547	$157,102	$0	$37,769	$0	$0	$0	$63,030	$0	$10,566	$13,231	$0	$8,200	$3,054	$524,194
FY 2006-07	$1,797	$20,389	$704,579	$0	$2,008	$0	$0	$0	$9,795	$0	$651	$3,133	$0	$0	$0	$742,352
FY 2007-08	$3,274	$1,762	$877,995	$0	$1,605	$0	$0	$0	$16,916	$0	$1,188	$2,208	$0	$0	$0	$904,948
FY 2008-09	($177)	$3,200	$917,027	$0	$5,034	$0	$0	$0	$16,561	$0	$0	$500	$0	$0	$0	$942,145
FY 2009-10 (DA)	$3,552	$8,332	$993,385	$0	$3,197	$0	$0	$0	$11,314	$0	$210	$0	$0	$0	$0	$1,019,990
FY 2010-11 (DA)	$1,979	$625	$1,025,861	$0	$5,099	$0	$0	$0	$2,021	$0	$1,059	$0	$0	$0	$0	$1,036,644
FY 2011-12	$2,162	$6,655	$1,122,186	$0	$9,727	$0	$0	$0	$12,996	$0	$2,223	$3,358	$0	$0	$0	$1,159,307
FY 2012-13	$2,767	$1,630	$1,345,692	$0	$6,506	$0	$0	$0	$3,632	$0	$1,304	$0	$0	$0	$0	$1,361,531
FY 2013-14	$11,744	$20,552	$1,215,523	$0	$26,425	$0	$0	$0	$60,491	$0	$21,718	$8,808	$0	$0	$0	$1,365,261
Estimated FY 2014-15	$15,392	$26,934	$1,592,989	$0	$34,631	$0	$0	$0	$79,276	$0	$28,462	$11,543	$0	$0	$0	$1,789,227
Estimated FY 2015-16	$20,772	$36,349	$2,149,838	$0	$46,737	$0	$0	$0	$106,988	$0	$38,411	$15,578	$0	$0	$0	$2,414,673
Estimated FY 2016-17	$27,628	$48,346	$2,859,406	$0	$62,163	$0	$0	$0	$142,300	$0	$51,088	$20,720	$0	$0	$0	$3,211,651

Percent Change in Cash Based Actuals

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	-99.16%	9.93%	348.49%	0.00%	-94.68%	0.00%	0.00%	0.00%	-84.46%	0.00%	-93.84%	-76.32%	0.00%	-100.00%	-100.00%	41.62%
FY 2007-08	82.19%	-91.36%	24.61%	0.00%	-20.07%	0.00%	0.00%	0.00%	72.70%	0.00%	82.49%	-29.52%	0.00%	0.00%	0.00%	21.90%
FY 2008-09	-105.41%	81.61%	4.45%	0.00%	213.64%	0.00%	0.00%	0.00%	-2.10%	0.00%	-100.00%	-77.36%	0.00%	0.00%	0.00%	4.11%
FY 2009-10 (DA)	-2106.78%	160.38%	8.33%	0.00%	-36.49%	0.00%	0.00%	0.00%	-31.68%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	8.26%
FY 2010-11 (DA)	-44.28%	-92.50%	3.27%	0.00%	59.49%	0.00%	0.00%	0.00%	-82.14%	0.00%	404.29%	0.00%	0.00%	0.00%	0.00%	1.63%
FY 2011-12	9.25%	964.80%	9.39%	0.00%	90.76%	0.00%	0.00%	0.00%	543.05%	0.00%	109.92%	0.00%	0.00%	0.00%	0.00%	11.83%
FY 2012-13	27.98%	-75.51%	19.92%	0.00%	-33.11%	0.00%	0.00%	0.00%	-72.05%	0.00%	-41.34%	-100.00%	0.00%	0.00%	0.00%	17.44%
FY 2013-14	324.43%	1160.86%	-9.67%	0.00%	306.16%	0.00%	0.00%	0.00%	1565.50%	0.00%	1565.49%	0.00%	0.00%	0.00%	0.00%	0.27%
Estimated FY 2014-15	31.06%	31.05%	31.05%	0.00%	31.05%	0.00%	0.00%	0.00%	31.05%	0.00%	31.05%	31.05%	0.00%	0.00%	0.00%	31.05%
Estimated FY 2015-16	34.95%	34.96%	34.96%	0.00%	34.96%	0.00%	0.00%	0.00%	34.96%	0.00%	34.96%	34.96%	0.00%	0.00%	0.00%	34.96%
Estimated FY 2016-17	33.01%	33.01%	33.01%	0.00%	33.01%	0.00%	0.00%	0.00%	33.01%	0.00%	33.00%	33.01%	0.00%	0.00%	0.00%	33.01%

Per Capita Cost

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$5.87	$3.07	$3.28	$0.00	$0.64	$0.00	$0.00	$0.00	$0.29	$0.00	$0.64	$2.58	$0.00	$1.32	$0.28	$1.30
FY 2006-07	$0.05	$3.37	$14.44	$0.00	$0.04	$0.00	$0.00	$0.00	$0.05	$0.00	$0.04	$0.60	$0.00	$0.00	$0.00	$1.89
FY 2007-08	$0.09	$0.29	$17.58	$0.00	$0.03	$0.00	$0.00	$0.00	$0.08	$0.00	$0.07	$0.35	$0.00	$0.00	$0.00	$2.31
FY 2008-09	$0.00	$0.50	$17.86	$0.00	$0.08	$0.00	$0.00	$0.00	$0.07	$0.00	$0.00	$0.07	$0.00	$0.00	$0.00	$2.16
FY 2009-10 (DA)	$0.09	$1.18	$18.65	$0.00	$0.04	$0.00	$0.00	$0.00	$0.04	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00	$2.04
FY 2010-11 (DA)	$0.05	$0.08	$18.23	$0.00	$0.06	$0.00	$0.00	$0.00	$0.01	$0.00	$0.06	$0.00	$0.00	$0.00	$0.00	$1.85
FY 2011-12	$0.05	$0.79	$18.88	$0.00	$0.10	$0.00	$0.00	$0.00	$0.04	$0.00	$0.12	$0.44	$0.00	$0.00	$0.00	$1.87
FY 2012-13	$0.07	$0.18	$21.73	$0.00	$0.07	$0.00	$0.00	$0.00	$0.01	$0.00	$0.07	$0.00	$0.00	$0.00	$0.00	$1.99
FY 2013-14	$0.28	$2.09	$18.87	$0.00	$0.21	$0.00	$0.00	$0.00	$0.15	$0.00	$1.19	$0.67	$0.00	$0.00	$0.00	$1.59
Estimated FY 2014-15	$0.37	$2.49	$23.90	$0.00	$0.22	$0.00	$0.00	$0.00	$0.18	$0.00	$1.38	$0.76	$0.00	$0.00	$0.00	$1.59
Estimated FY 2015-16	$0.48	$3.18	$31.14	$0.00	$0.27	$0.00	$0.00	$0.00	$0.23	$0.00	$1.84	$1.02	$0.00	$0.00	$0.00	$1.98
Estimated FY 2016-17	$0.63	$4.04	$40.16	$0.00	$0.33	$0.00	$0.00	$0.00	$0.29	$0.00	$2.41	$1.34	$0.00	$0.00	$0.00	$2.44

Percent Change in Per Capita Cost

HEALTH INSURANCE BUY-IN	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	-99.15%	9.77%	340.24%	0.00%	-93.75%	0.00%	0.00%	0.00%	-82.76%	0.00%	-93.75%	-76.74%	0.00%	-100.00%	-100.00%	45.38%
FY 2007-08	80.00%	-91.39%	21.75%	0.00%	-25.00%	0.00%	0.00%	0.00%	60.00%	0.00%	75.00%	-41.67%	0.00%	0.00%	0.00%	22.22%
FY 2008-09	-100.00%	72.41%	1.59%	0.00%	166.67%	0.00%	0.00%	0.00%	-12.50%	0.00%	-100.00%	-80.00%	0.00%	0.00%	0.00%	-6.49%
FY 2009-10 (DA)	0.00%	136.00%	4.42%	0.00%	-50.00%	0.00%	0.00%	0.00%	-42.86%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	-5.56%
FY 2010-11 (DA)	-44.44%	-93.22%	-2.25%	0.00%	50.00%	0.00%	0.00%	0.00%	-75.00%	0.00%	500.00%	0.00%	0.00%	0.00%	0.00%	-9.31%
FY 2011-12	0.00%	887.50%	3.57%	0.00%	66.67%	0.00%	0.00%	0.00%	300.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	1.08%
FY 2012-13	40.00%	-77.22%	15.10%	0.00%	-30.00%	0.00%	0.00%	0.00%	-75.00%	0.00%	-41.67%	-100.00%	0.00%	0.00%	0.00%	6.42%
FY 2013-14	300.00%	1061.11%	-13.16%	0.00%	200.00%	0.00%	0.00%	0.00%	1400.00%	0.00%	1600.00%	0.00%	0.00%	0.00%	0.00%	-20.10%
Estimated FY 2014-15	32.14%	19.14%	26.66%	0.00%	4.76%	0.00%	0.00%	0.00%	20.00%	0.00%	15.97%	13.43%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2015-16	29.73%	27.71%	30.29%	0.00%	22.73%	0.00%	0.00%	0.00%	27.78%	0.00%	33.33%	34.21%	0.00%	0.00%	0.00%	24.53%
Estimated FY 2016-17	31.25%	27.04%	28.97%	0.00%	22.22%	0.00%	0.00%	0.00%	26.09%	0.00%	30.98%	31.37%	0.00%	0.00%	0.00%	23.23%

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

Expenditure Trends																
Expenditure Trends	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Actual FY 2013-14 Expenditure	$11,744	$20,552	$1,215,523	$0	$26,425	$0	$0	$0	$60,491	$0	$21,718	$8,808	$0	$0	$0	$1,365,261
Average of FY 2007-08 through FY 2011-12	-433.01%	204.59%	10.01%	0.00%	61.47%	0.00%	0.00%	0.00%	99.97%	0.00%	99.34%	-41.38%	0.00%	0.00%	0.00%	9.55%
Average of FY 2008-09 through FY 2011-12	-561.81%	278.57%	6.36%	0.00%	81.85%	0.00%	0.00%	0.00%	106.78%	0.00%	103.55%	-44.34%	0.00%	0.00%	0.00%	6.46%
Average of FY 2009-10 through FY 2011-12	-713.94%	344.23%	7.00%	0.00%	37.92%	0.00%	0.00%	0.00%	143.08%	0.00%	171.40%	-33.33%	0.00%	0.00%	0.00%	7.24%
Average of FY 2010-11 through FY 2011-12	-17.52%	436.15%	6.33%	0.00%	75.13%	0.00%	0.00%	0.00%	230.46%	0.00%	257.11%	0.00%	0.00%	0.00%	0.00%	6.73%
Average of FY 2008-09 through FY 2012-13	-443.85%	207.76%	9.07%	0.00%	58.86%	0.00%	0.00%	0.00%	71.02%	0.00%	74.57%	-55.47%	0.00%	0.00%	0.00%	8.65%
Average of FY 2009-10 through FY 2012-13	-528.46%	239.29%	10.23%	0.00%	20.16%	0.00%	0.00%	0.00%	89.30%	0.00%	118.22%	-50.00%	0.00%	0.00%	0.00%	9.79%
Average of FY 2010-11 through FY 2012-13	-2.35%	265.60%	10.86%	0.00%	39.05%	0.00%	0.00%	0.00%	129.62%	0.00%	157.62%	-33.33%	0.00%	0.00%	0.00%	10.30%
Average of FY 2011-12 through FY 2012-13	18.62%	444.65%	14.66%	0.00%	28.83%	0.00%	0.00%	0.00%	235.50%	0.00%	34.29%	-50.00%	0.00%	0.00%	0.00%	14.64%
Average of FY 2009-10 through FY 2013-14	-357.88%	423.61%	6.25%	0.00%	77.36%	0.00%	0.00%	0.00%	384.54%	0.00%	407.67%	-40.00%	0.00%	0.00%	0.00%	7.89%
Average of FY 2010-11 through FY 2013-14	79.35%	489.41%	5.73%	0.00%	105.83%	0.00%	0.00%	0.00%	488.59%	0.00%	509.59%	-25.00%	0.00%	0.00%	0.00%	7.79%
Average of FY 2011-12 through FY 2013-14	120.55%	683.38%	6.55%	0.00%	121.27%	0.00%	0.00%	0.00%	678.83%	0.00%	544.69%	-33.33%	0.00%	0.00%	0.00%	9.85%
Average of FY 2012-13 through FY 2013-14	176.21%	542.68%	5.13%	0.00%	136.53%	0.00%	0.00%	0.00%	746.73%	0.00%	762.08%	-50.00%	0.00%	0.00%	0.00%	8.86%
Current Year Projection																
FY 2013-14 Expenditure	$11,744	$20,552	$1,215,523	$0	$26,425	$0	$0	$0	$60,491	$0	$21,718	$8,808	$0	$0	$0	$1,365,261
Estimated Incremental Expenditure for FY 2014-15																
SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$259	$451	$26,687	$0	$580	$0	$0	$0	$1,328	$0	$477	$193	$0	$0	$0	$29,975
SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$3,389	$5,931	$350,779	$0	$7,626	$0	$0	$0	$17,457	$0	$6,267	$2,542	$0	$0	$0	$393,991
Total Incremental Expenditure	$3,648	$6,382	$377,466	$0	$8,206	$0	$0	$0	$18,785	$0	$6,744	$2,735	$0	$0	$0	$423,966
Estimated FY 2014-15 Total Expenditure	**$15,392**	**$26,934**	**$1,592,989**	**$0**	**$34,631**	**$0**	**$0**	**$0**	**$79,276**	**$0**	**$28,462**	**$11,543**	**$0**	**$0**	**$0**	**$1,789,227**
Estimated FY 2014-15 Per Capita	$0.37	$2.49	$23.90	$0.00	$0.22	$0.00	$0.00	$0.00	$0.18	$0.00	$1.38	$0.76	$0.00	$0.00	$0.00	$1.59
% Change over FY 2013-14 Per Capita	32.14%	19.14%	26.66%	0.00%	4.76%	0.00%	0.00%	0.00%	20.00%	0.00%	15.97%	13.43%	0.00%	0.00%	0.00%	0.00%
Request Year Projection																
Estimated FY 2014-15 Expenditure	$15,392	$26,934	$1,592,989	$0	$34,631	$0	$0	$0	$79,276	$0	$28,462	$11,543	$0	$0	$0	$1,789,227
Estimated Incremental Expenditure for FY 2015-16																
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$381	$666	$39,370	$0	$856	$0	$0	$0	$1,959	$0	$703	$285	$0	$0	$0	$44,220
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$4,999	$8,749	$517,479	$0	$11,250	$0	$0	$0	$25,753	$0	$9,246	$3,750	$0	$0	$0	$581,226
Total Incremental Expenditure	$5,380	$9,415	$556,849	$0	$12,106	$0	$0	$0	$27,712	$0	$9,949	$4,035	$0	$0	$0	$625,446
Estimated FY 2015-16 Total Expenditure	**$20,772**	**$36,349**	**$2,149,838**	**$0**	**$46,737**	**$0**	**$0**	**$0**	**$106,988**	**$0**	**$38,411**	**$15,578**	**$0**	**$0**	**$0**	**$2,414,673**
Estimated FY 2015-16 Per Capita	$0.48	$3.18	$31.14	$0.00	$0.27	$0.00	$0.00	$0.00	$0.23	$0.00	$1.84	$1.02	$0.00	$0.00	$0.00	$1.98
% Change over FY 2014-15 Per Capita	29.73%	27.71%	30.29%	0.00%	22.73%	0.00%	0.00%	0.00%	27.78%	0.00%	33.33%	34.21%	0.00%	0.00%	0.00%	24.53%
Out Year Projection																
Estimated FY 2015-16 Expenditure	$20,772	$36,349	$2,149,838	$0	$46,737	$0	$0	$0	$106,988	$0	$38,411	$15,578	$0	$0	$0	$2,414,673
Estimated Incremental Expenditure for FY 2016-17																
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Provider Payment	$484	$848	$50,168	$0	$1,091	$0	$0	$0	$2,497	$0	$896	$364	$0	$0	$0	$56,348
Annualization of SB 10-167 "Medicaid Efficiency & False Claims" - Premiums Payment	$6,372	$11,149	$659,400	$0	$14,335	$0	$0	$0	$32,815	$0	$11,781	$4,778	$0	$0	$0	$740,630
Total Incremental Expenditure	$6,856	$11,997	$709,568	$0	$15,426	$0	$0	$0	$35,312	$0	$12,677	$5,142	$0	$0	$0	$796,978
Estimated FY 2016-17 Total Expenditure	**$27,628**	**$48,346**	**$2,859,406**	**$0**	**$62,163**	**$0**	**$0**	**$0**	**$142,300**	**$0**	**$51,088**	**$20,720**	**$0**	**$0**	**$0**	**$3,211,651**
Estimated FY 2016-17 Per Capita	$0.63	$4.04	$40.16	$0.00	$0.33	$0.00	$0.00	$0.00	$0.29	$0.00	$2.41	$1.34	$0.00	$0.00	$0.00	$2.44
% Change over FY 2015-16 Per Capita	31.25%	27.04%	28.97%	0.00%	22.22%	0.00%	0.00%	0.00%	26.09%	0.00%	30.98%	31.37%	0.00%	0.00%	0.00%	23.23%

Exhibit I - Service Management - Summary

FY 2014-15 Service Management Request																
Service Management	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Single Entry Points	$8,759,301	$2,383,238	$19,391,929	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$30,534,468
Disease Management	$36,040	$24,914	$162,186	$10,499	$249,019	$85,050	$266,023	$253	$301,651	$35,932	$34,092	$73,282	$1,214	$1,929	$18,728	$1,300,812
Prepaid Inpatient Health Plan	$749,167	$683,704	$5,541,852	$154,321	$17,109,631	$9,450,999	$33,302,313	$0	$60,526,274	$2,827,868	$2,266,232	$1,223,696	$68,343	$0	$5	$133,904,405
Total Service Management	**$9,544,508**	**$3,091,856**	**$25,095,967**	**$164,820**	**$17,358,650**	**$9,536,049**	**$33,568,336**	**$253**	**$60,827,925**	**$2,863,800**	**$2,300,324**	**$1,296,978**	**$69,557**	**$1,929**	**$18,733**	**$165,739,685**
FY 2015-16 Service Management Request																
Service Management	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Single Entry Points	$9,397,854	$2,556,261	$20,805,601	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$32,759,716
Disease Management	$36,040	$24,914	$162,186	$10,499	$249,019	$85,050	$266,023	$253	$301,651	$0	$34,092	$73,282	$1,214	$1,929	$18,728	$1,264,880
Prepaid Inpatient Health Plan	$712,507	$689,044	$5,619,749	$156,427	$17,607,047	$10,312,803	$37,398,052	$0	$60,302,781	$2,938,736	$2,304,634	$1,248,366	$70,393	$0	$2,300,189	$141,660,728
Total Service Management	**$10,146,401**	**$3,270,219**	**$26,587,536**	**$166,926**	**$17,856,066**	**$10,397,853**	**$37,664,075**	**$253**	**$60,604,432**	**$2,938,736**	**$2,338,726**	**$1,321,648**	**$71,607**	**$1,929**	**$2,318,917**	**$175,685,324**
FY 2016-17 Service Management Request																
Service Management	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
Single Entry Points	$10,082,958	$2,742,612	$22,322,329	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,147,899
Disease Management	$36,981	$26,106	$167,332	$11,932	$273,024	$92,329	$298,319	$89	$318,835	$0	$34,563	$74,104	$1,314	$1,874	$20,538	$1,357,340
Prepaid Inpatient Health Plan	$731,373	$707,287	$5,768,537	$160,569	$18,073,209	$11,267,005	$42,354,810	$0	$64,706,759	$3,016,542	$2,365,650	$1,281,419	$72,256	$0	$3,437,354	$153,942,770
Total Service Management	**$10,851,312**	**$3,476,005**	**$28,258,198**	**$172,501**	**$18,346,233**	**$11,359,334**	**$42,653,129**	**$89**	**$65,025,594**	**$3,016,542**	**$2,400,213**	**$1,355,523**	**$73,570**	**$1,874**	**$3,457,892**	**$190,448,009**

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

Cash Based Actuals

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$8,671,602	$1,294,860	$6,580,601	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$16,547,063
FY 2006-07	$9,171,616	$1,415,981	$7,414,939	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,002,536
FY 2007-08	$10,894,815	$1,743,587	$9,118,699	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$21,757,101
FY 2008-09	$11,356,087	$1,927,170	$9,783,919	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$23,067,176
FY 2009-10 (DA)	$11,622,897	$2,068,951	$10,015,703	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$23,707,551
FY 2010-11 (DA)	$11,482,516	$2,211,295	$10,327,849	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$24,021,660
FY 2011-12	$11,748,349	$2,505,790	$10,972,607	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$25,226,746
FY 2012-13	$11,133,931	$2,768,715	$13,073,915	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$26,976,561
FY 2013-14	$7,836,051	$2,131,642	$16,931,323	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$26,899,016
Estimated FY 2014-15	$8,759,301	$2,383,238	$19,391,929	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$30,534,468
Estimated FY 2015-16	$9,397,854	$2,556,261	$20,805,601	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$32,759,716
Estimated FY 2016-17	$10,082,958	$2,742,612	$22,322,329	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,147,899

Percent Change in Cash Based Actuals

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	5.77%	9.35%	12.68%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.80%
FY 2007-08	18.79%	23.14%	22.98%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	20.86%
FY 2008-09	4.23%	10.53%	7.30%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.02%
FY 2009-10 (DA)	2.35%	7.36%	2.37%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.78%
FY 2010-11 (DA)	-1.21%	6.88%	3.12%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.32%
FY 2011-12	2.32%	13.32%	6.24%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.02%
FY 2012-13	-5.23%	10.49%	19.15%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	6.94%
FY 2013-14	-29.62%	-23.01%	29.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.29%
Estimated FY 2014-15	11.78%	11.80%	14.53%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	13.52%
Estimated FY 2015-16	7.29%	7.26%	7.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.29%
Estimated FY 2016-17	7.29%	7.29%	7.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.29%

Per Capita Cost

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2005-06	$239.50	$214.31	$137.51	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$41.14
FY 2006-07	$255.56	$233.70	$151.95	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$45.90
FY 2007-08	$300.26	$283.69	$182.62	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$55.51
FY 2008-09	$301.87	$298.93	$190.52	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$52.81
FY 2009-10 (DA)	$302.00	$293.51	$188.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$47.53
FY 2010-11 (DA)	$295.34	$284.70	$183.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$42.84
FY 2011-12	$295.63	$298.91	$184.62	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$40.69
FY 2012-13	$272.71	$305.90	$211.14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$39.50
FY 2013-14	$187.30	$216.34	$262.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$31.24
Estimated FY 2014-15	$208.89	$219.90	$290.96	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$27.11
Estimated FY 2015-16	$218.25	$223.41	$301.35	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$26.81
Estimated FY 2016-17	$229.03	$229.03	$313.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$26.71

Percent Change in Per Capita Cost

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2006-07	6.71%	9.05%	10.50%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	11.57%
FY 2007-08	17.49%	21.39%	20.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	20.94%
FY 2008-09	0.54%	5.37%	4.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-4.86%
FY 2009-10 (DA)	0.04%	-1.81%	-1.30%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-10.00%
FY 2010-11 (DA)	-2.21%	-3.00%	-2.42%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-9.87%
FY 2011-12	0.10%	4.99%	0.62%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-5.02%
FY 2012-13	-7.75%	2.34%	14.36%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.92%
FY 2013-14	-31.32%	-29.28%	24.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-20.91%
Estimated FY 2014-15	11.53%	1.65%	10.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-13.22%
Estimated FY 2015-16	4.48%	1.60%	3.57%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.11%
Estimated FY 2016-17	4.94%	2.52%	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.37%

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

Home and Community Based Services (HCBS) Waiver Enrollment[1]																
SINGLE ENTRY POINTS	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
HCBS Average Monthly Enrollment																
FY 2010-11 (DA)	10,575	2,009	9,769	-	-	-	-	-	-	-	-	-	-	-	-	22,353
FY 2011-12	10,994	2,266	10,354	-	-	-	-	-	-	-	-	-	-	-	-	23,614
FY 2012-13	11,643	2,502	11,190	-	-	-	-	-	-	-	-	-	-	-	-	25,335
FY 2013-14	12,095	2,657	11,162	-	-	-	-	-	-	-	-	-	-	-	-	25,914
Estimated FY 2014-15	12,976	2,851	12,269	-	-	-	-	-	-	-	-	-	-	-	-	28,096
Estimated FY 2015-16	13,922	3,058	13,163	-	-	-	-	-	-	-	-	-	-	-	-	30,143
Estimated FY 2016-17	14,937	3,281	14,122	-	-	-	-	-	-	-	-	-	-	-	-	32,340
Percent Changes in Utilization																
FY 2008-09 to FY 2009-10	3.96%	12.79%	5.99%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.64%
FY 2009-10 to FY 2010-11	5.90%	10.41%	8.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.29%
FY 2010-11 to FY 2011-12	3.88%	6.20%	-0.25%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.29%
Estimated FY 2014-15	7.28%	7.30%	9.92%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	8.42%
Estimated FY 2015-16	7.29%	7.26%	7.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.29%
Estimated FY 2016-17	7.29%	7.29%	7.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	7.29%
Cost per Enrollee																
SINGLE ENTRY POINTS	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
FY 2010-11 (DA)	$1,085.82	$1,100.69	$1,057.21	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,074.65
FY 2011-12	$1,068.61	$1,105.82	$1,059.75	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,068.30
FY 2012-13	$956.28	$1,106.60	$1,168.36	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,064.79
FY 2013-14	$647.88	$802.27	$1,516.87	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,038.01
Estimated FY 2014-15	$675.04	$835.93	$1,580.56	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,086.79
Estimated FY 2015-16	$675.04	$835.93	$1,580.61	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,086.81
Estimated FY 2016-17	$675.03	$835.91	$1,580.68	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1,086.82
Percentage Change in Cost per Enrollee																
SINGLE ENTRY POINTS	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**TOTAL**
FY 2011-12	-1.58%	0.47%	0.24%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.59%
FY 2012-13	-10.51%	0.07%	10.25%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.33%
FY 2013-14	-32.25%	-27.50%	29.83%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.52%
Estimated FY 2014-15	4.19%	4.20%	4.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	4.70%
Estimated FY 2015-16	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2016-17	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

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

SINGLE ENTRY POINTS	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Current Year Projection																
FY 2014-15 Base Contracts	$7,836,051	$2,131,642	$16,931,323	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$26,899,016
Estimated Increase in HCBS Enrollment(2)	7.28%	7.30%	9.92%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Estimated FY 2014-15 Base Expenditure	$8,406,516	$2,287,252	$18,610,910	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$29,304,678
Bottom Line Impacts																
FY 2014-15 R#11: "Community Provider Rate Increase" Targeted - Single Entry Point case Management 10% Rate Increase	$352,785	$95,986	$781,019	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,229,790
Total Bottom Line Impacts	$352,785	$95,986	$781,019	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,229,790
Estimated FY 2014-15 Total Expenditure	**$8,759,301**	**$2,383,238**	**$19,391,929**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$30,534,468**
Estimated FY 2014-15 Per Capita	$208.89	$219.90	$290.96	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$27.11
% Change over FY 2013-14 Per Capita	11.53%	1.65%	10.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-13.22%
Request Year Projection																
Estimated FY 2015-16 Base Contracts	$8,759,301	$2,383,238	$19,391,929	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$30,534,468
Estimated Increase in HCBS Enrollment(2)	7.29%	7.26%	7.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Estimated FY 2015-16 Base Expenditure	$9,397,854	$2,556,261	$20,805,601	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$32,759,716
Bottom Line Impacts																
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2015-16 Total Expenditure	**$9,397,854**	**$2,556,261**	**$20,805,601**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$32,759,716**
Estimated FY 2015-16 Per Capita	$218.25	$223.41	$301.35	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$26.81
% Change over FY 2014-15 Per Capita	4.48%	1.60%	3.57%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-1.11%
Out Year Projection																
FY 2016-17 Base Contracts	$9,397,854	$2,556,261	$20,805,601	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$32,759,716
Estimated Increase in HCBS Enrollment(2)	7.29%	7.29%	7.29%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Estimated FY 2016-17 Base Expenditure	$10,082,958	$2,742,612	$22,322,329	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$35,147,899
Bottom Line Impacts																
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2016-17 Total Expenditure	**$10,082,958**	**$2,742,612**	**$22,322,329**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$35,147,899**
Estimated FY 2016-17 Per Capita	$229.03	$229.03	$313.49	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$26.71
% Change over FY 2015-16 Per Capita	4.94%	2.52%	4.03%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.37%

Footnotes

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

(2) To trend expenditure the Department selected the growth rate in per capita spending for each of the eligibility categories.

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

Cash Based Actuals

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$165,996	$92,931	$833,085	$0	$378,473	$0	$0	$12,812	$645,653	$0	$113,811	$87,964	$0	$0	$0	$2,330,726
FY 2008-09	$201,459	$112,661	$996,159	$0	$477,141	$0	$0	$13,568	$835,312	$0	$131,805	$114,165	$0	$0	$0	$2,882,271
FY 2009-10 (DA)	$4,570	$2,655	$23,534	$0	$12,589	$0	$0	$409	$21,785	$0	$3,047	$3,027	$0	$0	$0	$71,616
FY 2010-11 (DA)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FY 2011-12	$51,573	$36,611	$303,654	$218	$164,545	$45,358	$1,307	$5,612	$280,261	$0	$32,412	$34,593	$0	$22,913	$2,955	$982,012
FY 2012-13	$18,845	$38,614	$282,411	$10,185	$329,787	$91,251	$48,349	$0	$0	$0	$49,301	$88,367	$0	$0	$0	$957,110
FY 2013-14	$7,234	$17,469	$116,400	$7,957	$142,079	$40,697	$112,294	$0	$0	$0	$19,931	$62,892	$0	$0	$0	$526,953
Estimated FY 2014-15	$36,040	$24,914	$162,186	$10,499	$249,019	$85,050	$266,023	$253	$301,651	$35,932	$34,092	$73,282	$1,214	$1,929	$18,728	$1,300,812
Estimated FY 2015-16	$36,040	$24,914	$162,186	$10,499	$249,019	$85,050	$266,023	$253	$301,651	$0	$34,092	$73,282	$1,214	$1,929	$18,728	$1,264,880
Estimated FY 2016-17	$36,981	$26,106	$167,332	$11,932	$273,024	$92,329	$298,319	$89	$318,835	$0	$34,563	$74,104	$1,314	$1,874	$20,538	$1,357,340

Percent Change in Cash Based Actuals

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	21.36%	21.23%	19.57%	0.00%	26.07%	0.00%	0.00%	5.90%	29.37%	0.00%	15.81%	29.79%	0.00%	0.00%	0.00%	23.66%
FY 2009-10 (DA)	-97.73%	-97.64%	-97.64%	0.00%	-97.36%	0.00%	0.00%	-96.99%	-97.39%	0.00%	-97.69%	-97.35%	0.00%	0.00%	0.00%	-97.52%
FY 2010-11 (DA)	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	0.00%	0.00%	-100.00%	-100.00%	0.00%	-100.00%	-100.00%	0.00%	0.00%	0.00%	-100.00%
FY 2011-12	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%	100.00%	100.00%	0.00%	100.00%	100.00%	100.00%
FY 2012-13	-63.46%	5.47%	-7.00%	4572.02%	100.42%	101.18%	3599.23%	-100.00%	-100.00%	0.00%	52.11%	155.45%	0.00%	-100.00%	-100.00%	-2.54%
FY 2013-14	-61.61%	-54.76%	-58.78%	-21.88%	-56.92%	-55.40%	132.26%	0.00%	0.00%	0.00%	-59.57%	-28.83%	0.00%	0.00%	0.00%	-44.94%
Estimated FY 2014-15	398.20%	42.62%	39.34%	31.95%	75.27%	108.98%	136.90%	100.00%	100.00%	100.00%	71.05%	16.52%	100.00%	100.00%	100.00%	146.86%
Estimated FY 2015-16	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-2.76%
Estimated FY 2016-17	2.61%	4.78%	3.17%	13.65%	9.64%	8.56%	12.14%	-64.82%	5.70%	0.00%	1.38%	1.12%	8.24%	-2.85%	9.66%	7.31%

Per Capita Cost

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$4.57	$15.12	$16.68	$0.00	$7.08	$0.00	$0.00	$47.45	$3.16	$0.00	$6.64	$13.99	$0.00	$0.00	$0.00	$5.95
FY 2008-09	$5.36	$17.47	$19.40	$0.00	$7.71	$0.00	$0.00	$42.80	$3.55	$0.00	$7.31	$16.37	$0.00	$0.00	$0.00	$6.60
FY 2009-10 (DA)	$0.12	$0.38	$0.44	$0.00	$0.17	$0.00	$0.00	$0.96	$0.08	$0.00	$0.17	$0.39	$0.00	$0.00	$0.00	$0.14
FY 2010-11 (DA)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
FY 2011-12	$1.30	$4.37	$5.11	$4.19	$1.77	$1.28	$1.15	$9.40	$0.84	$0.00	$1.80	$4.53	$0.00	$8.27	$0.16	$1.58
FY 2012-13	$0.46	$4.27	$4.56	$11.47	$3.32	$2.20	$4.55	$0.00	$0.00	$0.00	$2.77	$11.01	$0.00	$0.00	$0.00	$1.40
FY 2013-14	$0.17	$1.77	$1.81	$3.11	$1.14	$0.86	$1.29	$0.00	$0.00	$0.00	$1.09	$4.78	$0.00	$0.00	$0.00	$0.61
Estimated FY 2014-15	$0.86	$2.30	$2.43	$2.84	$1.60	$1.32	$1.19	$0.69	$0.69	$0.69	$1.65	$4.85	$0.69	$0.69	$0.69	$1.15
Estimated FY 2015-16	$0.84	$2.18	$2.35	$2.41	$1.46	$1.21	$1.04	$1.50	$0.64	$0.00	$1.63	$4.78	$0.62	$0.70	$0.63	$1.04
Estimated FY 2016-17	$0.84	$2.18	$2.35	$2.41	$1.46	$1.21	$1.04	$1.51	$0.64	$0.00	$1.63	$4.78	$0.62	$0.70	$0.63	$1.03

Percent Change in Per Capita Cost

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	17.29%	15.54%	16.31%	0.00%	8.90%	0.00%	0.00%	-9.80%	12.34%	0.00%	10.09%	17.01%	0.00%	0.00%	0.00%	10.92%
FY 2009-10 (DA)	-97.76%	-97.82%	-97.73%	0.00%	-97.80%	0.00%	0.00%	0.00%	0.00%	0.00%	-97.67%	-97.62%	0.00%	0.00%	0.00%	-97.88%
FY 2010-11 (DA)	-100.00%	-100.00%	-100.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-100.00%	-100.00%	0.00%	0.00%	0.00%	-100.00%
FY 2011-12	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	100.00%	100.00%	0.00%	100.00%	100.00%	100.00%
FY 2012-13	-64.62%	-2.29%	-10.76%	173.75%	87.57%	71.88%	295.65%	-100.00%	-100.00%	0.00%	53.89%	143.05%	0.00%	-100.00%	-100.00%	-11.39%
FY 2013-14	-63.04%	-58.55%	-60.31%	-72.89%	-65.66%	-60.91%	-71.65%	0.00%	0.00%	0.00%	-60.65%	-56.58%	0.00%	0.00%	0.00%	-56.43%
Estimated FY 2014-15	405.88%	29.94%	34.25%	-8.68%	40.35%	53.49%	-7.75%	100.00%	100.00%	100.00%	51.38%	1.46%	100.00%	100.00%	100.00%	88.52%
Estimated FY 2015-16	-2.33%	-5.22%	-3.29%	-15.14%	-8.75%	-8.33%	-12.61%	117.39%	-7.25%	-100.00%	-1.21%	-1.44%	-10.14%	1.45%	-8.70%	-9.57%
Estimated FY 2016-17	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.96%

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

DISEASE MANAGEMENT	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2014-15 Projection																
Estimated FY 2014-15 Base Per Capita	$0.17	$1.61	$1.75	$2.15	$0.91	$0.63	$0.50	$0.00	$0.00	$0.00	$0.97	$4.16	$0.00	$0.00	$0.00	$0.47
Estimated FY 2014-15 Eligibles	41,932	10,838	66,648	3,700	155,667	64,563	223,775	368	439,097	52,304	20,614	15,124	1,767	2,808	27,261	1,126,466
Estimated FY 2014-15 Base Expenditure	**$7,234**	**$17,469**	**$116,400**	**$7,957**	**$142,079**	**$40,697**	**$112,294**	**$0**	**$0**	**$0**	**$19,931**	**$62,892**	**$0**	**$0**	**$0**	**$526,953**
Bottom Line Impacts																
Smoking Quit line	$28,806	$7,445	$45,786	$2,542	$106,940	$44,353	$153,729	$253	$301,651	$35,932	$14,161	$10,390	$1,214	$1,929	$18,728	$773,859
Total Bottom Line Impacts	**$28,806**	**$7,445**	**$45,786**	**$2,542**	**$106,940**	**$44,353**	**$153,729**	**$253**	**$301,651**	**$35,932**	**$14,161**	**$10,390**	**$1,214**	**$1,929**	**$18,728**	**$773,859**
Estimated FY 2014-15 Total Expenditure	**$36,040**	**$24,914**	**$162,186**	**$10,499**	**$249,019**	**$85,050**	**$266,023**	**$253**	**$301,651**	**$35,932**	**$34,092**	**$73,282**	**$1,214**	**$1,929**	**$18,728**	**$1,300,812**
Estimated FY 2014-15 Per Capita	$0.86	$2.30	$2.43	$2.84	$1.60	$1.32	$1.19	$0.69	$0.69	$0.69	$1.65	$4.85	$0.69	$0.69	$0.69	$1.15
% Change over FY 2013-14 Per Capita	498.50%	142.70%	139.14%	132.06%	175.30%	209.41%	237.14%	0.00%	0.00%	0.00%	170.65%	116.63%	0.00%	0.00%	0.00%	245.84%
FY 2015-16 Projection																
Percentage Selected to Modify Per Capita	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2015-16 Base Per Capita	$0.84	$2.18	$2.35	$2.41	$1.46	$1.21	$1.04	$1.50	$0.64	$0.00	$1.63	$4.78	$0.62	$0.70	$0.63	$1.04
Estimated FY 2015-16 Eligibles	43,060	11,442	69,042	4,359	170,935	70,573	255,924	169	468,884	56,726	20,920	15,333	1,971	2,742	29,785	1,221,865
Estimated FY 2015-16 Base Expenditure	**$36,040**	**$24,914**	**$162,186**	**$10,499**	**$249,019**	**$85,050**	**$266,023**	**$253**	**$301,651**	**$0**	**$34,092**	**$73,282**	**$1,214**	**$1,929**	**$18,728**	**$1,264,880**
Bottom Line Impacts																
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2015-16 Total Expenditure	**$36,040**	**$24,914**	**$162,186**	**$10,499**	**$249,019**	**$85,050**	**$266,023**	**$253**	**$301,651**	**$0**	**$34,092**	**$73,282**	**$1,214**	**$1,929**	**$18,728**	**$1,264,880**
Estimated FY 2015-16 Per Capita	$0.84	$2.18	$2.35	$2.41	$1.46	$1.21	$1.04	$1.50	$0.64	$0.00	$1.63	$4.78	$0.62	$0.70	$0.63	$1.04
% Change over FY 2014-15 Per Capita	-2.33%	-5.22%	-3.29%	-15.14%	-8.75%	-8.33%	-12.61%	117.39%	-7.25%	-100.00%	-1.21%	-1.44%	-10.14%	1.45%	-8.70%	-9.57%
FY 2016-17 Projection																
Percentage Selected to Modify Per Capita	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Estimated FY 2016-17 Base Per Capita	$0.84	$2.18	$2.35	$2.41	$1.46	$1.21	$1.04	$1.50	$0.64	$0.00	$1.63	$4.78	$0.62	$0.70	$0.63	$0.96
Estimated FY 2016-17 Eligibles	44,025	11,975	71,205	4,951	187,003	76,305	286,845	59	498,180	61,422	21,204	15,503	2,120	2,677	32,600	1,316,074
Estimated FY 2016-17 Base Expenditure	**$36,981**	**$26,106**	**$167,332**	**$11,932**	**$273,024**	**$92,329**	**$298,319**	**$89**	**$318,835**	**$0**	**$34,563**	**$74,104**	**$1,314**	**$1,874**	**$20,538**	**$1,264,880**
Bottom Line Impacts																
Total Bottom Line Impacts	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Estimated FY 2016-17 Total Expenditure	**$36,981**	**$26,106**	**$167,332**	**$11,932**	**$273,024**	**$92,329**	**$298,319**	**$89**	**$318,835**	**$0**	**$34,563**	**$74,104**	**$1,314**	**$1,874**	**$20,538**	**$1,357,340**
Estimated FY 2016-17 Per Capita	$0.84	$2.18	$2.35	$2.41	$1.46	$1.21	$1.04	$1.51	$0.64	$0.00	$1.63	$4.78	$0.62	$0.70	$0.63	$1.03
% Change over FY 2015-16 Per Capita	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.96%

Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$366,151	$74,505	$536,817	$0	$496,755	$0	$0	$0	$1,873,683	$0	$176,254	$85,306	$0	$0	$0	$3,609,472
FY 2008-09	$352,841	$75,159	$520,646	$0	$626,486	$0	$0	$0	$2,101,664	$0	$184,279	$74,059	$0	$0	$0	$3,935,134
FY 2009-10 (DA)	$331,989	$116,999	$938,116	$0	$713,502	$0	$0	$0	$2,715,378	$0	$208,304	$87,465	$0	$0	$0	$5,111,753
FY 2010-11 (DA)	$423,286	$228,214	$1,552,759	$0	$1,040,646	$311,525	$0	$0	$3,471,301	$0	$230,751	$104,173	$0	$0	$0	$7,362,655
FY 2011-12	$859,426	$440,019	$3,171,186	$1,471	$7,022,639	$2,795,661	$79,568	$0	$11,137,412	$0	$901,952	$388,585	$0	$107	$1,155	$26,799,181
FY 2012-13	$891,053	$554,699	$4,645,223	$30,429	$10,789,570	$4,566,601	$1,856,177	$0	$16,990,695	$915,393	$1,635,596	$510,477	$22,681	$518	$4,894	$43,414,006
FY 2013-14	$1,068,732	$720,108	$5,526,534	$132,557	$12,235,127	$4,379,816	$6,391,109	$0	$40,842,333	$1,993,195	$1,857,728	$977,081	$49,027	$842	$26,279	$76,200,468
Estimated FY 2014-15	$749,167	$683,704	$5,541,852	$154,321	$17,109,631	$9,450,999	$33,302,313	$0	$60,526,274	$2,827,868	$2,266,232	$1,223,696	$68,343	$0	$5	$133,904,405
Estimated FY 2015-16	$712,507	$689,044	$5,619,749	$156,427	$17,607,047	$10,312,803	$37,398,052	$0	$60,302,781	$2,938,736	$2,304,634	$1,248,366	$70,393	$0	$2,300,189	$141,660,728
Estimated FY 2016-17	$731,373	$707,287	$5,768,537	$160,569	$18,073,209	$11,267,005	$42,354,810	$0	$64,706,759	$3,016,542	$2,365,650	$1,281,419	$72,256	$0	$3,437,354	$153,942,770

Percent Change in Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	-3.64%	0.88%	-3.01%	0.00%	26.12%	0.00%	0.00%	0.00%	12.17%	0.00%	4.55%	-13.18%	0.00%	0.00%	0.00%	9.02%
FY 2009-10 (DA)	-5.91%	55.67%	80.18%	0.00%	13.89%	0.00%	0.00%	0.00%	29.20%	0.00%	13.04%	18.10%	0.00%	0.00%	0.00%	29.90%
FY 2010-11 (DA)	27.50%	95.06%	65.52%	0.00%	45.85%	100.00%	0.00%	0.00%	27.84%	0.00%	10.78%	19.10%	0.00%	0.00%	0.00%	44.03%
FY 2011-12	103.04%	92.81%	104.23%	100.00%	574.83%	797.41%	100.00%	0.00%	220.84%	0.00%	290.88%	273.02%	0.00%	100.00%	100.00%	263.99%
FY 2012-13	3.68%	26.06%	46.48%	1968.59%	53.64%	63.35%	2232.82%	0.00%	52.56%	100.00%	81.34%	31.37%	100.00%	384.11%	323.72%	62.00%
FY 2013-14	19.94%	29.82%	18.97%	335.63%	13.40%	-4.09%	244.32%	0.00%	140.38%	117.74%	13.58%	91.41%	116.16%	62.55%	436.96%	75.52%
Estimated FY 2014-15	-29.90%	-5.06%	0.28%	16.42%	39.84%	115.79%	421.07%	0.00%	48.19%	41.88%	21.99%	25.24%	39.40%	-100.00%	-99.98%	75.73%
Estimated FY 2015-16	-4.89%	0.78%	1.41%	1.36%	2.91%	9.12%	12.30%	0.00%	-0.37%	3.92%	1.69%	2.02%	3.00%	0.00%	46003680.00%	5.79%
Estimated FY 2016-17	2.65%	2.65%	2.65%	2.65%	2.65%	9.25%	13.25%	0.00%	7.30%	2.65%	2.65%	2.65%	2.65%	0.00%	49.44%	8.67%

Per Capita Cost

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2007-08	$10.09	$12.12	$10.75	$0.00	$9.29	$0.00	$0.00	$0.00	$9.18	$0.00	$10.28	$13.57	$0.00	$0.00	$0.00	$9.21
FY 2008-09	$9.38	$11.66	$10.14	$0.00	$10.13	$0.00	$0.00	$0.00	$8.94	$0.00	$10.22	$10.62	$0.00	$0.00	$0.00	$9.01
FY 2009-10 (DA)	$8.63	$16.60	$17.61	$0.00	$9.53	$0.00	$0.00	$0.00	$9.85	$0.00	$11.33	$11.17	$0.00	$0.00	$0.00	$10.25
FY 2010-11 (DA)	$10.89	$29.38	$27.59	$0.00	$12.83	$11.47	$0.00	$0.00	$11.48	$0.00	$12.55	$13.24	$0.00	$0.00	$0.00	$13.13
FY 2011-12	$21.63	$52.49	$53.36	$28.29	$75.33	$78.84	$70.17	$0.00	$33.28	$0.00	$50.01	$50.93	$0.00	$0.04	$0.06	$43.23
FY 2012-13	$21.83	$61.29	$75.02	$34.27	$108.56	$109.92	$174.55	$0.00	$47.22	$111.15	$92.01	$63.62	$66.01	$0.19	$0.23	$63.56
FY 2013-14	$25.55	$73.09	$85.78	$51.78	$98.13	$93.03	$73.26	$0.00	$102.78	$73.78	$101.70	$74.25	$46.38	$0.34	$1.12	$88.51
Estimated FY 2014-15	$17.87	$63.08	$83.15	$41.71	$109.91	$146.38	$148.82	$0.00	$137.84	$54.07	$109.94	$80.91	$38.68	$0.00	$0.00	$118.87
Estimated FY 2015-16	$16.55	$60.22	$81.40	$35.89	$103.00	$146.13	$146.13	$0.00	$128.61	$51.81	$110.16	$81.42	$35.71	$0.00	$77.23	$115.94
Estimated FY 2016-17	$16.61	$59.06	$81.01	$32.43	$96.65	$147.66	$147.66	$0.00	$129.89	$49.11	$111.57	$82.66	$34.08	$0.00	$105.44	$116.97

Percent Change in Per Capita Cost

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
FY 2008-09	-7.04%	-3.80%	-5.67%	0.00%	9.04%	0.00%	0.00%	0.00%	-2.61%	0.00%	-0.58%	-21.74%	0.00%	0.00%	0.00%	-2.17%
FY 2009-10 (DA)	-8.00%	42.37%	73.67%	0.00%	-5.92%	0.00%	0.00%	0.00%	10.18%	0.00%	10.86%	5.18%	0.00%	0.00%	0.00%	13.76%
FY 2010-11 (DA)	26.19%	76.99%	56.67%	0.00%	34.63%	100.00%	0.00%	0.00%	16.55%	0.00%	10.77%	18.53%	0.00%	0.00%	0.00%	28.10%
FY 2011-12	98.62%	78.66%	93.40%	100.00%	487.14%	587.36%	100.00%	0.00%	189.90%	0.00%	298.49%	284.67%	0.00%	100.00%	100.00%	229.25%
FY 2012-13	0.92%	16.77%	40.59%	21.14%	44.11%	39.42%	148.75%	0.00%	41.89%	100.00%	83.98%	24.92%	100.00%	375.00%	283.33%	47.03%
FY 2013-14	17.04%	19.25%	14.34%	51.09%	-9.61%	-15.37%	-58.03%	0.00%	117.66%	-33.62%	10.53%	16.71%	-29.74%	78.95%	386.96%	39.25%
Estimated FY 2014-15	-30.06%	-13.70%	-3.07%	-19.45%	12.00%	57.35%	103.14%	0.00%	34.11%	-26.71%	8.10%	8.97%	-16.60%	-100.00%	-100.00%	34.30%
Estimated FY 2015-16	-7.39%	-4.53%	-2.10%	-13.95%	-6.29%	-0.17%	-1.81%	0.00%	-6.70%	-4.18%	0.20%	0.63%	-7.68%	0.00%	100.00%	-2.46%
Estimated FY 2016-17	0.36%	-1.93%	-0.48%	-9.64%	-6.17%	1.05%	1.05%	0.00%	1.00%	-5.21%	1.28%	1.52%	-4.56%	0.00%	36.53%	0.89%

Exhibit I - SERVICE MANAGEMENT - Prepaid Inpatient Health Plan Administration

Current Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RMHP	$67,063	$24,067	$161,928	$4,571	$253,972	$83,293	$22,204	$0	$894,967	$14,543	$59,950	$28,604	$955	$0	$5	$1,616,122
Estimated Expenditure for Colorado Access	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for Kaiser Foundation Health	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for CAHI	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for RCCOs in the ACC	$464,595	$449,295	$3,664,390	$101,999	$11,480,778	$6,380,561	$22,667,849	$0	$40,616,256	$1,916,220	$1,502,750	$814,005	$45,900	$0	$0	$90,104,598
Bottom Line Impact (RCCOs in the ACC)	$53,678	$51,909	$423,366	$11,784	$1,326,432	$737,178	$2,618,931	$0	$4,692,602	$221,391	$173,620	$94,046	$5,303	$0	$0	$10,410,240
Estimated Expenditure for PCMPs in the ACC	$139,002	$134,424	$1,096,348	$30,517	$3,434,932	$1,908,999	$6,781,989	$0	$12,151,970	$573,314	$449,607	$243,542	$13,733	$0	$0	$26,958,377
Bottom Line Impact (PCMPs in the ACC)	$6,950	$6,719	$54,803	$1,525	$171,702	$95,425	$339,012	$0	$607,441	$28,658	$22,475	$12,174	$686	$0	$0	$1,347,570
Estimated Expenditure for SDAC in the ACC	$17,879	$17,290	$141,017	$3,925	$441,815	$245,543	$872,328	$0	$1,563,038	$73,742	$57,830	$31,325	$1,766	$0	$0	$3,467,498
Estimated FY 2014-15 Total Expenditure	$749,167	$683,704	$5,541,852	$154,321	$17,109,631	$9,450,999	$33,302,313	$0	$60,526,274	$2,827,868	$2,266,232	$1,223,696	$68,343	$0	$5	$133,904,405
Estimated FY 2014-15 Per Capita Cost	$17.87	$63.08	$83.15	$41.71	$109.91	$146.38	$148.82	$0.00	$137.84	$54.07	$109.94	$80.91	$38.68	$0.00	$0.00	$118.87

Request Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RMHP	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for Colorado Access	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for Kaiser Foundation Health	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for CAHI	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for RCCOs in the ACC	$542,100	$524,247	$4,275,692	$119,015	$13,396,028	$7,846,324	$28,453,684	$0	$45,880,364	$2,235,889	$1,753,442	$949,799	$53,557	$0	$1,750,060	$107,780,201
Bottom Line Impact (RCCOs in the ACC)	($12,699)	($12,280)	($100,158)	($2,788)	($313,802)	($183,800)	($666,528)	$0	($1,074,748)	($52,376)	($41,074)	($22,249)	($1,255)	$0	($40,995)	($2,524,752)
Estimated Expenditure for PCMPs in the ACC	$162,191	$156,849	$1,279,244	$35,608	$4,007,955	$2,347,540	$8,513,052	$0	13,726,937	$668,955	$524,612	$284,170	$16,024	$0	$523,600	$32,246,737
Bottom Line Impact (PCMPs in the ACC)	$4,066	$3,933	$32,075	$893	$100,494	$58,861	$213,453	$0	$344,184	$16,773	$13,154	$7,125	$402	$0	$13,129	$808,542
Estimated Expenditure for SDAC in the ACC	$16,849	$16,295	$132,896	$3,699	$416,372	$243,878	$884,391	$0	$1,426,044	$69,495	$54,500	$29,521	$1,665	$0	$54,395	$3,350,000
Estimated FY 2015-16 Total Expenditure	$712,507	$689,044	$5,619,749	$156,427	$17,607,047	$10,312,803	$37,398,052	$0	$60,302,781	$2,938,736	$2,304,634	$1,248,366	$70,393	$0	$2,300,189	$141,660,728
Estimated FY 2015-16 Per Capita Cost	$16.55	$60.22	$81.40	$35.89	$103.00	$146.13	$146.13	$0.00	$128.61	$51.81	$110.16	$81.42	$35.71	$0.00	$77.23	$115.94

Out Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL
Estimated Expenditure for RMHP	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for Colorado Access	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for Kaiser Foundation Health	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for CAHI	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for RCCOs in the ACC	$550,694	$532,559	$4,343,481	$120,902	$13,608,413	$8,483,610	$31,891,501	$0	48,721,637	$2,271,337	$1,781,241	$964,858	$54,406	$0	$2,588,192	$115,912,831
Bottom Line Impact (RCCOs in the ACC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for PCMPs in the ACC	$164,762	$159,336	$1,299,525	$36,173	$4,071,499	$2,538,210	$9,541,612	$0	14,577,017	$679,561	$532,929	$288,676	$16,278	$0	$774,361	$34,679,939
Bottom Line Impact (PCMPs in the ACC)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Estimated Expenditure for SDAC in the ACC	$15,917	$15,392	$125,531	$3,494	$393,297	$245,185	$921,697	$0	$1,408,105	$65,644	$51,480	$27,885	$1,572	$0	$74,801	$3,350,000
Estimated FY 2016-17 Total Expenditure	$731,373	$707,287	$5,768,537	$160,569	$18,073,209	$11,267,005	$42,354,810	$0	$64,706,759	$3,016,542	$2,365,650	$1,281,419	$72,256	$0	$3,437,354	$153,942,770
Estimated FY 2016-17 Per Capita Cost	$16.61	$59.06	$81.01	$32.43	$96.65	$147.66	$147.66	$0.00	$129.89	$49.11	$111.57	$82.66	$34.08	$0.00	$105.44	$116.97

Note: Current and Request Year Projections are calculated in pages EI-9 and EI-10.

Exhibit I - SERVICE MANAGEMENT - Prepaid Inpatient Health Plan Administration

Cash Based Actuals by Provider

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2004-05	$3,308,119	$0	$0	$0	$0	$0	$0	$3,308,119
FY 2005-06	$4,285,446	$0	$0	$0	$0	$0	$0	$4,285,446
FY 2006-07	$5,340,741	$0	$0	$0	$0	$0	$0	$5,340,741
FY 2007-08	$4,620,417	$0	$0	$0	$0	$0	$0	$4,620,417
FY 2008-09	$3,609,472	$0	$0	$0	$0	$0	$0	$3,609,472
FY 2009-10 (DA)	$3,935,134	$258,779	$65,940	$42,300	$0	$0	$0	$4,302,153
FY 2010-11 (DA)	$4,744,734	$705,541	$130,440	$201,750	$182,819	$54,592	$650,000	$6,669,877
FY 2011-12	$5,437,512	$0	$240,000	$263,550	$12,303,473	$2,904,360	$2,700,000	$23,848,895
FY 2012-13	$6,685,075	$0	$0	$0	$27,696,161	$6,130,270	$2,902,500	$43,414,006
FY 2013-14	$7,630,138	$0	$0	$0	$52,945,462	$12,674,868	$2,950,000	$76,200,468
Estimated FY 2014-15	$1,616,122	$0	$0	$0	$100,514,838	$28,305,947	$3,467,498	$133,904,405
Estimated FY 2015-16	$0	$0	$0	$0	$105,255,449	$33,055,279	$3,350,000	$141,660,728
Estimated FY 2016-17	$0	$0	$0	$0	$115,912,831	$34,679,939	$3,350,000	$153,942,770

Percent Change in Cash Based Actuals

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2005-06	29.54%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	29.54%
FY 2006-07	24.63%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	24.63%
FY 2007-08	-13.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-13.49%
FY 2008-09	-21.88%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-21.88%
FY 2009-10 (DA)	9.02%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	19.19%
FY 2010-11 (DA)	20.57%	172.64%	97.82%	376.95%	100.00%	100.00%	100.00%	55.04%
FY 2011-12	14.60%	-100.00%	83.99%	30.63%	6629.87%	5220.12%	315.38%	257.56%
FY 2012-13	22.94%	0.00%	-100.00%	-100.00%	125.11%	111.07%	7.50%	82.04%
FY 2013-14	14.14%	0.00%	0.00%	0.00%	91.17%	106.76%	1.64%	75.52%
Estimated FY 2014-15	-78.82%	0.00%	0.00%	0.00%	89.85%	123.32%	17.54%	75.73%
Estimated FY 2015-16	-100.00%	0.00%	0.00%	0.00%	4.72%	16.78%	-3.39%	5.79%
Estimated FY 2016-17	0.00%	0.00%	0.00%	0.00%	10.13%	4.91%	0.00%	8.67%

Prepaid Inpatient Health Plan Enrollment

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL[1]
Enrollment in Current Prepaid Inpatient Health Plans								
FY 2004-05	13,086	-	-	-	-	-	-	13,086
FY 2005-06	13,025	-	-	-	-	-	-	13,025
FY 2006-07	11,794	-	-	-	-	-	-	11,794
FY 2007-08	11,955	-	-	-	-	-	-	11,955
FY 2008-09	13,051	-	-	-	-	-	-	13,051
FY 2009-10 (DA)	16,123	2,186	275	24	-	-	-	18,608
FY 2010-11 (DA)	19,045	1,826	544	112	1,172	1,172	1,172	25,043
FY 2011-12	21,138	-	-	163	78,870	60,540	78,870	100,171
FY 2012-13	29,875	-	-	-	226,499	169,874	226,499	256,374
FY 2013-14	31,185	-	-	-	454,447	349,924	454,447	485,632
Estimated FY 2014-15	6,649	-	-	-	729,393	561,633	729,393	736,042
Estimated FY 2015-16	-	-	-	-	872,477	671,807	872,477	872,477
Estimated FY 2016-17	-	-	-	-	938,310	722,499	938,310	938,310
Annual Percent Change in Enrollment								
FY 2005-06	-0.47%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.47%
FY 2006-07	-9.45%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-9.45%
FY 2007-08	1.37%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.37%
FY 2008-09	9.17%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.17%
FY 2009-10 (DA)	23.54%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	42.58%
FY 2010-11 (DA)	18.12%	-16.47%	97.82%	366.67%	100.00%	100.00%	100.00%	34.58%
FY 2011-12	10.99%	-100.00%	-100.00%	45.54%	6629.52%	5065.53%	6629.52%	300.00%
FY 2012-13	41.33%	0.00%	0.00%	-100.00%	187.18%	180.60%	187.18%	155.94%
FY 2013-14	4.38%	0.00%	0.00%	0.00%	100.64%	105.99%	100.64%	89.42%
Estimated FY 2014-15	-78.68%	0.00%	0.00%	0.00%	60.50%	60.50%	60.50%	51.56%
Estimated FY 2015-16	-100.00%	0.00%	0.00%	0.00%	19.62%	19.62%	19.62%	18.54%
Estimated FY 2016-17	0.00%	0.00%	0.00%	0.00%	7.55%	7.55%	7.55%	7.55%

Exhibit I - SERVICE MANAGEMENT - Prepaid Inpatient Health Plan Administration

Cost Per Enrollee

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2004-05	$252.80	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$252.80
FY 2005-06	$329.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$329.02
FY 2006-07	$452.84	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$452.84
FY 2007-08	$386.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$386.48
FY 2008-09	$276.57	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$276.57
FY 2009-10 (DA)	$244.07	$118.38	$239.78	$1,762.50	$0.00	$0.00	$0.00	$231.20
FY 2010-11 (DA)	$249.13	$386.39	$239.78	$1,801.34	$155.99	$46.58	$554.61	$266.34
FY 2011-12	$257.24	$0.00	$0.00	$1,616.87	$156.00	$47.97	$34.23	$238.08
FY 2012-13	$223.77	$0.00	$0.00	$0.00	$122.28	$36.09	$12.81	$169.34
FY 2013-14	$244.67	$0.00	$0.00	$0.00	$116.51	$36.22	$6.49	$156.91
Estimated FY 2014-15	$243.06	$0.00	$0.00	$0.00	$137.81	$50.40	$4.75	$181.92
Estimated FY 2015-16	$0.00	$0.00	$0.00	$0.00	$120.64	$49.20	$3.84	$162.37
Estimated FY 2016-17	$0.00	$0.00	$0.00	$0.00	$123.53	$48.00	$3.57	$164.06

Percent Change in Cost Per Enrollee

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
FY 2005-06	30.15%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	30.15%
FY 2006-07	37.63%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	37.63%
FY 2007-08	-14.65%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-14.65%
FY 2008-09	-28.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-28.44%
FY 2009-10 (DA)	-11.75%	100.00%	100.00%	100.00%	0.00%	0.00%	0.00%	-16.40%
FY 2010-11 (DA)	2.07%	226.40%	0.00%	2.20%	100.00%	100.00%	100.00%	15.20%
FY 2011-12	3.26%	-100.00%	-100.00%	-10.24%	0.01%	2.98%	-93.83%	-10.61%
FY 2012-13	-13.01%	0.00%	0.00%	-100.00%	-21.62%	-24.77%	-62.58%	-28.87%
FY 2013-14	9.34%	0.00%	0.00%	0.00%	-4.72%	0.36%	-49.34%	-7.34%
Estimated FY 2014-15	-0.66%	0.00%	0.00%	0.00%	18.28%	39.15%	-26.81%	15.94%
Estimated FY 2015-16	-100.00%	0.00%	0.00%	0.00%	-12.46%	-2.38%	-19.16%	-10.75%
Estimated FY 2016-17	0.00%	0.00%	0.00%	0.00%	2.40%	-2.44%	-7.03%	1.04%

Current Year Projection

Estimated FY 2014-15 Enrollment	6,649	0	-	-	729,393	561,633	N/A	736,042
FY 2014-15 PMPM Administration Fee	$24.62	$0.00	$0.00	$0.00	$10.00	$4.00	N/A	
Number of Months Paid	6	-	-	-	12	12	N/A	
Estimated FY 2014-15 Base Expenditure	$982,190	$0	$0	$0	$90,104,598	$26,958,377	$3,467,498	$121,512,663
FY 2014-15 BA-12 "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees"	$0	$0	$0	$0	$10,410,240	$1,347,570	$0	$11,757,810
Total Bottom Line Impacts	$0	$0	$0	$0	$10,410,240	$1,347,570	$0	$11,757,810
Estimated Contract Payment to PIHP for Cost Avoidance	$633,932	$0	$0	$0	$0	$0	$0	$633,932
Estimated FY 2014-15 Total Expenditure	**$1,616,122**	**$0**	**$0**	**$0**	**$100,514,838**	**$28,305,947**	**$3,467,498**	**$133,904,405**
Estimated FY 2014-15 Cost Per Enrollee	$243.06	$0.00	$0.00	$0.00	$137.81	$50.40	$4.75	$181.92
% Change over FY 2013-14 Cost Per Enrollee	8.62%	0.00%	0.00%	0.00%	18.28%	39.15%	-26.81%	7.43%

Request Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
Estimated FY 2015-16 Enrollment	-	0	-	-	872,477	671,807	N/A	872,477
FY 2015-16 PMPM Administration Fee	$0.00	$0.00	$0.00	$0.00	$10.29	$4.00	N/A	
Number of Months Paid	-	-	-	-	12	12	N/A	
Estimated FY 2015-16 Base Expenditure	$0	$0	$0	$0	$107,780,201	$32,246,737	$3,350,000	$143,376,938
FY 2014-15 BA-12 "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees" Annualization	$0	$0	$0	$0	($2,524,752)	$808,542	$0	($1,716,210)
Total Bottom Line Impacts	$0	$0	$0	$0	($2,524,752)	$808,542	$0	($1,716,210)
Estimated FY 2015-16 Total Expenditure	**$0**	**$0**	**$0**	**$0**	**$105,255,449**	**$33,055,279**	**$3,350,000**	**$141,660,728**
Estimated FY 2015-16 Cost Per Enrollee	$0.00	$0.00	$0.00	$0.00	$120.64	$49.20	$3.84	$162.37
% Change over FY 2014-15 Cost Per Enrollee	0.00%	0.00%	-100.00%	0.00%	-12.46%	-2.38%	-19.16%	-10.75%

Out Year Projection

PREPAID INPATIENT HEALTH PLAN ADMINISTRATION	Rocky Mountain Health Plans (RMHP)	Colorado Access	Kaiser Foundation Health Plan	Colorado Alliance Health & Independence (CAHI)	ACC: Regional Care Collaboration Organizations (RCCOs)	ACC: Primary Care Medical Providers (PCMPs)	ACC: Statewide Data and Analytics Contractor (SDAC)	TOTAL
Estimated FY 2016-17 Enrollment	-	0	0	-	938,310	722,499	N/A	938,310
FY 2016-17 PMPM Administration Fee	$0.00	$0.00	$0.00	$0.00	$10.29	$4.00	N/A	
Number of Months Paid	-	-	-	-	12	12	N/A	
Estimated FY 2016-17 Base Expenditure	$0	$0	$0	$0	$115,912,831	$34,679,939	$3,350,000	$153,942,770
FY 2014-15 BA-12 "State Demonstration to Integrate Care for Full Benefit Medicare-Medicaid Enrollees" Annualization	$0	$0	$0	$0	$0	$0	$0	$0
Total Bottom Line Impacts	$0	$0	$0	$0	$0	$0	$0	$0
Estimated FY 2016-17 Total Expenditure	**$0**	**$0**	**$0**	**$0**	**$115,912,831**	**$34,679,939**	**$3,350,000**	**$153,942,770**
Estimated FY 2016-17 Cost Per Enrollee	$0.00	$0.00	$0.00	$0.00	$123.53	$48.00	$3.57	$164.06
% Change over FY 2015-16 Cost Per Enrollee	0.00%	0.00%	0.00%	0.00%	2.40%	-2.44%	-7.03%	1.04%

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

(2) Percentages selected to modify enrollment:

RMHP: FY 2014-15 trend is based on reaching 0 enrollment by December 2014.

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

Kaiser Foundation Health Plan: Program ended June 30, 2012; all clients were disenrolled from program.

Colorado Alliance Health & Independence: Program ended January 1, 2013; all clients transitioned to ACC program.

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

Exhibit J - Health Care Affordability Act of 2009 Estimates

Cash Funded Expansion Populations
Source of Funding

FY 2014-15 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Hospital Provider Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
HB 09-1293 Medicaid Expansion Clients							
MAGI Parents/Caretakers 69% to 133% FPL	64,563	$155,799,067	$0	$0	$0	$155,799,067	100.00%
Buy-In for Individuals with Disabilities	3,700	$46,612,491	$0	$21,851,703	$2,236,793	$22,523,995	50.76%
MAGI Adults	222,554	$963,457,841	$0	$0	$0	$963,457,841	100.00%
Non-Newly Eligibles	1,221	$13,571,308	$0	$6,682,512	$0	$6,888,796	50.76%
MAGI Parents/Caretakers 60% to 68% FPL	6,502	$10,598,944	$0	$5,218,920	$0	$5,380,024	50.76%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$1,190,039,651	$0	$33,753,135	$2,236,793	$1,154,049,723	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$492,122,770	$0	$242,333,555	$0	$249,789,215	50.76%
Outpatient Hospital Rates		$208,209,644	$0	$102,527,634	$0	$105,682,010	50.76%
Supplemental Hospital Payments (Upper Payment Limit)		$56,721,476	$0	$27,931,073	$0	$28,790,403	50.76%
Supplemental Hospital Payments (DSH)		$0	$0	$0	$0	$0	50.76%
Subtotal from HB 09-1293 Supplemental Payments		$757,053,890	$0	$372,792,262	$0	$384,261,628	
Cash Fund Financing		$0	($22,131,818)	$22,131,818	$0	$0	
HB 09-1293 Total		**$1,947,093,541**	**($22,131,818)**	**$428,677,215**	**$2,236,793**	**$1,538,311,351**	

FY 2015-16 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Hospital Provider Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
HB 09-1293 Medicaid Expansion Clients							
MAGI Parents/Caretakers 69% to 133% FPL	70,573	$165,384,264	$0	$0	$0	$165,384,264	100.00%
Buy-in for Individuals with Disabilities	4,359	$55,807,053	$0	$26,045,001	$2,643,141	$27,118,911	51.01%
MAGI Adults	254,703	$1,151,229,723	$0	$0	$0	$1,151,229,723	100.00%
Non-Newly Eligibles	1,221	$13,842,735	$0	$6,781,555	$0	$7,061,180	51.01%
MAGI Parents/Caretakers 60% to 68% FPL	6,502	$10,810,923	$0	$5,296,271	$0	$5,514,652	51.01%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$1,397,074,698	$0	$38,122,827	$2,643,141	$1,356,308,730	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$533,138,270	$0	$261,184,438	$0	$271,953,832	51.01%
Outpatient Hospital Rates		$225,562,678	$0	$110,503,156	$0	$115,059,522	51.01%
Supplemental Hospital Payments (Upper Payment Limit)		$61,448,873	$0	$30,103,803	$0	$31,345,070	51.01%
Supplemental Hospital Payments (DSH)		$0	$0	$0	$0	$0	51.01%
Subtotal from HB 09-1293 Supplemental Payments		$820,149,821	$0	$401,791,397	$0	$418,358,424	
Cash Fund Financing		$0	($15,700,000)	$15,700,000	$0	$0	
HB 09-1293 Total		**$2,217,224,519**	**($15,700,000)**	**$455,614,224**	**$2,643,141**	**$1,774,667,154**	

FY 2016-17 Summary

Eligibility Category	Expenditure		Fund Calculations				
	Caseload	Expenditure	General Fund	Hospital Provider Fee Cash Fund	Medicaid Buy-in Cash Fund	Federal Funds	FMAP
HB 09-1293 Medicaid Expansion Clients							
MAGI Parents/Caretakers 69% to 133% FPL	76,305	$169,370,184	$0	$4,234,255	$0	$165,135,929	97.50%
Buy-in for Individuals with Disabilities	4,951	$65,343,135	$0	$30,536,950	$3,010,108	$31,796,077	51.01%
MAGI Adults	285,624	$1,306,591,438	$0	$32,664,786	$0	$1,273,926,652	97.50%
Non-Newly Eligibles	1,221	$14,119,589	$0	$6,917,187	$0	$7,202,402	51.01%
MAGI Parents/Caretakers 60% to 68% FPL	6,502	$11,027,141	$0	$5,402,196	$0	$5,624,945	51.01%
Subtotal from HB 09-1293 Medicaid Expansion Clients		$1,566,451,487	$0	$79,755,374	$3,010,108	$1,483,686,005	
HB 09-1293 Supplemental Payments							
Inpatient Hospital Rates		$533,138,270	$0	$261,184,438	$0	$271,953,832	51.01%
Outpatient Hospital Rates		$225,562,678	$0	$110,503,156	$0	$115,059,522	51.01%
Supplemental Hospital Payments (Upper Payment Limit)		$61,448,873	$0	$30,103,803	$0	$31,345,070	51.01%
Supplemental Hospital Payments (DSH)		$0	$0	$0	$0	$0	51.01%
Subtotal from HB 09-1293 Supplemental Payments		$820,149,821	$0	$401,791,397	$0	$418,358,424	
Cash Fund Financing		$0	($15,700,000)	$15,700,000	$0	$0	
HB 09-1293 Total		**$2,386,601,308**	**($15,700,000)**	**$497,246,771**	**$3,010,108**	**$1,902,044,429**	

Hospital Provider Fee - Fund Splits and Service Category Impacts by Expansion Population
FY 2014-15

MAGI Parents/Caretakers 69% to 133% FPL[2]							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,262.55	$146,077,167	$0	$0	$0	$146,077,167
Community Based Long-Term Care		$2.88	$185,851	$0	$0	$0	$185,851
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$147.70	$9,536,049	$0	$0	$0	$9,536,049
Total	**64,563**	**$2,413.13**	**$155,799,067**	**$0**	**$0**	**$0**	**$155,799,067**
Buy-In for Individuals with Disabilities							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$12,007.91	$44,429,269	$0	$20,828,219	$2,132,027	$21,469,023
Community Based Long-Term Care		$437.36	$1,618,222	$0	$758,614	$77,654	$781,954
Long-Term Care		$108.16	$400,180	$0	$187,603	$19,203	$193,374
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$44.55	$164,820	$0	$77,267	$7,909	$79,644
Total	**3,700**	**$12,597.97**	**$46,612,491**	**$0**	**$21,851,703**	**$2,236,793**	**$22,523,995**
MAGI Adults[2]							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$4,168.05	$927,616,687	$0	$0	$0	$927,616,687
Community Based Long-Term Care		$10.48	$2,331,549	$0	$0	$0	$2,331,549
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$150.57	$33,509,605	$0	$0	$0	$33,509,605
Total	**222,554**	**$4,329.10**	**$963,457,841**	**$0**	**$0**	**$0**	**$963,457,841**
Non-Newly Eligibles							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$10,911.07	$13,322,419	$0	$6,559,959	$0	$6,762,460
Community Based Long-Term Care		$155.74	$190,158	$0	$93,634	$0	$96,524
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$48.10	$58,731	$0	$28,919	$0	$29,812
Total	**1,221**	**$11,114.91**	**$13,571,308**	**$0**	**$6,682,512**	**$0**	**$6,888,796**
MAGI Parents/Caretakers 60% to 68% FPL							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$1,526.93	$9,928,122	$0	$4,888,607	$0	$5,039,515
Community Based Long-Term Care		$0.00	$0	$0	$0	$0	$0
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$103.17	$670,822	$0	$330,313	$0	$340,509
Total	**6,502**	**$1,630.11**	**$10,598,944**	**$0**	**$5,218,920**	**$0**	**$5,380,024**
FY 2014-15 Summary							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**298,540**	**$3,986.20**	**$1,190,039,651**	**$0**	**$33,753,135**	**$2,236,793**	**$1,154,049,723**

(1) Figures may not sum due to rounding.

(2) The Department assumes that matching federal funds for this population will increase from 50% to 100% effective January 1, 2014 in accordance with the Affordable Care Act.

Hospital Provider Fee - Fund Splits and Service Category Impacts by Expansion Population
FY 2015-16

MAGI Parents/Caretakers 69% to 133% FPL[2]							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,193.26	$154,785,190	$0	$0	$0	$154,785,190
Community Based Long-Term Care		$2.85	$201,221	$0	$0	$0	$201,221
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$147.33	$10,397,853	$0	$0	$0	$10,397,853
Total	**70,573**	**$2,343.45**	**$165,384,264**	**$0**	**$0**	**$0**	**$165,384,264**
Buy-In for Individuals with Disabilities							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$12,254.99	$53,419,480	$0	$24,930,726	$2,530,061	$25,958,693
Community Based Long-Term Care		$415.91	$1,812,973	$0	$846,110	$85,866	$880,997
Long-Term Care		$93.52	$407,674	$0	$190,261	$19,308	$198,105
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$38.29	$166,926	$0	$77,904	$7,906	$81,116
Total	**4,359**	**$12,802.72**	**$55,807,053**	**$0**	**$26,045,001**	**$2,643,141**	**$27,118,911**
MAGI Adults[2]							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds[2]**
Acute Care		$4,361.79	$1,110,961,738	$0	$0	$0	$1,110,961,738
Community Based Long-Term Care		$10.46	$2,663,816	$0	$0	$0	$2,663,816
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$147.64	$37,604,169	$0	$0	$0	$37,604,169
Total	**254,703**	**$4,519.89**	**$1,151,229,723**	**$0**	**$0**	**$0**	**$1,151,229,723**
Non-Newly Eligibles							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$11,129.29	$13,588,868	$0	$6,657,186	$0	$6,931,682
Community Based Long-Term Care		$158.85	$193,961	$0	$95,021	$0	$98,940
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$49.06	$59,906	$0	$29,348	$0	$30,558
	1,221	**$11,337.21**	**$13,842,735**	**$0**	**$6,781,555**	**$0**	**$7,061,180**
MAGI Parents/Caretakers 60% to 68% FPL							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$1,557.47	$10,126,685	$0	$4,961,063	$0	$5,165,622
Community Based Long-Term Care		$0.00	$0	$0	$0	$0	$0
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$105.24	$684,238	$0	$335,208	$0	$349,030
Total	**6,502**	**$1,662.71**	**$10,810,923**	**$0**	**$5,296,271**	**$0**	**$5,514,652**
FY 2015-16 Summary							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**337,358**	**$4,141.22**	**$1,397,074,698**	**$0**	**$38,122,827**	**$2,643,141**	**$1,356,308,730**

(1) Figures may not sum due to rounding.

(2) The Department assumes that matching federal funds for this population will increase from 50% to 100% effective January 1, 2014 in accordance with the Affordable Care Act.

Hospital Provider Fee - Fund Splits and Service Category Impacts by Expansion Population
FY 2016-17

MAGI Parents/Caretakers 69% to 133% FPL[2]							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$2,067.94	$157,794,346	$0	$3,944,859	$0	$153,849,487
Community Based Long-Term Care		$2.84	$216,504	$0	$5,413	$0	$211,091
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$148.87	$11,359,334	$0	$283,983	$0	$11,075,351
Total	**76,305**	**$2,219.65**	**$169,370,184**	**$0**	**$4,234,255**	**$0**	**$165,135,929**
Buy-In for Individuals with Disabilities							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$12,672.93	$62,743,677	$0	$29,322,140	$2,890,361	$30,531,176
Community Based Long-Term Care		$407.05	$2,015,293	$0	$941,811	$92,837	$980,645
Long-Term Care		$83.15	$411,664	$0	$192,384	$18,964	$200,316
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$34.84	$172,501	$0	$80,615	$7,946	$83,940
Total	**4,951**	**$13,197.97**	**$65,343,135**	**$0**	**$30,536,950**	**$3,010,108**	**$31,796,077**
MAGI Adults[2]							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds[1]**
Acute Care		$4,414.92	$1,261,007,396	$0	$31,525,185	$0	$1,229,482,211
Community Based Long-Term Care		$10.48	$2,992,017	$0	$74,800	$0	$2,917,217
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$149.12	$42,592,025	$0	$1,064,801	$0	$41,527,224
Total	**285,624**	**$4,574.52**	**$1,306,591,438**	**$0**	**$32,664,786**	**$0**	**$1,273,926,652**
Non-Newly Eligibles							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$11,351.88	$13,860,645	$0	$6,790,330	$0	$7,070,315
Community Based Long-Term Care		$162.03	$197,840	$0	$96,922	$0	$100,918
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$50.04	$61,104	$0	$29,935	$0	$31,169
Total	**1,221**	**$11,563.95**	**$14,119,589**	**$0**	**$6,917,187**	**$0**	**$7,202,402**
MAGI Parents/Caretakers 60% to 68% FPL							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Acute Care		$1,588.62	$10,329,218	$0	$5,060,284	$0	$5,268,934
Community Based Long-Term Care		$0.00	$0	$0	$0	$0	$0
Long-Term Care		$0.00	$0	$0	$0	$0	$0
Insurance		$0.00	$0	$0	$0	$0	$0
Service Management		$107.34	$697,923	$0	$341,912	$0	$356,011
Total	**6,502**	**$1,695.96**	**$11,027,141**	**$0**	**$5,402,196**	**$0**	**$5,624,945**
FY 2016-17 Summary							
	Caseload	**Per Capita**	**Total Funds [1]**	**General Fund**	**Hospital Provider Fee Fund**	**Medicaid Buy-in Fund**	**Federal Funds**
Total	**374,603**	**$4,181.63**	**$1,566,451,487**	**$0**	**$79,755,374**	**$3,010,108**	**$1,483,686,005**

(1) Figures may not sum due to rounding.

(2) The Department assumes that matching federal funds for this population will decrease from 100% to 95% effective January 1, 2017 in accordance with the Affordable Care Act.

Exhibit K - Upper Payment Limit Financing

Summary of Upper Payment Limit Financing

Nursing Facilities UPL	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**
Total Funds	$4,145,989	$4,229,696	$4,270,527
General Fund	($4,145,988)	($4,272,205)	($4,446,613)
Cash Funds	$4,145,989	$4,229,696	$4,270,527
Federal Funds	$4,145,988	$4,272,205	$4,446,613
Home Health UPL			
Total Funds	$919,804	$928,683	$952,195
General Fund	($929,048)	($966,976)	($991,456)
Cash Funds	$919,804	$928,683	$952,195
Federal Funds	$929,048	$966,976	$991,456
Total Upper Payment Limit Financing			
Total Funds	$5,065,793	$5,158,379	$5,222,722
General Fund	($5,075,036)	($5,239,181)	($5,438,069)
Cash Funds	$5,065,793	$5,158,379	$5,222,722
Federal Funds	$5,075,036	$5,239,181	$5,438,069

Exhibit K - Upper Payment Limit Financing

Nursing Facilities Upper Payment Limit Calculation
Estimate Based on Calendar Year 2013 Actual Upper Payment Limit

State Nursing Facilities		
Provider Name	**Upper Payment Limit (Amount Remaining after Medicaid Payment)**	**Certified Uncompensated Cost[(1)]**
Colorado St. Veterans - Fitzsimmons	$2,405,245	$1,533,922
Colorado St. Veterans - Florence	$1,166,594	$951,818
Colorado St. Veterans - Homelake	($545,838)	($35,435)
Colorado St. Veterans - Rifle	$1,200,472	$1,008,221
Colorado St. Veterans - Walsenburg	$393,980	$592,060
State Nursing Facilities Total	**$4,620,453**	**$4,050,586**
Government Nursing Facilities		
Arkansas Valley	$755,141	$661,376
Bent County Healthcare Center	($40,839)	($213,325)
Cheyenne Manor	$567,840	$304,999
Cripple Creek Rehabilitation & Wellness Center	$239,758	$8,517
E. Dene Moore Care Center	$1,014,905	$1,255,640
Gunnison Valley Health Senior Care	$169,941	$68,569
Lincoln Community Hospital & Nursing Home	$369,990	$21,614
Prospect Park Living Center	$284,875	$275,578
Sedgwick County Hospital & Nursing Home	$8,704	($23,609)
Southeast Colorado Hospital & LTC Center	$210,678	$450,135
Walbridge Memorial Convalescent Wing	$622,142	$578,988
Walsh Healthcare Center	$166,103	$387,909
Washington County Nursing Home	($66,561)	$6,990
Weisbrod Memorial County Hospital & Nursing Home	$190,667	$295,422
Government Nursing Facilities Total	**$4,493,344**	**$4,078,803**

(1) Certified uncompensated costs will be updated in the Department's February Medical Services Premiums request.

Exhibit K - Upper Payment Limit Financing

Supplemental Medicaid Nursing Facilities Payment	
Estimated CY 2013 Upper Payment Limit	$8,291,977
Estimated CY 2014 Upper Payment Limit	$8,501,901
Estimated CY 2015 Upper Payment Limit	$8,717,140
Supplemental Medicaid Nursing Facility Payment FY 2014-15	
Total Funds	$4,145,989
General Fund (offset by Federal Funds)	($4,145,988)
Cash Funds	$4,145,989
Federal Funds	$4,145,988
Supplemental Medicaid Nursing Facility Payment FY 2015-16	
Total Funds	$4,229,696
General Fund (offset by Federal Funds)	($4,272,205)
Cash Funds	$4,229,696
Federal Funds	$4,272,205
Supplemental Medicaid Nursing Facility Payment FY 2016-17	
Total Funds	$4,270,527
General Fund (offset by Federal Funds)	($4,446,613)
Cash Funds	$4,270,527
Federal Funds	$4,446,613
CY 2013 Inflation Factor [(1)]	**2.53%**
(1) Consumer Price Index for Urban Wage Earners and Clerical Workers, Medical Care, US City Average	

Exhibit K - Upper Payment Limit Financing

Home Health Certified Public Expenditure Calculation
Estimate Based on Calendar Year 2014 Estimate (Based on CY 2013 Expenditures)

Provider Name	Total Federal Funds by Provider
Alamosa County Nursing Service	($23,351)
Bent County Nursing Service	$21,464
Delta Montrose Home Health Services	$75,407
Estes Park Home Health	$46,965
Grand County Nursing Service	$11,080
Kiowa Home Health	$25,550
Kit Carson County Home Health	$6,360
Lincoln Community Home Health	$9,141
Pioneers Hospital Home Health	$4,580
Prowers Home Health	$12,858
Rangely District Home Health	$0
Southeast Colorado Hospital Home Health	$13,760
St Vincent Home Health Care	$1,599,629
Yuma District Home Health Care	$45,409
Home Health Total	**$1,848,852**

Exhibit K - Upper Payment Limit Financing

Supplemental Medicaid Home Health Payment	
CY 2014 Upper Payment Limit	$1,848,852
CY 2015 Upper Payment Limit	$1,895,659
CY 2016 Upper Payment Limit	$1,943,651
Supplemental Medicaid Home Health Payment FY 2014-15	
Total Funds	$919,804
General Fund	($929,048)
Cash Funds	$919,804
Federal Funds	$929,048
Supplemental Medicaid Home Health Payment FY 2015-16	
Total Funds	$928,683
General Fund	($966,976)
Cash Funds	$928,683
Federal Funds	$966,976
Supplemental Medicaid Home Health Payment FY 2016-17	
Total Funds	$952,195
General Fund	($991,456)
Cash Funds	$952,195
Federal Funds	$991,456
CY 2013 Inflation Factor [(1)]	**2.53%**
(1) Consumer Price Index for Urban Wage Earners and Clerical Workers, Medical Care, US City Average.	

Exhibit K - Upper Payment Limit Financing

Medicaid Eligible Inpatient Days from the Cost Report ending in Calendar Year 2012 for FY 2013-14 Participating Colorado Indigent Care Program Providers per HB 04-1438

Hospitals	Medicaid Eligible Inpatient Days	Total Inpatient Days	Percent of Medicaid Eligible Inpatient Days
State Owned			
University of Colorado Hospital	34,054	129,693	26.26%
Non State Owned Public			
Arkansas Valley Regional Medical Center	2,419	6,623	36.52%
Aspen Valley Hospital	275	2,946	9.33%
Delta County Memorial Hospital	1,622	7,233	22.42%
Denver Health Medical Center	54,002	111,354	48.50%
East Morgan County Hospital	310	1,616	19.18%
Grand River Medical Center	179	1,035	17.29%
Gunnison Valley Hospital	266	1,533	17.35%
Heart of the Rockies Regional Medical Center	521	3,580	14.55%
Middle Park Medical Center	40	241	16.60%
Melissa Memorial Hospital	98	453	21.63%
The Memorial Hospital	651	87,463	0.74%
Memorial Hospital	25,091	87,463	28.69%
Montrose Memorial Hospital	2,182	11,687	18.67%
North Colorado Medical Center	14,924	56,657	26.34%
Poudre Valley Hospital	14,714	29,216	50.36%
Prowers Medical Center	977	2,287	42.72%
Sedgwick County Memorial Hospital	115	450	25.56%
Southeast Colorado Hospital	571	508	112.40%
Southwest Memorial Hospital	1,320	4,166	31.69%
Spanish Peaks Regional Health Center	188	698	26.93%
St. Vincent General Hospital District	125	567	22.05%
Wray Community District Hospital	304	1,179	25.78%
Yuma District Hospital	158	774	20.41%

Exhibit K - Upper Payment Limit Financing

Medicaid Eligible Inpatient Days from the Cost Report ending in Calendar Year 2012 for FY 2013-14 Participating Colorado Indigent Care Program Providers per HB 04-1438

Hospitals	Medicaid Eligible Inpatient Days	Total Inpatient Days	Percent of Medicaid Eligible Inpatient Days
Private			
Boulder Community Hospital	4,285	40,492	10.58%
Centura Health - Penrose -St. Francis Health Services	14,549	90,290	16.11%
Centura Health - St. Mary-Corwin Medical Center	9,484	31,613	30.00%
Centura Health - St. Thomas More Hospital	1,763	7,149	24.66%
Colorado Plains Medical Center	2,115	7,033	30.07%
Community Hospital	1,866	5,953	31.35%
Conejos County Hospital	257	524	49.05%
Highlands Behavioral Health System	0	23,568	0.00%
Longmont United Hospital	6,458	29,202	22.11%
McKee Medical Center	3,445	17,095	20.15%
Medical Center of the Rockies	3,008	15,130	19.88%
Mercy Medical Center	1,532	16,246	9.43%
Mount San Rafael Hospital	1,043	2,380	43.82%
National Jewish Health	90	188	47.87%
Parkview Medical Center	20,578	74,887	27.48%
Pikes Peak Regional Hospital	266	1,432	18.58%
Platte Valley Medical Center	4,020	11,296	35.59%
Rio Grande Hospital	248	1,048	23.66%
San Luis Valley Regional Medical Center	2,643	6,863	38.51%
St. Mary's Hospital and Medical Center	10,738	61,297	17.52%
Sterling Regional MedCenter	1,013	4,130	24.53%
Children's Hospital Colorado	43,494	86,483	50.29%
Valley View Hospital	6,751	10,973	61.52%
Yampa Valley Medical Center	815	4,530	17.99%

Note: Figures from Cost Report Year End (CRYE) 2012. Totals will be updated with CRYE 2013 data in the Department's February 2015 Medical Services Premiums request.

Exhibit L - Recoveries

Department Recovery Revenue									
Recovery Category	**FY 2008-09**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**Estimated FY 2014-15**	**Estimated FY 2015-16**	**Estimated FY 2016-17**
Estate Recoveries[1]	$3,168,376	$3,682,865	$3,006,302	$2,993,722	$4,679,459	$5,283,510	$6,096,833	$7,035,355	$8,118,350
Income Trust and Repayments[1]	$3,242,100	$3,217,373	$4,021,065	$4,202,267	$3,976,905	$3,467,692	$4,001,494	$4,617,468	$5,328,263
Third Party Health Insurance	$8,705,554	$14,857,476	$17,714,457	$19,834,962	$27,406,316	$21,063,474	$24,305,901	$28,047,454	$32,364,968
Third Party Casualty	$3,812,718	$3,917,944	$4,664,590	$6,983,907	$5,660,459	$7,093,986	$8,186,006	$9,446,127	$10,900,226
Total Recoveries Including Bottom Line Impacts[2]	**$18,928,748**	**$25,675,658**	**$29,406,414**	**$34,014,858**	**$41,723,139**	**$36,908,661**	**$42,590,234**	**$49,146,404**	**$56,711,806**

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

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

Contingency and Contractor Payments									
Recovery Category	**Contingency Amount[4]**	**FY 2009-10**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**FY 2013-14**	**Estimated FY 2014-15**	**Estimated FY 2015-16**	**Estimated FY 2016-17**
Estate Recoveries	11.50%	$386,701	$315,662	$314,341	$491,343	$554,769	$701,136	$809,066	$933,610
Income Trust and Repayments[3]	0.00%	$0	$0	$0	$0	$0	$0	$0	$0
Third Party Health Insurance	6.90%	$876,591	$1,045,153	$1,170,263	$1,616,973	$1,242,745	$1,677,107	$1,935,274	$2,233,183
Third Party Casualty	9.40%	$329,107	$391,826	$586,648	$475,479	$595,895	$769,485	$887,936	$1,024,621
Total		**$1,592,399**	**$1,752,641**	**$2,071,252**	**$2,583,795**	**$2,393,409**	**$3,147,728**	**$3,632,276**	**$4,191,414**

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

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

Fund Splits					
Total Medical Services Premiums Impact	**Total Funds**	**General Fund**	**Cash Funds**	**Federal Funds**	**FFP**
FY 2014-15	$0	($19,721,253)	$39,442,506	($19,721,253)	50.00%
FY 2015-16	$0	($18,933,877)	$45,514,128	($26,580,251)	58.40%
FY 2016-17	$0	($17,442,022)	$52,520,392	($35,078,370)	66.79%

Recovery Trend for FY 2013-14 to FY 2014-15	15.39%
Recovery Trend for FY 2014-15 to FY 2015-16	15.39%
Recovery Trend for FY 2015-16 to FY 2016-17	15.39%

Cash-based Actuals																
FY 2013-14	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care																
Physician Services & EPSDT	$4,043,358	$9,764,022	$65,059,985	$4,447,494	$79,412,236	$22,746,644	$62,764,565	$0	$140,057,642	$7,150,906	$11,140,179	$32,810,094	$2,342,191	$5,996,669	$6,241	$447,742,226
Emergency Transportation	$122,767	$386,959	$2,292,281	$74,609	$1,688,406	$377,423	$2,529,108	$0	$1,828,742	$101,343	$217,731	$417,922	$13,119	$74,649	$793	$10,125,852
Non-emergency Medical Transportation	$2,801,468	$1,681,808	$6,714,864	$104,987	$787,858	$134,029	$884,418	$0	$1,311,128	$15,344	$186,648	$108,329	$158	$1,171	$2,733	$14,734,943
Dental Services	$1,794,852	$558,246	$6,514,545	$182,628	$9,153,795	$2,701,535	$7,009,072	$0	$104,119,680	$8,541,901	$5,427,900	$750,185	$40,847	$6,551	$2,203	$146,803,940
Family Planning	$171	$148	$21,457	$519	$324,023	$120,585	$108,540	$0	$233,506	$16,551	$87,920	$40,688	$4,468	$0	$0	$958,576
Health Maintenance Organizations	$5,677,843	$8,172,001	$42,251,264	$413,617	$24,329,657	$7,208,136	$990,043	$0	$42,468,749	$669,190	$842,135	$2,809,459	$57,645	$0	$983	$135,890,722
Inpatient Hospitals	$12,214,429	$15,459,639	$100,723,524	$9,865,184	$53,019,260	$14,695,913	$82,271,168	$0	$95,663,616	$4,392,433	$5,454,304	$50,204,702	$4,454,216	$29,904,181	($11,278)	$478,311,291
Outpatient Hospitals	$4,073,018	$8,674,477	$63,033,295	$4,581,825	$83,219,305	$28,408,884	$80,209,873	$0	$94,774,613	$8,822,676	$6,710,556	$11,729,493	$922,940	$1,990,324	$18,275	$397,169,554
Lab & X-Ray	$561,228	$1,308,244	$8,043,314	$412,716	$19,064,302	$5,597,136	$12,668,155	$0	$7,907,340	$761,171	$1,363,487	$6,344,321	$498,413	$154,559	$389	$64,684,775
Durable Medical Equipment	$19,993,666	$6,603,977	$58,381,851	$1,146,426	$6,130,253	$1,697,299	$6,071,020	$0	$13,719,965	$776,900	$4,764,199	$321,824	$12,827	$191	$41,277	$119,661,675
Prescription Drugs	$7,635,879	$20,390,022	$140,653,748	$5,070,325	$74,904,567	$23,282,207	$70,931,016	$0	$84,192,460	$2,580,080	$18,780,213	$4,650,844	$100,082	$0	$19,995	$453,191,438
Drug Rebate	($3,290,157)	($8,785,678)	($60,605,064)	($2,184,708)	($32,274,974)	($10,031,867)	($30,562,845)	$0	($36,242,885)	($1,145,777)	($8,092,042)	($2,003,033)	($44,052)	$0	($8,616)	($195,271,698)
Rural Health Centers	$76,264	$269,623	$1,260,474	$49,323	$2,842,709	$927,828	$1,552,329	$0	$6,607,213	$393,261	$338,606	$469,523	$28,873	$9,802	$68	$14,825,896
Federally Qualified Health Centers	$1,026,219	$1,398,281	$8,662,577	$258,811	$17,770,985	$6,072,398	$19,765,328	$0	$57,631,709	$3,750,977	$1,880,042	$8,868,545	$646,513	$373,196	$1,908	$128,107,489
Co-Insurance (Title XVIII-Medicare)	$22,734,911	$3,929,241	$16,405,226	$756,407	$1,713,377	$564,799	$277,023	$0	$24,172	$658	$6,921	$51,209	$1,510	$0	$8,438,925	$54,904,379
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$8,879,647	$0	$0	$0	$0	$0	$0	$0	$8,879,647
Prepaid Inpatient Health Plan Services	$1,461,833	$2,659,699	$15,888,654	$598,122	$14,862,251	$3,626,623	$888,577	$0	$12,683,640	$202,815	$1,928,356	$3,999,920	$129,215	$0	$2,858	$58,932,563
Other Medical Services	$849	$686	$5,161	$227	$2,945	$903	$2,768	$68	$5,147	$322	$548	$931	$76	$304	$56	$20,991
Home Health	$30,998,094	$10,343,791	$141,360,112	$1,581,353	$1,020,992	$240,128	$1,602,584	$0	$8,897,054	$346,230	$12,454,043	$87,493	$2,994	$0	$400,318	$209,335,186
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$111,926,692**	**$82,815,186**	**$616,667,268**	**$27,359,865**	**$357,971,947**	**$108,370,603**	**$319,962,742**	**$8,879,715**	**$635,883,491**	**$37,376,981**	**$63,491,746**	**$121,662,449**	**$9,212,035**	**$38,511,597**	**$8,917,128**	**$2,549,009,445**
Community Based Long Term Care																
HCBS - Elderly, Blind, and Disabled	$137,529,774	$24,219,087	$115,680,698	$724,923	$186,239	$29,760	$263,750	$0	$1,630	$0	$148,720	$0	$0	$0	$738,607	$279,523,188
HCBS - Mental Illness	$4,841,365	$4,065,194	$22,793,556	$33,366	$4,185	$40	$54,018	$0	$0	$0	$649	$35	$0	$0	$126,821	$31,919,229
HCBS - Disabled Children	$0	$0	$7,856,110	$17	$0	$0	$0	$0	$245,654	$0	$0	$0	$0	$0	$0	$8,101,781
HCBS - Persons Living with AIDS	$9,821	$813	$125,099	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$135,733
HCBS - Consumer Directed Attendant Support	$1,147,005	$201,988	$964,783	$6,046	$1,553	$248	$2,200	$0	$14	$0	$1,240	$0	$0	$0	$6,160	$2,331,237
HCBS - Brain Injury	$412,822	$1,254,551	$12,464,998	$4,821	$12,089	$0	$18,321	$0	$0	$0	$0	$0	$0	$0	$16,475	$14,184,077
HCBS - Children with Autism	$0	$0	$733,096	$2,563	$0	$0	$0	$0	$13,349	$0	$15,294	$0	$0	$0	$0	$764,302
HCBS - Pediatric Hospice	$0	$0	$214,922	$0	$0	$0	$0	$0	$3,510	$0	$3,200	$0	$0	$0	$0	$221,632
HCBS - Spinal Cord Injury	$214,216	$19,446	$1,537,988	$0	$1,105	$0	$817	$0	$0	$0	$0	$0	$0	$0	$0	$1,773,572
Private Duty Nursing	$3,039,698	$734,755	$35,345,893	$280,781	$0	$0	$43,544	$0	$3,373,711	$400	$10,310,507	$0	$0	$0	$25,614	$53,154,903
Hospice	$31,935,985	$3,814,200	$7,418,711	$344,667	$158,722	$144,242	$1,024,926	$0	$149,582	$0	$0	$0	$0	$0	$26,219	$45,017,254
Subtotal Community Based Long Term Care	**$179,130,686**	**$34,310,034**	**$205,135,854**	**$1,397,184**	**$363,893**	**$174,290**	**$1,407,576**	**$0**	**$3,787,450**	**$400**	**$10,479,610**	**$35**	**$0**	**$0**	**$939,896**	**$437,126,908**
Long Term Care																
Class I Nursing Facilities	$440,587,143	$38,148,380	$81,720,674	$387,966	$125,945	$0	$570,397	$0	$0	$0	$0	$0	$0	$0	$784,886	$562,325,391
Class II Nursing Facilities	$393,954	$298,879	$2,748,163	$0	$0	$0	$43,770	$0	$0	$0	$0	$0	$0	$0	$0	$3,484,766
Program of All-Inclusive Care for the Elderly	$85,832,165	$10,249,500	$4,393,152	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$100,474,817
Subtotal Long Term Care	**$526,813,262**	**$48,696,759**	**$88,861,989**	**$387,966**	**$125,945**	**$0**	**$614,167**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$784,886**	**$666,284,974**
Insurance																
Supplemental Medicare Insurance Benefit	$68,884,741	$4,016,960	$36,108,399	$0	$225,857	$0	$0	$0	$0	$0	$0	$0	$0	$0	$19,932,724	$129,168,681
Health Insurance Buy-In Program	$11,744	$20,552	$1,215,523	$0	$26,425	$0	$0	$0	$60,491	$0	$21,718	$8,808	$0	$0	$0	$1,365,261
Subtotal Insurance	**$68,896,485**	**$4,037,512**	**$37,323,922**	**$0**	**$252,282**	**$0**	**$0**	**$0**	**$60,491**	**$0**	**$21,718**	**$8,808**	**$0**	**$0**	**$19,932,724**	**$130,533,942**
Service Management																
Single Entry Points	$7,836,051	$2,131,642	$15,256,301	$107,844	$14,555	$3,169	$35,876	$376	$1,156,908	$0	$248,772	$161	$0	$0	$107,361	$26,899,016
Disease Management	$7,234	$17,469	$116,400	$7,957	$142,079	$40,697	$112,294	$0	$0	$0	$19,931	$62,892	$0	$0	$0	$526,953
Prepaid Inpatient Health Plan Administration	$521,003	$251,547	$1,474,302	$43,729	$1,553,848	$424,799	$88,292	$0	$2,691,223	$43,733	$263,625	$262,766	$8,772	$0	$2,499	$7,630,138
Accountable Care Collaborative	$547,729	$468,561	$4,052,232	$88,828	$10,681,279	$3,955,017	$6,302,817	$0	$38,151,110	$1,949,462	$1,594,103	$714,315	$40,255	$842	$23,780	$68,570,330
Subtotal Service Management	**$8,912,017**	**$2,869,219**	**$20,899,235**	**$248,358**	**$12,391,761**	**$4,423,682**	**$6,539,279**	**$376**	**$41,999,241**	**$1,993,195**	**$2,126,431**	**$1,040,134**	**$49,027**	**$842**	**$133,640**	**$103,626,437**
Total Services	**$895,679,142**	**$172,728,710**	**$968,888,268**	**$29,393,373**	**$371,105,828**	**$112,968,575**	**$328,523,764**	**$8,880,091**	**$681,730,673**	**$39,370,576**	**$76,119,505**	**$122,711,426**	**$9,261,062**	**$38,512,439**	**$30,708,274**	**$3,886,581,706**
Financing & Supplemental Payments																
Upper Payment Limit Financing	$2,285,513	$275,715	$1,380,129	$32,126	$417,977	$141,962	$407,973	$0	$557,640	$0	$92,728	$63,147	$0	$9,866	$5,774	$5,670,550
Hospital Supplemental Payments	$11,507,426	$17,112,897	$116,213,340	$10,229,747	$97,403,214	$30,866,151	$115,720,548	$0	$145,115,367	$0	$8,680,400	$47,459,273	$0	$22,394,362	$5,329	$622,708,054
Nursing Facility Supplemental Payments	$70,338,750	$6,090,303	$13,046,522	$61,938	$20,107	$0	$91,063	$0	$0	$0	$0	$0	$0	$0	$125,305	$89,773,988
Physician Supplemental Payments	$50,744	$122,537	$816,497	$55,816	$996,616	$285,468	$787,689	$0	$1,847,454	$0	$139,808	$441,158	$0	$75,258	$78	$5,619,123
Outstationing Payments	$65,720	$139,967	$1,017,072	$73,930	$1,342,783	$458,391	$1,294,224	$0	$1,671,591	$0	$108,278	$204,153	$0	$32,115	$295	$6,408,519
Accounting Adjustments	$436,709	$90,753	$505,639	$16,283	$198,896	$61,001	$187,748	$4,585	$353,291	$17,572	$42,577	$64,254	$3,682	$20,535	$4,735	$2,008,260
Subtotal Financing & Supplemental Payments	**$84,684,862**	**$23,832,172**	**$132,979,199**	**$10,469,840**	**$100,379,593**	**$31,812,973**	**$118,489,245**	**$4,585**	**$149,545,343**	**$17,572**	**$9,063,791**	**$48,231,985**	**$3,682**	**$22,532,136**	**$141,516**	**$732,188,494**
Total	**$980,364,004**	**$196,560,882**	**$1,101,867,467**	**$39,863,213**	**$471,485,421**	**$144,781,548**	**$447,013,009**	**$8,884,676**	**$831,276,016**	**$39,388,148**	**$85,183,296**	**$170,943,411**	**$9,264,744**	**$61,044,575**	**$30,849,790**	**$4,618,770,200**

Exhibit M

Cash-based Actuals																
FY 2012-13	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**SB 11-008 Eligible Children**	**Foster Care**	**MAGI Pregnant Adults**	**SB 11-250 Eligible Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care																
Physician Services & EPSDT	$3,733,246	$7,649,554	$55,946,660	$2,017,690	$65,332,114	$18,077,268	$9,578,088	$0	$113,235,322	$2,820,853	$9,766,797	$16,755,632	$750,233	$5,679,532	$1,154	$311,344,143
Emergency Transportation	$124,218	$323,127	$2,163,425	$32,160	$1,485,643	$369,950	$641,885	$0	$1,637,796	$26,420	$187,373	$167,195	$8,312	$106,156	$0	$7,273,660
Non-emergency Medical Transportation	$2,046,589	$978,360	$4,716,005	$41,726	$433,180	$97,299	$194,838	$0	$914,535	$3,640	$102,262	$47,670	$334	$188	$129	$9,576,755
Dental Services	$1,392,227	$396,231	$5,433,896	$53,656	$5,859,871	$1,742,902	$662,572	$0	$92,806,672	$2,680,354	$5,018,241	$309,878	$16,150	$13,185	$203	$116,386,038
Family Planning	$30	$103	$22,595	$693	$263,357	$91,428	$11,356	$0	$192,173	$7,719	$77,522	$30,742	$1,502	$0	$0	$699,220
Health Maintenance Organizations	$5,627,161	$7,554,375	$40,140,958	$244,617	$23,044,932	$8,493,510	$0	$0	$38,756,103	$544,994	$785,911	$1,295,209	$43,813	$0	$0	$126,531,583
Inpatient Hospitals	$15,837,813	$18,086,253	$113,024,520	$3,818,807	$68,007,485	$13,393,053	$15,941,298	$0	$85,415,409	$2,638,015	$5,291,669	$28,564,111	$1,274,916	$35,472,048	$19,522	$406,784,919
Outpatient Hospitals	$3,353,219	$7,133,724	$57,838,186	$2,506,283	$71,204,056	$22,620,079	$14,655,972	$0	$85,203,477	$2,151,345	$5,978,631	$6,306,950	$276,268	$1,919,513	$302	$281,148,005
Lab & X-Ray	$488,758	$1,018,642	$7,339,265	$205,214	$16,311,375	$4,656,054	$1,995,854	$0	$7,258,518	$467,903	$1,468,092	$4,130,559	$161,187	$151,951	$13	$45,653,385
Durable Medical Equipment	$19,066,652	$6,220,600	$54,238,022	$369,556	$4,767,095	$1,520,743	$1,349,129	$0	$10,732,598	$160,536	$4,520,423	$142,596	$6,366	$3,137	$28,801	$103,126,254
Prescription Drugs	$6,719,553	$18,246,448	$126,656,626	$2,095,797	$58,302,300	$21,010,283	$12,450,869	$0	$65,383,399	$2,300,381	$18,488,514	$2,447,209	$102,473	$0	$262	$334,204,114
Drug Rebate	($3,599,458)	($9,774,062)	($67,846,065)	($1,122,654)	($31,230,752)	($11,254,563)	($6,669,548)	$0	($35,023,879)	($1,232,243)	($9,903,729)	($1,310,895)	($54,892)	$0	($140)	($179,022,880)
Rural Health Centers	$68,840	$302,964	$1,310,864	$32,728	$2,371,639	$886,068	$187,860	$0	$6,447,858	$122,104	$296,822	$294,754	$14,997	$7,574	$521	$12,345,593
Federally Qualified Health Centers	$944,509	$1,199,727	$8,478,727	$140,279	$16,982,037	$4,871,971	$4,036,338	$0	$54,024,086	$1,245,246	$1,894,311	$5,363,217	$207,877	$402,879	$0	$99,791,204
Co-Insurance (Title XVIII-Medicare)	$17,569,039	$3,024,606	$12,446,112	$274,031	$537,695	$888,995	$8,564	$0	$13,711	$1,394	$3,037	$34,811	$375	$112	$6,036,730	$40,839,212
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$9,559,144	$0	$0	$0	$0	$0	$0	$0	$9,559,144
Prepaid Inpatient Health Plan Services	$1,059,766	$1,577,317	$9,663,961	$647,691	$12,557,982	$4,456,972	$0	$0	$21,163,282	$158,949	$1,869,895	$4,464,891	$34,808	$0	$0	$57,655,514
Other Medical Services	$752	$599	$4,562	$92	$2,518	$741	$467	$72	$4,354	$0	$486	$517	$0	$327	$45	$15,532
Home Health	$25,773,486	$9,007,397	$125,419,441	$448,533	$752,343	$177,661	$224,892	$0	$4,165,705	$47,028	$11,074,099	$45,788	$1,587	$0	$217,948	$177,355,908
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,075,000	$0	$0	$0	$3,075,000
Subtotal of Acute Care	**$100,206,400**	**$72,945,965**	**$556,997,760**	**$11,806,899**	**$316,984,870**	**$92,100,414**	**$55,270,434**	**$9,559,216**	**$552,331,119**	**$14,144,638**	**$56,920,356**	**$72,165,834**	**$2,846,306**	**$43,756,602**	**$6,305,490**	**$1,964,342,303**
Community Based Long-Term Care																
HCBS - Elderly, Blind, and Disabled	$119,755,823	$19,994,030	$102,379,886	$47,026	$14,857	$39,338	$5,289	$0	$0	$0	$57,950	$0	$0	$0	$200,361	$242,494,560
HCBS - Mental Illness	$3,978,510	$3,706,685	$20,590,876	$0	$1,936	$0	$2,399	$0	$0	$0	$10,306	$0	$0	$0	$18,700	$28,309,412
HCBS - Disabled Children	$0	$0	$5,350,385	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,350,385
HCBS - Persons Living with AIDS	$30,653	$8,994	$441,281	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$480,928
HCBS - Consumer Directed Attendant Support	$1,314,616	$219,484	$1,123,872	$516	$163	$432	$58	$0	$0	$0	$636	$0	$0	$0	$2,200	$2,661,977
HCBS - Brain Injury	$274,983	$899,956	$11,674,531	$0	$0	$0	$0	$0	$0	$0	$212	$0	$0	$0	$0	$12,849,682
HCBS - Children with Autism	$0	$0	$868,411	$0	$0	$0	$0	$0	$17,013	$0	$0	$0	$0	$0	$0	$885,424
HCBS - Pediatric Hospice	$0	$0	$207,061	$0	$0	$0	$0	$0	$0	$0	$70	$0	$0	$0	$0	$207,131
HCBS - Spinal Cord Injury	$6,686	$0	$245,823	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$252,509
Private Duty Nursing	$2,364,123	$557,116	$24,342,047	$18,478	$0	$0	$0	$0	$1,069,272	$5,806	$8,490,119	$0	$0	$0	$0	$36,846,961
Hospice	$33,427,166	$2,868,294	$6,505,178	$140,227	$168,345	$92,875	$117,103	$0	$37,390	$0	$0	$0	$0	$0	$40,522	$43,397,100
Subtotal Community Based Long-Term Care	**$161,152,560**	**$28,254,559**	**$173,729,351**	**$206,247**	**$185,301**	**$132,645**	**$124,849**	**$0**	**$1,123,675**	**$5,806**	**$8,559,293**	**$0**	**$0**	**$0**	**$261,783**	**$373,736,069**
Long-Term Care																
Class I Nursing Facilities	$418,131,480	$35,559,417	$78,452,737	$0	$0	$0	$12,430	$0	$0	$0	$0	$0	$0	$0	$249,186	$532,405,250
Class II Nursing Facilities	$180,939	$825,327	$4,101,296	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,107,562
Program of All-Inclusive Care for the Elderly	$84,386,436	$8,794,508	$4,165,414	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$97,346,358
Subtotal Long-Term Care	**$502,698,855**	**$45,179,252**	**$86,719,447**	**$0**	**$0**	**$0**	**$12,430**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$249,186**	**$634,859,170**
Insurance																
Supplemental Medicare Insurance Benefit	$63,920,416	$3,727,469	$33,506,170	$0	$209,579	$0	$0	$0	$0	$0	$0	$0	$0	$0	$18,496,230	$119,859,864
Health Insurance Buy-In Program	$2,767	$1,630	$1,345,692	$0	$6,506	$0	$0	$0	$3,632	$0	$1,304	$0	$0	$0	$0	$1,361,531
Subtotal Insurance	**$63,923,183**	**$3,729,099**	**$34,851,862**	**$0**	**$216,085**	**$0**	**$0**	**$0**	**$3,632**	**$0**	**$1,304**	**$0**	**$0**	**$0**	**$18,496,230**	**$121,221,395**
Service Management																
Single Entry Points	$11,133,931	$2,768,715	$11,274,336	$8,561	$1,712	$5,993	$0	$856	$1,443,430	$0	$285,947	$0	$0	$0	$53,080	$26,976,561
Disease Management	$18,845	$38,614	$282,411	$10,185	$329,787	$91,251	$48,349	$0	$0	$0	$49,301	$88,367	$0	$0	$0	$957,110
Prepaid Inpatient Health Plan Administration	$314,516	$102,047	$728,309	$10,723	$1,049,127	$425,319	$0	$0	$3,699,162	$27,783	$246,713	$80,747	$629	$0	$0	$6,685,075
Accountable Care Collaborative	$576,537	$452,652	$3,916,914	$19,706	$9,740,443	$4,141,282	$1,856,177	$0	$13,291,533	$887,610	$1,388,883	$429,730	$22,052	$518	$4,894	$36,728,931
Subtotal Service Management	**$12,043,829**	**$3,362,028**	**$16,201,970**	**$49,175**	**$11,121,069**	**$4,663,845**	**$1,904,526**	**$856**	**$18,434,125**	**$915,393**	**$1,970,844**	**$598,844**	**$22,681**	**$518**	**$57,974**	**$71,347,677**
Total Services	**$840,024,827**	**$153,470,903**	**$868,500,390**	**$12,062,321**	**$328,507,325**	**$96,896,904**	**$57,312,239**	**$9,560,072**	**$571,892,551**	**$15,065,837**	**$67,451,797**	**$72,764,678**	**$2,868,987**	**$43,757,120**	**$25,370,663**	**$3,165,506,614**
Financing and Supplemental Payments																
Upper Payment Limit Financing	$2,595,353	$301,488	$1,530,078	$17,718	$433,958	$137,505	$89,799	$0	$551,431	$0	$100,170	$39,993	$0	$11,581	$2,709	$5,811,783
Hospital Supplemental Payments	$17,975,042	$23,731,862	$161,163,996	$5,980,773	$132,279,730	$34,389,153	$29,033,679	$0	$166,578,858	$0	$10,717,741	$34,123,275	$0	$34,836,430	$18,440	$650,828,979
Nursing Facility Supplemental Payments	$66,564,067	$5,660,850	$12,489,213	$0	$0	$0	$1,979	$0	$0	$0	$0	$0	$0	$0	$39,669	$84,755,778
Physician Supplemental Payments	$161,698	$331,324	$2,423,211	$87,392	$2,829,723	$782,979	$414,855	$0	$5,026,728	$0	$423,028	$758,230	$0	$245,997	$50	$13,485,215
Outstationing Payments	$183,823	$391,070	$3,170,686	$137,394	$3,903,403	$1,240,032	$803,440	$0	$4,788,787	$0	$327,748	$360,892	$0	$105,228	$17	$15,412,520
Accounting Adjustments	$395,443	$79,505	$451,107	$6,504	$174,992	$51,549	$32,482	$5,040	$297,169	$5,883	$38,144	$34,940	$949	$22,723	$3,415	$1,599,845
Subtotal Financing and Supplemental Payments	**$87,875,426**	**$30,496,099**	**$181,228,291**	**$6,229,781**	**$139,621,806**	**$36,601,218**	**$30,376,234**	**$5,040**	**$177,242,973**	**$5,883**	**$11,606,831**	**$35,317,330**	**$949**	**$35,221,959**	**$64,300**	**$771,894,120**
Total	**$927,900,253**	**$183,967,002**	**$1,049,728,681**	**$18,292,102**	**$468,129,131**	**$133,498,122**	**$87,688,473**	**$9,565,112**	**$749,135,524**	**$15,071,720**	**$79,058,628**	**$108,082,008**	**$2,869,936**	**$78,979,079**	**$25,434,963**	**$3,937,400,734**

Exhibit M

Cash-based Actuals														
FY 2011-12	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**Disabled Buy-In**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**MAGI Adults**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care														
Physician Services & EPSDT	$3,496,026	$7,111,322	$54,312,685	$65,386	$64,061,263	$16,729,289	$254,561	$0	$108,220,089	$10,282,293	$16,641,874	$5,841,664	$3,787	$287,020,239
Emergency Transportation	$127,388	$284,073	$2,131,467	$133	$1,416,682	$326,160	$26,001	$0	$1,599,438	$194,707	$167,590	$87,424	($5)	$6,361,058
Non-emergency Medical Transportation	$2,170,701	$1,007,841	$5,235,088	$443	$509,852	$130,804	$1,752	$0	$1,217,489	$131,419	$55,775	$1,230	($228)	$10,462,166
Dental Services	$1,227,623	$328,572	$5,016,624	$1,339	$5,415,654	$1,489,789	$36,007	$0	$85,091,328	$4,962,709	$336,789	$5,353	$0	$103,911,787
Family Planning	$0	$168	$16,872	$94	$239,510	$88,899	$1,072	$0	$157,184	$52,601	$22,557	$0	$0	$578,957
Health Maintenance Organizations	$6,436,982	$6,682,350	$39,413,533	$6,100	$22,554,171	$7,791,492	$0	$0	$35,919,341	$845,047	$1,066,895	$0	$0	$120,715,911
Inpatient Hospitals	$13,661,835	$15,340,090	$114,582,636	$177,773	$63,034,133	$12,964,966	$891,142	$0	$76,041,187	$4,890,304	$26,947,586	$33,984,087	($13,122)	$362,502,617
Outpatient Hospitals	$2,955,034	$6,281,086	$52,781,917	$73,670	$64,165,414	$19,539,773	$570,577	$0	$73,411,714	$5,760,929	$5,461,418	$1,478,314	$0	$232,479,846
Lab & X-Ray	$459,363	$872,743	$6,962,429	$4,882	$14,880,312	$3,943,322	$72,092	$0	$7,263,261	$1,727,639	$3,649,035	$142,603	$322	$39,978,003
Durable Medical Equipment	$18,449,168	$5,367,881	$50,025,626	$5,509	$4,189,111	$1,297,015	$19,968	$0	$9,835,195	$4,337,018	$159,994	$0	$19,967	$93,706,452
Prescription Drugs	$6,894,276	$18,586,340	$132,005,966	$66,035	$56,328,543	$17,910,509	$486,584	$0	$63,118,535	$21,082,476	$2,262,197	$0	$0	$318,741,461
Drug Rebate	($3,239,849)	($8,734,338)	($62,033,986)	($31,032)	($26,470,652)	($8,416,743)	($228,662)	$0	($29,661,495)	($9,907,355)	($1,063,081)	$0	$0	($149,787,193)
Rural Health Centers	$59,913	$297,322	$1,232,984	$272	$2,175,921	$650,762	$8,863	$0	$5,497,429	$310,962	$310,347	$23,141	$0	$10,567,916
Federally Qualified Health Centers	$945,395	$1,068,432	$8,305,722	$7,949	$17,414,509	$4,922,023	$252,682	$0	$54,487,052	$1,927,134	$5,087,649	$371,769	$167	$94,790,483
Co-Insurance (Title XVIII-Medicare)	$16,681,939	$2,722,367	$11,215,656	$5,057	$461,993	$629,323	$0	$0	$26,223	$17,454	$41,240	$1,973	$5,233,327	$37,036,552
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$0	$0	$10,272,613	$0	$0	$0	$0	$0	$10,272,613
Prepaid Inpatient Health Plan Services	$1,808,943	$2,331,859	$18,074,087	$14,849	$10,256,623	$2,867,598	$0	$0	$16,657,333	$2,332,229	$2,119,598	$0	$0	$56,463,119
Other Medical Services	$766	$590	$4,856	$3	$2,573	$718	$21	$84	$4,256	$543	$504	$339	$42	$15,295
Home Health	$22,261,489	$7,461,699	$116,508,674	$0	$539,390	$154,478	$490	$0	$4,089,841	$10,377,685	$50,035	$268	$163,684	$161,607,733
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$94,396,992**	**$67,010,397**	**$555,792,836**	**$398,462**	**$301,175,002**	**$83,020,177**	**$2,393,150**	**$10,272,697**	**$512,975,400**	**$59,325,794**	**$63,318,002**	**$41,938,165**	**$5,407,941**	**$1,797,425,015**
Community Based Long-Term Care														
HCBS - Elderly, Blind, and Disabled	$112,080,401	$18,862,257	$93,931,903	$0	$2,834	$17,029	$0	$0	$0	$69,862	$0	$0	$221,425	$225,185,711
HCBS - Mental Illness	$3,683,462	$3,266,023	$18,943,039	$0	$507	$3,220	$0	$0	$0	$10,762	$0	$0	$27,242	$25,934,255
HCBS - Disabled Children	$0	$0	$3,129,357	$0	$0	$0	$0	$0	$716	$0	$0	$0	$0	$3,130,073
HCBS - Persons Living with AIDS	$27,143	($1,798)	$482,666	$0	$0	$0	$0	$0	$0	$0	$0	$0	$8,025	$516,036
HCBS - Consumer Directed Attendant Support	$1,722,964	$289,961	$1,443,974	$0	$44	$262	$0	$0	$0	$1,074	$0	$0	$3,404	$3,461,683
HCBS - Brain Injury	$165,215	$851,608	$11,535,816	$0	$5,163	$0	$0	$0	$0	$29,164	$0	$0	$165	$12,587,131
HCBS - Children with Autism	$0	$0	$1,015,699	$0	$0	$0	$0	$0	$6,688	$0	$0	$0	$0	$1,022,387
HCBS - Pediatric Hospice	$0	$0	$170,418	$0	$0	$0	$0	$0	$0	$492	$0	$0	$0	$170,910
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$1,832,636	$135,105	$20,720,340	$0	$0	$0	$0	$0	$601,939	$7,854,133	$0	$0	$0	$31,144,153
Hospice	$32,103,872	$2,846,601	$6,969,248	$15,185	$114,106	$67,245	$4,370	$0	$116,333	$1,215	$1,787	$0	$86,846	$42,326,808
Subtotal Community Based Long-Term Care	**$151,615,693**	**$26,249,757**	**$158,342,460**	**$15,185**	**$122,654**	**$87,756**	**$4,370**	**$0**	**$725,676**	**$7,966,702**	**$1,787**	**$0**	**$347,107**	**$345,479,147**
Long-Term Care														
Class I Nursing Facilities	$411,201,009	$33,559,826	$76,088,316	$0	$0	$0	$0	$0	$0	$0	$0	$0	$395,618	$521,244,769
Class II Nursing Facilities	$0	$583,751	$1,915,323	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,499,074
Program of All-Inclusive Care for the Elderly	$73,671,387	$8,052,921	$3,756,277	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$85,480,585
Subtotal Long-Term Care	**$484,872,396**	**$42,196,498**	**$81,759,916**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$395,618**	**$609,224,428**
Insurance														
Supplemental Medicare Insurance Benefit	$63,201,668	$3,688,256	$33,153,682	$46,299	$207,374	$0	$0	$0	$0	$0	$0	$0	$18,301,648	$118,598,927
Health Insurance Buy-In Program	$2,162	$6,655	$1,122,186	$0	$9,727	$0	$0	$0	$12,996	$2,223	$3,358	$0	$0	$1,159,307
Subtotal Insurance	**$63,203,830**	**$3,694,911**	**$34,275,868**	**$46,299**	**$217,101**	**$0**	**$0**	**$0**	**$12,996**	**$2,223**	**$3,358**	**$0**	**$18,301,648**	**$119,758,234**
Service Management														
Single Entry Points	$11,748,349	$2,505,790	$10,910,528	$0	$5,343	$1,263	$0	$0	$1,749	$8,355	$0	$0	$45,369	$25,226,746
Disease Management	$51,573	$36,611	$303,654	$218	$164,545	$45,358	$1,307	$5,612	$280,261	$32,412	$34,593	$22,913	$2,955	$982,012
Prepaid Inpatient Health Plan Administration	$514,348	$183,069	$1,118,391	$1,094	$1,332,529	$526,053	$0	$0	$4,776,807	$325,880	$113,177	$0	$0	$8,891,348
Accountable Care Collaborative	$345,078	$256,950	$2,052,795	$377	$5,690,110	$2,269,608	$79,568	$0	$6,360,605	$576,072	$275,408	$107	$1,155	$17,907,833
Subtotal Service Management	**$12,659,348**	**$2,982,420**	**$14,385,368**	**$1,689**	**$7,192,527**	**$2,842,282**	**$80,875**	**$5,612**	**$11,419,422**	**$942,719**	**$423,178**	**$23,020**	**$49,479**	**$53,007,939**
Total Services	**$806,748,259**	**$142,133,983**	**$844,556,448**	**$461,635**	**$308,707,284**	**$85,950,215**	**$2,478,395**	**$10,278,309**	**$525,133,494**	**$68,237,438**	**$63,746,325**	**$41,961,185**	**$24,501,793**	**$2,924,894,763**
Financing and Supplemental Payments														
Upper Payment Limit Financing	$3,006,644	$328,259	$1,725,903	$520	$457,096	$139,126	$4,034	$0	$547,701	$114,617	$38,935	$10,444	$3,886	$6,377,165
Hospital Supplemental Payments	$17,049,970	$22,262,870	$172,465,286	$258,926	$131,847,819	$33,793,401	$1,509,784	$0	$154,850,875	$11,052,910	$33,244,021	$36,231,786	($13,389)	$614,554,259
Nursing Facility Supplemental Payments	$68,465,150	$5,587,726	$12,668,738	$0	$0	$0	$0	$0	$0	$0	$0	$0	$65,871	$86,787,485
Physician Supplemental Payments	$60,715	$123,502	$943,247	$1,136	$1,112,553	$290,538	$4,421	$0	$1,879,459	$178,573	$289,020	$101,452	$66	$4,984,682
Outstationing Payments	$18,395	$39,101	$328,574	$459	$399,437	$121,637	$3,552	$0	$456,997	$35,862	$33,998	$9,203	$0	$1,447,215
Accounting Adjustments	$763,823	$147,724	$878,727	$451	$337,808	$94,928	$2,831	$9,629	$556,699	$78,990	$65,448	$43,897	$6,238	$2,987,193
Subtotal Financing and Supplemental Payments	**$89,364,697**	**$28,489,182**	**$189,010,475**	**$261,492**	**$134,154,713**	**$34,439,630**	**$1,524,622**	**$9,629**	**$158,291,731**	**$11,460,952**	**$33,671,422**	**$36,396,782**	**$62,672**	**$717,137,999**
Total	**$896,112,956**	**$170,623,165**	**$1,033,566,923**	**$723,127**	**$442,861,997**	**$120,389,845**	**$4,003,017**	**$10,287,938**	**$683,425,225**	**$79,698,390**	**$97,417,747**	**$78,357,967**	**$24,564,465**	**$3,642,032,762**

Exhibit M

Cash-based Actuals												
FY 2010-11	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,269,992	$6,951,129	$52,819,492	$61,394,491	$12,531,062	$0	$108,898,551	$10,934,900	$18,198,453	$6,592,130	$1,842	$282,592,042
Emergency Transportation	$135,881	$262,494	$2,067,025	$1,347,570	$236,352	$0	$1,665,110	$236,484	$196,837	$88,493	$5	$6,236,250
Non-emergency Medical Transportation	$2,248,809	$1,043,480	$5,199,711	$500,754	$72,340	$0	$1,156,790	$195,450	$48,109	$3,420	$243	$10,469,107
Dental Services	$980,947	$296,165	$5,001,214	$5,332,025	$1,211,640	$0	$89,583,233	$5,780,945	$379,656	$4,838	$30	$108,570,692
Family Planning	$0	$16	$12,731	$193,371	$60,160	$0	$120,830	$38,845	$15,461	$0	$0	$441,414
Health Maintenance Organizations	$6,832,995	$6,431,178	$38,459,466	$21,704,093	$6,456,182	$0	$35,589,978	$823,759	$1,190,805	$0	$0	$117,488,456
Inpatient Hospitals	$13,928,315	$14,401,355	$109,555,355	$64,961,507	$10,000,540	$0	$83,895,044	$6,584,854	$30,244,597	$38,292,048	($1,668)	$371,861,948
Outpatient Hospitals	$3,159,881	$5,575,085	$50,038,984	$57,298,854	$14,717,844	$0	$73,155,361	$6,071,798	$6,013,521	$1,460,551	$1,031	$217,492,911
Lab & X-Ray	$558,717	$853,427	$6,862,072	$13,332,748	$2,936,506	$0	$7,589,083	$1,757,292	$3,807,140	$164,351	$784	$37,862,120
Durable Medical Equipment	$19,960,510	$4,911,081	$48,169,450	$3,505,807	$797,869	$0	$8,735,552	$4,353,214	$180,213	$5	$14,245	$90,627,945
Prescription Drugs	$8,014,198	$16,245,119	$119,835,487	$46,135,231	$11,840,965	$0	$56,157,223	$20,762,963	$2,287,737	$23	$4	$281,278,949
Drug Rebate	($3,615,910)	($7,329,604)	($54,068,344)	($20,815,666)	($5,342,502)	$0	($25,337,470)	($9,368,002)	($1,032,200)	($10)	($2)	($126,909,710)
Rural Health Centers	$53,270	$206,418	$1,122,812	$1,871,662	$557,927	$0	$5,357,537	$698,495	$285,879	$33,931	$75	$10,188,005
Federally Qualified Health Centers	$916,375	$1,051,613	$7,588,335	$15,885,638	$3,802,322	$0	$53,308,981	$2,132,545	$5,192,824	$427,890	$0	$90,306,523
Co-Insurance (Title XVIII-Medicare)	$16,505,219	$2,494,667	$11,474,583	$349,523	$446,438	$0	$43,461	$31,683	$56,279	$44	$4,985,517	$36,387,414
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$10,106,643	$0	$0	$0	$0	$0	$10,106,643
Prepaid Inpatient Health Plan Services	$2,221,510	$2,361,149	$19,107,158	$10,370,751	$2,076,156	$0	$9,365,354	$2,583,913	$2,763,503	$0	$0	$50,849,494
Other Medical Services	$770	$518	$4,450	$2,275	$509	$78	$4,077	$555	$525	$361	$40	$14,158
Home Health	$24,477,150	$7,498,890	$123,874,168	$567,964	$159,040	$0	$4,219,760	$11,551,887	$48,684	$0	$236,226	$172,633,768
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$100,648,630**	**$63,254,181**	**$547,124,148**	**$283,938,597**	**$62,561,349**	**$10,106,721**	**$513,508,455**	**$65,171,579**	**$69,878,023**	**$47,068,074**	**$5,238,372**	**$1,768,498,130**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$107,968,359	$16,811,191	$87,178,265	$19,464	$11,962	$0	$0	$72,439	$0	$0	$134,462	$212,196,143
HCBS - Mental Illness	$3,642,260	$2,685,012	$18,587,746	$9,419	$0	$0	$0	$14,257	$0	$0	$8,097	$24,946,790
HCBS - Disabled Children	$0	$0	$1,963,855	$0	$0	$0	$572	$577	$0	$0	$0	$1,965,004
HCBS - Persons Living with AIDS	$29,837	$3,598	$532,418	$0	$0	$0	$0	$0	$0	$0	$1,682	$567,535
HCBS - Consumer Directed Attendant Support	$1,506,730	$234,605	$1,216,870	$0	$167	$0	$0	$1,011	$0	$0	$1,876	$2,961,259
HCBS - Brain Injury	$158,989	$815,885	$11,318,639	$3,254	$0	$0	$0	$0	$0	$0	$497	$12,297,265
HCBS - Children with Autism	$0	$0	$1,355,067	$0	$0	$0	$2,545	$0	$0	$0	$0	$1,357,612
HCBS - Pediatric Hospice	$0	$0	$126,097	$0	$0	$0	$211	$395	$0	$0	$0	$126,702
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$1,328,952	$0	$17,573,121	$0	$0	$0	$521,410	$8,338,212	$0	$0	$0	$27,761,694
Hospice	$30,470,765	$2,124,046	$6,934,493	$235,444	$39,141	$0	$60,107	$3,517	$0	$0	($4,548)	$39,862,966
Subtotal Community Based Long-Term Care	**$145,105,892**	**$22,674,337**	**$146,786,571**	**$267,581**	**$51,269**	**$0**	**$584,845**	**$8,430,408**	**$0**	**$0**	**$142,067**	**$324,042,970**
Long-Term Care												
Class I Nursing Facilities	$397,056,172	$32,228,696	$78,280,022	$7,615	$0	$0	$0	$0	$0	$0	$569,344	$508,141,849
Class II Nursing Facilities	($200,939)	$647,887	$1,915,758	$0	$0	$0	$0	$0	$0	$0	$0	$2,362,706
Program of All-Inclusive Care for the Elderly	$73,242,922	$7,896,872	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$84,429,683
Subtotal Long-Term Care	**$470,098,154**	**$40,773,456**	**$83,485,668**	**$7,615**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$569,344**	**$594,934,237**
Insurance												
Supplemental Medicare Insurance Benefit	$63,751,826	$3,717,638	$33,417,798	$209,027	$0	$0	$0	$0	$0	$0	$18,447,446	$119,543,734
Health Insurance Buy-In Program	$2,287	$1,347	$1,111,909	$5,375	$0	$0	$3,001	$1,077	$0	$0	$0	$1,124,996
Subtotal Insurance	**$63,754,113**	**$3,718,985**	**$34,529,707**	**$214,402**	**$0**	**$0**	**$3,001**	**$1,077**	**$0**	**$0**	**$18,447,446**	**$120,668,731**
Service Management												
Single Entry Points	$11,482,516	$2,211,295	$10,261,280	$6,052	$0	$0	$4,841	$9,683	$0	$38,731	$7,262	$24,021,660
Disease Management	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$411,355	$211,517	$1,451,791	$793,726	$238,521	$0	$3,063,511	$216,554	$88,268	$0	$0	$6,475,244
Accountable Care Collaborative	$11,931	$16,697	$100,967	$246,920	$73,004	$0	$407,790	$14,196	$15,905	$0	$0	$887,411
Subtotal Service Management	**$11,905,802**	**$2,439,509**	**$11,814,039**	**$1,046,698**	**$311,525**	**$0**	**$3,476,143**	**$240,433**	**$104,173**	**$38,731**	**$7,262**	**$31,384,315**
Total Services	**$791,512,591**	**$132,860,467**	**$823,740,133**	**$285,474,893**	**$62,924,144**	**$10,106,721**	**$517,572,443**	**$73,843,497**	**$69,982,196**	**$47,106,805**	**$24,404,491**	**$2,839,528,383**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$7,676,810	$823,929	$4,599,470	$1,105,520	$284,166	$0	$1,474,141	$323,850	$115,813	$27,916	$14,559	$16,446,173
Hospital Supplemental Payments	$13,043,327	$15,343,201	$122,857,357	$95,078,024	$19,381,431	$0	$122,110,435	$9,849,776	$27,640,610	$30,044,552	($428)	$455,348,284
Nursing Facility Supplemental Payments	$59,632,155	$4,840,289	$11,756,539	$1,144	$0	$0	$0	$0	$0	$0	$85,507	$76,315,634
Physician Supplemental Payments	$41,037	$66,804	$507,620	$590,030	$120,429	$0	$1,046,566	$105,090	$174,896	$63,353	$18	$2,715,842
Outstationing Payments	$76,764	$135,437	$1,215,606	$1,391,971	$357,543	$0	$1,777,176	$147,503	$146,088	$35,481	$25	$5,283,594
Accounting Adjustments	($2,643)	($483)	($3,002)	($1,102)	($247)	($38)	($1,975)	($299)	($254)	($175)	($22)	($10,239)
Subtotal Financing and Supplemental Payments	**$80,467,449**	**$21,209,175**	**$140,933,589**	**$98,165,587**	**$20,143,323**	**($38)**	**$126,406,344**	**$10,425,920**	**$28,077,153**	**$30,171,128**	**$99,658**	**$556,099,288**
Grand Total	**$871,980,040**	**$154,069,643**	**$964,673,722**	**$383,640,480**	**$83,067,467**	**$10,106,683**	**$643,978,787**	**$84,269,417**	**$98,059,349**	**$77,277,933**	**$24,504,150**	**$3,395,627,671**

Exhibit M

Cash-based Actuals												
FY 2010-11 Adjusted Totals for June 2010 Payment Delay	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,130,719	$6,703,561	$51,097,852	$59,291,660	$12,375,689	$0	$105,296,010	$10,585,051	$17,581,872	$6,320,750	$1,842	$273,385,005
Emergency Transportation	$132,219	$249,128	$1,981,658	$1,308,793	$234,530	$0	$1,614,807	$227,759	$191,791	$83,441	$5	$6,024,130
Non-emergency Medical Transportation	$2,229,276	$1,030,710	$5,146,701	$497,276	$72,195	$0	$1,144,273	$191,774	$47,504	$3,420	$243	$10,363,372
Dental Services	$955,956	$287,848	$4,837,631	$5,162,280	$1,188,067	$0	$86,467,469	$5,552,512	$362,347	$4,838	$30	$104,818,977
Family Planning	$0	$16	$12,280	$185,274	$59,388	$0	$117,776	$38,636	$15,103	$0	$0	$428,473
Health Maintenance Organizations	$6,832,995	$6,431,178	$38,459,477	$21,704,066	$6,456,182	$0	$35,589,962	$823,759	$1,190,805	$0	$0	$117,488,424
Inpatient Hospitals	$13,226,398	$13,708,601	$104,724,509	$62,699,943	$9,835,760	$0	$80,955,351	$6,191,811	$29,151,219	$36,914,044	$3,263	$357,410,898
Outpatient Hospitals	$3,056,720	$5,426,119	$48,146,249	$55,076,725	$14,489,889	$0	$70,566,037	$5,827,169	$5,797,920	$1,403,889	$510	$209,791,226
Lab & X-Ray	$536,134	$822,885	$6,615,374	$12,854,214	$2,895,486	$0	$7,328,814	$1,689,199	$3,680,612	$157,642	$784	$36,581,144
Durable Medical Equipment	$19,273,724	$4,734,880	$46,704,499	$3,394,827	$780,295	$0	$8,456,549	$4,218,565	$167,275	$5	$14,696	$87,745,314
Prescription Drugs	$7,696,196	$15,713,437	$116,023,969	$44,475,389	$11,693,984	$0	$54,593,081	$20,062,946	$2,210,846	$23	$4	$272,469,874
Drug Rebate	($3,615,910)	($7,329,604)	($54,068,344)	($20,815,666)	($5,342,502)	$0	($25,337,470)	($9,368,002)	($1,032,200)	($10)	($2)	($126,909,710)
Rural Health Centers	$51,237	$201,149	$1,081,153	$1,802,215	$549,705	$0	$5,208,165	$685,199	$277,916	$30,833	$75	$9,887,646
Federally Qualified Health Centers	$877,182	$1,014,344	$7,353,061	$15,328,948	$3,746,392	$0	$51,735,998	$2,065,438	$4,996,706	$411,996	$0	$87,530,065
Co-Insurance (Title XVIII-Medicare)	$15,904,615	$2,389,850	$11,036,287	$332,809	$438,293	$0	$42,212	$30,660	$55,401	$44	$4,813,375	$35,043,547
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$9,817,118	$0	$0	$0	$0	$0	$9,817,118
Prepaid Inpatient Health Plan Services	$2,221,510	$2,361,149	$19,107,158	$10,370,751	$2,076,156	$0	$9,365,354	$2,583,913	$2,763,503	$0	$0	$50,849,494
Other Medical Services	$770	$518	$4,450	$2,275	$509	$78	$4,077	$555	$525	$361	$40	$14,158
Home Health	$23,878,879	$7,291,128	$120,949,799	$557,984	$157,786	$0	$4,170,550	$11,395,772	$48,399	$0	$231,822	$168,682,120
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$97,388,620**	**$61,036,898**	**$529,213,760**	**$274,229,762**	**$61,707,804**	**$9,817,196**	**$497,319,012**	**$62,802,717**	**$67,507,543**	**$45,331,275**	**$5,066,688**	**$1,711,421,275**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$105,868,153	$16,511,174	$85,914,477	$19,421	$11,962	$0	$0	$71,172	$0	$0	$129,956	$208,526,316
HCBS - Mental Illness	$3,587,367	$2,652,010	$18,317,043	$9,419	$0	$0	$0	$13,599	$0	$0	$8,097	$24,587,535
HCBS - Disabled Children	$0	$0	$1,886,052	$0	$0	$0	$572	$577	$0	$0	$0	$1,887,201
HCBS - Persons Living with AIDS	$29,046	$3,470	$516,199	$0	$0	$0	$0	$0	$0	$0	$1,682	$550,397
HCBS - Consumer Directed Attendant Support	$1,506,730	$234,605	$1,216,870	$0	$167	$0	$0	$1,011	$0	$0	$1,876	$2,961,259
HCBS - Brain Injury	$158,168	$809,327	$11,211,671	$3,254	$0	$0	$0	$0	$0	$0	$497	$12,182,916
HCBS - Children with Autism	$0	$0	$1,326,032	$0	$0	$0	$2,545	$0	$0	$0	$0	$1,328,577
HCBS - Pediatric Hospice	$0	$0	$118,667	$0	$0	$0	$211	$395	$0	$0	$0	$119,273
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$1,319,815	$0	$17,252,161	$0	$0	$0	$502,792	$8,251,188	$0	$0	$0	$27,325,957
Hospice	$30,229,237	$2,102,622	$6,889,023	$228,537	$39,141	$0	$60,107	$3,517	$0	$0	($4,548)	$39,547,635
Subtotal Community Based Long-Term Care	**$142,698,517**	**$22,313,208**	**$144,648,196**	**$260,631**	**$51,269**	**$0**	**$566,227**	**$8,341,459**	**$0**	**$0**	**$137,560**	**$319,017,067**
Long-Term Care												
Class I Nursing Facilities	$390,609,241	$31,625,232	$76,509,001	$7,615	$0	$0	$0	$0	$0	$0	$564,302	$499,315,391
Class II Nursing Facilities	($84,407)	$729,155	$2,518,445	$0	$0	$0	$0	$0	$0	$0	$0	$3,163,194
Program of All-Inclusive Care for the Elderly	$73,232,307	$7,892,082	$3,289,888	$0	$0	$0	$0	$0	$0	$0	$0	$84,414,277
Subtotal Long-Term Care	**$463,757,141**	**$40,246,469**	**$82,317,334**	**$7,615**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$564,302**	**$586,892,862**
Insurance												
Supplemental Medicare Insurance Benefit	$63,751,826	$3,717,638	$33,417,798	$209,027	$0	$0	$0	$0	$0	$0	$18,447,446	$119,543,734
Health Insurance Buy-In Program	$1,979	$625	$1,025,861	$5,099	$0	$0	$2,021	$1,059	$0	$0	$0	$1,036,644
Subtotal Insurance	**$63,753,805**	**$3,718,263**	**$34,443,659**	**$214,125**	**$0**	**$0**	**$2,021**	**$1,059**	**$0**	**$0**	**$18,447,446**	**$120,580,378**
Service Management												
Single Entry Points	$11,482,516	$2,211,295	$10,261,280	$6,052	$0	$0	$4,841	$9,683	$0	$38,731	$7,262	$24,021,660
Disease Management	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$411,355	$211,517	$1,451,791	$793,726	$238,521	$0	$3,063,511	$216,554	$88,268	$0	$0	$6,475,244
Accountable Care Collaborative	$11,931	$16,697	$100,967	$246,920	$73,004	$0	$407,790	$14,196	$15,905	$0	$0	$887,411
Subtotal Service Management	**$11,905,802**	**$2,439,509**	**$11,814,039**	**$1,046,698**	**$311,525**	**$0**	**$3,476,143**	**$240,433**	**$104,173**	**$38,731**	**$7,262**	**$31,384,315**
Total Services	**$779,503,885**	**$129,754,347**	**$802,436,988**	**$275,758,831**	**$62,070,599**	**$9,817,196**	**$501,363,403**	**$71,385,668**	**$67,611,716**	**$45,370,006**	**$24,223,258**	**$2,769,295,897**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$7,676,810	$823,929	$4,599,470	$1,105,520	$284,166	$0	$1,474,141	$323,850	$115,813	$27,916	$14,559	$16,446,173
Hospital Supplemental Payments	$13,043,327	$15,343,201	$122,857,357	$95,078,024	$19,381,431	$0	$122,110,435	$9,849,776	$27,640,610	$30,044,552	($428)	$455,348,284
Nursing Facility Supplemental Payments	$59,632,155	$4,840,289	$11,756,539	$1,144	$0	$0	$0	$0	$0	$0	$85,507	$76,315,634
Physician Supplemental Payments	$41,037	$66,804	$507,620	$590,030	$120,429	$0	$1,046,566	$105,090	$174,896	$63,353	$18	$2,715,842
Outstationing Payments	$76,764	$135,437	$1,215,606	$1,391,971	$357,543	$0	$1,777,176	$147,503	$146,088	$35,481	$25	$5,283,594
Accounting Adjustments	($2,643)	($483)	($3,002)	($1,102)	($247)	($38)	($1,975)	($299)	($254)	($175)	($22)	($10,239)
Subtotal Financing and Supplemental Payments	**$80,467,449**	**$21,209,175**	**$140,933,589**	**$98,165,587**	**$20,143,323**	**($38)**	**$126,406,344**	**$10,425,920**	**$28,077,153**	**$30,171,128**	**$99,658**	**$556,099,288**
Grand Total	**$859,971,334**	**$150,963,522**	**$943,370,577**	**$373,924,418**	**$82,213,922**	**$9,817,158**	**$627,769,747**	**$81,811,588**	**$95,688,869**	**$75,541,134**	**$24,322,917**	**$3,325,395,185**

Exhibit M

Cash-based Actuals												
FY 2009-10	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,504,959	$5,841,290	$45,027,403	$57,248,710	$379,950	$0	$97,071,331	$9,752,159	$16,382,526	$6,720,532	$553	$242,929,414
Emergency Transportation	$132,013	$206,450	$1,629,961	$1,215,599	$5,733	$0	$1,553,739	$202,199	$184,865	$87,075	$0	$5,217,633
Non-emergency Medical Transportation	$2,230,609	$868,873	$4,556,037	$365,170	$463	$0	$964,382	$100,146	$44,731	$1,244	$0	$9,131,655
Dental Services	$790,484	$236,617	$4,188,551	$4,364,415	$54,703	$0	$73,534,295	$5,281,907	$353,118	$2,724	$43	$88,806,857
Family Planning	$0	$24	$11,970	$149,435	$1,828	$0	$110,955	$30,688	$17,076	$0	$0	$321,975
Health Maintenance Organizations	$6,690,235	$6,808,868	$45,687,858	$21,208,184	$149,518	$0	$35,072,614	$902,745	$1,131,694	$0	$0	$117,651,717
Inpatient Hospitals	$15,121,066	$10,933,612	$94,203,357	$60,316,941	$225,968	$0	$82,963,155	$5,813,909	$29,535,689	$38,240,653	$4,098	$337,358,448
Outpatient Hospitals	$2,483,053	$3,912,610	$33,983,522	$42,016,658	$591,764	$0	$51,528,633	$4,616,132	$4,813,849	$1,009,919	$0	$144,956,141
Lab & X-Ray	$542,175	$702,690	$5,366,358	$11,597,243	$113,194	$0	$6,592,607	$1,625,242	$3,462,744	$145,427	$638	$30,148,317
Durable Medical Equipment	$18,160,548	$3,979,784	$40,816,114	$3,035,899	$21,565	$0	$8,177,251	$3,905,570	$172,313	$559	$3,359	$78,272,962
Prescription Drugs	$7,741,380	$13,544,934	$97,612,578	$41,216,168	$524,963	$618	$44,622,098	$18,661,722	$2,189,164	$0	$462	$226,114,086
Drug Rebate	($3,418,708)	($5,981,643)	($43,107,160)	($18,201,670)	($231,831)	($273)	($19,705,779)	($8,241,293)	($966,767)	$0	($204)	($99,855,328)
Rural Health Centers	$40,614	$147,085	$904,243	$1,585,161	$22,504	$0	$4,562,102	$405,207	$300,495	$26,268	$142	$7,993,821
Federally Qualified Health Centers	$903,859	$792,591	$6,070,348	$13,704,904	$182,692	$0	$47,091,192	$1,962,149	$5,080,079	$456,394	$154	$76,244,360
Co-Insurance (Title XVIII-Medicare)	$9,563,469	$1,441,719	$6,576,134	$269,357	$4,014	$0	$21,034	$17,428	$24,075	$32	$2,934,912	$20,852,175
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$8,716,269	$0	$0	$0	$0	$0	$8,716,269
Prepaid Inpatient Health Plan Services	$2,375,072	$2,021,423	$17,073,019	$9,355,563	$183,288	$0	$8,648,317	$2,128,848	$2,918,289	$0	$0	$44,703,819
Other Medical Services	$3,033	$1,762	$15,618	$8,354	$0	$271	$14,457	$2,022	$2,008	$1,457	$158	$49,140
Home Health	$23,855,013	$6,522,006	$110,646,480	$502,065	$1,616	$0	$3,749,623	$10,908,657	$50,128	$0	$212,833	$156,448,421
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$91,718,875**	**$51,980,694**	**$471,262,390**	**$249,958,158**	**$2,231,930**	**$8,716,886**	**$446,572,005**	**$58,075,438**	**$65,696,077**	**$46,692,284**	**$3,157,147**	**$1,496,061,883**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$101,286,005	$14,326,522	$70,577,472	$13,343	$0	$0	$0	$77,881	$0	$0	$144,853	$186,426,075
HCBS - Mental Illness	$3,418,565	$2,358,037	$16,839,277	$80	$0	$0	$0	$22,942	$0	$0	$42,459	$22,681,360
HCBS - Disabled Children	$0	$0	$1,762,739	$0	$0	$0	$0	$471	$0	$0	$0	$1,763,210
HCBS - Persons Living with AIDS	$19,745	$28,343	$533,292	$0	$0	$0	$0	$0	$0	$0	$25	$581,405
HCBS - Consumer Directed Attendant Support	$1,910,755	$270,269	$1,331,531	$161	$0	$0	$0	$1,469	$0	$0	$2,733	$3,516,917
HCBS - Brain Injury	$143,522	$526,310	$10,806,523	$5,718	$0	$0	$0	$0	$0	$0	$0	$11,482,073
HCBS - Children with Autism	$0	$0	$1,565,700	$0	$0	$0	$0	$0	$0	$0	$0	$1,565,700
HCBS - Pediatric Hospice	$0	$0	$94,295	$0	$0	$0	$0	$485	$0	$0	$0	$94,781
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$1,026,115	$240,541	$14,816,119	$0	$0	$0	$586,102	$6,561,939	$0	$0	$0	$23,230,817
Hospice	$33,775,857	$3,004,027	$6,070,145	$196,954	$0	$0	$231,678	$34,952	$0	$1,279	$6,603	$43,321,496
Subtotal Community Based Long-Term Care	**$141,580,564**	**$20,754,049**	**$124,397,093**	**$216,256**	**$0**	**$0**	**$817,780**	**$6,700,139**	**$0**	**$1,279**	**$196,672**	**$294,663,833**
Long-Term Care												
Class I Nursing Facilities	$386,581,897	$28,352,812	$72,076,695	$5,285	$0	$0	$0	$0	$0	$0	$57,644	$487,074,333
Class II Nursing Facilities	$78,087	$345,366	$1,592,381	$0	$0	$0	$0	$0	$0	$0	$0	$2,015,835
Program of All-Inclusive Care for the Elderly	$61,913,944	$4,981,340	$2,345,339	$0	$0	$0	$0	$0	$0	$0	$0	$69,240,623
Subtotal Long-Term Care	**$448,573,929**	**$33,679,519**	**$76,014,415**	**$5,285**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$57,644**	**$558,330,791**
Insurance												
Supplemental Medicare Insurance Benefit	$54,965,748	$3,205,285	$28,812,261	$180,219	$0	$0	$0	$0	$0	$0	$15,905,077	$103,068,590
Health Insurance Buy-In Program	$3,244	$7,611	$907,337	$2,920	$0	$0	$10,334	$192	$0	$0	$0	$931,637
Subtotal Insurance	**$54,968,992**	**$3,212,895**	**$29,719,598**	**$183,139**	**$0**	**$0**	**$10,334**	**$192**	**$0**	**$0**	**$15,905,077**	**$104,000,227**
Service Management												
Single Entry Points	$11,622,897	$2,068,951	$9,956,430	$2,637	$0	$0	$1,458	$8,329	$0	$41,435	$5,414	$23,707,551
Disease Management	$4,570	$2,655	$23,534	$12,589	$0	$409	$21,785	$3,047	$3,027	$0	$0	$71,616
Prepaid Inpatient Health Plan Administration	$331,989	$116,999	$938,116	$713,502	$0	$0	$2,715,378	$208,304	$87,465	$0	$0	$5,111,753
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,959,457**	**$2,188,605**	**$10,918,080**	**$728,728**	**$0**	**$409**	**$2,738,620**	**$219,680**	**$90,492**	**$41,435**	**$5,414**	**$28,890,920**
Total Services	**$748,801,817**	**$111,815,763**	**$712,311,577**	**$251,091,566**	**$2,231,930**	**$8,717,294**	**$450,138,739**	**$64,995,449**	**$65,786,568**	**$46,734,999**	**$19,321,953**	**$2,481,947,656**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$11,041,603	$915,688	$3,009,973	$1,192,576	$16,794	$0	$1,462,375	$131,005	$136,616	$28,661	$1,636	$17,936,927
Hospital Supplemental Payments	$11,404,874	$9,618,163	$83,046,197	$66,297,084	$529,770	$0	$87,130,848	$6,757,128	$22,253,436	$25,428,584	$2,655	$312,468,739
Nursing Facility Supplemental Payments	$37,661,309	$2,762,168	$7,021,805	$515	$0	$0	$0	$0	$0	$0	$5,616	$47,451,412
Physician Supplemental Payments	$268,976	$348,764	$2,688,435	$3,418,128	$22,686	$0	$5,795,803	$582,269	$978,146	$401,260	$33	$14,504,498
Outstationing Payments	$60,301	$95,018	$825,288	$1,020,373	$14,371	$0	$1,251,371	$112,103	$116,904	$24,526	$0	$3,520,254
Accounting Adjustments	($5,210)	($778)	($4,956)	($1,747)	($16)	($61)	($3,132)	($452)	($458)	($325)	($134)	($17,268)
Subtotal Financing and Supplemental Payments	**$60,431,853**	**$13,739,022**	**$96,586,742**	**$71,926,929**	**$583,605**	**($61)**	**$95,637,265**	**$7,582,053**	**$23,484,644**	**$25,882,706**	**$9,805**	**$395,864,563**
Grand Total	**$809,233,671**	**$125,554,785**	**$808,898,319**	**$323,018,495**	**$2,815,535**	**$8,717,234**	**$545,776,004**	**$72,577,502**	**$89,271,212**	**$72,617,705**	**$19,331,759**	**$2,877,812,218**

Exhibit M

Cash-based Actuals												
FY 2009-10 Adjusted Totals for June 2010 Payment Delay	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,644,233	$6,088,859	$46,749,044	$59,351,541	$535,323	$0	$100,673,872	$10,102,008	$16,999,107	$6,991,912	$553	$252,136,452
Emergency Transportation	$135,675	$219,816	$1,715,328	$1,254,377	$7,555	$0	$1,604,042	$210,924	$189,910	$92,127	$0	$5,429,754
Non-emergency Medical Transportation	$2,250,142	$881,642	$4,609,047	$368,648	$608	$0	$976,900	$103,821	$45,337	$1,244	$0	$9,237,390
Dental Services	$815,475	$244,934	$4,352,134	$4,534,160	$78,276	$0	$76,650,059	$5,510,341	$370,427	$2,724	$43	$92,558,572
Family Planning	$0	$24	$12,420	$157,531	$2,601	$0	$114,009	$30,897	$17,434	$0	$0	$334,916
Health Maintenance Organizations	$6,690,235	$6,808,868	$45,687,847	$21,208,211	$149,518	$0	$35,072,631	$902,745	$1,131,694	$0	$0	$117,651,750
Inpatient Hospitals	$15,822,984	$11,626,366	$99,034,203	$62,578,505	$390,748	$0	$85,902,848	$6,206,952	$30,629,066	$39,618,658	($833)	$351,809,498
Outpatient Hospitals	$2,586,214	$4,061,576	$35,876,257	$44,238,788	$819,720	$0	$54,117,957	$4,860,761	$5,029,450	$1,066,582	$521	$152,657,826
Lab & X-Ray	$564,758	$733,232	$5,613,057	$12,075,777	$154,214	$0	$6,852,876	$1,693,335	$3,589,272	$152,136	$638	$31,429,294
Durable Medical Equipment	$18,847,335	$4,155,984	$42,281,065	$3,146,879	$39,139	$0	$8,456,254	$4,040,219	$185,251	$559	$2,908	$81,155,593
Prescription Drugs	$8,059,382	$14,076,616	$101,424,097	$42,876,010	$671,944	$618	$46,186,239	$19,361,739	$2,266,055	$0	$462	$234,923,161
Drug Rebate	($3,418,708)	($5,981,643)	($43,107,160)	($18,201,670)	($231,831)	($273)	($19,705,779)	($8,241,293)	($966,767)	$0	($204)	($99,855,328)
Rural Health Centers	$42,647	$152,354	$945,902	$1,654,608	$30,726	$0	$4,711,474	$418,503	$308,458	$29,366	$142	$8,294,180
Federally Qualified Health Centers	$943,051	$829,861	$6,305,622	$14,261,595	$238,621	$0	$48,664,174	$2,029,256	$5,276,198	$472,287	$154	$79,020,818
Co-Insurance (Title XVIII-Medicare)	$10,164,073	$1,546,536	$7,014,431	$286,071	$12,158	$0	$22,284	$18,450	$24,953	$32	$3,107,054	$22,196,042
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$9,005,795	$0	$0	$0	$0	$0	$9,005,795
Prepaid Inpatient Health Plan Services	$2,375,072	$2,021,423	$17,073,019	$9,355,563	$183,288	$0	$8,648,317	$2,128,848	$2,918,289	$0	$0	$44,703,819
Other Medical Services	$3,033	$1,762	$15,618	$8,354	$0	$271	$14,457	$2,022	$2,008	$1,457	$158	$49,140
Home Health	$24,453,284	$6,729,768	$113,570,849	$512,045	$2,869	$0	$3,798,833	$11,064,772	$50,413	$0	$217,237	$160,400,069
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$94,978,885**	**$54,197,977**	**$489,172,778**	**$259,666,993**	**$3,085,476**	**$9,006,411**	**$462,761,448**	**$60,444,300**	**$68,066,557**	**$48,429,084**	**$3,328,831**	**$1,553,138,739**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$103,386,211	$14,626,539	$71,841,260	$13,385	$0	$0	$0	$79,147	$0	$0	$149,360	$190,095,902
HCBS - Mental Illness	$3,473,457	$2,391,039	$17,109,979	$80	$0	$0	$0	$23,600	$0	$0	$42,459	$23,040,614
HCBS - Disabled Children	$0	$0	$1,840,542	$0	$0	$0	$0	$471	$0	$0	$0	$1,841,013
HCBS - Persons Living with AIDS	$20,536	$28,470	$549,511	$0	$0	$0	$0	$0	$0	$0	$25	$598,542
HCBS - Consumer Directed Attendant Support	$1,910,755	$270,269	$1,331,531	$161	$0	$0	$0	$1,469	$0	$0	$2,733	$3,516,917
HCBS - Brain Injury	$144,343	$532,868	$10,913,491	$5,718	$0	$0	$0	$0	$0	$0	$0	$11,596,421
HCBS - Children with Autism	$0	$0	$1,594,735	$0	$0	$0	$0	$0	$0	$0	$0	$1,594,735
HCBS - Pediatric Hospice	$0	$0	$101,725	$0	$0	$0	$0	$485	$0	$0	$0	$102,210
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$1,035,252	$240,541	$15,137,079	$0	$0	$0	$604,720	$6,648,963	$0	$0	$0	$23,666,555
Hospice	$34,017,386	$3,025,452	$6,115,615	$203,862	$0	$0	$231,678	$34,952	$0	$1,279	$6,603	$43,636,826
Subtotal Community Based Long-Term Care	**$143,987,940**	**$21,115,178**	**$126,535,468**	**$223,206**	**$0**	**$0**	**$836,398**	**$6,789,088**	**$0**	**$1,279**	**$201,179**	**$299,689,736**
Long-Term Care												
Class I Nursing Facilities	$393,028,828	$28,956,277	$73,847,716	$5,285	$0	$0	$0	$0	$0	$0	$62,685	$495,900,792
Class II Nursing Facilities	($38,446)	$264,098	$989,694	$0	$0	$0	$0	$0	$0	$0	$0	$1,215,347
Program of All-Inclusive Care for the Elderly	$61,924,560	$4,986,130	$2,345,339	$0	$0	$0	$0	$0	$0	$0	$0	$69,256,028
Subtotal Long-Term Care	**$454,914,942**	**$34,206,505**	**$77,182,749**	**$5,285**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$62,685**	**$566,372,167**
Insurance												
Supplemental Medicare Insurance Benefit	$54,965,748	$3,205,285	$28,812,261	$180,219	$0	$0	$0	$0	$0	$0	$15,905,077	$103,068,590
Health Insurance Buy-In Program	$3,552	$8,332	$993,385	$3,197	$0	$0	$11,314	$210	$0	$0	$0	$1,019,989
Subtotal Insurance	**$54,969,300**	**$3,213,617**	**$29,805,646**	**$183,416**	**$0**	**$0**	**$11,314**	**$210**	**$0**	**$0**	**$15,905,077**	**$104,088,580**
Service Management												
Single Entry Points	$11,622,897	$2,068,951	$9,956,430	$2,637	$0	$0	$1,458	$8,329	$0	$41,435	$5,414	$23,707,551
Disease Management	$4,570	$2,655	$23,534	$12,589	$0	$409	$21,785	$3,047	$3,027	$0	$0	$71,616
Prepaid Inpatient Health Plan Administration	$331,989	$116,999	$938,116	$713,502	$0	$0	$2,715,378	$208,304	$87,465	$0	$0	$5,111,753
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,959,457**	**$2,188,605**	**$10,918,080**	**$728,728**	**$0**	**$409**	**$2,738,620**	**$219,680**	**$90,492**	**$41,435**	**$5,414**	**$28,890,920**
Total Services	**$760,810,523**	**$114,921,883**	**$733,614,722**	**$260,807,628**	**$3,085,476**	**$9,006,820**	**$466,347,779**	**$67,453,278**	**$68,157,048**	**$48,471,798**	**$19,503,186**	**$2,552,180,141**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$11,041,603	$915,688	$3,009,973	$1,192,576	$16,794	$0	$1,462,375	$131,005	$136,616	$28,661	$1,636	$17,936,927
Hospital Supplemental Payments	$11,404,874	$9,618,163	$83,046,197	$66,297,084	$529,770	$0	$87,130,848	$6,757,128	$22,253,436	$25,428,584	$2,655	$312,468,739
Nursing Facility Supplemental Payments	$37,661,309	$2,762,168	$7,021,805	$515	$0	$0	$0	$0	$0	$0	$5,616	$47,451,412
Physician Supplemental Payments	$268,976	$348,764	$2,688,435	$3,418,128	$22,686	$0	$5,795,803	$582,269	$978,146	$401,260	$33	$14,504,498
Outstationing Payments	$60,301	$95,018	$825,288	$1,020,373	$14,371	$0	$1,251,371	$112,103	$116,904	$24,526	$0	$3,520,254
Accounting Adjustments	($5,210)	($778)	($4,956)	($1,747)	($16)	($61)	($3,132)	($452)	($458)	($325)	($134)	($17,268)
Subtotal Financing and Supplemental Payments	**$60,431,853**	**$13,739,022**	**$96,586,742**	**$71,926,929**	**$583,605**	**($61)**	**$95,637,265**	**$7,582,053**	**$23,484,644**	**$25,882,706**	**$9,805**	**$395,864,563**
Grand Total	**$821,242,377**	**$128,660,905**	**$830,201,464**	**$332,734,557**	**$3,669,080**	**$9,006,759**	**$561,985,044**	**$75,035,330**	**$91,641,692**	**$74,354,504**	**$19,512,991**	**$2,948,044,704**

Exhibit M

Cash-based Actuals												
FY 2008-09	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$4,994,147	$6,222,450	$45,788,069	$52,318,152	$0	$0	$89,495,781	$9,896,241	$15,568,366	$8,628,882	$603	$232,912,692
Emergency Transportation	$137,865	$236,302	$1,633,597	$1,114,036	$0	$0	$1,342,177	$176,882	$183,755	$109,310	$157	$4,934,082
Non-emergency Medical Transportation	$2,169,408	$784,497	$4,355,943	$402,309	$0	$0	$809,400	$131,628	$35,042	$791	$0	$8,689,018
Dental Services	$982,210	$236,181	$3,967,399	$3,888,603	$0	$0	$61,485,476	$5,488,468	$396,626	$11,462	$0	$76,456,424
Family Planning	$0	$120	$9,036	$150,297	$0	$0	$101,028	$34,059	$23,734	$1,150	$0	$319,424
Health Maintenance Organizations	$8,589,196	$7,896,327	$59,131,526	$17,895,483	$0	$0	$33,428,257	$1,052,528	$1,081,509	$0	$0	$129,074,827
Inpatient Hospitals	$16,801,697	$13,598,479	$98,702,338	$62,944,719	$0	$0	$84,101,547	$6,535,184	$27,109,511	$46,764,468	$18,694	$356,576,636
Outpatient Hospitals	$3,004,874	$3,827,049	$40,287,696	$42,356,575	$0	$0	$52,180,563	$5,471,149	$5,159,881	$1,612,752	$1,216	$153,901,754
Lab & X-Ray	$541,036	$700,896	$5,345,769	$10,575,314	$0	$0	$5,923,803	$1,888,019	$3,098,394	$364,434	$158	$28,437,823
Durable Medical Equipment	$19,191,857	$4,023,304	$40,203,019	$2,422,621	$0	$0	$7,113,934	$3,897,828	$147,294	$8,611	$3,345	$77,011,816
Prescription Drugs	$8,113,773	$12,092,935	$104,378,704	$38,493,946	$0	$1,722	$47,409,911	$21,136,869	$1,959,449	$78,621	$378	$233,666,309
Drug Rebate	($3,188,270)	($4,751,863)	($41,015,133)	($15,126,019)	$0	($677)	($18,629,507)	($8,305,636)	($769,957)	($30,894)	($148)	($91,818,104)
Rural Health Centers	$50,160	$147,174	$965,699	$1,418,805	$0	$0	$4,193,025	$300,376	$348,898	$34,346	$0	$7,458,484
Federally Qualified Health Centers	$964,422	$691,839	$5,907,249	$12,590,508	$0	$0	$44,940,460	$2,237,254	$4,162,016	$1,595,266	$0	$73,089,013
Co-Insurance (Title XVIII-Medicare)	$13,247,112	$1,936,238	$8,768,139	$362,516	$0	$0	$31,202	$20,241	$41,983	$1,112	$3,689,845	$28,098,389
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$7,042,030	$0	$0	$0	$0	$0	$7,042,030
Prepaid Inpatient Health Plan Services	$2,208,485	$1,744,095	$12,109,816	$5,020,548	$0	$0	$11,378,089	$1,586,101	$1,942,062	$0	$0	$35,989,196
Other Medical Services	$3,147	$1,760	$15,560	$7,453	$0	$212	$13,048	$2,059	$1,783	$1,776	$148	$46,946
Home Health	$24,428,105	$6,617,163	$102,068,348	$523,488	$0	$0	$3,328,955	$10,164,895	$25,103	$0	$172,081	$147,328,138
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$102,239,226**	**$56,004,946**	**$492,622,774**	**$237,359,354**	**$0**	**$7,043,287**	**$428,647,150**	**$61,714,145**	**$60,515,451**	**$59,182,087**	**$3,886,476**	**$1,509,214,896**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$97,156,797	$13,604,791	$65,434,378	$15,400	$0	$0	$0	$77,857	$0	$0	$192,447	$176,481,671
HCBS - Mental Illness	$3,588,896	$2,137,938	$17,180,010	$1,005	$0	$0	$0	$6,584	$0	$0	$44,433	$22,958,866
HCBS - Disabled Children	$0	$0	$1,747,600	$0	$0	$0	$50	$33	$0	$0	$0	$1,747,683
HCBS - Persons Living with AIDS	$12,764	$32,458	$546,457	$0	$0	$0	$0	$0	$0	$0	$1,066	$592,744
HCBS - Consumer Directed Attendant Support	$2,271,433	$318,067	$1,529,803	$351	$0	$0	$0	$1,820	$0	$0	$4,499	$4,125,973
HCBS - Brain Injury	$159,346	$507,164	$11,361,726	$0	$0	$0	$0	$0	$0	$0	$0	$12,028,236
HCBS - Children with Autism	$0	$0	$1,293,932	$0	$0	$0	$0	$0	$0	$0	$0	$1,293,932
HCBS - Pediatric Hospice	$0	$0	$26,940	$0	$0	$0	$0	$2,372	$0	$0	$0	$29,312
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$725,106	$186,844	$14,728,104	$0	$0	$0	$250,793	$5,460,562	$0	$0	$0	$21,351,408
Hospice	$31,767,623	$2,005,681	$5,941,975	$45,064	$0	$0	$77,422	$3,390	$2,017	$0	$59,700	$39,902,873
Subtotal Community Based Long-Term Care	**$135,681,964**	**$18,792,943**	**$119,790,925**	**$61,820**	**$0**	**$0**	**$328,265**	**$5,552,618**	**$2,017**	**$0**	**$302,145**	**$280,512,697**
Long-Term Care												
Class I Nursing Facilities	$423,682,370	$29,953,087	$77,004,135	$22,194	$0	$0	$0	$0	$0	$0	$256,886	$530,918,672
Class II Nursing Facilities	$0	$335,754	$1,935,960	$0	$0	$0	$0	$0	$0	$0	$0	$2,271,714
Program of All-Inclusive Care for the Elderly	$54,470,714	$4,395,937	$2,183,184	$0	$0	$0	$0	$0	$0	$0	$0	$61,049,836
Subtotal Long-Term Care	**$478,153,084**	**$34,684,778**	**$81,123,279**	**$22,194**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$256,886**	**$594,240,222**
Insurance												
Supplemental Medicare Insurance Benefit	$49,992,538	$2,915,276	$26,205,375	$163,913	$0	$0	$0	$0	$0	$0	$14,466,011	$93,743,114
Health Insurance Buy-In Program	($177)	$3,200	$917,027	$5,034	$0	$0	$16,561	$0	$500	$0	$0	$942,145
Subtotal Insurance	**$49,992,361**	**$2,918,475**	**$27,122,403**	**$168,948**	**$0**	**$0**	**$16,561**	**$0**	**$500**	**$0**	**$14,466,011**	**$94,685,260**
Service Management												
Single Entry Points	$11,356,087	$1,927,170	$9,708,485	$3,228	$0	$0	$1,507	$7,102	$0	$56,818	$6,779	$23,067,175
Disease Management	$201,459	$112,661	$996,159	$477,141	$0	$13,568	$835,312	$131,805	$114,165	$0	$0	$2,882,271
Prepaid Inpatient Health Plan Administration	$352,841	$75,159	$520,646	$626,486	$0	$0	$2,101,664	$184,279	$74,059	$0	$0	$3,935,134
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,910,387**	**$2,114,989**	**$11,225,291**	**$1,106,856**	**$0**	**$13,568**	**$2,938,483**	**$323,187**	**$188,224**	**$56,818**	**$6,779**	**$29,884,581**
Total Services	**$777,977,023**	**$114,516,131**	**$731,884,672**	**$238,719,172**	**$0**	**$7,056,855**	**$431,930,459**	**$67,589,950**	**$60,706,191**	**$59,238,905**	**$18,918,298**	**$2,508,537,655**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$11,596,400	$918,068	$3,187,728	$959,312	$0	$0	$1,418,150	$148,694	$140,234	$43,831	$7,015	$18,419,432
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$10,655	$1,568	$10,023	$3,269	$0	$97	$5,915	$926	$831	$811	$259	$34,355
Subtotal Financing and Supplemental Payments	**$11,607,055**	**$919,637**	**$3,197,752**	**$962,581**	**$0**	**$97**	**$1,424,066**	**$149,619**	**$141,065**	**$44,642**	**$7,274**	**$18,453,787**
Grand Total	**$789,584,078**	**$115,435,768**	**$735,082,424**	**$239,681,753**	**$0**	**$7,056,952**	**$433,354,524**	**$67,739,569**	**$60,847,257**	**$59,283,547**	**$18,925,572**	**$2,526,991,443**

Exhibit M

Cash-based Actuals												
FY 2007-08	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$3,469,726	$5,866,568	$39,253,495	$42,993,990	$0	$0	$71,109,993	$8,011,424	$12,603,872	$7,354,450	$309	$190,663,827
Emergency Transportation	$76,213	$207,485	$1,572,693	$981,840	$0	$0	$1,291,389	$163,859	$150,448	$106,578	$0	$4,550,505
Non-emergency Medical Transportation	$1,890,521	$807,146	$3,907,628	$289,364	$0	$0	$713,422	$99,207	$24,313	$2,348	$0	$7,733,949
Dental Services	$692,450	$171,089	$3,093,306	$2,871,537	$0	$0	$42,256,276	$4,543,616	$250,711	$14,716	$189	$53,893,890
Family Planning	$101	$0	$7,167	$83,516	$0	$0	$70,705	$30,651	$8,462	$1,470	$0	$202,073
Health Maintenance Organizations	$9,349,039	$5,367,124	$44,519,944	$13,895,038	$0	$0	$27,309,963	$873,700	$902,068	$0	$0	$102,216,877
Inpatient Hospitals	$12,490,039	$11,578,942	$87,911,992	$58,686,715	$0	$0	$77,716,643	$6,608,100	$23,195,257	$42,710,199	$1,406	$320,899,293
Outpatient Hospitals	$2,279,079	$3,626,609	$36,371,235	$33,981,921	$0	$0	$44,067,264	$4,594,124	$3,998,659	$1,273,061	$243	$130,192,196
Lab & X-Ray	$415,678	$628,260	$4,813,487	$8,199,820	$0	$0	$4,844,562	$1,480,894	$2,110,120	$281,245	$175	$22,774,240
Durable Medical Equipment	$19,099,564	$3,724,534	$40,421,276	$2,088,605	$0	$0	$6,388,678	$3,963,555	$114,866	$7,053	$7,843	$75,815,972
Prescription Drugs	$6,819,298	$11,618,863	$102,291,859	$34,081,457	$0	$1,305	$39,162,305	$21,130,262	$1,689,121	$69,578	$90	$216,864,136
Drug Rebate	($1,744,101)	($2,971,636)	($26,162,127)	($8,716,660)	$0	($334)	($10,016,136)	($5,404,268)	($432,009)	($17,795)	($23)	($55,465,088)
Rural Health Centers	$33,486	$118,828	$885,721	$1,140,150	$0	$0	$3,411,821	$384,803	$239,581	$28,394	$0	$6,242,784
Federally Qualified Health Centers	$686,433	$672,208	$5,232,210	$10,292,590	$0	$0	$38,528,501	$2,053,130	$3,358,983	$1,797,419	$0	$62,621,473
Co-Insurance (Title XVIII-Medicare)	$10,666,122	$1,603,558	$7,081,693	$206,011	$0	$0	$13,250	$8,349	$30,611	$1,086	$2,896,987	$22,507,668
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$7,088,411	$0	$0	$0	$0	$0	$7,088,411
Prepaid Inpatient Health Plan Services	$2,144,360	$1,683,438	$11,566,837	$4,327,500	$0	$0	$10,068,498	$1,601,890	$2,289,781	$0	$0	$33,682,305
Other Medical Services	$2,310	$1,293	$11,593	$5,267	$0	$178	$8,985	$1,584	$1,224	$1,347	$106	$33,888
Home Health	$22,853,620	$6,013,415	$87,841,043	$524,398	$0	$0	$3,209,955	$8,809,726	$37,335	$2,426	$423,280	$129,715,198
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$3,770,690	$0	$0	$3,770,690
Subtotal of Acute Care	**$91,223,938**	**$50,717,725**	**$450,621,054**	**$205,933,059**	**$0**	**$7,089,560**	**$360,156,073**	**$58,954,606**	**$54,344,094**	**$53,633,572**	**$3,330,605**	**$1,336,004,286**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$86,813,975	$10,527,340	$43,329,761	$37,887	$0	$0	$0	$13,583	$0	$0	$509,299	$141,231,844
HCBS - Mental Illness	$3,181,676	$1,943,044	$15,184,323	$2,509	$0	$0	$0	$9,277	$0	$0	$89,059	$20,409,887
HCBS - Disabled Children	$0	$0	$1,352,728	$0	$0	$0	$973	$147	$0	$0	$0	$1,353,847
HCBS - Persons Living with AIDS	$12,757	$31,627	$549,627	$0	$0	$0	$0	$0	$0	$0	$1,395	$595,406
HCBS - Consumer Directed Attendant Support	$8,673,182	$1,051,738	$4,328,897	$3,764	$0	$0	$0	$1,357	$0	$0	$50,882	$14,109,819
HCBS - Brain Injury	$79,917	$459,639	$10,226,782	$0	$0	$0	$0	$0	$0	$0	$19,249	$10,785,587
HCBS - Children with Autism	$0	$0	$693,081	$0	$0	$0	$2,504	$0	$0	$0	$0	$695,586
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$313,936	$207,166	$13,885,052	$0	$0	$0	$500,847	$4,832,273	$0	$0	$9,988	$19,749,262
Hospice	$25,148,153	$2,134,632	$5,123,646	$77,203	$0	$0	$86,351	$0	$0	$0	$240,791	$32,810,776
Subtotal Community Based Long-Term Care	**$124,223,595**	**$16,355,185**	**$94,673,897**	**$121,364**	**$0**	**$0**	**$590,675**	**$4,856,636**	**$0**	**$0**	**$920,662**	**$241,742,014**
Long-Term Care												
Class I Nursing Facilities	$389,399,454	$25,395,243	$69,952,848	$6,325	$0	$0	$0	$0	$0	$0	$1,814,628	$486,568,498
Class II Nursing Facilities	$74,970	$191,024	$1,924,394	$0	$0	$0	$0	$0	$0	$0	$45,248	$2,235,636
Program of All-Inclusive Care for the Elderly	$44,272,143	$3,549,809	$1,596,904	$0	$0	$0	$0	$0	$0	$0	$0	$49,418,855
Subtotal Long-Term Care	**$433,746,567**	**$29,136,075**	**$73,474,146**	**$6,325**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$1,859,876**	**$538,222,989**
Insurance												
Supplemental Medicare Insurance Benefit	$43,978,504	$2,564,572	$23,052,905	$144,195	$0	$0	$0	$0	$0	$0	$12,725,770	$82,465,946
Health Insurance Buy-In Program	$3,274	$1,762	$877,995	$1,605	$0	$0	$16,916	$1,188	$2,208	$0	$0	$904,947
Subtotal Insurance	**$43,981,778**	**$2,566,334**	**$23,930,899**	**$145,800**	**$0**	**$0**	**$16,916**	**$1,188**	**$2,208**	**$0**	**$12,725,770**	**$83,370,893**
Service Management												
Single Entry Points	$10,894,815	$1,743,587	$8,992,484	$2,602	$0	$0	$1,301	$2,602	$0	$0	$119,709	$21,757,100
Disease Management	$165,996	$92,931	$833,085	$378,473	$0	$12,812	$645,653	$113,811	$87,964	$0	$0	$2,330,726
Prepaid Inpatient Health Plan Administration	$366,151	$74,505	$536,817	$496,755	$0	$0	$1,873,683	$176,254	$85,306	$0	$0	$3,609,472
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$11,426,962**	**$1,911,023**	**$10,362,386**	**$877,831**	**$0**	**$12,812**	**$2,520,636**	**$292,668**	**$173,270**	**$0**	**$119,709**	**$27,697,298**
Total Services	**$704,602,839**	**$100,686,342**	**$653,062,382**	**$207,084,379**	**$0**	**$7,102,372**	**$363,284,302**	**$64,105,098**	**$54,519,572**	**$53,633,572**	**$18,956,623**	**$2,227,037,481**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$7,640,056	$566,098	$2,073,951	$584,574	$0	$0	$859,573	$89,613	$77,998	$24,832	$35,401	$11,952,096
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$33,799	$4,830	$31,327	$9,934	$0	$341	$17,426	$3,075	$2,615	$2,573	$909	$106,828
Subtotal Financing and Supplemental Payments	**$7,673,855**	**$570,928**	**$2,105,277**	**$594,508**	**$0**	**$341**	**$877,000**	**$92,688**	**$80,613**	**$27,405**	**$36,310**	**$12,058,924**
Grand Total	**$712,276,694**	**$101,257,270**	**$655,167,660**	**$207,678,887**	**$0**	**$7,102,713**	**$364,161,301**	**$64,197,785**	**$54,600,185**	**$53,660,977**	**$18,992,933**	**$2,239,096,405**

Exhibit M

Cash-based Actuals												
FY 2006-07	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$2,557,590	$4,913,899	$32,157,433	$40,209,605	$0	$0	$61,863,460	$6,843,560	$9,019,205	$6,665,024	$2,652	$164,232,428
Emergency Transportation	$75,398	$169,825	$1,386,996	$955,546	$0	$0	$1,313,302	$139,118	$129,933	$114,504	$0	$4,284,622
Non-emergency Medical Transportation	($18,672)	($8,454)	($25,794)	($1,823)	$0	$0	($4,150)	($1,652)	($176)	($17)	($2)	($60,740)
Dental Services	$662,760	$164,830	$2,924,310	$2,833,345	$0	$0	$38,168,661	$4,365,105	$239,992	$8,130	$0	$49,367,133
Family Planning	$0	$0	$464	$7,050	$0	$0	$7,323	$3,119	$422	$55	$0	$18,433
Health Maintenance Organizations	$9,906,026	$5,316,092	$44,014,281	$19,171,730	$0	$0	$28,259,688	$667,693	$1,093,523	$0	$0	$108,429,033
Inpatient Hospitals	$12,785,899	$10,333,981	$77,352,935	$61,110,745	$0	$0	$74,070,764	$5,149,408	$19,508,543	$44,375,127	$0	$304,687,402
Outpatient Hospitals	$1,996,199	$3,500,504	$31,579,126	$31,901,572	$0	$0	$38,657,701	$3,944,746	$2,972,677	$1,214,531	$217	$115,767,273
Lab & X-Ray	$336,966	$575,229	$4,080,667	$7,908,380	$0	($112)	$4,565,655	$1,172,479	$1,552,063	$255,725	$91	$20,447,143
Durable Medical Equipment	$17,788,206	$3,417,083	$34,532,449	$2,022,631	$0	$0	$5,382,698	$3,535,980	$114,018	$7,737	$21,364	$66,822,166
Prescription Drugs	$6,520,078	$10,234,109	$88,778,681	$30,668,561	$0	$1,088	$33,279,711	$19,027,403	$1,277,899	$45,745	$174	$189,833,449
Drug Rebate	($2,014,232)	($3,161,599)	($27,426,192)	($9,474,367)	$0	($336)	($10,281,023)	($5,878,091)	($394,778)	($14,132)	($54)	($58,644,804)
Rural Health Centers	$33,187	$105,329	$792,378	$1,087,608	$0	$0	$3,407,281	$221,847	$212,217	$20,555	$0	$5,880,402
Federally Qualified Health Centers	$603,731	$558,662	$4,565,903	$10,480,699	$0	$0	$36,599,910	$1,514,903	$2,874,034	$1,762,260	$0	$58,960,102
Co-Insurance (Title XVIII-Medicare)	$9,351,692	$1,308,275	$5,742,590	$100,441	$0	$0	$6,279	$8,956	$17,869	$0	$2,440,303	$18,976,405
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$5,554,934	$0	$0	$0	$0	$0	$5,554,934
Prepaid Inpatient Health Plan Services	$2,175,087	$1,620,965	$10,503,017	$4,341,534	$0	$0	$9,283,867	$1,386,666	$1,974,179	$0	$0	$31,285,316
Other Medical Services	$1,879	$1,007	$8,697	$4,562	$0	$122	$7,155	$1,185	$855	$1,192	$82	$26,736
Home Health	$20,648,369	$5,431,838	$72,782,098	$502,197	$0	$0	$2,622,088	$7,357,801	$18,370	$1,011	$283,291	$109,647,063
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$7,849,344	$0	$0	$7,849,344
Subtotal of Acute Care	**$83,410,163**	**$44,481,575**	**$383,750,038**	**$203,830,016**	**$0**	**$5,555,696**	**$327,210,370**	**$49,460,226**	**$48,460,189**	**$54,457,447**	**$2,748,118**	**$1,203,363,838**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$77,897,470	$9,019,369	$36,497,817	$40,463	$0	$0	$0	$5,953	$0	$0	$211,964	$123,673,036
HCBS - Mental Illness	$2,759,506	$1,696,177	$12,752,277	$2,377	$0	$0	$0	$470	$0	$0	$35,513	$17,246,320
HCBS - Disabled Children	$0	$0	$904,544	$0	$0	$0	$264	$0	$0	$0	$75	$904,883
HCBS - Persons Living with AIDS	$16,836	$17,189	$468,801	$0	$0	$0	$0	$0	$0	$0	$704	$503,530
HCBS - Consumer Directed Attendant Support	$7,923,897	$917,469	$3,712,636	$4,116	$0	$0	$0	$606	$0	$0	$21,561	$12,580,285
HCBS - Brain Injury	$73,747	$313,937	$10,724,693	$151	$0	$0	$0	$0	$0	$0	$0	$11,112,528
HCBS - Children with Autism	$0	$0	$18,801	$0	$0	$0	$0	$0	$0	$0	$0	$18,801
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$354,877	$155,949	$12,205,855	$0	$0	$0	$562,535	$3,983,279	$0	$0	$37,261	$17,299,756
Hospice	$23,913,110	$1,986,641	$5,611,231	$46,496	$0	$0	$141,295	$0	$0	$0	$88,575	$31,787,348
Subtotal Community Based Long-Term Care	**$112,939,443**	**$14,106,731**	**$82,896,656**	**$93,603**	**$0**	**$0**	**$704,094**	**$3,990,308**	**$0**	**$0**	**$395,653**	**$215,126,488**
Long-Term Care												
Class I Nursing Facilities	$384,275,629	$24,171,304	$68,903,820	$1,596	$0	$0	$0	$0	$0	$0	$951,138	$478,303,487
Class II Nursing Facilities	$106,064	$27,660	$2,100,702	$0	$0	$0	$0	$0	$0	$0	$35,710	$2,270,136
Program of All-Inclusive Care for the Elderly	$37,878,793	$3,182,900	$1,810,588	$0	$0	$0	$0	$0	$0	$0	$0	$42,872,281
Subtotal Long-Term Care	**$422,260,486**	**$27,381,864**	**$72,815,110**	**$1,596**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$986,848**	**$523,445,904**
Insurance												
Supplemental Medicare Insurance Benefit	$44,106,993	$2,572,065	$23,120,257	$144,616	$0	$0	$0	$0	$0	$0	$12,762,950	$82,706,881
Health Insurance Buy-In Program	$1,797	$20,389	$704,579	$2,008	$0	$0	$9,795	$651	$3,133	$0	$0	$742,352
Subtotal Insurance	**$44,108,790**	**$2,592,454**	**$23,824,836**	**$146,624**	**$0**	**$0**	**$9,795**	**$651**	**$3,133**	**$0**	**$12,762,950**	**$83,449,233**
Service Management												
Single Entry Points	$9,171,616	$1,415,981	$7,352,685	$4,528	$0	$0	$0	$1,132	$0	$0	$56,594	$18,002,536
Disease Management	$31,652	$16,971	$146,541	$76,859	$0	$2,053	$120,548	$19,962	$14,413	$0	$0	$428,999
Prepaid Inpatient Health Plan Administration	$505,046	$102,136	$772,630	$519,429	$0	$0	$2,412,273	$223,401	$85,502	$0	$0	$4,620,417
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$9,708,314**	**$1,535,088**	**$8,271,856**	**$600,816**	**$0**	**$2,053**	**$2,532,821**	**$244,495**	**$99,915**	**$0**	**$56,594**	**$23,051,952**
Total Services	**$672,427,196**	**$90,097,712**	**$571,558,496**	**$204,672,655**	**$0**	**$5,557,749**	**$330,457,080**	**$53,695,680**	**$48,563,237**	**$54,457,447**	**$16,950,163**	**$2,048,437,415**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$8,446,320	$605,079	$2,197,186	$666,891	$0	$0	$845,299	$86,257	$65,001	$26,557	$20,803	$12,959,393
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Financing and Supplemental Payments	**$8,446,320**	**$605,079**	**$2,197,186**	**$666,891**	**$0**	**$0**	**$845,299**	**$86,257**	**$65,001**	**$26,557**	**$20,803**	**$12,959,393**
Grand Total	**$680,873,516**	**$90,702,791**	**$573,755,682**	**$205,339,546**	**$0**	**$5,557,749**	**$331,302,380**	**$53,781,937**	**$48,628,238**	**$54,484,004**	**$16,970,966**	**$2,061,396,808**

Exhibit M

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

Exhibit M

Cash-based Actuals												
FY 2004-05	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$3,423,604	$3,193,975	$21,628,805	$32,599,653	$0	$0	$43,820,013	$5,026,864	$8,927,565	$5,498,719	$142	$124,119,339
Emergency Transportation	$154,437	$125,096	$1,062,237	$761,877	$0	$0	$1,030,699	$114,920	$115,808	$108,563	$104	$3,473,741
Non-emergency Medical Transportation	$65,695	$29,745	$90,757	$6,414	$0	$0	$14,601	$5,811	$618	$60	$5	$213,706
Dental Services	$1,138,025	$185,567	$2,573,418	$3,009,041	$0	$0	$29,245,153	$3,562,887	$266,892	$32,867	$0	$40,013,849
Family Planning	$0	$26	$4,351	$97,103	$0	$0	$46,021	$29,939	$7,912	$669	$0	$186,021
Health Maintenance Organizations	$14,841,610	$10,000,351	$80,033,438	$22,355,311	$0	$0	$34,237,510	($91,468)	$713,180	$0	$315	$162,090,246
Inpatient Hospitals	$12,100,223	$8,017,452	$58,771,508	$59,068,158	$0	$0	$70,183,080	$4,604,884	$17,929,034	$35,337,108	$0	$266,011,447
Outpatient Hospitals	$2,308,115	$2,676,602	$22,949,379	$25,028,931	$0	$0	$32,440,056	$3,875,487	$3,256,924	$1,082,574	$49	$93,618,116
Lab & X-Ray	$383,268	$393,747	$2,972,445	$6,616,645	$0	$0	$3,692,266	$1,040,626	$2,080,982	$304,349	$427	$17,484,755
Durable Medical Equipment	$13,866,449	$2,344,377	$24,809,129	$1,387,625	$0	$0	$4,463,726	$3,231,168	$84,778	$15,993	$96,006	$50,299,251
Prescription Drugs	$80,910,411	$14,897,365	$122,641,655	$21,534,152	$0	$0	$24,054,575	$15,406,676	$1,297,940	$79,392	$108,732	$280,930,899
Drug Rebate	($25,860,524)	($3,853,558)	($33,644,073)	($2,532,799)	$0	$0	($2,541,517)	($2,821,952)	($363,610)	($1,803)	($36,838)	($71,656,675)
Rural Health Centers	$49,536	$71,821	$593,992	$806,931	$0	$0	$2,749,051	$172,803	$123,398	$30,392	$471	$4,598,395
Federally Qualified Health Centers	$554,197	$478,212	$3,082,202	$10,107,145	$0	$0	$35,200,815	$1,398,913	$3,824,437	$2,198,858	$786	$56,845,564
Co-Insurance (Title XVIII-Medicare)	$8,401,158	$1,189,659	$5,961,109	$65,701	$0	$0	$3,136	$3,446	$14,758	$0	$1,718,734	$17,357,700
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$2,490,090	$0	$0	$0	$0	$0	$2,490,090
Prepaid Inpatient Health Plan Services	$8,205,532	$3,161,532	$22,924,314	$9,831,589	$0	$0	$18,756,993	$1,883,211	$3,711,132	$0	$0	$68,474,304
Other Medical Services	$3,767	$1,188	$10,643	$4,356	$0	$60	$5,588	$1,058	$1,424	$1,325	$59	$29,468
Home Health	$13,643,727	$3,729,460	$49,395,318	$315,958	$0	$0	$2,142,906	$5,260,733	$34,531	$7,192	$4,787	$74,534,611
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$134,189,229**	**$46,642,619**	**$385,860,624**	**$191,063,789**	**$0**	**$2,490,150**	**$299,544,670**	**$42,706,006**	**$42,027,702**	**$44,696,256**	**$1,893,780**	**$1,191,114,826**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$63,998,370	$5,231,339	$24,985,616	$857	$0	$0	$0	$0	$0	$0	$0	$94,216,182
HCBS - Mental Illness	$2,003,427	$1,267,654	$9,747,334	$891	$0	$0	$0	$0	$0	$0	$157	$13,019,463
HCBS - Disabled Children	$242,689	$30,421	$195,393	$437	$0	$0	$2,061	$10,913	$7	$0	$5	$481,927
HCBS - Persons Living with AIDS	$14,775	$480	$443,196	$0	$0	$0	$0	$0	$0	$0	$0	$458,451
HCBS - Consumer Directed Attendant Support	$2,977,355	$373,212	$2,397,120	$5,362	$0	$0	$25,291	$133,881	$90	$0	$61	$5,912,371
HCBS - Brain Injury	$5,499	$99,150	$9,119,694	$1,248	$0	$0	$0	$0	$0	$0	$0	$9,225,591
HCBS - Children with Autism	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$119,147	$360,893	$9,569,473	$0	$0	$0	$505,864	$3,516,516	$0	$0	$0	$14,071,893
Hospice	$17,144,015	$1,326,788	$4,807,057	$117,796	$0	$0	$156,717	$4,293	$2,364	$0	$0	$23,559,031
Subtotal Community Based Long-Term Care	**$86,505,276**	**$8,689,937**	**$61,264,884**	**$126,591**	**$0**	**$0**	**$689,933**	**$3,665,603**	**$2,461**	**$0**	**$224**	**$160,944,908**
Long-Term Care												
Class I Nursing Facilities	$342,142,204	$19,699,056	$61,974,535	$56,072	$0	$0	$0	$0	$0	$0	$6,466	$423,878,333
Class II Nursing Facilities	$0	$0	$1,383,445	$0	$0	$0	$0	$0	$0	$0	$0	$1,383,445
Program of All-Inclusive Care for the Elderly	$31,140,652	$2,557,598	$1,461,755	$0	$0	$0	$0	$0	$0	$0	$0	$35,160,005
Subtotal Long-Term Care	**$373,282,857**	**$22,256,654**	**$64,819,734**	**$56,072**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$6,466**	**$460,421,784**
Insurance												
Supplemental Medicare Insurance Benefit	$31,170,839	$1,817,703	$16,339,309	$102,202	$0	$0	$0	$0	$0	$0	$9,019,700	$58,449,753
Health Insurance Buy-In Program	$246,429	$21,489	$182,018	$43,760	$0	$0	$73,026	$12,242	$15,329	$9,501	$3,538	$607,332
Subtotal Insurance	**$31,417,268**	**$1,839,192**	**$16,521,327**	**$145,961**	**$0**	**$0**	**$73,026**	**$12,242**	**$15,329**	**$9,501**	**$9,023,238**	**$59,057,085**
Service Management												
Single Entry Points	$9,077,168	$1,312,201	$6,855,305	$4,865	$0	$0	$1,216	$0	$0	$0	$6,081	$17,256,835
Disease Management	$26,163	$8,253	$73,925	$30,257	$0	$420	$38,813	$7,351	$9,889	$9,202	$408	$204,682
Prepaid Inpatient Health Plan Administration	$373,290	$76,345	$697,995	$487,706	$0	$0	$2,458,050	$114,363	$77,587	$22	$88	$4,285,446
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$9,476,621**	**$1,396,799**	**$7,627,226**	**$522,827**	**$0**	**$420**	**$2,498,080**	**$121,714**	**$87,476**	**$9,224**	**$6,576**	**$21,746,963**
Total Services	**$634,871,251**	**$80,825,201**	**$536,093,795**	**$191,915,241**	**$0**	**$2,490,571**	**$302,805,710**	**$46,505,565**	**$42,132,968**	**$44,714,981**	**$10,930,284**	**$1,893,285,567**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$18,097,381	$1,175,615	$4,461,893	$1,317,963	$0	$0	$1,704,397	$203,618	$171,118	$56,878	$342	$27,189,205
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$22,384	$2,850	$18,902	$6,767	$0	$88	$10,676	$1,640	$1,486	$1,577	$385	$66,754
Subtotal Financing and Supplemental Payments	**$18,119,765**	**$1,178,464**	**$4,480,795**	**$1,324,730**	**$0**	**$88**	**$1,715,073**	**$205,257**	**$172,604**	**$58,455**	**$728**	**$27,255,959**
Grand Total	**$652,991,016**	**$82,003,665**	**$540,574,590**	**$193,239,971**	**$0**	**$2,490,659**	**$304,520,783**	**$46,710,822**	**$42,305,572**	**$44,773,436**	**$10,931,012**	**$1,920,541,525**

Cash-based Actuals												
FY 2003-04	**Adults 65 and Older (OAP-A)**	**Disabled Adults 60 to 64 (OAP-B)**	**Disabled Individuals to 59 (AND/AB)**	**MAGI Parents/ Caretakers to 68% FPL**	**MAGI Parents/ Caretakers 69% to 133% FPL**	**Breast & Cervical Cancer Program**	**Eligible Children (AFDC-C/BC)**	**Foster Care**	**MAGI Pregnant Adults**	**Non-Citizens-Emergency Services**	**Partial Dual Eligibles**	**COFRS TOTAL**
Acute Care												
Physician Services & EPSDT	$3,871,515	$3,520,279	$25,923,882	$34,967,666	$0	$0	$23,226,514	$5,500,090	$17,403,246	$8,213,373	$47,103	$122,673,666
Emergency Transportation	$589,405	$218,872	$1,669,140	$782,002	$0	$0	$1,178,072	$149,707	$153,433	$111,945	$0	$4,852,575
Non-emergency Medical Transportation	$806,566	$278,282	$1,243,917	$36,470	$0	$0	$107,240	$143,175	$700	$0	$0	$2,616,352
Dental Services	$2,390,281	$413,398	$5,498,742	$2,990,555	$0	$0	$24,329,953	$3,166,313	$364,666	$31,047	$4,502	$39,189,457
Family Planning	$0	$0	$6,041	$120,575	$0	$0	$32,419	$22,427	$21,222	$1,861	$0	$204,545
Health Maintenance Organizations	$15,369,265	$11,545,880	$99,362,574	$26,008,450	$0	$0	$44,430,797	$545,391	$635,781	$0	$0	$197,898,138
Inpatient Hospitals	$11,297,635	$8,477,930	$60,780,794	$54,483,931	$0	$0	$69,238,974	$5,735,633	$21,617,641	$41,614,823	$0	$273,247,361
Outpatient Hospitals	$2,086,806	$2,521,476	$23,163,401	$22,844,361	$0	$0	$28,358,793	$3,449,321	$5,301,550	$1,321,484	$0	$89,047,191
Lab & X-Ray	$343,381	$364,374	$3,137,799	$5,956,882	$0	$0	$1,691,656	$943,094	$4,523,890	$264,248	$0	$17,225,324
Durable Medical Equipment	$15,032,626	$2,282,023	$25,537,628	$1,166,432	$0	$0	$1,968,676	$3,103,265	$107,680	$13,259	$33,928	$49,245,516
Prescription Drugs	$79,379,246	$13,536,350	$124,035,077	$19,634,829	$0	$0	$12,605,392	$14,335,007	$2,117,560	$86,425	$67,788	$265,797,673
Drug Rebate	($19,302,428)	($2,876,315)	($25,112,109)	($1,890,494)	$0	$0	($1,897,002)	($2,106,320)	($271,400)	($1,346)	($27,496)	($53,484,910)
Rural Health Centers	$26,246	$76,640	$497,819	$772,756	$0	$0	$2,262,303	$163,086	$83,294	$27,166	$0	$3,909,310
Federally Qualified Health Centers	$640,225	$522,098	$4,107,835	$12,142,028	$0	$0	$17,649,180	$1,856,885	$11,045,830	$3,434,383	$434	$51,398,899
Co-Insurance (Title XVIII-Medicare)	$9,322,772	$1,280,424	$6,604,447	$21,924	$0	$0	$2,475	$2,777	$8,276	$0	$1,962,635	$19,205,728
Breast and Cervical Cancer Treatment Program	$0	$0	$0	$0	$0	$2,668,652	$0	$0	$0	$0	$0	$2,668,652
Prepaid Inpatient Health Plan Services	$2,310,425	$922,019	$6,720,440	$2,493,384	$0	$0	$3,674,896	$320,084	$794,356	$0	$0	$17,235,604
Other Medical Services	$12,866	$4,059	$36,353	$14,879	$0	$207	$19,087	$3,615	$4,863	$4,525	$201	$100,654
Home Health	$11,572,193	$3,031,991	$49,085,659	$278,805	$0	$0	$863,860	$4,836,114	$22,643	$5,790	$0	$69,697,057
Presumptive Eligibility	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal of Acute Care	**$135,749,025**	**$46,119,779**	**$412,299,443**	**$182,825,434**	**$0**	**$2,668,859**	**$229,743,284**	**$42,169,663**	**$63,935,230**	**$55,128,983**	**$2,089,094**	**$1,172,728,792**
Community Based Long-Term Care												
HCBS - Elderly, Blind, and Disabled	$64,355,491	$5,260,531	$25,125,040	$861	$0	$0	$0	$0	$0	$0	$0	$94,741,923
HCBS - Mental Illness	$2,440,729	$1,455,627	$11,134,445	$0	$0	$0	$0	$145	$0	$0	$0	$15,030,947
HCBS - Disabled Children	$184,675	$20,711	$145,817	$378	$0	$0	$479	$6,830	$0	$0	$0	$358,891
HCBS - Persons Living with AIDS	$16,669	$5,220	$540,329	$0	$0	$0	$0	$0	$0	$0	$0	$562,218
HCBS - Consumer Directed Attendant Support	$1,577,022	$176,863	$1,245,201	$3,231	$0	$0	$4,088	$58,327	$0	$0	$1	$3,064,733
HCBS - Brain Injury	$11,970	$46,893	$8,906,818	$0	$0	$0	$0	$27,116	$0	$0	$0	$8,992,797
HCBS - Children with Autism	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Pediatric Hospice	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
HCBS - Spinal Cord Injury	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Private Duty Nursing	$75,531	$315,738	$9,645,058	$0	$0	$0	$190,788	$2,949,031	$0	$0	$0	$13,176,147
Hospice	$17,064,571	$1,016,913	$4,530,283	$163,150	$0	$0	$18,029	$2,715	$0	$0	$0	$22,795,661
Subtotal Community Based Long-Term Care	**$85,726,658**	**$8,298,496**	**$61,272,991**	**$167,620**	**$0**	**$0**	**$213,385**	**$3,044,165**	**$0**	**$0**	**$1**	**$158,723,316**
Long-Term Care												
Class I Nursing Facilities	$336,650,323	$16,720,841	$62,600,540	$12,286	$0	$0	$0	$0	$0	$0	$27,022	$416,011,012
Class II Nursing Facilities	$0	$0	$1,104,554	$0	$0	$0	$0	$0	$0	$0	$0	$1,104,554
Program of All-Inclusive Care for the Elderly	$24,097,092	$1,864,579	$1,067,498	$0	$0	$0	$0	$0	$0	$0	$0	$27,029,169
Subtotal Long-Term Care	**$360,747,415**	**$18,585,420**	**$64,772,592**	**$12,286**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$27,022**	**$444,144,736**
Insurance												
Supplemental Medicare Insurance Benefit	$25,391,796	$1,480,703	$13,310,017	$83,254	$0	$0	$0	$0	$0	$0	$7,347,457	$47,613,226
Health Insurance Buy-In Program	$280,042	$24,420	$206,845	$49,728	$0	$0	$82,987	$13,912	$17,420	$10,796	$4,021	$690,172
Subtotal Insurance	**$25,671,838**	**$1,505,123**	**$13,516,862**	**$132,982**	**$0**	**$0**	**$82,987**	**$13,912**	**$17,420**	**$10,796**	**$7,351,477**	**$48,303,398**
Service Management												
Single Entry Points	$7,810,601	$1,041,413	$5,676,359	$1,094	$0	$0	$0	$1,094	$0	$0	$0	$14,530,561
Disease Management	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prepaid Inpatient Health Plan Administration	$347,815	$66,518	$562,748	$369,742	$0	$0	$1,829,096	$76,791	$55,410	$0	$0	$3,308,119
Accountable Care Collaborative	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal Service Management	**$8,158,415**	**$1,107,932**	**$6,239,107**	**$370,836**	**$0**	**$0**	**$1,829,096**	**$77,885**	**$55,410**	**$0**	**$0**	**$17,838,681**
Total Services	**$616,053,351**	**$75,616,749**	**$558,100,995**	**$183,509,158**	**$0**	**$2,668,859**	**$231,868,751**	**$45,305,624**	**$64,008,060**	**$55,139,779**	**$9,467,595**	**$1,841,738,922**
Financing and Supplemental Payments												
Upper Payment Limit Financing	$18,054,683	$1,025,615	$4,571,216	$1,218,259	$0	$0	$1,511,523	$183,849	$282,573	$70,435	$1,440	$26,919,593
Hospital Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Nursing Facility Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Physician Supplemental Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Outstationing Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Accounting Adjustments	$30,679	$3,766	$27,793	$9,138	$0	$133	$11,547	$2,256	$3,188	$2,746	$471	$91,716
Subtotal Financing and Supplemental Payments	**$18,085,361**	**$1,029,381**	**$4,599,009**	**$1,227,397**	**$0**	**$133**	**$1,523,070**	**$186,105**	**$285,760**	**$73,181**	**$1,912**	**$27,011,308**
Grand Total	**$634,138,712**	**$76,646,130**	**$562,700,004**	**$184,736,556**	**$0**	**$2,668,992**	**$233,391,821**	**$45,491,729**	**$64,293,820**	**$55,212,960**	**$9,469,507**	**$1,868,750,230**

Exhibit N - Expenditure History by Service Category

ACUTE CARE	FY 2013-14	Percent Change from Prior Year	FY 2012-13	Percent Change from Prior Year	FY 2011-12	Percent Change from Prior Year	FY 2010-11	Percent Change From Prior Year	FY 2009-10	Percent Change From Prior Year	FY 2008-09	Percent Change From Prior Year	FY 2007-08	Percent Change From Prior Year	FY 2006-07	Percent Change From Prior Year	FY 2005-06	Percent Change From Prior Year
Physician Services & EPSDT	$447,742,226	43.81%	$311,344,143	8.47%	$287,020,239	1.57%	$282,592,042	16.33%	$242,929,414	4.30%	$232,912,692	22.16%	$190,663,827	16.09%	$164,232,428	13.84%	$144,266,423	16.23%
Emergency Transportation	$10,125,852	39.21%	$7,273,660	14.35%	$6,361,058	2.00%	$6,236,250	19.52%	$5,217,633	5.75%	$4,934,082	8.43%	$4,550,505	6.21%	$4,284,622	18.64%	$3,611,441	3.96%
Non-Emergency Medical Transportation	$14,734,943	53.86%	$9,576,755	-8.46%	$10,462,166	-0.07%	$10,469,107	14.65%	$9,131,655	5.09%	$8,689,018	12.35%	$7,733,949	-12832.88%	($60,740)	444.07%	($11,164)	-105.22%
Dental Services	$146,803,940	26.14%	$116,386,038	12.00%	$103,911,787	-4.29%	$108,570,692	22.25%	$88,806,857	16.15%	$76,456,424	41.86%	$53,893,890	9.17%	$49,367,133	5.70%	$46,705,514	16.72%
Family Planning	$958,576	37.09%	$699,220	20.77%	$578,957	31.16%	$441,414	37.10%	$321,975	0.80%	$319,424	58.07%	$202,073	996.27%	$18,433	-95.49%	$409,119	119.93%
Health Maintenance Organizations	$135,890,722	7.40%	$126,531,583	4.82%	$120,715,911	2.75%	$117,488,456	-0.14%	$117,651,717	-8.85%	$129,074,827	26.28%	$102,216,877	-5.73%	$108,429,033	-29.95%	$154,782,191	-4.51%
Inpatient Hospitals	$478,311,291	17.58%	$406,784,919	12.22%	$362,502,617	-2.52%	$371,861,948	10.23%	$337,358,448	-5.39%	$356,576,636	11.12%	$320,899,293	5.32%	$304,687,402	2.66%	$296,800,124	11.57%
Outpatient Hospitals	$397,169,554	41.27%	$281,148,005	20.93%	$232,479,846	6.89%	$217,492,911	50.04%	$144,956,141	-5.81%	$153,901,754	18.21%	$130,192,196	12.46%	$115,767,273	10.03%	$105,213,743	12.39%
Lab & X-Ray	$64,684,775	41.69%	$45,653,385	14.20%	$39,978,003	5.59%	$37,862,120	25.59%	$30,148,317	6.01%	$28,437,823	24.87%	$22,774,240	11.38%	$20,447,143	6.22%	$19,250,037	10.10%
Durable Medical Equipment	$119,661,675	16.03%	$103,126,254	10.05%	$93,706,452	3.40%	$90,627,945	15.78%	$78,272,962	1.64%	$77,011,816	1.58%	$75,815,972	13.46%	$66,822,166	13.93%	$58,652,169	16.61%
Prescription Drugs	$453,191,438	35.60%	$334,204,114	4.85%	$318,741,461	13.32%	$281,278,949	24.40%	$226,114,086	-3.23%	$233,666,309	7.75%	$216,864,136	14.24%	$189,833,449	-19.88%	$236,947,825	-15.66%
Drug Rebate	($195,271,698)	9.08%	($179,022,880)	19.52%	($149,787,193)	18.03%	($126,909,710)	27.09%	($99,855,328)	8.75%	($91,818,104)	65.54%	($55,465,088)	-5.42%	($58,644,804)	-25.83%	($79,068,617)	10.34%
Rural Health Centers	$14,825,896	20.09%	$12,345,593	16.82%	$10,567,916	3.73%	$10,188,005	27.45%	$7,993,821	7.18%	$7,458,484	19.47%	$6,242,784	6.16%	$5,880,402	23.76%	$4,751,330	3.33%
Federally Qualified Health Centers	$128,107,489	28.38%	$99,791,204	5.28%	$94,790,483	4.97%	$90,306,523	18.44%	$76,244,360	4.32%	$73,089,013	16.72%	$62,621,473	6.21%	$58,960,102	-4.84%	$61,957,718	8.99%
Co-Insurance (Title XVIII-Medicare)	$54,904,379	34.44%	$40,839,212	10.27%	$37,036,552	1.78%	$36,387,414	74.50%	$20,852,175	-25.79%	$28,098,389	24.84%	$22,507,668	18.61%	$18,976,405	5.88%	$17,922,444	3.25%
Breast and Cervical Cancer Treatment Program	$8,879,647	-7.11%	$9,559,144	-6.95%	$10,272,613	1.64%	$10,106,643	15.95%	$8,716,269	23.77%	$7,042,030	-0.65%	$7,088,411	27.61%	$5,554,934	-18.41%	$6,808,264	173.41%
Prepaid Inpatient Health Plan Services	$58,932,563	2.21%	$57,655,514	2.11%	$56,463,119	11.04%	$50,849,494	13.75%	$44,703,819	24.21%	$35,989,196	6.85%	$33,682,305	7.66%	$31,285,316	-5.16%	$32,987,230	-51.83%
Other Medical Services	$20,991	35.15%	$15,532	1.55%	$15,295	8.03%	$14,158	-71.19%	$49,140	4.67%	$46,946	38.53%	$33,888	26.75%	$26,736	-10.59%	$29,903	1.48%
Home Health	$209,335,186	18.03%	$177,355,908	9.74%	$161,607,733	-6.39%	$172,633,768	10.35%	$156,448,421	6.19%	$147,328,138	13.58%	$129,715,198	18.30%	$109,647,063	18.89%	$92,227,451	23.74%
Presumptive Eligibility	$0	-100.00%	$3,075,000	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	-100.00%	$3,770,690	-51.96%	$7,849,344	196.81%	$2,644,540	0.00%
Subtotal of Acute Care	**$2,549,009,445**	**29.76%**	**$1,964,342,303**	**9.29%**	**$1,797,425,015**	**1.64%**	**$1,768,498,130**	**18.21%**	**$1,496,061,883**	**-0.87%**	**$1,509,214,896**	**12.96%**	**$1,336,004,286**	**11.02%**	**$1,203,363,838**	**-0.29%**	**$1,206,887,685**	**1.32%**
COMMUNITY BASED LONG-TERM CARE																		
HCBS - Elderly, Blind, and Disabled	$279,523,188	15.27%	$242,494,560	7.69%	$225,185,711	6.12%	$212,196,143	13.82%	$186,426,075	5.63%	$176,481,671	24.96%	$141,231,844	14.20%	$123,673,036	15.28%	$107,276,565	13.86%
HCBS - Mental Illness	$31,919,229	12.75%	$28,309,412	9.16%	$25,934,255	3.96%	$24,946,790	9.99%	$22,681,360	-1.21%	$22,958,866	12.49%	$20,409,887	18.34%	$17,246,320	15.10%	$14,984,173	15.09%
HCBS - Disabled Children	$8,101,781	51.42%	$5,350,385	70.93%	$3,130,073	59.29%	$1,965,004	11.44%	$1,763,210	0.89%	$1,747,683	29.09%	$1,353,847	49.62%	$904,883	36.73%	$661,823	37.33%
HCBS - Persons Living with AIDS	$135,733	-71.78%	$480,928	-6.80%	$516,036	-9.07%	$567,535	-2.39%	$581,405	-1.91%	$592,744	-0.45%	$595,406	18.25%	$503,530	6.50%	$472,783	3.13%
HCBS - Consumer Directed Attendant Support	$2,331,237	-12.42%	$2,661,977	-23.10%	$3,461,683	16.90%	$2,961,259	-15.80%	$3,516,917	-14.76%	$4,125,973	-70.76%	$14,109,819	12.16%	$12,580,285	73.81%	$7,237,889	22.42%
HCBS - Brain Injury	$14,184,077	10.38%	$12,849,682	2.09%	$12,587,131	2.36%	$12,297,265	7.10%	$11,482,073	-4.54%	$12,028,236	11.52%	$10,785,587	-2.94%	$11,112,528	26.08%	$8,813,686	-4.46%
HCBS - Children with Autism	$764,302	-13.68%	$885,424	-13.40%	$1,022,387	-24.69%	$1,357,612	-13.29%	$1,565,700	21.00%	$1,293,932	86.02%	$695,586	3599.64%	$18,801	0.00%	$0	0.00%
HCBS - Pediatric Hospice	$221,632	7.00%	$207,131	21.19%	$170,910	34.89%	$126,702	33.68%	$94,781	223.36%	$29,312	0.00%	$0	0.00%	$0	0.00%	$0	0.00%
HCBS - Spinal Cord Injury	$1,773,572	602.38%	$252,509	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%
Private Duty Nursing	$53,154,903	44.26%	$36,846,961	18.31%	$31,144,153	12.18%	$27,761,694	19.50%	$23,230,817	8.80%	$21,351,408	8.11%	$19,749,262	14.16%	$17,299,756	10.78%	$15,616,760	10.98%
Hospice	$45,017,254	3.73%	$43,397,100	2.53%	$42,326,808	6.18%	$39,862,966	-7.98%	$43,321,496	8.57%	$39,902,873	21.62%	$32,810,776	3.22%	$31,787,348	11.51%	$28,507,087	21.00%
Subtotal of Community Based Long-Term Care	**$437,126,908**	**16.96%**	**$373,736,069**	**8.18%**	**$345,479,147**	**6.62%**	**$324,042,970**	**9.97%**	**$294,663,833**	**5.04%**	**$280,512,697**	**16.04%**	**$241,742,014**	**12.37%**	**$215,126,488**	**17.19%**	**$183,570,766**	**14.06%**
LONG-TERM CARE AND INSURANCE																		
Class I Nursing Facilities	$562,325,391	5.62%	$532,405,250	2.14%	$521,244,769	2.58%	$508,141,849	4.33%	$487,074,333	-8.26%	$530,918,672	9.11%	$486,568,498	1.73%	$478,303,487	4.77%	$456,520,328	7.70%
Class II Nursing Facilities	$3,484,766	-31.77%	$5,107,562	104.38%	$2,499,074	5.77%	$2,362,706	17.21%	$2,015,835	-11.26%	$2,271,714	1.61%	$2,235,636	-1.52%	$2,270,136	57.99%	$1,436,850	3.86%
Program of All-Inclusive Care for the Elderly	$100,474,817	3.21%	$97,346,358	13.88%	$85,480,585	1.24%	$84,429,683	21.94%	$69,240,623	13.42%	$61,049,836	23.54%	$49,418,855	15.27%	$42,872,281	5.93%	$40,470,490	15.10%
Supplemental Medicare Insurance Benefit	$129,168,681	7.77%	$119,859,864	1.06%	$118,598,927	-0.79%	$119,543,734	15.98%	$103,068,590	9.95%	$93,743,114	13.67%	$82,465,946	-0.29%	$82,706,881	16.86%	$70,775,604	21.09%
Health Insurance Buy-In Program	$1,365,261	0.27%	$1,361,531	17.44%	$1,159,307	3.05%	$1,124,996	20.75%	$931,637	-1.12%	$942,145	4.11%	$904,947	21.90%	$742,352	41.62%	$524,194	-13.69%
Subtotal of Long-Term Care and Insurance	**$796,818,916**	**5.39%**	**$756,080,565**	**3.72%**	**$728,982,662**	**1.87%**	**$715,602,968**	**8.04%**	**$662,331,019**	**-3.86%**	**$688,925,481**	**10.83%**	**$621,593,882**	**2.42%**	**$606,895,137**	**6.52%**	**$569,727,466**	**9.67%**
SERVICE MANAGEMENT																		
Single Entry Points	$26,899,016	-0.29%	$26,976,561	6.94%	$25,226,746	5.02%	$24,021,660	1.32%	$23,707,551	2.78%	$23,067,175	6.02%	$21,757,100	20.86%	$18,002,536	8.80%	$16,547,063	-4.11%
Disease Management	$526,953	-44.94%	$957,110	-2.54%	$982,012	0.00%	$0	-100.00%	$71,616	-97.52%	$2,882,271	23.66%	$2,330,726	443.29%	$428,999	33.08%	$322,355	57.49%
Prepaid Inpatient Health Plan Administration	$7,630,138	14.14%	$6,685,075	-24.81%	$8,891,348	37.31%	$6,475,244	26.67%	$5,111,753	29.90%	$3,935,134	9.02%	$3,609,472	-21.88%	$4,620,417	-13.49%	$5,340,741	24.63%
Accountable Care Collaborative	$68,570,330	86.69%	$36,728,931	105.10%	$17,907,833	1917.99%	$887,411	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%
Subtotal Service Management	$103,626,437	**45.24%**	$71,347,677	**34.60%**	$53,007,939	**68.90%**	$31,384,315	**8.63%**	$28,890,920	**-3.32%**	$29,884,581	**7.90%**	$27,697,298	**20.15%**	$23,051,952	**3.79%**	$22,210,159	**2.13%**
Total Services	**$3,886,581,706**	**22.78%**	**$3,165,506,614**	**8.23%**	**$2,924,894,763**	**3.01%**	**$2,839,528,383**	**14.41%**	**$2,481,947,656**	**-1.06%**	**$2,508,537,655**	**12.64%**	**$2,227,037,481**	**8.72%**	**$2,048,437,415**	**3.33%**	**$1,982,396,076**	**4.71%**
FINANCING AND SUPPLEMENTAL PAYMENTS																		
Upper Payment Limit Financing	$5,670,550	-2.43%	$5,811,783	-8.87%	$6,377,165	-61.22%	$16,446,173	-8.31%	$17,936,927	-2.62%	$18,419,432	54.11%	$11,952,096	-7.77%	$12,959,393	-6.55%	$13,868,231	-48.99%
Hospital Supplemental Payments	$622,708,054	-4.32%	$650,828,979	5.90%	$614,554,259	34.96%	$455,348,284	45.73%	$312,468,739	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%
Nursing Facility Supplemental Payments	$89,773,988	5.92%	$84,755,778	-2.34%	$86,787,485	13.72%	$76,315,634	60.83%	$47,451,412	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%
Physician Supplemental Payments	$5,619,123	-58.33%	$13,485,215	170.53%	$4,984,682	83.54%	$2,715,842	-81.28%	$14,504,498	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%
Outstationing Payments	$6,408,519	-58.42%	$15,412,520	964.98%	$1,447,215	-72.61%	$5,283,594	50.09%	$3,520,254	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%
Accounting Adjustments	$2,008,260	25.53%	$1,599,845	-46.44%	$2,987,193	-29274.17%	($10,239)	-40.70%	($17,268)	-150.26%	$34,355	-67.84%	$106,828	0.00%	$0	-100.00%	$1	-100.00%
Subtotal Financing and Supplemental Payments	**$732,188,494**	**-5.14%**	**$771,894,120**	**7.64%**	**$717,137,999**	**28.96%**	**$556,099,288**	**40.48%**	**$395,864,563**	**2045.17%**	**$18,453,787**	**53.03%**	**$12,058,924**	**-6.95%**	**$12,959,393**	**-6.55%**	**$13,868,232**	**-49.12%**
Grand Total	**$4,618,770,200**	**17.31%**	**$3,937,400,734**	**8.11%**	**$3,642,032,762**	**7.26%**	**$3,395,627,671**	**17.99%**	**$2,877,812,218**	**13.88%**	**$2,526,991,443**	**12.86%**	**$2,239,096,405**	**8.62%**	**$2,061,396,808**	**3.26%**	**$1,996,264,308**	**3.94%**

Exhibit N - Expenditure History by Service Category

ACUTE CARE	FY 2004-05
Physician Services & EPSDT	$124,119,339
Emergency Transportation	$3,473,741
Non-Emergency Medical Transportation	$213,706
Dental Services	$40,013,849
Family Planning	$186,021
Health Maintenance Organizations	$162,090,246
Inpatient Hospitals	$266,011,447
Outpatient Hospitals	$93,618,116
Lab & X-Ray	$17,484,755
Durable Medical Equipment	$50,299,251
Prescription Drugs	$280,930,899
Drug Rebate	($71,656,675)
Rural Health Centers	$4,598,395
Federally Qualified Health Centers	$56,845,564
Co-Insurance (Title XVIII-Medicare)	$17,357,700
Breast and Cervical Cancer Treatment Program	$2,490,090
Prepaid Inpatient Health Plan Services	$68,474,304
Other Medical Services	$29,468
Home Health	$74,534,611
Presumptive Eligibility	$0
Subtotal of Acute Care	**$1,191,114,826**
COMMUNITY BASED LONG-TERM CARE	
HCBS - Elderly, Blind, and Disabled	$94,216,182
HCBS - Mental Illness	$13,019,463
HCBS - Disabled Children	$481,927
HCBS - Persons Living with AIDS	$458,451
HCBS - Consumer Directed Attendant Support	$5,912,371
HCBS - Brain Injury	$9,225,591
HCBS - Children with Autism	$0
HCBS - Pediatric Hospice	$0
HCBS - Spinal Cord Injury	$0
Private Duty Nursing	$14,071,893
Hospice	$23,559,031
Subtotal of Community Based Long-Term Care	**$160,944,908**
LONG-TERM CARE AND INSURANCE	
Class I Nursing Facilities	$423,878,333
Class II Nursing Facilities	$1,383,445
Program of All-Inclusive Care for the Elderly	$35,160,005
Supplemental Medicare Insurance Benefit	$58,449,753
Health Insurance Buy-In Program	$607,332
Subtotal of Long-Term Care and Insurance	**$519,478,869**
SERVICE MANAGEMENT	
Single Entry Points	$17,256,835
Disease Management	$204,682
Prepaid Inpatient Health Plan Administration	$4,285,446
Accountable Care Collaborative	$0
Subtotal Service Management	$21,746,963
Total Services	**$1,893,285,567**
FINANCING AND SUPPLEMENTAL PAYMENTS	
Upper Payment Limit Financing	$27,189,205
Hospital Supplemental Payments	$0
Nursing Facility Supplemental Payments	$0
Physician Supplemental Payments	$0
Outstationing Payments	$0
Accounting Adjustments	$66,754
Subtotal Financing and Supplemental Payments	**$27,255,959**
Grand Total	**$1,920,541,525**

Exhibit N - Expenditure History by Service Category - Delay Adjusted

ACUTE CARE	FY 2013-14	Percent Change from Prior Year	FY 2012-13	Percent Change from Prior Year	FY 2011-12	Percent Change from Prior Year	FY 2010-11 (DA)	Percent Change From Prior Year	FY 2009-10 (DA)	Percent Change From Prior Year	FY 2008-09	Percent Change From Prior Year	FY 2007-08	Percent Change From Prior Year	FY 2006-07	Percent Change From Prior Year	FY 2005-06	Percent Change From Prior Year	FY 2004-05
Physician Services & EPSDT	$447,742,226	43.81%	$311,344,143	8.47%	$287,020,239	4.99%	$273,385,005	8.43%	$252,136,452	8.25%	$232,912,692	22.16%	$190,663,827	16.09%	$164,232,428	13.84%	$144,266,423	16.23%	$124,119,339
Emergency Transportation	$10,125,852	39.21%	$7,273,660	14.35%	$6,361,058	5.59%	$6,024,130	10.95%	$5,429,754	10.05%	$4,934,082	8.43%	$4,550,505	6.21%	$4,284,622	18.64%	$3,611,441	3.96%	$3,473,741
Non-emergency Medical Transportation	$14,734,943	53.86%	$9,576,755	-8.46%	$10,462,166	0.95%	$10,363,372	12.19%	$9,237,390	6.31%	$8,689,018	12.35%	$7,733,949	-12832.88%	($60,740)	444.07%	($11,164)	-105.22%	$213,706
Dental Services	$146,803,940	26.14%	$116,386,038	12.00%	$103,911,787	-0.87%	$104,818,977	13.25%	$92,558,572	21.06%	$76,456,424	41.86%	$53,893,890	9.17%	$49,367,133	5.70%	$46,705,514	16.72%	$40,013,849
Family Planning	$958,576	37.09%	$699,220	20.77%	$578,957	35.12%	$428,473	27.93%	$334,916	4.85%	$319,424	58.07%	$202,073	996.27%	$18,433	-95.49%	$409,119	119.93%	$186,021
Health Maintenance Organizations	$135,890,722	7.40%	$126,531,583	4.82%	$120,715,911	2.75%	$117,488,424	-0.14%	$117,651,750	-8.85%	$129,074,827	26.28%	$102,216,877	-5.73%	$108,429,033	-29.95%	$154,782,191	-4.51%	$162,090,246
Inpatient Hospitals	$478,311,291	17.58%	$406,784,919	12.22%	$362,502,617	1.42%	$357,410,898	1.59%	$351,809,498	-1.34%	$356,576,636	11.12%	$320,899,293	5.32%	$304,687,402	2.66%	$296,800,124	11.57%	$266,011,447
Outpatient Hospitals	$397,169,554	41.27%	$281,148,005	20.93%	$232,479,846	10.81%	$209,791,226	37.43%	$152,657,826	-0.81%	$153,901,754	18.21%	$130,192,196	12.46%	$115,767,273	10.03%	$105,213,743	12.39%	$93,618,116
Lab & X-Ray	$64,684,775	41.69%	$45,653,385	14.20%	$39,978,003	9.29%	$36,581,144	16.39%	$31,429,294	10.52%	$28,437,823	24.87%	$22,774,240	11.38%	$20,447,143	6.22%	$19,250,037	10.10%	$17,484,755
Durable Medical Equipment	$119,661,675	16.03%	$103,126,254	10.05%	$93,706,452	6.79%	$87,745,314	8.12%	$81,155,593	5.38%	$77,011,816	1.58%	$75,815,972	13.46%	$66,822,166	13.93%	$58,652,169	16.61%	$50,299,251
Prescription Drugs	$453,191,438	35.60%	$334,204,114	4.85%	$318,741,461	16.98%	$272,469,874	15.98%	$234,923,161	0.54%	$233,666,309	7.75%	$216,864,136	14.24%	$189,833,449	-19.88%	$236,947,825	-15.66%	$280,930,899
Drug Rebate	($195,271,698)	9.08%	($179,022,880)	19.52%	($149,787,193)	18.03%	($126,909,710)	27.09%	($99,855,328)	8.75%	($91,818,104)	65.54%	($55,465,088)	-5.42%	($58,644,804)	-25.83%	($79,068,617)	10.34%	($71,656,675)
Rural Health Centers	$14,825,896	20.09%	$12,345,593	16.82%	$10,567,916	6.88%	$9,887,646	19.21%	$8,294,180	11.20%	$7,458,484	19.47%	$6,242,784	6.16%	$5,880,402	23.76%	$4,751,330	3.33%	$4,598,395
Federally Qualified Health Centers	$128,107,489	28.38%	$99,791,204	5.28%	$94,790,483	8.29%	$87,530,065	10.77%	$79,020,818	8.12%	$73,089,013	16.72%	$62,621,473	6.21%	$58,960,102	-4.84%	$61,957,718	8.99%	$56,845,564
Co-Insurance (Title XVIII-Medicare)	$54,904,379	34.44%	$40,839,212	10.27%	$37,036,552	5.69%	$35,043,547	57.88%	$22,196,042	-21.01%	$28,098,389	24.84%	$22,507,668	18.61%	$18,976,405	5.88%	$17,922,444	3.25%	$17,357,700
Breast and Cervical Cancer Treatment Program	$8,879,647	-7.11%	$9,559,144	-6.95%	$10,272,613	4.64%	$9,817,118	9.01%	$9,005,795	27.89%	$7,042,030	-0.65%	$7,088,411	27.61%	$5,554,934	-18.41%	$6,808,264	173.41%	$2,490,090
Prepaid Inpatient Health Plan Services	$58,932,563	2.21%	$57,655,514	2.11%	$56,463,119	11.04%	$50,849,494	13.75%	$44,703,819	24.21%	$35,989,196	6.85%	$33,682,305	7.66%	$31,285,316	-5.16%	$32,987,230	-51.83%	$68,474,304
Other Medical Services	$20,991	35.15%	$15,532	1.55%	$15,295	8.03%	$14,158	-71.19%	$49,140	4.67%	$46,946	38.53%	$33,888	26.75%	$26,736	-10.59%	$29,903	1.48%	$29,468
Home Health	$209,335,186	18.03%	$177,355,908	9.74%	$161,607,733	-4.19%	$168,682,120	5.16%	$160,400,069	8.87%	$147,328,138	13.58%	$129,715,198	18.30%	$109,647,063	18.89%	$92,227,451	23.74%	$74,534,611
Presumptive Eligibility	$0	-100.00%	$3,075,000	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	-100.00%	$3,770,690	-51.96%	$7,849,344	196.81%	$2,644,540	0.00%	$0
Subtotal of Acute Care	**$2,549,009,445**	**29.76%**	**$1,964,342,303**	**9.29%**	**$1,797,425,015**	**5.03%**	**$1,711,421,275**	**10.19%**	**$1,553,138,739**	**2.91%**	**$1,509,214,896**	**12.96%**	**$1,336,004,286**	**11.02%**	**$1,203,363,838**	**-0.29%**	**$1,206,887,685**	**1.32%**	**$1,191,114,826**
COMMUNITY BASED LONG-TERM CARE																			
HCBS - Elderly, Blind, and Disabled	$279,523,188	15.27%	$242,494,560	7.69%	$225,185,711	7.99%	$208,526,316	9.70%	$190,095,902	7.71%	$176,481,671	24.96%	$141,231,844	14.20%	$123,673,036	15.28%	$107,276,565	13.86%	$94,216,182
HCBS - Mental Illness	$31,919,229	12.75%	$28,309,412	9.16%	$25,934,255	5.48%	$24,587,535	6.71%	$23,040,614	0.36%	$22,958,866	12.49%	$20,409,887	18.34%	$17,246,320	15.10%	$14,984,173	15.09%	$13,019,463
HCBS - Disabled Children	$8,101,781	51.42%	$5,350,385	70.93%	$3,130,073	65.86%	$1,887,201	2.51%	$1,841,013	5.34%	$1,747,683	29.09%	$1,353,847	49.62%	$904,883	36.73%	$661,823	37.33%	$481,927
HCBS - Persons Living with AIDS	$135,733	-71.78%	$480,928	-6.80%	$516,036	-6.24%	$550,397	-8.04%	$598,542	0.98%	$592,744	-0.45%	$595,406	18.25%	$503,530	6.50%	$472,783	3.13%	$458,451
HCBS - Consumer Directed Attendant Support	$2,331,237	-12.42%	$2,661,977	-23.10%	$3,461,683	16.90%	$2,961,259	-15.80%	$3,516,917	-14.76%	$4,125,973	-70.76%	$14,109,819	12.16%	$12,580,285	73.81%	$7,237,889	22.42%	$5,912,371
HCBS - Brain Injury	$14,184,077	10.38%	$12,849,682	2.09%	$12,587,131	3.32%	$12,182,916	5.06%	$11,596,421	-3.59%	$12,028,236	11.52%	$10,785,587	-2.94%	$11,112,528	26.08%	$8,813,686	-4.46%	$9,225,591
HCBS - Children with Autism	$764,302	-13.68%	$885,424	-13.40%	$1,022,387	-23.05%	$1,328,577	-16.69%	$1,594,735	23.25%	$1,293,932	86.02%	$695,586	3599.64%	$18,801	0.00%	$0	0.00%	$0
HCBS - Pediatric Hospice	$221,632	7.00%	$207,131	21.19%	$170,910	43.29%	$119,273	16.69%	$102,210	248.70%	$29,312	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
HCBS - Spinal Cord Injury	$1,773,572	602.38%	$252,509	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Private Duty Nursing	$53,154,903	44.26%	$36,846,961	18.31%	$31,144,153	13.97%	$27,325,957	15.46%	$23,666,555	10.84%	$21,351,408	8.11%	$19,749,262	14.16%	$17,299,756	10.78%	$15,616,760	10.98%	$14,071,893
Hospice	$45,017,254	3.73%	$43,397,100	2.53%	$42,326,808	7.03%	$39,547,635	-9.37%	$43,636,826	9.36%	$39,902,873	21.62%	$32,810,776	3.22%	$31,787,348	11.51%	$28,507,087	21.00%	$23,559,031
Subtotal Community Based Long-Term Care	**$437,126,908**	**16.96%**	**$373,736,069**	**8.18%**	**$345,479,147**	**8.29%**	**$319,017,067**	**6.45%**	**$299,689,736**	**6.84%**	**$280,512,697**	**16.04%**	**$241,742,014**	**12.37%**	**$215,126,488**	**17.19%**	**$183,570,766**	**14.06%**	**$160,944,908**
LONG-TERM CARE AND INSURANCE																			
Class I Nursing Facilities	$562,325,391	5.62%	$532,405,250	2.14%	$521,244,769	4.39%	$499,315,391	0.69%	$495,900,792	-6.60%	$530,918,672	9.11%	$486,568,498	1.73%	$478,303,487	4.77%	$456,520,328	7.70%	$423,878,333
Class II Nursing Facilities	$3,484,766	-31.77%	$5,107,562	104.38%	$2,499,074	-21.00%	$3,163,194	160.27%	$1,215,347	-46.50%	$2,271,714	1.61%	$2,235,636	-1.52%	$2,270,136	57.99%	$1,436,850	3.86%	$1,383,445
Program of All-Inclusive Care for the Elderly	$100,474,817	3.21%	$97,346,358	13.88%	$85,480,585	1.26%	$84,414,277	21.89%	$69,256,028	13.44%	$61,049,836	23.54%	$49,418,855	15.27%	$42,872,281	5.93%	$40,470,490	15.10%	$35,160,005
Supplemental Medicare Insurance Benefit	$129,168,681	7.77%	$119,859,864	1.06%	$118,598,927	-0.79%	$119,543,734	15.98%	$103,068,590	9.95%	$93,743,114	13.67%	$82,465,946	-0.29%	$82,706,881	16.86%	$70,775,604	21.09%	$58,449,753
Health Insurance Buy-In Program	$1,365,261	0.27%	$1,361,531	17.44%	$1,159,307	11.83%	$1,036,644	1.63%	$1,019,989	8.26%	$942,145	4.11%	$904,947	21.90%	$742,352	41.62%	$524,194	-13.69%	$607,332
Subtotal Long-Term Care and Insurance	**$796,818,916**	**5.39%**	**$756,080,565**	**3.72%**	**$728,982,662**	**3.04%**	**$707,473,240**	**5.52%**	**$670,460,746**	**-2.68%**	**$688,925,481**	**10.83%**	**$621,593,882**	**2.42%**	**$606,895,137**	**6.52%**	**$569,727,466**	**9.67%**	**$519,478,869**
SERVICE MANAGEMENT																			
Single Entry Points	$26,899,016	-0.29%	$26,976,561	6.94%	$25,226,746	5.02%	$24,021,660	1.32%	$23,707,551	2.78%	$23,067,175	6.02%	$21,757,100	20.86%	$18,002,536	8.80%	$16,547,063	-4.11%	$17,256,835
Disease Management	$526,953	-44.94%	$957,110	-2.54%	$982,012	0.00%	$0	-100.00%	$71,616	-97.52%	$2,882,271	23.66%	$2,330,726	443.29%	$428,999	33.08%	$322,355	57.49%	$204,682
Prepaid Inpatient Health Plan Administration	$7,630,138	14.14%	$6,685,075	-24.81%	$8,891,348	37.31%	$6,475,244	26.67%	$5,111,753	29.90%	$3,935,134	9.02%	$3,609,472	-21.88%	$4,620,417	-13.49%	$5,340,741	24.63%	$4,285,446
Accountable Care Collaborative	$68,570,330	86.69%	$36,728,931	105.10%	$17,907,833	1917.99%	$887,411	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Subtotal Service Management	$103,626,437	**45.24%**	$71,347,677	**34.60%**	$53,007,939	**68.90%**	$31,384,315	**8.63%**	$28,890,920	**-3.32%**	$29,884,581	**7.90%**	$27,697,298	**20.15%**	$23,051,952	**3.79%**	$22,210,159	**2.13%**	$21,746,963
Total Services	**$3,886,581,706**	**22.78%**	**$3,165,506,614**	**8.23%**	**$2,924,894,763**	**5.62%**	**$2,769,295,897**	**8.51%**	**$2,552,180,141**	**1.74%**	**$2,508,537,655**	**12.64%**	**$2,227,037,481**	**8.72%**	**$2,048,437,415**	**3.33%**	**$1,982,396,076**	**4.71%**	**$1,893,285,567**
FINANCING AND SUPPLEMENTAL PAYMENTS																			
Upper Payment Limit Financing	$5,670,550	-2.43%	$5,811,783	-8.87%	$6,377,165	-61.22%	$16,446,173	-8.31%	$17,936,927	-2.62%	$18,419,432	54.11%	$11,952,096	-7.77%	$12,959,393	-6.55%	$13,868,231	-48.99%	$27,189,205
Hospital Supplemental Payments	$622,708,054	-4.32%	$650,828,979	5.90%	$614,554,259	34.96%	$455,348,284	45.73%	$312,468,739	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Nursing Facility Supplemental Payments	$89,773,988	5.92%	$84,755,778	-2.34%	$86,787,485	13.72%	$76,315,634	60.83%	$47,451,412	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Physician Supplemental Payments	$5,619,123	-58.33%	$13,485,215	170.53%	$4,984,682	83.54%	$2,715,842	-81.28%	$14,504,498	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Outstationing Payments	$6,408,519	-58.42%	$15,412,520	964.98%	$1,447,215	-72.61%	$5,283,594	50.09%	$3,520,254	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Accounting Adjustments	$2,008,260	25.53%	$1,599,845	-46.44%	$2,987,193	-29274.17%	($10,239)	-40.70%	($17,268)	-150.26%	$34,355	-67.84%	$106,828	0.00%	$0	-100.00%	$1	-100.00%	$66,754
Subtotal Financing and Supplemental Payments	**$732,188,494**	**-5.14%**	**$771,894,120**	**7.64%**	**$717,137,999**	**28.96%**	**$556,099,288**	**40.48%**	**$395,864,563**	**2045.17%**	**$18,453,787**	**53.03%**	**$12,058,924**	**-6.95%**	**$12,959,393**	**-6.55%**	**$13,868,232**	**-49.12%**	**$27,255,959**
Grand Total	**$4,618,770,200**	**17.31%**	**$3,937,400,734**	**8.11%**	**$3,642,032,762**	**9.52%**	**$3,325,395,185**	**12.80%**	**$2,948,044,704**	**16.66%**	**$2,526,991,443**	**12.86%**	**$2,239,096,405**	**8.62%**	**$2,061,396,808**	**3.26%**	**$1,996,264,308**	**3.94%**	**$1,920,541,525**

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

Exhibit O - Appropriations and Expenditures

Final FY 2013-14 Funding Splits

	Total Funds	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
SB 13-230 FY 2013-14 Long Bill Appropriation	**$4,438,829,600**	**$918,044,659**	**$596,441,858**	**$719,515,157**	**$936,892**	**$2,203,891,034**
HB 13-1152 "Nursing Facility Per Diem Rates"	($9,735,708)	($4,867,854)	$0	$0	$0	($4,867,854)
SB 13-167 "Intermediate Care Facilities for Individuals with Intellectual Disabilities"	$228,953	($85,984)	$0	$200,460	$0	$114,477
SB 13-200 "Expand Medicaid Eligibility"	$274,743,117	($934,367)	$0	($136,755,613)	$0	$412,433,097
SB 13-232 "Disease Management Transfer"	$0	($2,000,000)	$0	$0	$2,000,000	$0
SB 13-242 "Adult Dental Benefit Medicaid"	$32,858,915	($738,262)	$0	$10,972,059	$0	$22,625,118
HB 14-1252 "Intellectual & Developmental Disabilities Services System Capacity"	($15,977)	($7,988)	$0	$0	$0	($7,989)
Ref C Adjustment - JBC	$0	($45,794,099)	$45,794,099	$0	$0	$0
FY 2014-15 Tobacco Tax Forecast Update FY13	$0	$1,563,801	$0	($1,563,801)	$0	$0
2014-15 BA#12 "Enroll Dual Eligibles in ACC" FY14	$167,500	$0	$0	$0	$0	$167,500
HB 14-1236 FY 13-14 Supplemental Bill FY14	$52,407,943	$17,580,433	$0	($8,629,648)	$0	$43,457,158
HB 14-1236 FY 13-14 Supplemental Bill JBC Technical Adjustment	$1	$0	$0	$70,072,387	$0	($70,072,386)
14-15 Long Bill Add-on	$52,022,363	$14,408,764	$0	$1,535,440	$0	$36,078,159
Hospice 8.2% Increase	$476,498	$238,249	$0	$0	$0	$238,249
SB 13-276 "Disability and Investigational Pilot Support Fund"	($100,000)	$0	$0	($50,000)	$0	($50,000)
Appropriations Totals	$4,841,883,205	$897,407,352	$642,235,957	$655,296,441	$2,936,892	$2,644,006,563
Final Expenditures	$4,618,770,195	$926,160,050	$642,235,957	$567,267,337	$2,936,892	$2,480,169,959
Remaining Balance (Over Expenditure)	**$223,113,010**	**($28,752,698)**	**$0**	**$88,029,104**	**$0**	**$163,836,604**

Totals reflect final COFRS close; they do not include post-closing entries.

Totals may not match those found elsewhere, due to rounding.

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

FY 2013-14 Final Actuals			
Aid Category	**Caseload**	**Per Capita**	**Total**
Adults 65 and Older (OAP-A)	41,836	$23,433.50	$980,364,004
Disabled Adults 60 to 64 (OAP-B)	9,853	$19,949.34	$196,560,882
Disabled Individuals to 59 (AND/AB)	64,424	$17,103.37	$1,101,867,467
Disabled Buy-In	2,560	$15,571.57	$39,863,213
MAGI Parents/Caretakers to 68% FPL	124,680	$3,781.56	$471,485,421
MAGI Parents/Caretakers 69% to 133% FPL	47,082	$3,075.09	$144,781,548
MAGI Adults	87,243	$5,123.77	$447,013,009
Breast & Cervical Cancer Program	559	$15,893.87	$8,884,676
Eligible Children (AFDC-C/BC)	397,362	$2,091.99	$831,276,016
SB 11-008 Eligible Children	27,015	$1,458.01	$39,388,148
Foster Care	18,267	$4,663.23	$85,183,296
MAGI Pregnant Adults	13,160	$12,989.62	$170,943,411
SB 11-250 Eligible Pregnant Adults	1,057	$8,765.13	$9,264,744
Non-Citizens- Emergency Services	2,481	$24,604.83	$61,044,575
Partial Dual Eligibles	23,378	$1,319.61	$30,849,790
TOTAL	**860,957**	**TF**	**$4,618,770,195**
Total Funds include upper payment limit financing and supplemental payments and other Medicaid financing. Totals may not match due to rounding.		**GF**	$926,160,050
		GFE	$642,235,957
		CF	$567,267,337
		CFE	$2,936,892
		FF	$2,480,169,959

Exhibit O - Comparison of Budget Requests and Appropriations

FY 2013-14 Comparison of Requests and Appropriations

FY 2013-14	November 1, 2012	February 15, 2013	% Change	FY 2013-14 Long Bill and Special Bills Appropriation	November 1, 2013	February 15, 2014	% Change over Appropriation	FY 2013-14 Final Appropriation	FY 2013-14 Actuals	% Change over Feb.
Acute Care	$2,174,445,773	$2,168,005,305	-0.30%	$2,544,926,477	$2,584,442,652	$2,623,684,739	3.09%	$2,623,684,739	$2,561,037,087	-2.39%
Community Based Long-Term Care	$408,280,145	$401,621,950	-1.63%	$401,621,950	$440,818,906	$447,022,158	11.30%	$447,482,679	$437,126,908	-2.21%
Long-Term Care	$771,817,264	$794,414,636	2.93%	$794,414,636	$759,391,767	$758,808,722	-4.48%	$758,808,722	$756,058,962	-0.36%
Insurance	$143,464,674	$140,037,994	-2.39%	$140,037,994	$135,193,113	$130,317,188	-6.94%	$130,317,188	$130,533,942	0.17%
Service Management	$78,217,544	$94,878,782	21.30%	$94,878,782	$109,104,408	$120,129,252	26.61%	$120,296,752	$103,626,437	-13.74%
Financing	$705,563,531	$690,945,038	-2.07%	$760,945,038	$760,281,975	$761,293,125	0.05%	$761,293,125	$630,386,864	-17.20%
Total	$4,281,788,931	$4,289,903,705	0.19%	$4,736,824,877	$4,789,232,821	$4,841,255,184	2.20%	$4,841,883,205	$4,618,770,200	-4.60%
Class I Nursing Facilities	$661,718,428	$664,106,471	0.36%	$664,106,471	$639,574,931	$640,925,225	-3.49%	$640,925,225	$652,099,379	1.74%

FY 2014-15 Comparison of Requests and Appropriations

FY 2014-15	November 1, 2013	February 15, 2014	% Change	FY 2014-15 Long Bill and Special Bills Appropriation	November 1, 2014	February 15, 2015	% Change over Appropriation	FY 2014-15 Final Appropriation	FY 2014-15 Actuals	% Change over Feb.
Acute Care	$3,203,347,669	$3,247,889,365	1.39%	$3,450,240,965	$3,478,974,928		0.83%			
Community Based Long-Term Care	$473,754,400	$480,270,854	1.38%	$484,081,629	$469,738,984		-2.96%			
Long-Term Care	$784,692,921	$782,898,539	-0.23%	$778,144,517	$816,580,653		4.94%			
Insurance	$152,376,558	$140,231,303	-7.97%	$140,231,303	$137,528,242		-1.93%			
Service Management	$120,357,559	$150,709,318	25.22%	$150,709,318	$165,739,685		9.97%			
Financing	$770,252,284	$771,289,309	0.13%	$720,945,038	$797,682,058		10.64%			
Total	$5,504,781,391	$5,573,288,688	1.24%	$5,724,352,770	$5,866,244,550		2.48%			
Class I Nursing Facilities	$648,830,813	$648,605,818	-0.03%	$643,851,796	$672,758,697		4.49%			

FY 2015-16 Comparison of Requests and Appropriations

FY 2015-16	November 1, 2014	February 15, 2015	% Change	FY 2014-15 Long Bill and Special Bills Appropriation	November 1, 2015	February 15, 2016	% Change over Appropriation	FY 2015-16 Final Appropriation	FY 2015-16 Actuals	% Change over Feb.
Acute Care	$3,793,497,022									
Community Based Long-Term Care	$514,157,611									
Long-Term Care	$836,879,748									
Insurance	$145,436,492									
Service Management	$175,685,324									
Financing	$860,870,575									
Total	$6,326,526,772									
Class I Nursing Facilities	$686,986,774									

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

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	COFRS TOTAL
FY 1998-99	$463,746,968	$48,533,442	$361,070,568	$0	$71,509,445	$0	$0	$0	$149,648,954	$0	$23,328,439	$31,471,476	$0	$20,738,242	$6,185,875	$1,176,233,410
FY 1999-00	$498,371,676	$54,962,843	$406,908,458	$0	$80,904,393	$0	$0	$0	$169,614,835	$0	$27,483,127	$33,530,293	$0	$29,675,611	$6,968,865	$1,308,420,100
FY 2000-01	$515,213,506	$61,119,754	$450,888,114	$0	$88,758,327	$0	$0	$0	$193,552,834	$0	$30,746,407	$31,503,592	$0	$36,930,022	$7,822,852	$1,416,535,408
FY 2001-02	$571,065,382	$61,284,519	$465,027,758	$0	$104,227,966	$0	$0	$0	$220,555,126	$0	$33,206,413	$33,946,549	$0	$39,372,440	$8,118,537	$1,536,804,691
FY 2002-03	$564,628,021	$64,679,670	$516,439,288	$0	$139,745,425	$0	$0	$1,428,780	$227,992,629	$0	$37,567,968	$42,521,465	$0	$48,734,092	$7,933,536	$1,651,670,874
FY 2003-04	$634,138,712	$76,646,130	$562,700,004	$0	$184,736,556	$0	$0	$2,668,992	$233,391,821	$0	$45,491,729	$64,293,820	$0	$55,212,960	$9,469,507	$1,868,750,230
FY 2004-05	$652,991,016	$82,003,665	$540,574,590	$0	$193,239,971	$0	$0	$2,490,659	$304,520,783	$0	$46,710,822	$42,305,572	$0	$44,773,436	$10,931,012	$1,920,541,525
FY 2005-06	$670,399,260	$87,347,546	$554,870,504	$0	$200,372,841	$0	$0	$6,810,399	$317,181,796	$0	$49,374,100	$41,186,119	$0	$55,353,863	$13,367,880	$1,996,264,308
FY 2006-07	$680,873,516	$90,702,791	$573,755,682	$0	$205,339,546	$0	$0	$5,557,749	$331,302,380	$0	$53,781,937	$48,628,238	$0	$54,484,004	$16,970,966	$2,061,396,808
FY 2007-08	$712,276,694	$101,257,270	$655,167,660	$0	$207,678,887	$0	$0	$7,102,713	$364,161,301	$0	$64,197,785	$54,600,185	$0	$53,660,977	$18,992,933	$2,239,096,405
FY 2008-09	$789,584,078	$115,435,768	$735,082,424	$0	$239,681,753	$0	$0	$7,056,952	$433,354,524	$0	$67,739,569	$60,847,257	$0	$59,283,547	$18,925,572	$2,526,991,443
FY 2009-10 (DA)	$821,242,377	$128,660,905	$830,201,464	$0	$332,734,557	$3,669,080	$0	$9,006,759	$561,985,044	$0	$75,035,330	$91,641,692	$0	$74,354,504	$19,512,991	$2,948,044,704
FY 2010-11 (DA)	$859,971,334	$150,963,522	$943,370,577	$0	$373,924,418	$82,213,922	$0	$9,817,158	$627,769,747	$0	$81,811,588	$95,688,869	$0	$75,541,134	$24,322,917	$3,325,395,185
FY 2011-12	$896,112,956	$170,623,165	$1,033,566,923	$723,127	$442,861,997	$120,389,845	$4,003,017	$10,287,938	$683,425,225	$0	$79,698,390	$97,417,747	$0	$78,357,967	$24,564,465	$3,642,032,762
FY 2012-13	$927,900,253	$183,967,002	$1,049,728,681	$18,292,102	$468,129,131	$133,498,122	$87,688,473	$9,565,112	$749,135,524	$15,071,720	$79,058,628	$108,082,008	$2,869,936	$78,979,079	$25,434,963	$3,937,400,734
FY 2013-14	$980,364,004	$196,560,882	$1,101,867,467	$39,863,213	$471,485,421	$144,781,548	$447,013,009	$8,884,676	$831,276,016	$39,388,148	$85,183,296	$170,943,411	$9,264,744	$61,044,575	$30,849,790	$4,618,770,200

Fiscal Year	Expenditures	Percent Change	Dollar Increase/ Decrease	Average Yearly Percent Change From FY 97-98	Percent Change	Three-year Moving Average	Percent Change
FY 1998-99	$1,176,233,410						
FY 1999-00	$1,308,420,100	11.24%	$132,186,690				
FY 2000-01	$1,416,535,408	8.26%	$108,115,307	9.75%			
FY 2001-02	$1,536,804,691	8.49%	$120,269,284	9.33%	-4.31%	9.33%	
FY 2002-03	$1,651,670,874	7.47%	$114,866,182	8.87%	-4.97%	8.08%	-13.45%
FY 2003-04	$1,868,750,230	13.14%	$217,079,357	9.72%	9.65%	9.70%	20.14%
FY 2004-05	$1,920,541,525	2.77%	$51,791,295	8.56%	-11.92%	7.80%	-19.65%
FY 2005-06	$1,996,264,308	3.94%	$75,722,783	7.90%	-7.71%	6.62%	-15.10%
FY 2006-07	$2,061,396,808	3.26%	$65,132,500	7.32%	-7.34%	3.33%	-49.76%
FY 2007-08	$2,239,096,405	8.62%	$177,699,597	7.47%	1.97%	5.28%	58.62%
FY 2008-09	$2,526,991,443	12.86%	$287,895,038	8.01%	7.22%	8.25%	56.33%
FY 2009-10 (DA)	$2,948,044,704	16.66%	$421,053,261	8.79%	9.83%	12.71%	54.16%
FY 2010-11 (DA)	$3,325,395,185	12.80%	$377,350,481	9.13%	3.80%	14.11%	10.96%
FY 2011-12	$3,642,032,762	9.52%	$316,637,577	9.16%	0.33%	12.99%	-7.88%
FY 2012-13	$3,937,400,734	8.11%	$295,367,972	9.08%	-0.82%	10.14%	-21.94%
FY 2013-14	$4,618,770,200	17.31%	$681,369,466	9.63%	6.04%	11.65%	14.80%

	Official Projection	Percent Change	Dollar Increase/ Decrease	Projection Using Most Recent Average Change	Percent Change over Official Projection	Projection Using Most Recent Three-year Average	Percent Change over Premium Workbook Projection
FY 2014-15 Projection	$5,866,244,550	27.01%	$1,247,474,350	$5,063,597,673	-13.68%	$5,156,654,261	-12.10%
FY 2015-16 Projection	$6,326,526,772	7.85%	$460,282,222	$6,431,214,580	1.65%	$6,549,404,635	3.52%
FY 2016-17 Projection	$6,629,079,220	4.78%	$302,552,448	$6,935,825,956	4.63%	$7,063,289,539	6.55%
FY 2014-15 Appropriation	$5,719,286,977						
Difference Between FY 2014-15 Projections and FY 2014-15 Appropriation	$146,957,573	2.57%		($655,689,304)	-11.46%	($562,632,716)	-9.84%
Difference Between FY 2015-16 Projections and FY 2014-15 Appropriation	$607,239,795	10.62%		$711,927,603	12.45%	$830,117,658	14.51%
Difference Between FY 2016-17 Projections and FY 2014-15 Appropriation	$909,792,243	15.91%		$1,216,538,979	21.27%	$1,344,002,562	23.50%

Actuals, Projection, and Appropriation exclude Upper Payment Limit Financing.

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

Fiscal Year	Total Expenditures*	Annual % Change	Total Caseload**	Annual % Change
FY 1997-98	$1,104,970,992		250,098	
FY 1998-99	$1,176,233,410	6.45%	238,594	-4.60%
FY 1999-00	$1,308,420,100	11.24%	237,598	-0.42%
FY 2000-01	$1,416,535,408	8.26%	253,254	6.59%
FY 2001-02	$1,536,804,691	8.49%	275,399	8.74%
FY 2002-03	$1,651,670,874	7.47%	331,800	20.48%
FY 2003-04	$1,868,750,230	13.14%	367,559	10.78%
FY 2004-05	$1,920,541,525	2.77%	406,024	10.46%
FY 2005-06	$1,996,264,308	3.94%	402,218	-0.94%
FY 2006-07	$2,061,396,808	3.26%	392,228	-2.48%
FY 2007-08	$2,239,096,405	8.62%	391,962	-0.07%
FY 2008-09	$2,526,991,443	12.86%	436,812	11.44%
FY 2009-10	$2,948,044,704	16.66%	498,797	14.19%
FY 2010-11	$3,325,395,185	12.80%	560,759	12.42%
FY 2011-12	$3,642,032,762	9.52%	619,963	10.56%
FY 2012-13	$3,937,400,734	8.11%	682,994	10.17%
FY 2013-14	$4,618,770,200	17.31%	860,957	26.06%
FY 2013-14 Projection	$5,866,244,550	27.01%	1,126,466	30.84%
FY 2014-15 Projection	$6,326,526,772	7.85%	1,221,865	8.47%
FY 2015-16 Projection	$6,629,079,220	4.78%	1,316,074	7.71%

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

**Caseload does not include retroactivity.

Exhibit Q - Title XIX and Title XXI Services Expenditure History by Service Category - Delay Adjusted

	FY 2013-14	Percent Change from Prior Year	FY 2012-13	Percent Change from Prior Year	FY 2011-12	Percent Change from Prior Year	FY 2010-11 (DA)	Percent Change from Prior Year	FY 2009-10 (DA)	Percent Change From Prior Year	FY 2008-09	Percent Change From Prior Year	FY 2007-08	Percent Change From Prior Year	FY 2006-07
Title XIX - Medical Services Premiums															
Acute Care	$2,502,420,429	28.50%	$1,947,351,359	8.34%	$1,797,425,015	5.03%	$1,711,421,275	10.19%	$1,553,138,739	2.91%	$1,509,214,896	12.96%	$1,336,004,286	11.02%	$1,203,363,838
Community-Based Long-Term Care	$437,126,508	16.96%	$373,730,263	8.18%	$345,479,147	8.29%	$319,017,067	6.45%	$299,689,736	6.84%	$280,512,697	16.04%	$241,742,014	12.37%	$215,126,488
Long-Term Care and Insurance	$796,818,916	5.39%	$756,080,565	3.72%	$728,982,662	3.04%	$707,473,240	5.52%	$670,460,746	-2.68%	$688,925,481	10.83%	$621,593,882	2.42%	$606,895,137
Service Management	$101,584,215	44.28%	$70,409,603	32.83%	$53,007,939	68.90%	$31,384,315	8.63%	$28,890,920	-3.32%	$29,884,581	7.90%	$27,697,298	20.15%	$23,051,952
Total Services	**$3,837,950,068**	**21.93%**	**$3,147,571,790**	**7.61%**	**$2,924,894,763**	**5.62%**	**$2,769,295,897**	**8.51%**	**$2,552,180,141**	**1.74%**	**$2,508,537,655**	**12.64%**	**$2,227,037,481**	**8.72%**	**$2,048,437,415**
Financing and Supplemental Payments	$732,167,240	-5.15%	$771,887,288	7.63%	$717,137,999	28.96%	$556,099,288	40.48%	$395,864,563	2045.17%	$18,453,787	53.03%	$12,058,924	-6.95%	$12,959,393
Total Medical Services Premiums Expenditure	**$4,570,117,308**	**16.60%**	**$3,919,459,078**	**7.62%**	**$3,642,032,762**	**9.52%**	**$3,325,395,185**	**12.80%**	**$2,948,044,704**	**16.66%**	**$2,526,991,443**	**12.86%**	**$2,239,096,405**	**8.62%**	**$2,061,396,808**
Title XIX - Medicaid Mental Health															
Capitations	$414,828,541	37.68%	$301,303,046	10.97%	$271,506,635	8.11%	$251,146,027	10.82%	$226,620,818	4.98%	$215,860,937	10.13%	$196,011,033	6.16%	$184,640,568
Fee-for-Service	$5,216,732	14.17%	$4,569,198	17.39%	$3,892,397	0.56%	$3,870,594	49.58%	$2,587,662	45.68%	$1,776,253	32.98%	$1,335,736	-2.35%	$1,367,867
Total Mental Health Expenditure	**$420,045,273**	**37.33%**	**$305,872,244**	**11.07%**	**$275,399,032**	**7.99%**	**$255,016,621**	**11.26%**	**$229,208,480**	**5.32%**	**$217,637,190**	**10.28%**	**$197,346,769**	**6.10%**	**$186,008,435**
Title XIX - Other Medicaid Services															
Office of Community Living	$348,330,959	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Medicare Modernization Act	$106,376,992	4.48%	$101,817,855	8.80%	$93,582,494	29.30%	$72,377,768	25.60%	$57,624,126	-21.83%	$73,720,837	3.32%	$71,350,801	-1.58%	$72,494,301
Public School Health Services	$43,494,624	-5.33%	$45,945,267	12.81%	$40,726,548	102.02%	$20,159,699	-11.92%	$22,887,024	11.65%	$20,498,622	88.51%	$10,874,283	-41.66%	$18,638,273
Total Other Medicaid Services Expenditure	**$498,202,575**	**237.16%**	**$147,763,122**	**10.02%**	**$134,309,043**	**45.14%**	**$92,537,467**	**14.94%**	**$80,511,150**	**-14.55%**	**$94,219,460**	**14.59%**	**$82,225,085**	**-9.77%**	**$91,132,574**
Title XIX - DHS - Medicaid Funded															
Child Welfare Services	$7,935,965	-5.83%	$8,427,164	-22.94%	$10,935,478	-10.19%	$12,176,287	-6.84%	$13,070,654	-5.73%	$13,865,507	0.63%	$13,778,035	-14.29%	$16,074,966
Mental Health Institutes	$6,207,423	18.97%	$5,217,447	9.71%	$4,755,641	2.89%	$4,622,208	17.25%	$3,942,309	-2.63%	$4,048,837	18.67%	$3,411,941	-20.32%	$4,282,038
High Risk Pregnant Women Program	$1,138,015	8.15%	$1,052,271	-6.57%	$1,126,309	-5.44%	$1,191,166	-19.24%	$1,474,989	1.00%	$1,460,363	-2.98%	$1,505,150	35.67%	$1,109,447
Regional Centers	$54,324,467	-1.63%	$55,222,864	8.09%	$51,089,926	-5.00%	$53,778,482	1.86%	$52,798,099	-12.59%	$60,402,671	34.57%	$44,884,700	-1.05%	$45,361,969
Division of Youth Corrections Medicaid Funding	$1,636,744	12.24%	$1,458,298	0.12%	$1,456,613	-42.91%	$2,551,596	32.49%	$1,925,815	25.60%	$1,533,274	-21.09%	$1,943,074	-28.32%	$2,710,942
Mental Health Treatment Services for Youth (HB 99-1116)	$20,624	-53.37%	$44,226	-78.06%	$201,543	36.32%	$147,846	-27.89%	$205,024	17.51%	$174,467	49.97%	$116,331	9.22%	$106,507
DHS Office of Community Living	$0	-100.00%	$325,077,613	-0.54%	$326,845,621	-3.18%	$337,594,785	7.45%	$314,191,865	8.86%	$288,622,175	10.87%	$260,325,269	15.50%	$225,382,833
Total DHS - Medicaid Funded Expenditure	**$71,263,238**	**-82.03%**	**$396,499,884**	**0.02%**	**$396,411,131**	**-3.80%**	**$412,062,370**	**6.31%**	**$387,608,754**	**4.73%**	**$370,107,295**	**13.54%**	**$325,964,499**	**10.49%**	**$295,028,702**
Total Title XIX Services Expenditure	**$5,559,628,394**	**16.56%**	**$4,769,594,327**	**7.23%**	**$4,448,151,968**	**8.89%**	**$4,085,011,643**	**12.06%**	**$3,645,373,088**	**13.60%**	**$3,208,955,387**	**12.81%**	**$2,844,632,757**	**8.01%**	**$2,633,566,519**
Title XXI															
CHP+ Children	$170,744,026	0.36%	$170,136,500	5.65%	$161,043,047	3.76%	$155,207,326	-4.47%	$162,471,143	44.29%	$112,599,454	17.24%	$96,038,557	23.07%	$78,038,209
Medicaid SB 11-008 Eligible Children Services	$40,503,590	168.84%	$15,065,837	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Medicaid SB 11-008 Eligible Children Financing and Supplemental Payments	$17,572	198.69%	$5,883	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
CHP+ Prenatal	$12,009,028	-43.97%	$21,433,958	0.11%	$21,411,076	-3.01%	$22,076,574	37.77%	$16,023,878	-11.41%	$18,086,904	4.18%	$17,361,986	-5.92%	$18,454,066
Medicaid SB 11-250 Eligible Pregnant Adults Services	$9,312,459	224.59%	$2,868,987	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Medicaid SB 11-250 Eligible Pregnant Adults Financing and Supplemental Payments	$3,682	287.99%	$949	100.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0	0.00%	$0
Total Title XXI Services Expenditure	**$232,590,357**	**11.02%**	**$209,512,114**	**14.83%**	**$182,454,123**	**2.92%**	**$177,283,899**	**-0.68%**	**$178,495,021**	**36.58%**	**$130,686,358**	**15.24%**	**$113,400,543**	**17.52%**	**$96,492,276**
Total Services Expenditure	**$5,792,218,751**	**16.33%**	**$4,979,106,441**	**7.53%**	**$4,630,606,091**	**8.64%**	**$4,262,295,543**	**11.47%**	**$3,823,868,109**	**14.50%**	**$3,339,641,745**	**12.90%**	**$2,958,033,300**	**8.35%**	**$2,730,058,795**

Note: Due to prior year reconciliations and adjustments made for payment delays, figures for FY 2009-10 and FY 2010-11 will not match figures reported on the Schedule 3.

Exhibit Q - Title XIX and Title XXI Services Per Capita History by Eligibility Category - Delay Adjusted

Total Title XIX and Title XXI Services Per Capita Costs - Adjusted for Payment Delays

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Breast & Cervical Cancer Program	Eligible Children (AFDC-C/BC)	Foster Care	MAGI Pregnant Adults	Non-Citizens-Emergency Services	Partial Dual Eligibles	TOTAL Title XIX		Title XXI Children	Title XXI Prenatal	TOTAL Title XXI
FY 2006-07	$20,203.93	$22,464.07	$18,471.64	-	$3,917.73	-	-	$24,624.72	$1,846.24	$7,669.99	$9,873.66	$10,475.68	$2,590.57	$6,714.36		$1,495.00	$13,816.37	$1,802.41
FY 2007-08	$20,832.53	$24,595.06	$20,330.18	-	$4,148.36	-	-	$26,529.23	$2,005.83	$8,036.90	$9,163.19	$12,803.86	$2,474.70	$7,257.42		$1,661.71	$11,058.59	$1,910.23
% Change from FY 2006-07	3.11%	9.49%	10.06%	-	5.89%	-	-	7.73%	8.64%	4.78%	-7.20%	22.22%	-4.47%	8.09%		11.15%	-19.96%	5.98%
FY 2008-09	$22,205.13	$26,908.43	$22,303.14	-	$4,145.23	-	-	$22,492.20	$2,078.39	$7,974.02	$9,155.31	$14,869.21	$2,355.89	$7,346.31		$1,828.45	$10,863.01	$2,066.29
% Change from FY 2007-08	6.59%	9.41%	9.70%	-	-0.08%	-	-	-15.22%	3.62%	-0.78%	-0.09%	16.13%	-4.80%	1.22%		10.03%	-1.77%	8.17%
FY 2009-10 (DA)	$22,307.26	$26,969.31	$23,650.87	-	$4,722.20	$1,339.80	-	$21,422.86	$2,263.09	$7,871.35	$12,100.12	$20,133.90	$2,040.72	$7,308.33		$2,364.08	$10,271.72	$2,539.59
% Change from FY 2008-09	0.46%	0.23%	6.04%	-	13.92%	-	-	-4.75%	8.89%	-1.29%	32.17%	35.41%	-13.38%	-0.52%		29.29%	-5.44%	22.91%
FY 2010-11 (DA)	$23,288.94	$28,136.50	$25,015.85	-	4,908.34	$3,318.40	-	$18,741.34	$2,304.71	$7,744.91	$12,538.72	$23,511.09	$2,408.13	$7,285.34		$2,320.61	$12,680.40	$2,583.45
% Change from FY 2009-10 (DA)	4.40%	4.33%	5.77%	-	3.94%	147.68%	-	-12.52%	1.84%	-1.61%	3.62%	16.77%	18.00%	-0.31%		-1.84%	23.45%	1.73%
FY 2011-12	$23,936.51	$28,621.70	$25,323.94	$17,076.63	$5,058.43	$3,690.91	$3,622.13	$17,497.51	$2,309.91	$7,513.66	$13,153.49	$28,288.07	$2,479.58	$7,174.87		$2,168.46	$10,373.58	$2,390.33
% Change from FY 2010-11 (DA)	2.78%	1.72%	1.23%	-	3.06%	11.23%	-	-6.64%	0.23%	-2.99%	4.90%	20.32%	2.97%	-1.52%		-6.56%	-18.19%	-7.48%
FY 2012-13	$24,132.31	$28,382.42	$24,676.80	$23,303.94	$5,029.70	$3,504.94	$9,490.42	$15,597.84	$2,364.91	$7,293.22	$13,857.60	$29,425.89	$2,442.26	$7,072.21		$2,151.78	$12,434.31	$2,380.10
% Change from FY 2011-12	0.82%	-0.84%	-2.56%	36.47%	-0.57%	-5.04%	162.01%	-10.86%	2.38%	-2.93%	5.35%	4.02%	-1.51%	-1.43%		-0.77%	19.87%	-0.43%
FY 2013-14	$24,790.13	$27,963.04	$24,861.19	$18,381.00	$4,132.04	$3,299.35	$6,201.85	$16,388.31	$2,375.33	$7,536.15	$13,352.33	$24,604.83	$2,533.80	$6,675.15		$2,385.34	$10,613.50	$2,567.86
% Change from FY 2012-13	2.73%	-1.48%	0.75%	-21.12%	-17.85%	-5.87%	-34.65%	5.07%	0.44%	3.33%	-3.65%	-16.38%	3.75%	-5.61%		10.85%	-14.64%	7.89%

See Exhibit N for a list of services that are included in the calculations for per capita costs for Title XIX and Title XXI services.

See narrative for a description of events that alter trends.

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

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-02

Request Titles

R-02 Behavioral Health Request

Dept. Approval By: Josh Block

OSPB Approval By:

	Supplemental FY 2014-15
X	**Change Request FY 2015-16**
	Base Reduction FY 2015-16
	Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	**Total**	**$555,208,663**	**$0**	**$555,383,534**	**$72,784,265**	**$144,951,962**
	FTE	-	-	-	-	-
	GF	$174,504,409	$0	$173,825,571	$19,340,878	$33,906,979
	CF	$4,534,586	$0	$4,500,945	$467,470	$1,205,483
	RF	$0	$0	$0	$0	$0
	FF	$376,169,668	$0	$377,057,018	$52,975,917	$109,839,500

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
03. Behavioral Health Community Programs - Behavioral Health Capitation Payments	**Total**	**$548,101,614**	**$0**	**$548,263,817**	**$72,061,853**	**$143,626,497**
	CF	$4,534,586	$0	$4,500,945	$383,939	$1,115,475
	FF	$372,562,308	$0	$373,428,468	$51,399,974	$107,856,328
	GF	$171,004,720	$0	$170,334,404	$20,277,940	$34,654,694
03. Behavioral Health Community Programs - Behavioral Health Fee-for-Service Payments	**Total**	**$7,107,049**	**$0**	**$7,119,717**	**$722,412**	**$1,325,465**
	CF	$0	$0	$0	$83,531	$90,008
	FF	$3,607,360	$0	$3,628,550	$1,575,943	$1,983,172
	GF	$3,499,689	$0	$3,491,167	($937,062)	($747,715)

Letternote Text Revision Required? Yes X No

If Yes, describe the Letternote Text Revision:
See Exhibit BB

Cash or Federal Fund Name and CORE Fund Number: Hospital Provider Fee (Fund 24A0); Breast and Cervical Cancer Prevention and Treatment fund (Fund 15D0); Federal Funds: Title XIX

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? Yes No **Not Required:** X

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Department of Health Care Policy and Financing
Behavioral Health Community Programs

FY 2014-15, FY 2015-16, and FY 2016-17 Budget Request

November 1, 2014

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BEHAVIORAL HEALTH COMMUNITY PROGRAMS

The following is a description of the budget projection for the Behavioral Health Community Programs.

History and Background Information

In 1993, under Section 1915 (b) and Section 1902 (a) of Title XIX of the Social Security Act, the Centers for Medicare and Medicaid Services (CMS) granted the State waivers that allowed the State to implement a pilot managed care mental health program. The pilot program operated until 1995. In 1995, SB 95-078 directed the Department and the Department of Human Services to implement a statewide capitated mental health managed care program. In 1997, SB 97-005 authorized the Department to provide behavioral health services through a managed care program.

The structure of managed care has changed over time. In 1995, implementation of the Behavioral Health Capitation Program in 51 counties of the State was complete, with the remaining 12 counties added in 1998. A 64th county was added when Broomfield became a county in November 2001. Through a competitive bid process, eight behavioral health assessment and service agencies were awarded contracts to be service providers in the program. Again through competitive procurement, the Department reduced the number of regions from eight to five and awarded managed care contracts to five behavioral health organizations effective January 1, 2005. The five behavioral health organizations were reprocured through a competitive bid process effective July 1, 2009. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged. In July 2014, the Department when through another competitive bid process to reprocure the contractors of the five behavioral health regions. As a result of this reprocurement, four of the five prior behavioral health organizations won their respective bids. The only change was in the northeast region. Access Behavioral Care Northeast began providing services in this region effective July 1, 2014.

Each behavioral health organization is responsible for providing or arranging medically necessary mental health services to Medicaid-eligible adults 65 and older, disabled individuals through 64, MAGI Parents and Caretakers, MAGI Adults, eligible children, foster care children, and Breast and Cervical Cancer Program adults enrolled with a behavioral health organization. Services provided by those organizations include, but are not limited to: inpatient hospitalization, psychiatric care, rehabilitation, and outpatient care; clinic services, case management, medication management, and physician care; and non-hospital residential care as it pertains to behavioral health. The capitation program also includes alternatives to institutionalization. The Department is required to make monthly capitation payments to contracted behavioral health organizations for services for each eligible Medicaid recipient. Payments vary across each behavioral health organization, as well as each eligibility category.

Since the inception of the Behavioral Health Community Programs, the Department has been responsible for oversight and contracting with the managed care organizations. The budget projections, day-to-day operations, and administration of the program were the

responsibility of the Department of Human Services. In 2004, the administration and programmatic duties were transferred from the Department of Human Services to the Department. These duties include budget projections and accounting for the program, site reviews of the institutions, and contract negotiations. The transfer resulted in a new Long Bill group for the Department in the FY 2004-05 Long Bill (HB 04-1422). Subsequently, SB 05-112 transferred: (1) the Mental Health Administration appropriation for Personal Services, Operating Expenses, and External Quality Review Organization Mental Health from Behavioral Health Community Programs – Program Administration to the Executive Director's Office Long Bill group; (2) Single Entry Point case management services from Medicaid Mental Health Fee-for-Service Payments to Medical Services Premiums; and (3) services for the developmentally disabled from the Colorado Department of Human Services for People with Disabilities – Community Services and Regional Centers to Non-Emergency Medical Transportation, Medical Services Premiums, and Mental Health Fee-for-Service appropriations within the Department. As a result, only the Behavioral Health Community Programs expenditures are addressed in this section.

The recent history of the Behavioral Health Community Programs is summarized as follows:

- SB 11-008, "Aligning Medicaid Eligibility for Children," will expand Medicaid eligibility from 100% to up to 133% of the federal poverty level for children ages six through 18. The bill shifts impacted children from the Children's Basic Health Plan (CHP+) to Medicaid beginning January 1, 2013. The Department assumes the expenditure for these children will continue to receive a 65% federal match rate, which is the rate for CHP+. SB 11-250, "Eligibility for Pregnant Women in Medicaid," will expand Medicaid eligibility from 133% to 185% of the federal poverty level for all pregnant women. Similar to SB 11-008, this bill shifts impacted women from CHP+ to Medicaid on January 1, 2013. The Department assumes the expenditure for these women will continue to receive the enhanced federal match rate in FY 2014-15, but effective August 1, 2015, expenditure for these women will receive the standard Medicaid match.

- SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL for parents of Medicaid eligible children and adults without dependent children, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 133% FPL and all adults without dependent children will receive a 100% federal match rate, while adults up to 60% FPL will receive the standard Medicaid match.

- As of January 1, 2014, the Medicaid benefit for the Behavioral Health Community Programs also includes a substance use disorder benefit. This expands the range of services that will be covered under Medicaid for disorders relating to substance use for currently enrolled members.

- HB 14-1045, "Continuation of the Breast and Cervical Cancer Prevention and Treatment Program", will extend the repeal date by five years for the program, through June 30, 2019. One hundred percent of the State's share will come from the Breast and Cervical Cancer Prevention and Treatment fund.

- SB 14-215, "Disposition of Marijuana Revenue", expands on the current school-based prevention and early intervention benefit within the BHO contract as well as creates a grant program that extends this benefit beyond just the Medicaid population. The expansion within the BHOs and the grant program provides additional resources in schools to target at risk youth as a result of the legalization of marijuana. This funding is currently only available for one year (FY 2014-15).

Program Administration

In FY 2005-06, SB 05-112 transferred all of Behavioral Health Community Programs - Program Administration expenditures into the Executive Director's Office Long Bill group and is reflected in the lines for Personal Services, Operating Expenses, and Mental Health External Quality Review Organization. The current year and out-year requests for Program Administration are included in the Executive Director's Office Long Bill group.

Medicaid Anti-Psychotic Pharmaceuticals

Prior to FY 2008-09, as part of the Long Bill, estimated expenditures for anti-psychotic pharmaceuticals were appropriated to this Long Bill group as Cash Funds Exempt. This was an informational-only line item; the costs for these drugs were and are paid in the Department's Medical Services Premiums Long Bill group, and no actual transfer took place. Because there was no corresponding decrease to the Medical Services Premiums Long Bill group, this double counted the funding for these drugs.

In its November 1, 2007 Budget Request, the Department officially requested the removal of the Medicaid Anti-Psychotic Pharmaceuticals line item and subsequently received approval. The Department continues to report expenditure for anti-psychotics in its Budget Request (such as in Exhibit F of the exhibits for Medical Services Premiums, and/or the Strategic Plan).

Significant Changes between FY 2014-15 S-2A and FY 2015-16 R-2

<u>FY 2014-15</u>

- For the Disabled Individuals category, the rate estimate decreased by $8.25 per member per month (PMPM), causing a $7.6 million decrease from prior forecast.

- For the Low Income Adults category, the caseload estimate increased by approximately 27,000 per month (PM), causing an $8.9 million increase from prior forecast. A significant portion of this increase is attributed to the 0-68% FPL group (General Fund is used for the state contribution for this population).
- For the Eligible Children category, the rate estimate increased by $0.57 PMPM, causing a $3.0 million increase from prior forecast. Also within this category, the caseload estimate increased by about 38,000 PM, causing an $8.5 million increase from prior forecast.
- For the MAGI Adults category, the caseload estimate increased by approximately 60,000 PM, causing a $60 million increase from prior forecast. The rate estimate for this category decreased by approximately $23.00 PMPM, causing a $46.0 million decrease from prior forecast. Due to the large changes in the two components, compounding effects contributed a $21.0 million decrease from the prior forecast.
- For the Foster Care category, the caseload estimate increased by approximately 2,500 PM, causing a $5.0 million increase from prior forecast. Rates also increased by about $28.00 PMPM, causing a $6.2 million increase from the prior forecast.
- SB 14-215 "Disposition of Marijuana Related Revenue
    - The Department was appropriated $4.3 million within the Behavioral Health Capitation line to enhance the school-based substance abuse prevention and early intervention program by providing additional resources in schools.
    - The Department was also appropriated $2.0 million for a grant program designed to bridge the gap between prevention and early intervention services for the Medicaid and non-Medicaid populations (not included in current request).
- HB 14-1045 "Continuation of BCCP Program" reauthorized the Breast and Cervical Cancer Prevention and Treatment Program through June 30, 2019. The program was set to end June 30, 2014.
- The retroactivity policy was changed effective Jan 1, 2014 from 18 months to 3 months. The policy change results in paying less claims from prior periods in the current period, and as a result increases our incurred but not reported (IBNR) factor. The increase to the IBNR factor means that we are paying more claims in the period in which they were incurred and thus getting to payment completion quicker for each period.

<u>FY 2015-16</u>

- The caseload changes from the prior forecast to the current followed a similar pattern to FY 2014-15 with the exception of Eligible Children and Magi Adults, which grew at a fast pace in FY 2015-16 Q3 and Q4. Also, rate changes from the prior forecast to the current followed a similar pattern to FY 2014-15 but to a lesser degree.

BEHAVIORAL HEALTH CAPITATION PAYMENTS AND MEDICAID BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

The Behavioral Health Capitation Payments line item reflects the appropriation that funds behavioral health services throughout Colorado through managed care providers contracted by the Department. As a result of competitive procurement, five behavioral health organizations were awarded contracts with updated capitation rates and services effective January 1, 2005. Payments for Mental Health Institute Rate Refinance Adjustment, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Pueblo, Alternatives to Inpatient Hospitalization at the Mental Health Institute at Fort Logan, and Alternatives to the Fort Logan Aftercare Program were separate payments prior to FY 2005-06 and incorporated into the Behavioral Health Capitation Payments line item in FY 2005-06. Effective July 1, 2009, the five behavioral health organizations were reprocured through a competitive bid process. As a result of the reprocurement, the same five organizations won their respective contract bids, leaving the program unchanged. Effective July 1, 2014, the behavioral health services contracts were up for reprocurement through a competitive bid process. Four of the five BHO's from the previous rebid won their respective regions with the exception of the northeast region. That region is now managed by Access Behavioral Health – Northeast.

The behavioral health organizations are responsible for providing or arranging all medically necessary behavioral health services to Medicaid-eligible clients within a specified geographic location for a pre-determined capitation rate. The Department pays actuarially certified rates to each behavioral health organization for each Medicaid client in each Medicaid eligibility category. Amounts are prorated for partial months of service and retroactive eligibility is covered. Payments vary across behavioral health organizations, as well as eligibility categories.

The Medicaid populations that are eligible for behavioral health services covered by capitation rates are combined into seven categories, as indicated below. Partial dual-eligible clients and non-citizens are ineligible for behavioral health services.

The eligible behavioral health populations are:

- Adults 65 and Older
- Disabled Individuals Through 64
- Low Income Adults
- MAGI Adults
- Eligible Children
- Foster Care
- Breast and Cervical Cancer Prevention and Treatment Program

Analysis of Historical Expenditure Allocations across Eligibility Categories

At the beginning of a contract cycle, behavioral health organization capitation rates were entered in the Medicaid Management Information System (MMIS). Monthly payments were paid based on eligibility categories. The MMIS provided detailed expenditures by behavioral health organization and eligibility category but did not include offline transactions and accounting adjustments. The only source that included all actual expenditure activity is the Colorado Financial Reporting System (COFRS). The drawback was the COFRS provided total expenditures, but not by eligibility category. The exception was the Breast and Cervical Cancer Treatment Program eligibility category, which was reported separately in the COFRS. Since an allocation had to be calculated to determine the amount of actual expenditures across the other eligibility categories, a ratio was calculated for each eligibility category by dividing the MMIS eligibility category expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) by the total MMIS expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category). The ratio for each category was multiplied by the total expenditures (less the Breast and Cervical Cancer Treatment Program eligibility category) from the COFRS. This calculation estimated actual COFRS expenditures across each eligibility category. Variance between the two systems was less than 0.67%. Beginning July 1, 2014, the Department is using a new financial reporting tool. The Colorado Operations Resource Engine (CORE) will be used in place of COFRS and the same overlay methodology will be used between CORE and the MMIS.

Description of Methodology

The Department utilizes a capitation trend forecast model. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends directly, rather than through a per-capita methodology, future expenditures are forecasted directly through the primary cost drivers: the actuarially agreed-upon capitation rate and caseload. By tying forecasts directly to capitation rates, the methodology may provide more accurate estimates of expenditures by eligibility category, rather than simply in aggregate, as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to behavioral health organizations.

Additionally, the forecast utilizes an incurred but not reported methodology similar to other portions of this Request submitted by the Department (e.g., Nursing Facilities; see Section E, Exhibit H). The Department adjusts its request to capture the reality that some behavioral health claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

The following narrative describes in greater detail the assumptions and calculations used in developing the current year and out-year requests for Behavioral Health Community Programs. It should be noted that the data and values in many of the exhibits are contained

and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted.

EXHIBIT AA - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

Effective with the November 2, 2009 Budget Request, in this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from Exhibit BB. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

Exhibit AA now presents a concise summary of spending authority affecting the Behavioral Health Community Programs. In previous budget requests, the Department presented historical expenditure and caseload figures in graphical form. This information can be found in table form in Exhibit DD (see below).

For the request year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected estimated request year expenditure from Exhibit BB. The difference between the two figures is the Department's Funding Request in the November Budget Request and the Department's Budget Amendment in the February Supplemental Budget Request.

EXHIBIT BB - CALCULATION OF FUND SPLITS

Exhibit BB details fund splits for all Behavioral Health Community Programs budget lines for the current fiscal year supplemental and the out-year Budget Request. For all of the capitation payments for the base traditional clients, the state receives the standard Medicaid federal match with the State's share coming from General Fund. In FY 2014-15 the federal match is 50.76%. Payments for clients in the Breast and Cervical Cancer Program receive an enhanced federal match rate, which in FY 2014-15 is 65.53% and is described separately below. Capitation expenditures are split between traditional clients and expansion clients. Expansion clients are funded from Hospital Provider Fee funds with the exception of the parents and caretakers from 69% to 133% FPL and MAGI Adults, which are 100% federally funded. Finally, the reconciliation from prior years for behavioral health capitation overpayments, retractions for capitations paid for clients later determined to be deceased, and the addition of the marijuana tax money appropriation are also presented (see Exhibit II for reconciliation calculations). A summary of applicable FMAP rates for each of the forecast years is provided below:

Population	FY 2014-15 Match Rate	FY 2015-16 Match Rate	FY 2016-17 Match Rate
Standard Medicaid	50.76%	51.01%	51.01%
Former CHP+ Children	65.53%	82.96%	88.71%
Former CHP+ Prenatal	65.53%	52.24%	51.01%
Expansion Adults	100.00%	100.00%	100.00%
BCCP	65.53%	65.71%	65.71%

The Department also calculates the fund splits for the fee-for-service expenditure in Exhibit BB. The make-up of the fee-for-service population is the same as the capitation program and therefore the same funding mechanisms are used for the same populations mentioned above in the fee-for-service environment (see Exhibit JJ and Exhibit KK for fee-for-service calculations).

Medicaid Behavioral Health Fee-for-Service base traditional clients also receive the standard Medicaid federal match with the State's share coming from General Fund. In FY 2014-15 the federal match is 50.76%. Similar to the populations within the capitation payments line, as of July 1, 2014, the Department is breaking out the fee-for-service expenditure by funding source according to population so that it may claim the correct federal match associated with who is obtaining services. The sum of the capitations and the fee-for-service payments comprise the Department's request.

Behavioral Health Services for Breast and Cervical Cancer Program Adults

SB 01S2-012 created the Breast and Cervical Cancer Prevention and Treatment Program. SB 05-209 and HB 08-1373 incorporated funding for the Breast and Cervical Cancer patients into the appropriation for Behavioral Health Community Programs Capitation Payments, effective with the FY 2005-06 budget. Behavioral health care for clients in the Breast and Cervical Cancer Program is managed through the capitation contracts with the behavioral health organizations. Therefore, the budget is based on the behavioral health caseload that includes the Breast and Cervical Cancer Program eligibility category. For this reason, they are shown as a separate eligibility category where appropriate.

Annual designations of General Fund contributions to program costs are specified in sections 25.5-5-308(9), C.R.S. (2014). Exhibit BB details funds splits for the Behavioral Health Community Programs Capitations line. The funding for the clients enrolled in the program,

is 34.47% cash funds from the Breast and Cervical Cancer Prevention and Treatment Fund, and 65.53% federal funds in FY 2014-15. The program was reauthorized in FY 2014-15 and sunsets at the end of FY 2018-19, with the potential to extend the program through new legislation.

Behavioral Health Services for Hospital Provider Fee Expansion Clients

HB 09-1293 established a funding mechanism for a series of expansion clients. The first set of expansion clients that are funded through the bill was parents with income up to 100% of the Federal Poverty Limit (FPL). Services for these clients were funded through the Hospital Provider Fee cash fund. These clients are assumed to be similar to other adult clients and expenditure for these clients is therefore calculated using the same per capita rate as other adult clients (see Exhibit JJ). Starting in FY 2011-12, additional expansion populations also received funding through the Hospital Provider Fee cash fund. These include disabled individuals with income limits up to 450% of the federal poverty level and MAGI Adults, both of which received services through the BHOs as part of their benefit package. The disabled individuals with income limits up to 450% are assumed to be similar to other disabled clients, and expenditure for these clients is therefore calculated using the same per-capita rate as other disabled clients (see exhibit JJ). For MAGI Adults, the BHOs will be reimbursed at a separate capitation rate than other eligibility categories. The Department estimated expenditure for this population using preliminary assumptions about the rate that will be set for MAGI Adults and the reconciliation method that will be used to ensure that the Department adequately pays the BHOs to serve this new population. See exhibits EE, GG, II, and JJ for more detailed explanations of these assumptions.

Behavioral Health Services for Expansion Populations in SB 11-008 and SB 11-250

SB 11-008, "Aligning Medicaid Eligibility for Children," extended Medicaid eligibility to up to 133% of the federal poverty level (FPL) for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifted impacted children from CHP+ to Medicaid beginning January 1, 2013. The Department assumes that the expenditure for these children will continue to receive the enhanced federal match rate, which in FY 2014-15 is 65.53%.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extended Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifted impacted women from CHP+ to Medicaid on January 1, 2013. The Department assumes that the expenditure for these women will continue to receive the enhanced federal match rate, which is 65.53% in FY 2014-15, but effective August 1, 2015, the federal match will drop to the standard Medicaid Match of 51.01%.

Behavioral Health Services for Expansion populations in SB 13-200

SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL parents of Medicaid eligible children and MAGI Adults, effective January 1, 2014. The Department assumes that the expenditure for parents from 60% to 68% FPL will receive the standard Medicaid match rate, with the state share coming from Hospital Provider Fee cash fund, and all parents from 69% - 133% FPL and newly eligible MAGI Adults will receive a 100% federal match rate, while adults up to 60% FPL and non-newly eligible MAGI Adults will continue to receive the standard Medicaid match.

EXHIBIT CC - BEHAVIORAL HEALTH COMMUNITY PROGRAMS SUMMARY

Exhibit CC presents a summary of behavioral health caseload and capitation expenditures itemized by eligibility category as well as a summary of the rest of the Behavioral Health Community Programs. The net capitation payments include the impacts of actions with perpetual effect, such as caseload driven impacts such as the various reconciliations and retractions for clients determined to be ineligible. Exhibit EE illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT DD - BEHAVIORAL HEALTH CASELOAD, PER CAPITA, AND EXPENDITURE HISTORY

Exhibit DD contains the caseload, per-capita, and expenditure history for each of the 13 eligibility categories. Each of the tables that comprise Exhibit DD is described below.

Behavioral Health Community Programs Caseload

Behavioral Health Community Programs caseload is displayed in two tables. The first table shows total caseload for each of the rate cells which the Department pays a capitation on. The second table displays caseload by all behavioral health eligibility categories that make up the seven rate cells. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The behavioral health caseload excludes the caseload for partial dual eligible clients and non-citizens and ties to the caseload presented in the Request for Medical Services Premiums, Section E, Exhibit B. Please see the Medicaid Caseload section of the Medical Services Premiums narrative for further discussion of Medicaid caseload projections. The caseload numbers are used in numerous exhibits throughout the Behavioral Health Community Programs exhibits and narrative.

Behavioral Health Community Programs Per-Capita Historical Summary

As with caseload, Behavioral Health Community Programs per-capita is displayed in two tables. The first table sets forth total per-capita for each rate cell the Department pays a capitation on. The second table displays per-capita for all behavioral health eligibility categories. However, since the actual per capita from the first table for the combined categories have a single per-capita, the true per-

capita is shown in those categories and will not mathematically be the same as dividing each individual category expenditure by the caseload. Figures for fiscal years up to the present fiscal year are actual per-capita, while the current fiscal year and the request year per-capita are estimates.

Behavioral Health Community Programs Expenditures Historical Summary

The history of expenditures includes combined category and expanded category tables as well as total expenditures for both capitation and fee-for-service expenditures. For fee-for-service expenditure, service categories are listed separately.

Actual expenditures are only available from the Colorado Operations Resource Engine (CORE). Expenditures by eligibility category, other than the Breast and Cervical Cancer Treatment Program, are not available from the CORE. The Medicaid Management Information System (MMIS) does provide expenditures by eligibility category but does not include offline transactions and accounting adjustments. The two systems typically have minor discrepancies in reported expenditure, often due to accounting adjustments made to the CORE as fiscal periods close. Because the variance is minor, data from the MMIS can be used to distribute total expenditures from the CORE across eligibility categories.

A ratio is calculated for each eligibility category by dividing the MMIS eligibility category expenditures by the total MMIS expenditures. The ratio is multiplied by the total expenditures from the CORE. This calculation estimates actual CORE expenditures across each eligibility category. The Breast and Cervical Cancer Treatment Program expenditures are carved out of both totals before the calculations are done, since this is the only category that does not need to be estimated. Once the overall expenditures by eligibility category are determined, they may be divided by the actual average monthly caseload for each eligibility category to determine the actual per capita for each eligibility category.

EXHIBIT EE - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

Exhibit EE provides capitation expenditure calculations for the current fiscal year and the request year.

The Department has adopted a methodology based on forecasting a capitation rate, multiplying that rate by monthly caseload, multiplying again by the number of months that the forecasted rate will be in effect, and then adjusting for incurred claims that will be paid in subsequent years as well as for claims from former years that will be paid in the year of the request. The methodology is a zero-based budget tool that allows the Department to examine projected expenditures each year without building in inappropriate assumptions, estimates, or calculations from preceding years.

The forecasted capitation rate is derived from exhibits FF through HH and will be presented in more detail below. The caseload is the same as presented in Medicaid Medical Services Premiums, Section E, Exhibit B (excepting partial dual eligible clients and non-citizens, as discussed above).

The Department has broken down the current fiscal year and the request year into two components: a first and second quarter estimate (Q1 and Q2) and a third and fourth quarter estimate (Q3 and Q4). This accounts for the fact that the Department makes rate adjustments on a calendar year basis. As such, the Q1 and Q2 capitation rate is known and is the point estimate rate from the previous two quarters (the first two quarters of the calendar year). Typically, for the Department's November requests, the current year's Q1 and Q2 rates are known and the remaining rates are estimated. In the February supplemental, the rates for the current year and the first half of the request year are known and only the final two quarters of the request year are estimated. By the time February numbers are presented, the Department has completed its most recent rate setting process, adding to the known set of data. Because BHO contracts were rebid for FY 2014-15, the rate setting process was different than previous years. For the new contract, an 18-month actuarially sound capitation rate was set for the BHO's and their respective winning bids would be their rate in effect for 12 months, so through FY 2014-15. This differs from previous practices because of it being a rebid year. Therefore in this request, FY 2014-15 point estimate rates are known and FY 2015-16 and FY 2016-17 are estimates. In January 2015, a six month rate will be negotiated between the Department and BHOs for FY 2015-16 Q1 & Q2 to allow for rate setting to take place again on a calendar year basis in 2016. As presented in Exhibit EE, the estimated capitation rate is multiplied by the monthly caseload and then multiplied by the number of months the rate will be in effect.

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown starting on page E.EE-4.

After calculating total expenditure, the anticipated date-of-death retractions for each fiscal year are estimated and added to total expenditure. The Department began an aggressive retraction of payments for deceased clients in FY 2009-10; this activity resulted in retraction of payments originally made between FY 2004-05 and FY 2008-09 and reduced prior period dates of service expenditure. The Department is continuing to identify these claims and retracts payments twice a year. For the current year, the retractions are estimated as a 10% reduction in the total amount retracted in the previous year. For the request year, the retractions are estimated as a

10% reduction in the estimated amount that will be retracted in the current year. The retractions are expected to decline, as there is a smaller pool of historical clients from which to retract and current processes of identification become more effective.

Incurred-but-not-Reported Estimates

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred-but-not-reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims incurred in July of the current fiscal year have 11 more months of the fiscal year in which the claims can be paid; however, claims incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years and determined the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Pages E.EE-4 through E.EE-5 presents the percentage of claims paid in a six-month period that come from that same period and those which come from previous periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

Historically, for each eligibility category except disabled individuals through 64, over 99% of incurred claims are paid by the end of the fiscal year in which the claims were incurred. For the disabled individuals, it takes a full 18 months for 99% of claims to be paid. This is likely due to the relative difficulty in determining and documenting disability as opposed to criteria such as age or income. Hence, a larger percentage of claims from previous periods exist for this category of clients.

It is of note that beginning January 1, 2014, the Department instituted a policy of denying retroactive capitation claims that are from a period beyond three months prior to the payment month. For those clients with retroactive claims beyond three months who are found to have received services, the Department will reimburse the BHOs through a fee-for-service payment. Since capitations are calculated to pay for actual services delivered by spreading that cost to caseload regardless of whether services are received, the net effect of eliminating cap payments and reimbursing for services may be cost neutral. The Department will monitor this policy change, and, should there be any expenditure fluctuations, the Department will seek to adjust through future budget requests.

On pages E.EE-6 through E.EE-7, the Department calculates the estimated outstanding expenditure from claims remaining from previous period by aid category. The sums are then carried forward to the calculations on pages E.EE-1, E.EE-2, and E.EE-3.

Actuarially Certified Capitation Rates

Capitated rates for the behavioral health organizations are required to be actuarially certified and approved by CMS, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit EE. The methodology for determining the forecasted capitation rate is the subject of Exhibits FF through HH.

EXHIBIT FF - BEHAVIORAL HEALTH RETROACTIVITY ADJUSTMENT AND PARTIAL MONTH ADJUSTMENT MULTIPLIER

Capitations are paid for clients from the date the client's eligibility is effective, resulting in claims paid retroactively. As such, any projection which derives expenditure by using non-retroactive caseload must take into account these retroactive claims. Since expenditures are calculated as the estimated capitation rate multiplied by the non-retroactive caseload, an adjustment for retroactivity can be applied to either the forecasted capitation rate or the caseload figure. In order to maintain the uniform presentation of caseload across all Departmental estimates and requests, the Department chose to make its retroactivity adjustment to the forecasted capitation rate itself.

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments paid to the behavioral health organizations to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can (and indeed do) trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the Behavioral Health Capitation program. This difference is captured through a partial-month adjustment multiplier.

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last six months of claims and caseload data. Historically the Department would analyze the previous five years of data, but due to the policy change relating to retroactivity beginning January 1, 2014, that data would not provide an accurate depiction retroactivity based on current policy. Page E.FF-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The relatively steady percentage values across each respective eligibility category suggest the ratio is indeed systemic (as created by retroactivity) rather than a unique circumstance. The Department analyzed the data, however, and determined the amount of retroactivity in the claims incurred each period is steadily changing over time and has trended downward

for all eligibility categories except for disabled individuals. For this reason, the Department previously assumed the most recent period with adequate time for run-out of claims is the best representation of how much retroactivity will affect the claims-to-caseload ratio in the current and request years. As a result of the retroactivity policy change noted above the Department has seen a substantial decline in retroactivity. As such, the Department analyzed FY 2013-14 Q3 & Q4 for actual retroactivity and used those percentages as the basis for the factor.

Partial Month Adjustment Multiplier

To derive the partial month adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last five years of data were examined. Prior to FY 2006-07, capitation rates were radically adjusted to capture systemic changes including, but not limited to, shifting to the Department the bulk of Medicaid program responsibility from the Department of Human Services, the consolidation to five behavioral health organizations from eight, and program and financing adjustments resulting from the Goebel lawsuit. Due to these adjustments, the volatility of capitation rates prior to FY 2006-07 would not be a quality indicator of any future comparisons to claims paid.

As presented on page E.FF-2, for each eligibility category, the weighted average claims-based rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was compared to the weighted capitation rate (similarly weighted). Then, the claims-based rate as a percentage of the capitation rate was calculated, providing a simple comparison of any trend in claims-based rates as compared to capitation rates. The percentages are similar across years, indicating claims-based trends are matching capitation trends. The Department analyzed the data, however, and determined the amount of partial months paid each period is steadily changing over time within each eligibility category. For this reason, the Department assumes the most recent period with adequate time for run out of claims is the best representation of how much partial-month payments will affect the claims-based rate in the current and request years.

EXHIBIT GG - BEHAVIORAL HEALTH CAPITATION RATE TRENDS AND FORECASTS

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e., the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual behavioral health organization) was examined. Exhibit GG presents historical data as well as the forecasted weighted rates.

Beginning in January 2009, the Department switched its rate-setting cycle from a state fiscal year cycle to a calendar year cycle. Capitation rates are now effective from January 1 through December 31. Therefore, the Department now presents its forecasted rates

in six-month blocks to account for the rate change occurring in the middle of a state fiscal year. As mentioned above, FY 2014-15 rates were set on a state fiscal year basis, due to the BHO contract reprocurement, but will be switching back to a calendar year basis in 2016.

The weighted rate is presented along with the percentage change from the previous six months as well as from the average rate of the entire previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit HH.

Based on the Department's calculations and rate-setting process and input from the behavioral health organizations, the Department's actuaries certify a capitation rate range for each BHO and eligibility type; the Department is permitted to pay any rate within this range and maintain an actuarially sound capitation payment. To develop the range, the actuaries calculate a single rate (the "point estimate") and the upper and lower bounds around this rate that maintain actuarial soundness.

It is important to note the overall weighted rate point estimate presented in the exhibit is weighted across two factors. First, the rate is weighted within an eligibility category (that is, weighted by the behavioral health organizations' proportion of claims processed within that eligibility category). Second, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the Weighted Behavioral Health Total rate may not be a clear indicator of the rate trends across all eligibility categories.

Exhibit GG presents the weighted point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit GG in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years.

The Department added a new rate cell in FY 2011-12 for the MAGI Adults population, which was funded through the Hospital Provider Fee Cash Fund initially, but with the passage of the Affordable Care Act will be funded entirely with federal funds. The MAGI Adults rate is based on data from Disabled Adults and Low-Income Adults rates. In prior budget requests, the Department assumed a large reconciliation component to be paid retroactively; this was, in part, due to the fact there were a great number of unknowns related to the rate setting process. With the new rate setting methodology used beginning July 1, 2014, the Department still expects a number of unknowns and therefore expects to continue the reconciliation process in FY 2014-15 and the foreseeable future. The Department is currently in the process of analyzing the data surrounding the MAGI Adults rate and the outcome of the reconciliation process should be completed prior to the February supplement request.

EXHIBIT HH - FORECAST MODEL COMPARISONS

Exhibit HH produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in Exhibit EE. Pages E.HH-1 and E.HH-2 present the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in Exhibit FF.

On page E.HH-3, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into pages E.HH-1 and E.HH-2. Based on the point estimates, the adjustments presented in Exhibit FF are then applied and the final, adjusted point estimate is then used in the expenditure calculations of Exhibit EE.

Final Forecasts

Page E.HH-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page E.HH-3 (see below). Typically, for Funding Requests, the rate applied to the first six months of the current year is known due to the calendar year rate setting cycle (see the description of Exhibit GG, above). The rate applied to the next six months of the current year is then estimated from a series of trend models and historical changes (see below). That same rate is then carried forward into the first six months of the request year due to the calendar year rate setting cycle. The rate for the last six months of the request year is estimated by taking the percent change in rates from the last known rate to the first forecasted rate and carrying that percentage change forward. Of note, for FY 2014-15 rates for the entire fiscal year are known as a result of the rates being set on a fiscal year basis due to the reprocurement of the BHO contracts. For FY 2015-16 Q1 & Q2, the Department will set a six month rate to allow rate setting to take place on a calendar year basis moving forward. The Department will utilize the prior methodology when it reverts back to calendar year rate setting in 2016.

Typically, for Supplemental Requests, the rate for the entirety of the current year and the first six months of the request year are known due to the calendar year rate setting cycle. The rate for the final six months of the request year is estimated using the various trend models and historical information described below. Similar to above, the FY 2014-15 supplemental request will differ because we will only know FY 2014-15 rates and no part of FY 2015-16 that the time of submittal.

The projected rate is then adjusted by any policy impacts. In accordance with the FY 2010-11 ES-2 budget action, beginning September 1, 2009, the Department paid rates that were 2.5% below the actuarial midpoint. This rate cut is now incorporated in the data used during the rate-setting process and is no longer included as an adjustment factor in exhibit HH. There are currently no additional policy changes that impact the rates and therefore the only other adjustments are those to the account for partial month and retroactive eligibility (see below).

The forecasted rate is also adjusted by the partial month adjustment multiplier, calculated on page E.FF-2. The multiplier is applied to adjust for the fact that the full capitation rate is not paid for every member month. The rate for paid claims is impacted by payments made for partial months of eligibility; this type of payment will not be for a "whole" capitation payment at the current fiscal period's capitation rate. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Finally the claims-based rate is adjusted a third time, this time by the retroactivity adjustment. From Exhibit FF, page E.FF-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for Exhibit FF, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep behavioral health caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to drive the expenditure calculation presented in Exhibit EE. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page E.HH-3 and historical midpoint rates are presented in Exhibit GG.

For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

Capitation rates are required to be actuarially sound and are built from a blend of historical rates and recent year encounter data (provider expenditure on services). The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to

be fundamentally different than historical periods. Beginning with FY 2008-09 the Department has experienced unusual trends for the behavioral health capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models' reliance on historical performance for predicting future performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. As such, the Department believes the most recent years' experience is the most predictive of the likely current year and future year experiences. The following table shows the trends selected for the current and request years by eligibility category.

Aid Category	FY 2015-16 Q1 & Q2 Trend Selection	CY 2016 Trend Selection	CY 2017 Trend Selection
Adults 65 and Older	0.36%	1.96%	1.96%
	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Trend is average annual percent growth from FY 2009-10 to FY 2011-12 and FY 2013-14.	Trend is average annual percent growth from FY 2009-10 to FY 2011-12 and FY 2013-14.
Disabled Individuals Through 64	1.87%	1.39%	1.39%
	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Trend is average annual percent growth from FY 2011-12 through FY 2014-15.	Trend is average annual percent growth from FY 2011-12 through FY 2014-15.

Low Income Adults	2.90%	5.51%	5.51%
	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Trend is average annual percent growth in from FY 2011-12 through FY 2014-15.	Trend is average annual percent growth in from FY 2011-12 through FY 2014-15.
MAGI Adults	2.90%	5.51%	5.51%
	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Trend is average annual percent growth from FY 2008-09 through FY 2014-15	Trend is average annual percent growth from FY 2008-09 through FY 2014-15
Eligible Children	2.12%	4.23%	4.23%
	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Trend is average growth in rates from FY 2008-09 through FY 2014-15	Trend is average growth in rates from FY 2008-09 through FY 2014-15

Foster Care	1.58% Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	1.58% Trend is half of the percent growth from FY 2013-14 Q3 & Q4 to FY 2013-14 Q1 & Q2.	1.58% Trend is half of the percent growth from FY 2013-14 Q3 & Q4 to FY 2013-14 Q1 & Q2.

Trend Justification

The rate setting methodology has changed for rates effective January 1, 2014. The previous rate setting process involved the actuaries setting rates that were actuarially sound in aggregate. The new methodology now involves setting actuarially sounds rates for each aid category. With a lack of data points to base the trend selection on the current models outputs, the trend selected for FY 2015-16 Q1 & Q2 is half of the projected growth in FY 2015-16 based on the average growth model. A six month rate will be negotiated with the BHO's to allow for the rate setting process to revert to calendar year in 2016. The six month rate must still fall within the 18-month actuarially sound rate range set July 1, 2014. The CY 2016 and CY 2017 trends were chosen because the Department predict how the new methodology is going to affect future rates and using a historical average provides a conservative estimate.

The selected point estimates of the capitation rates are adjusted on pages E.HH-1 and E.HH-2, as described above, for use in the expenditure calculations presented in Exhibit EE.

EXHIBIT II - MAGI ADULTS RECONCILIATION

Recoupments

Capitation payments are made on a monthly basis throughout the year in the Medicaid Management Information System (MMIS). When clients are determined to be eligible for benefits retroactively, retroactive capitation payments are made to the behavioral health organizations through the MMIS. When clients are determined to be ineligible for Medicaid benefits retroactively, a recoupment of the capitation payments is completed separately. When known, this exhibit also shows the impact of the reconciliation process surrounding

the MAGI Adults population. For this request, as in years past, there is a risk corridor placed on the MAGI Adults rate due to the uncertainty of the true cost of this population. This risk corridor allows the risk of not setting an accurate rate to be split between the Department and the BHOs. Depending on how far off the rate is from the actual encounter based rate, either the Department or the BHOs may receive money; for example, if the rates were set too high, the Department would recoup funding. Exhibit II summarizes the expected fiscal impacts. The reconciliation surrounding the payments made for FY 2013-14 have not been calculated by the Department to date, but will be updated once calculations have been made.

The Department has worked to reduce the payments to the behavioral health organizations for clients later deemed ineligible for Medicaid. Historically, monthly capitation payments were made on a prospective basis. In February 2004, the Department converted to concurrent capitation payments. FY 2004-05 was the first full year for monthly capitation payments on a concurrent basis.

No recoupments were made during FY 2005-06 due to a computer programming change, and this has delayed the recoupment process. In FY 2006-07, recoupments from FY 2003-04 were processed. In FY 2007-08, no recoupments were processed as the Department sought to verify eligibility information provided by the behavioral health organizations. This process has proven to be complicated by the various reporting practices of the community behavioral health centers that provide services to clients. The Department collaborated with the Centers for Medicare and Medicaid Services (CMS) to develop a retrospective eligibility validation process which the Department implemented in FY 2009-10. Recoupments from FY 2005-06 through FY 2007-08 were processed in the latter half of FY 2009-10. In FY 2010-11, recoupments were collected for FY 2004-05. The Department recouped expenditure for FY 2008-09 ineligibles at the beginning of FY 2011-12. The recoupments from incurred expenses in FY 2008-09 were altered in their federal fund split due to the impact of the American Recovery and Reinvestment Act. Since those expenditures were made with enhanced federal funds, any recoupments will also see a disproportionate share of federal funds retrieved. Recoupments from FY 2009-10 were set for collection in FY 2012-13, but due to timely filling, requirements from CMS were collected in FY 2011-12. Recoupments for FY 2009-10 are altered by the enhanced federal match from the year the claims were processed. Due to timely filing issues raised by federal authorities, the Department will not be processing reconciliations for FY 2010-11. As a result, the Department estimates that reconciliations will be lower in FY 2012-13 that previously estimated. Reconciliations are anticipated to return to previous levels in subsequent years. Recoupments from FY 2011-12 will be collected in FY 2012-13, and those from FY 2012-13 as well as future recoupments will no longer be made by the Department due to issues related to timely filing; instead, capitation rates will be adjusted accordingly.

EXHIBIT JJ – ALTERNATIVE FINANCING POPULATIONS

Exhibit JJ is a stand-alone exhibit designed to show the effect of the Colorado Health Care Affordability Act (HB 09-1293), Aligning Medicaid Eligibility for Children (SB 11-008), Eligibility for Pregnant Women in Medicaid (SB 11-250), and Expanding Medicaid Eligibility in Colorado (SB 13-200) to the Behavioral Health Community Programs fund splits. This exhibit presents projected caseload

and costs itemized by eligibility category for the current year and the request year. The exhibit also separates out the funding source and the calculation of federal match associated with each category. Note the caseloads shown are the average monthly number over each year and will fluctuate throughout the year.

Colorado Health Care Affordability Act

HB 09-1293, the "Colorado Health Care Affordability Act" provided funding to provide health care coverage for uninsured Coloradans in FY 2009-10 and beyond. The Department began collecting fees from hospitals in April 2010 for the Hospital Provider Fee cash fund and started extending benefits to expansion clients in May 2010.

The Department also expanded eligibility to cover MAGI Adults, formally known as adults without dependent children in FY 2011-12. The program was initially limited to 10,000 clients. In February 2013, additional enrollees were added from the waitlist beginning in April through September 2013 because the Department had sufficient funding to support the addition. Beginning January 1, 2014, with the passage and implementation of SB 13-200 referenced below, that cap was lifted on the amount of clients served with the MAGI Adults population. This population received the full range of behavioral health services provided by the BHOs, and the BHOs are paid at a different capitation rate for these members than any of its other eligibility categories. The Department's caseload projections for all expansion populations are provided in this Budget Request (see exhibit B in Medical Services Premiums).

Aligning Medicaid Eligibility for Children and Eligibility for Pregnant Women in Medicaid

SB 11-008, "Aligning Medicaid Eligibility for Children," extended Medicaid eligibility to up to 133% of the FPL for all children under the age of 19. Formerly, the eligibility limit for children ages six through 18 was 100% of the FPL and 133% of the FPL for children five and under. The bill shifted impacted children from the CHP+ to Medicaid beginning January 1, 2013. The Department assumed the expenditure for these children will continue to receive a 65.53% federal match rate, which is the rate for CHP+. As with most of the Hospital Provider Fee populations, the Department assumed the per-capita costs for this expansion population would be the same as for the traditional population since the majority of behavioral health expenditure is paid through the capitation program.

SB 11-250, "Eligibility for Pregnant Women in Medicaid," extended Medicaid eligibility from 133% to 185% of the FPL for all pregnant women. This bill shifted impacted women from CHP+ Medicaid on January 1, 2013. The Department assumes the expenditure for these women will continue to receive a 65.53% federal match rate and that the per-capita costs will be the same as for the traditional population.

Expanding Medicaid Eligibility in Colorado

SB 13-200, "Expanding Medicaid Eligibility in Colorado," extends Medicaid eligibility to up to 133% of the FPL parents and caretakers of Medicaid eligible children and MAGI Adults, effective January 1, 2014. The Department assumes that the expenditure for parents and caretakers from 60% to 68% FPL will be funded with the standard Medicaid match, with the State's share coming from the Hospital Provider Fee fund. The Department assumes that parents and caretakers from 69% to 133% FPL and all MAGI Adults will receive a 100% federal match rate, while parents up to 60% FPL will receive the standard Medicaid match, with the State's share coming from General Fund.

EXHIBIT KK - MEDICAID BEHAVIORAL HEALTH FEE-FOR-SERVICE PAYMENTS

Medicaid Behavioral Health Fee-for-Service Payments is a separate budget line item in Behavioral Health Community Programs. Expenditures for this line are calculated in Exhibit KK. The data from Exhibit KK also appear in Exhibit BB, where the fund splits relating to the fee-for-service payments are calculated.

The Medicaid Behavioral Health Fee-for-Service Payments appropriation allows Medicaid clients not enrolled in a behavioral health organization to receive behavioral health services or enrolled Medicaid clients to receive behavioral health services not covered by the behavioral health organizations. The services are not covered either because the client is not enrolled in a behavioral health organization or the services are outside the scope of the behavioral health organization contract. Medicare crossover claims are included in the fee-for-service category; these are behavioral health organization covered services for clients enrolled in a behavioral health organization who are eligible for both Medicare and Medicaid.

Fee-for-service providers include, but are not limited to hospitals, psychiatrists, psychologists, primary care physicians, and behavioral health centers. The State also reimburses providers through fee-for-service if either the diagnosis or the procedure is not included in the behavioral health organization contract or the patient is not enrolled in a behavioral health organization.

History and Background Information

The nature of Medicaid Behavioral Health Fee-for-Service Payments has changed in recent years. Prior to FY 2002-03, Fee-for-Service Payments were included in the Behavioral Health Capitation base appropriation. During FY 2002-03, case management services provided by community mental health centers were included in the Behavioral Health Fee-for-Service Payments appropriation. During FY 2003-04, case management services were provided by Single Entry Point agencies and were still part of the Behavioral Health Fee-for-Service Payments appropriation, but they were moved to the Medical Services Premiums appropriation in FY 2004-05. Also during FY 2004-05, fee-for-service behavioral health care for developmentally disabled clients living in Regional Centers was transferred from

the Department of Human Services to the Department's Behavioral Health Fee-for-Service Payments appropriation. The changes to case management services and behavioral health care for developmentally disabled clients are discussed below.

Historically, community mental health centers provided case management services to the Children's Home- and Community-Based Services for the Mentally Ill waiver clients on a fee-for-service basis. Effective July 1, 2003, the Department began utilizing contracted Single Entry Point agencies for these services instead of the community mental health centers. Funding for these case management services remained in the fee-for-service payments appropriation for FY 2003-04. However, since Single Entry Point contracts are customarily paid from the Medical Services Premiums, the Department requested these services be transferred to the Medical Services Premiums Long Bill group. The supplemental appropriation to the Department (SB 05-112) moved Single Entry Point case management from the Behavioral Health Fee-for-Service Payments line item to the Medical Services Premiums line item in FY 2004-05 and was effective July 1, 2004.

The supplemental appropriation to the Department (SB 05-112) also authorized the transfer of the fee-for-service behavioral health care for developmentally disabled clients living in Regional Centers from the Department of Human Services to the Department. This followed a September 3, 2004 1331 Supplemental which was approved by the Joint Budget Committee on September 21, 2004, for the transfer of funds from the Department of Human Services for Developmental Disability State Plan services. This action funded State Plan services provided to clients in the Developmentally Disabled waiver for Children's Home and Community Based Services as required by the Centers for Medicare and Medicaid Services, effective October 1, 2004.

The expenditures in Exhibit KK are broken out into the three major categories which make up Medicaid Behavioral Health Fee-for-Service: inpatient services, outpatient services, and physician services.

Current Calculations

The current fiscal year's total estimated expenditure is based on the actual expenditures from FY 2013-14, trended forward based upon the expected change in caseload from FY 2013-14 to FY 2014-15. The request year estimate is the result of a forward trend of the current-year estimate by the factor of the anticipated change in caseload, and this is then trended forward by the anticipated change in caseload for the out-year estimate.

Beginning July 1, 2014, the Department has changed the fund split methodology for fee-for-service expenditure. Previously, fee-for-service expenditure made up a significantly smaller portion of the behavioral health programs total expenditure and it was assumed that the Department would claim the standard Medicaid federal match on all expenditure. As the fee-for-service component continues to grow and expenditure for populations that receive a match other than the standard Medicaid match continue to grow and make up a

larger portion of total fee-for-service expenditure, the Department felt it would be best to forecast expenditure for each population separately in order to better estimate the actual cost to the state.

The Departments current method for determining expenditure in the current year, request year, and out year is to apply the same proportion of total expenditure attributed to each population from the most recent complete fiscal year to the current estimated total fee-for-service expenditure in the years being forecasted. Although this method may not accurately forecast the correct proportions from one year to the next, the Department believes this will give the most accurate representation at this time. The Department will continue to evaluate the methodology in the future and make changes as more information becomes available. Fund splits for fee-for-service expenditure is broken out in more detail in Exhibit BB.

No rate or utilization increases are forecasted, although the Department is currently investigating the feasibility and necessity of incorporating such adjustments. Behavioral health fee-for-service expenditure has increased over previous years. The Department has been performing data analysis using fee-for-service claims in an attempt to determine what caused the increase and whether or not it will continue to grow in the future. The Department will continue to monitor its impact as more data becomes available over time and may request for a decrease in its appropriation if the expenditure decreases as expected through the standard budget process.

EXHIBIT LL - GLOBAL REASONABLENESS TEST FOR BEHAVIORAL HEALTH CAPITATION PAYMENTS

The Global Reasonableness Test presented in Exhibit LL compares the percent change between behavioral health capitation expenditures as reported in Exhibit DD and forecasted in Exhibit EE. The FY 2014-15 appropriation is 30.12% higher than FY 2013-14actual expenditures, primarily due to caseload growth. The FY 2014-15 estimate incorporates increased caseload projections along with various rate adjustments and results in a 29.67% increase from FY 2013-14 actual expenditures and a -0.34% decrease from the current appropriation. The FY 2015-16 estimate is built on the FY 2014-15 estimate and presents a 13.57% expenditure increase. This increase is primarily due to: 1) increased caseload projections for traditional clients; 2) increased caseload due to the Colorado Health Care Affordability Act expansion populations; and 3) projected increases in capitation rates from CY 2013 to CY 2015. The FY 2015-16 request represents a 13.18% increase over the current FY 2014-15 appropriation. The FY 2016-17 Budget Request is built on the FY 2015-16 estimate and represents an 11.54% expenditure increase over the FY 2015-16 request and a 26.23% increase over the FY 2014-15 appropriation.

Exhibit	Title of Exhibit
Exhibit AA	Calculation of Current Total Long Bill Group Impact
Exhibit BB	Calculation of Fund Splits
Exhibit CC	Behavioral Health Community Programs Summary
Exhibit DD	Behavioral Health Community Programs, Caseload
Exhibit DD	Behavioral Health Community Programs, Behavioral Health Capitation Payments Per Capita Historical Summary
Exhibit DD	Behavioral Health Community Programs, Expenditures Historical Summary
Exhibit EE	Expenditure Calculations by Eligibility Category
Exhibit EE	Incurred But Not Reported Runout by Fiscal Period
Exhibit EE	Incurred But Not Reported Expenditures by Fiscal Period
Exhibit FF	Medicaid Behavioral Health Retroactivity Adjustment
Exhibit FF	Medicaid Behavioral Health Partial Month Adjustment Multiplier
Exhibit GG	Medicaid Behavioral Health Capitation Rate Trends and Forecasts
Exhibit HH	Forecast Model Comparisons - Final Forecasts
Exhibit HH	Forecast Model Comparisons - Capitation Trend Models
Exhibit II	Reconciliations for MAGI Adults
Exhibit JJ	Alternative Financing Populations
Exhibit KK	Medicaid Behavioral Health Fee For Service Forecast
Exhibit LL	Global Reasonableness Test for Medicaid Behavioral Health Capitation Payments

Exhibit AA - Calculation of Current Total Long Bill Group Impact						
FY 2014-15 Behavioral Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2014-15 Behavioral Health Capitation Appropriation						
FY 2014-15 Long Bill Appropriation (HB 14-1336)	$543,607,968	$169,004,720	$0	$4,489,831	$0	$370,113,417
HB 14-1045 "Continuation of BCCP"	$129,839	$0	$0	$44,755	$0	$85,084
SB 14-215 "Disposition of Legal Marijuana Related Revenue"	$4,363,807	$2,000,000	$0	$0	$0	$2,363,807
FY 2014-15 Total Behavioral Heath Capitation Spending Authority	**$548,101,614**	**$171,004,720**	**$0**	**$4,534,586**	**$0**	**$372,562,308**
Projected Total FY 2014-15 Behavioral Health Capitation Expenditure	**$546,217,162**	**$179,427,863**	**$0**	**$4,111,958**	**$0**	**$362,677,341**
FY 2014-15 Behavioral Health Capitation Estimated Change from Appropriation	**($1,884,452)**	**$8,423,143**	**$0**	**($422,628)**	**$0**	**($9,884,967)**
Percent Change from Spending Authority	-0.34%	4.93%	-	-9.32%	-	-2.65%
FY 2014-15 Behavioral Health Fee-for-Service						
FY 2014-15 Behavioral Health Fee-For-Service Appropriation						
FY 2014-15 Long Bill Appropriation (HB 14-1336)	$7,107,049	$3,499,689	$0	$0	$0	$3,607,360
FY 2014-15 Total Behavioral Heath Fee-For-Service Spending Authority	**$7,107,049**	**$3,499,689**	**$0**	**$0**	**$0**	**$3,607,360**
Projected Total FY 2014-15 Behavioral Health Fee-for-Service Expenditure	**$7,229,305**	**$2,384,310**	**$0**	**$77,351**	**$0**	**$4,767,644**
Total FY 2014-15 Behavioral Health Fee-For-Service Change from Appropriation	**$122,256**	**($1,115,379)**	**$0**	**$77,351**	**$0**	**$1,160,284**
Percent Change from Spending Authority	1.72%	-31.87%	-	-	-	32.16%
FY 2014-15 Medicaid Behavioral Health Programs						
FY 2014-15 Total Spending Authority	**$555,208,663**	**$174,504,409**	**$0**	**$4,534,586**	**$0**	**$376,169,668**
Total Projected FY 2014-15 Expenditures	$553,446,467	$181,812,173	$0	$4,189,309	$0	$367,444,985
FY 2014-15 Estimated Change from Appropriation	**($1,762,196)**	**$7,307,764**	**$0**	**($345,277)**	**$0**	**($8,724,683)**
Percent Change from Spending Authority	-0.32%	4.19%	-	-7.61%	-	-2.32%

Exhibit AA - Calculation of Current Total Long Bill Group Impact						
FY 2015-16 Behavioral Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2014-15 Behavioral Health Capitation Appropriation Plus Special Bills	**$548,101,614**	**$171,004,720**	**$0**	**$4,534,586**	**$0**	**$372,562,308**
Annualization of HB 14-1336	$227,583	($670,316)	$0	($10,988)	$0	$908,887
HB 14-1045 Annualization "Continuation of BCCP"	($65,380)	$0	$0	($22,653)	$0	($42,727)
FY 2015-16 Behavioral Health Capitation Base Amount	**$548,263,817**	**$170,334,404**	**$0**	**$4,500,945**	**$0**	**$373,428,468**
Projected Total FY 2015-16 Behavioral Health Capitation Expenditure	**$620,325,670**	**$190,612,344**	**$0**	**$4,884,884**	**$0**	**$424,828,442**
Total FY 2015-16 Behavioral Health Capitation Request	**$72,061,853**	**$20,277,940**	**$0**	**$383,939**	**$0**	**$51,399,974**
Percent Change from FY 2015-16 Behavioral Health Capitation Base	13.14%	11.90%	-	8.53%	-	13.76%
Percent Change from FY 2014-15 Estimated Behavioral Health Capitation Expenditure	13.57%	6.23%	-	18.80%	-	17.14%
FY 2015-16 Behavioral Health Fee-for-Service						
FY 2014-15 Behavioral Health Fee-For-Service Appropriation Plus Special Bills	**$7,107,049**	**$3,499,689**	**$0**	**$0**	**$0**	**$3,607,360**
Annualization of HB 14-1336	$12,668	($8,522)	$0	$0	$0	$21,190
FY 2015-16 Behavioral Health Fee-For-Service Base Amount	**$7,119,717**	**$3,491,167**	**$0**	**$0**	**$0**	**$3,628,550**
Projected Total FY 2015-16 Behavioral Health Fee-for-Service Expenditure	**$7,842,129**	**$2,554,105**	**$0**	**$83,531**	**$0**	**$5,204,493**
Total FY 2015-16 Behavioral Health Fee-For-Service Request	**$722,412**	**($937,062)**	**$0**	**$83,531**	**$0**	**$1,575,943**
Percent Change from FY 2015-16 Behavioral Health Fee-For-Service Base	10.15%	-26.84%	-	-	-	43.43%
Percent Change from FY 2014-15 Estimated Behavioral Health Fee-For-Service Expenditure	8.48%	7.12%	-	-	-	9.16%
FY 2015-16 Medicaid Behavioral Health Programs						
FY 2015-16 Base Amount	**$555,383,534**	**$173,825,571**	**$0**	**$4,500,945**	**$0**	**$377,057,018**
Total Projected FY 2015-16 Expenditure	$628,167,799	$193,166,449	$0	$4,968,415	$0	$430,032,935
Total FY 2015-16 Request	**$72,784,265**	**$19,340,878**	**$0**	**$467,470**	**$0**	**$52,975,917**
Percent Change from Spending Authority	13.11%	11.13%	-	10.39%	-	14.05%

Exhibit AA - Calculation of Current Total Long Bill Group Impact						
FY 2016-17 Behavioral Health Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2015-16 Behavioral Health Capitation Appropriation Plus Special Bills	**$548,263,817**	**$170,334,404**	**$0**	**$4,500,945**	**$0**	**$373,428,468**
FY 2016-17 Behavioral Health Capitation Base Amount	**$548,263,817**	**$170,334,404**	**$0**	**$4,500,945**	**$0**	**$373,428,468**
Projected Total FY 2016-17 Behavioral Health Capitation Expenditure	**$691,890,314**	**$204,989,098**	**$0**	**$5,616,420**	**$0**	**$481,284,796**
Total FY 2016-17 Behavioral Health Capitation Continuation Amount	**$143,626,497**	**$34,654,694**	**$0**	**$1,115,475**	**$0**	**$107,856,328**
Percent Change from FY 2016-17 Behavioral Health Capitation Base	26.20%	20.35%	-	24.78%	-	28.88%
Percent Change from FY 2015-16 Estimated Behavioral Health Capitation Expenditure	11.54%	7.54%	-	14.98%	-	13.29%
FY 2016-17 Behavioral Health Fee-for-Service						
FY 2015-16 Behavioral Health Fee-For-Service Appropriation Plus Special Bills	**$7,119,717**	**$3,491,167**	**$0**	**$0**	**$0**	**$3,628,550**
FY 2016-17 Behavioral Health Fee-For-Service Base Amount	**$7,119,717**	**$3,491,167**	**$0**	**$0**	**$0**	**$3,628,550**
Projected Total FY 2016-17 Behavioral Health Fee-for-Service Expenditure	**$8,445,182**	**$2,743,452**	**$0**	**$90,008**	**$0**	**$5,611,722**
Total FY 2016-17 Behavioral Health Fee-For-Service Continuation Amount	**$1,325,465**	**($747,715)**	**$0**	**$90,008**	**$0**	**$1,983,172**
Percent Change from FY 2016-17 Behavioral Health Fee-For-Service Base	18.62%	-21.42%	-	-	-	54.65%
Percent Change from FY 2015-16 Estimated Behavioral Health Fee-For-Service Expenditure	7.69%	7.41%	-	-	-	7.82%
FY 2016-17 Medicaid Behavioral Health Programs						
FY 2016-17 Base Amount	**$555,383,534**	**$173,825,571**	**$0**	**$4,500,945**	**$0**	**$377,057,018**
Total Projected FY 2016-17 Expenditure	$700,335,496	$207,732,550	$0	$5,706,428	$0	$486,896,518
Total FY 2016-17 Continuation Amount	**$144,951,962**	**$33,906,979**	**$0**	**$1,205,483**	**$0**	**$109,839,500**
Percent Change from Spending Authority	26.10%	19.51%	-	26.78%	-	29.13%

Exhibit BB - Calculation of Fund Splits

Calculation of Fund Splits - FY 2014-15 Behavioral Health Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate [1]	Source of Funding
Behavioral Health Capitation Base Traditional Clients	$352,489,713	$173,565,935	$0	$0	$178,923,778	50.76%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$122,006	$0	$42,055	$0	$79,951	65.53%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$1,543,100	$0	$759,822	$0	$783,278	50.76%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Parents and Caretakers 69% - 133% FPL and MAGI Adults	$175,499,934	$0	$0	$0	$175,499,934	100.00%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$138,635	$0	$68,264	$0	$70,371	50.76%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$6,583,706	$0	$3,241,817	$0	$3,341,889	50.76%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$11,876,669	$4,093,888	$0	$0	$7,782,781	65.53%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$581,873	$200,572	$0	$0	$381,301	65.53%	General Fund
Estimated FY 2014-15 Capitation Expenditure Before Adjustments	**$548,835,636**	**$177,860,395**	**$4,111,958**	**$0**	**$366,863,283**		
Date of Death Retractions	($579,218)	($285,207)	$0	$0	($294,011)	50.76%	General Fund
Estimated MAGI Adults Rate Reconciliations	($6,403,063)	($147,325)	$0	$0	($6,255,738)	Variable	General Fund
SB 14-215: Disposition of Marijuana Revenue	$4,363,807	$2,000,000	$0	$0	$2,363,807	50.76%	General Fund
Estimated FY 2014-15 Capitation Expenditure	**$546,217,162**	**$179,427,863**	**$4,111,958**	**$0**	**$362,677,341**		
Behavioral Health Fee-for-Service Traditional Clients	$4,766,144	$2,346,849	$0	$0	$2,419,295	50.76%	General Fund
MAGI Parents and Caretakers 60% - 68% FPL	$46,532	$0	$22,912	$0	$23,620	50.76%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Parents and Caretakers 69% - 133% FPL and MAGI Adults	$2,197,394	$0	$0	$0	$2,197,394	100.00%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$12,770	$0	$6,288	$0	$6,482	50.76%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$97,788	$0	$48,151	$0	$49,637	50.76%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$105,077	$36,220	$0	$0	$68,857	65.53%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$3,600	$1,241	$0	$0	$2,359	65.53%	General Fund
Estimated FY 2014-15 Fee-for-Service Payments	**$7,229,305**	**$2,384,310**	**$77,351**	**$0**	**$4,767,644**		
Final Estimated FY 2014-15 Medicaid Behavioral Health Community Programs Expenditure	**$553,446,467**	**$181,812,173**	**$4,189,309**	**$0**	**$367,444,985**		

[1] Using a weighted average FFP because of the FFY 15 implementation date. Accounts for three months at old FFP rate and nine at new FFP rate.

Exhibit BB - Calculation of Fund Splits							
Calculation of Fund Split - FY 2015-16 Behavioral Health Estimate							
Item	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Source of Funding**
Behavioral Health Capitation Base Traditional Clients	$384,254,384	$188,246,223	$0	$0	$196,008,161	51.01%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$58,626	$0	$20,103	$0	$38,523	65.71%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$1,798,126	$0	$880,902	$0	$917,224	51.01%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Parents and Caretakers 69% - 133% FPL and MAGI Adults	$212,461,254	$0	$0	$0	$212,461,254	100.00%	Federal Funds
Non Newly Eligible	$160,765	$0	$78,759	$0	$82,006	51.01%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$7,971,260	$0	$3,905,120	$0	$4,066,140	51.01%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$13,453,705	$2,292,511	$0	$0	$11,161,194	82.96%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$688,845	$328,992	$0	$0	$359,853	52.24%	General Fund
Estimated FY 2015-16 Capitation Expenditure Before Adjustments	**$620,846,965**	**$190,867,726**	**$4,884,884**	**$0**	**$425,094,355**		
Date of Death Retractions	($521,295)	($255,382)	$0	$0	($265,913)	51.01%	General Fund
Estimated FY 2015-16 Capitation Expenditure	**$620,325,670**	**$190,612,344**	**$4,884,884**	**$0**	**$424,828,442**		
Behavioral Health Fee-for-Service Traditional Clients	$5,170,069	$2,532,817	$0	$0	$2,637,252	51.01%	General Fund
MAGI Parents and Caretakers 60% - 68% FPL	$50,476	$0	$24,728	$0	$25,748	51.01%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Parents and Caretakers 69% - 133% FPL and MAGI Adults	$2,383,665	$0	$0	$0	$2,383,665	100.00%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$13,953	$0	$6,836	$0	$7,117	51.01%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$106,077	$0	$51,967	$0	$54,110	51.01%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$113,984	$19,423	$0	$0	$94,561	82.96%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$3,905	$1,865	$0	$0	$2,040	52.24%	General Fund
Estimated FY 2015-16 Fee-for-Service Payments	**$7,842,129**	**$2,554,105**	**$83,531**	**$0**	**$5,204,493**		
Final Estimated FY 2015-16 Medicaid Behavioral Health Community Programs Expenditure	**$628,167,799**	**$193,166,449**	**$4,968,415**	**$0**	**$430,032,935**		

Exhibit BB - Calculation of Fund Splits							
Calculation of Fund Split - FY 2016-17 Behavioral Health Estimate							
Item	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Source of Funding**
Behavioral Health Capitation Base Traditional Clients	$414,617,158	$203,120,946	$0	$0	$211,496,212	51.01%	General Fund
Breast and Cervical Cancer Program Traditional and Expansion Clients	$21,461	$0	$9,290	$0	$12,171	56.71%	CF: Breast and Cervical Cancer Prevention and Treatment Fund
MAGI Parents and Caretakers 60% - 68% FPL	$2,076,257	$0	$1,017,158	$0	$1,059,099	51.01%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Parents and Caretakers 69% - 133% FPL and MAGI Adults	$250,303,780	$0	$0	$0	$250,303,780	100.00%	Federal Funds
Non Newly Eligible	$184,056	$0	$90,169	$0	$93,887	51.01%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$9,185,145	$0	$4,499,803	$0	$4,685,342	51.01%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$15,189,661	$1,714,913	$0	$0	$13,474,748	88.71%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$781,962	$383,083	$0	$0	$398,879	51.01%	General Fund
Estimated FY 2016-17 Capitation Expenditure Before Adjustments	**$692,359,480**	**$205,218,942**	**$5,616,420**	**$0**	**$481,524,118**		
Date of Death Retractions	($469,166)	($229,844)	$0	$0	($239,322)	51.01%	General Fund
Estimated FY 2016-17 Capitation Expenditure	**$691,890,314**	**$204,989,098**	**$5,616,420**	**$0**	**$481,284,796**		
Behavioral Health Fee-for-Service Traditional Clients	$5,567,533	$2,727,534	$0	$0	$2,839,999	51.01%	General Fund
MAGI Parents and Caretakers 60% - 68% FPL	$54,358	$0	$26,630	$0	$27,728	51.01%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Parents and Caretakers 69% - 133% FPL and MAGI Adults	$2,566,966	$0	$0	$0	$2,566,966	100.00%	CF: Hospital Provider Fee Cash Fund
Non Newly Eligible	$15,136	$0	$7,415	$0	$7,721	51.01%	CF: Hospital Provider Fee Cash Fund
HB 09-1293: Buy-In for Disabled Individuals	$114,234	$0	$55,963	$0	$58,271	51.01%	CF: Hospital Provider Fee Cash Fund
SB 11-008: Aligning Medicaid Eligibility for Children	$122,750	$13,858	$0	$0	$108,892	88.71%	General Fund
SB 11-250: Eligibility for Pregnant Women in Medicaid	$4,205	$2,060	$0	$0	$2,145	51.01%	General Fund
Estimated FY 2016-17 Fee-for-Service Payments	**$8,445,182**	**$2,743,452**	**$90,008**	**$0**	**$5,611,722**		
Final Estimated FY 2016-17 Medicaid Behavioral Health Community Programs Expenditure	**$700,335,496**	**$207,732,550**	**$5,706,428**	**$0**	**$486,896,518**		

Cash Funds Report									
Cash Fund	**FY 2014-15**			**FY 2015-16**			**FY 2016-17**		
	Spending Authority	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**	**Base Spending Authority**	**Estimate**	**Change**
Cash Funds									
Hospital Provider Fee Cash Fund	$4,489,831	$4,147,254	($342,577)	$4,478,843	$4,948,312	$469,469	$4,478,843	$5,697,138	$1,218,295
Breast and Cervical Cancer Prevention and Treatment Fund	$44,755	$42,055	($2,700)	$22,102	$20,103	($1,999)	$22,102	$9,290	($12,812)
Total Cash Funds	**$4,534,586**	**$4,189,309**	**($345,277)**	**$4,500,945**	**$4,968,415**	**$467,470**	**$4,500,945**	**$5,706,428**	**$1,205,483**

Exhibit CC - Medicaid Behavioral Health Community Programs Expenditure Summary

Actuals, Appropriations and Estimates Prior to Recoupments

ITEM	FY 2013-14 Actual		FY 2014-15 Appropriated		FY 2014-15 Estimate		FY 2014-15 Change from Appropriation		FY 2015-16 Estimate		FY 2015-16 Change from FY 2014-15 Estimate		FY 2015-16 Change from FY 2014-15 Appropriation		FY 2016-17 Estimate		FY 2016-17 Change from FY 2015-16 Estimate	
	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure	Caseload	Expenditure
Behavioral Health Capitation Payments																		
Adults 65 and Older (OAP-A)	41,836	$6,794,071	43,419	$7,895,282	41,932	$6,965,269	(1,487)	($930,013)	43,060	$7,247,798	1,128	$282,529	(359)	($647,484)	44,025	$7,558,222	965	$310,424
Disabled Individuals	76,837	$135,811,614	81,878	$156,614,647	81,186	$144,865,782	(692)	($11,748,865)	84,843	$155,516,709	3,657	$10,650,927	2,965	($1,097,938)	88,131	$163,829,526	3,288	$8,312,817
Low Income Adults	185,979	$52,617,174	210,629	$70,367,103	237,121	$78,096,424	26,492	$7,729,321	258,812	$90,464,634	21,691	$12,368,210	48,183	$20,097,531	280,931	$103,632,253	22,119	$13,167,619
MAGI Adults	87,243	$92,611,488	163,808	$166,746,721	223,775	$154,577,629	59,967	($12,169,092)	255,924	$188,178,037	32,149	$33,600,408	92,116	$21,431,316	286,845	$222,583,140	30,921	$34,405,103
Eligible Children	424,377	$88,922,742	458,337	$101,121,533	491,401	$111,588,499	33,064	$10,466,966	525,610	$124,664,440	34,209	$13,075,941	67,273	$23,542,907	559,602	$138,391,530	33,992	$13,727,090
Foster Care	18,267	$38,922,470	18,248	$40,862,682	20,614	$52,620,027	2,366	$11,757,345	20,920	$54,716,721	306	$2,096,694	2,672	$13,854,039	21,204	$56,343,348	284	$1,626,627
Breast and Cervical Cancer Program	559	$253,774	368	$129,839	368	$122,006	0	($7,833)	169	$58,626	(199)	($63,380)	(199)	($71,213)	59	$21,461	(110)	($37,165)
Sub-total Behavioral Health Capitation Payments	**835,098**	**$415,933,333**	**976,687**	**$543,737,807**	**1,096,397**	**$548,835,636**	**119,710**	**$5,097,829**	**1,189,338**	**$620,846,965**	**92,941**	**$72,011,329**	**212,651**	**$77,109,158**	**1,280,797**	**$692,359,480**	**91,459**	**$71,512,515**
Date of Death Retractions		($643,578)		$0		($579,218)		($579,218)		($521,295)		$57,923		($521,295)		($469,166)		$52,129
SB 14-215: Disposition of Marijuana Revenue				$4,363,807		$4,363,807		$0		$0		($4,363,807)		($4,363,807)		$0		$0
MAGI Adults Rate Reconciliation						($6,403,063)		($6,403,063)										
Total Behavioral Health Capitation Payments	**835,098**	**$415,289,755**	**976,687**	**$548,101,614**	**1,096,397**	**$546,217,162**	**119,710**	**($1,884,452)**	**1,189,338**	**$620,325,670**	**92,941**	**$74,108,508**	**212,651**	**$72,224,056**	**1,280,797**	**$691,890,314**	**91,459**	**$71,564,644**
Incremental Percent Change							12.26%	-0.34%			8.48%	13.57%	21.77%	13.18%			7.69%	11.54%
Behavioral Health Fee-for Service-Payments																		
Inpatient Services		$1,277,088		$1,713,695		$1,743,174		$29,479		$1,890,942		$147,768		$177,247		$2,036,354		$145,412
Outpatient Services		$3,956,128		$5,308,634		$5,399,954		$91,320		$5,857,705		$457,751		$549,071		$6,308,157		$450,452
Physician Services		$63,135		$84,720		$86,177		$1,457		$93,482		$7,305		$8,762		$100,671		$7,189
Total Behavioral Health Fee-for-Service Payments		**$5,296,351**		**$7,107,049**		**$7,229,305**		**$122,256**		**$7,842,129**		**$612,824**		**$735,080**		**$8,445,182**		**$603,053**
Total Behavioral Health Community Programs		**$420,586,106**		**$555,208,663**		**$553,446,467**		**($1,762,196)**		**$628,167,799**		**$74,721,332**		**$72,959,136**		**$700,335,496**		**$72,167,697**
Incremental Percent Change								-0.32%				13.50%		13.14%				11.49%

Exhibit DD - Medicaid Behavioral Health Community Programs, Caseload

Medicaid Behavioral Health Community Programs Average Monthly Caseload

Item	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2006-07 Actuals	35,888	54,858	61,032	-	205,390	16,724	228	374,120
FY 2007-08 Actuals	36,284	56,079	59,761	-	204,022	17,141	270	373,557
% Change from FY 2006-07	1.10%	2.23%	-2.08%	-	-0.67%	2.49%	18.42%	-0.15%
FY 2008-09 Actuals	37,619	57,802	68,850	-	235,129	18,033	317	417,750
% Change from FY 2007-08	3.68%	3.07%	15.21%	-	15.25%	5.20%	17.41%	11.83%
FY 2009-10 Actuals	38,487	60,313	85,907	-	275,672	18,381	425	479,185
% Change from FY 2008-09	2.31%	4.34%	24.77%	-	17.24%	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,879	64,052	116,149	-	302,410	18,393	531	540,414
% Change from FY 2009-10	1.02%	6.20%	35.20%	-	9.70%	0.07%	24.94%	12.78%
FY 2011-12 Actuals	39,740	67,869	136,315	1,134	334,633	18,034	597	598,322
% Change from FY 2010-11	2.21%	5.96%	17.36%	-	10.66%	-1.95%	12.43%	10.72%
FY 2012-13 Actuals	40,827	71,859	149,305	10,634	368,079	17,777	623	659,104
% Change from FY 2011-12	2.74%	5.88%	9.53%	837.74%	9.99%	-1.43%	4.36%	10.16%
FY 2013-14 Actuals	41,836	76,837	185,979	87,243	424,377	18,267	559	835,098
% Change from FY 2012-13	2.47%	6.93%	24.56%	720.42%	15.30%	2.76%	-10.27%	26.70%
FY 2014-15 Projection	41,932	81,186	237,121	223,775	491,401	20,614	368	1,096,397
% Change from FY 2013-14	2.71%	12.98%	58.82%	2004.00%	34.00%	16.00%	-41.00%	31.29%
FY 2015-16 Projection	43,060	84,843	258,812	255,924	525,610	20,920	169	1,189,338
% Change from FY 2014-15	2.69%	4.50%	9.15%	14.37%	6.96%	1.48%	-70.00%	8.48%
FY 2016-17 Projection	44,025	88,131	280,931	286,845	559,602	21,204	59	1,280,797
% Change from FY 2015-16	2.24%	3.88%	8.55%	12.08%	6.47%	1.36%	-84.00%	7.69%
FY 2014-15 Appropriation	43,419	81,878	210,629	163,808	458,337	18,248	464	976,783
Difference between the FY 2014-15 Appropriation and the FY 2014-15 Projection	-1,487	-692	26,492	59,967	33,064	2,366	-96	119,614

Expanded Medicaid Average Monthly Caseload for Behavioral Health Community Programs

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	MAGI Adults	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Breast & Cervical Cancer Program	TOTAL BEHAVIORAL HEALTH
FY 2006-07 Actuals	35,888	6,059	48,799	-	55,850	-	5,182	-	-	205,390	-	16,724	228	374,120
FY 2007-08 Actuals	36,284	6,146	49,933	-	53,473	-	6,288	-	-	204,022	-	17,141	270	373,557
% Change from FY 2006-07	1.10%	1.44%	2.32%	-	-4.26%	-	21.34%	-	-	-0.67%	-	2.49%	18.42%	-0.15%
FY 2008-09 Actuals	37,619	6,447	51,355	-	61,874	-	6,976	-	-	235,129	-	18,033	317	417,750
% Change from FY 2007-08	3.68%	4.90%	2.85%	-	15.71%	-	10.94%	-	-	15.25%	-	5.20%	17.41%	11.83%
FY 2009-10 Actuals	38,487	7,049	53,264	-	74,839	3,238	7,830	-	-	275,672	-	18,381	425	479,185
% Change from FY 2008-09	2.31%	9.34%	3.72%	-	20.95%	-	12.24%	-	-	17.24%	-	1.93%	34.07%	14.71%
FY 2010-11 Actuals	38,879	7,767	56,285	-	81,114	27,167	7,868	-	-	302,410	-	18,393	531	540,414
% Change from FY 2009-10	1.02%	10.19%	5.67%	-	8.38%	739.01%	0.49%	-	-	9.70%	-	0.07%	24.94%	12.78%
FY 2011-12 Actuals	39,740	8,383	59,434	52	93,224	35,461	7,630	-	1,134	334,633	-	18,034	597	598,322
% Change from FY 2010-11	2.21%	7.93%	5.59%	-	14.93%	30.53%	-3.02%	-	-	10.66%	-	-1.95%	12.43%	10.72%
FY 2012-13 Actuals	40,827	9,051	61,920	888	99,392	41,545	8,024	344	10,634	359,843	8,236	17,777	623	659,104
% Change from FY 2011-12	2.74%	7.97%	4.18%	1607.69%	6.62%	17.16%	5.16%	-	837.74%	7.53%	-	-1.43%	4.36%	10.16%
FY 2013-14 Actuals	41,836	9,853	64,424	2,560	124,680	47,082	13,160	1,057	87,243	397,362	27,015	18,267	559	835,098
% Change from FY 2012-13	2.47%	8.86%	4.04%	188.29%	25.44%	13.33%	64.01%	207.64%	720.42%	10.43%	228.01%	2.76%	-10.27%	26.70%
FY 2014-15 Projection	41,932	10,838	66,648	3,700	155,667	64,563	15,124	1,767	223,775	439,097	52,304	20,614	368	1,096,397
% Change from FY 2013-14	0.23%	10.00%	3.45%	44.53%	24.85%	37.13%	14.92%	67.17%	156.50%	10.50%	93.61%	12.85%	-34.17%	31.29%
FY 2015-16 Projection	43,060	11,442	69,042	4,359	170,935	70,573	15,333	1,971	255,924	468,884	56,726	20,920	169	1,189,338
% Change from FY 2014-15	2.69%	5.57%	3.59%	17.81%	9.81%	9.31%	1.38%	11.54%	14.37%	6.78%	8.45%	1.48%	-54.08%	8.48%
FY 2016-17 Projection	44,025	11,975	71,205	4,951	187,003	76,305	15,503	2,120	286,845	498,180	61,422	21,204	59	1,280,797
% Change from FY 2015-16	2.24%	4.66%	3.13%	13.58%	9.40%	8.12%	1.11%	7.56%	12.08%	6.25%	8.28%	1.36%	-65.09%	7.69%
FY 2014-15 Appropriation	43,419	10,537	67,688	3,653	125,572	68,592	14,346	2,119	163,808	431,244	27,093	18,248	464	976,783
Difference between the FY 2014-15 Appropriation and the FY 2014-15 Projection	(1,487)	301	(1,040)	47	30,095	(4,029)	778	(352)	59,967	7,853	25,211	2,366	(96)	119,614

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

Annual Total Expenditures

Item		Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults	MAGI Adults	Eligible Children	Foster Care	Breast & Cervical Cancer Program	MENTAL HEALTH TOTAL
FY 2007-08	Capitations	$5,785,556	$82,620,046	$14,524,307	$0	$37,565,608	$55,455,338	$60,178	$196,011,033
	Fee-For-Service								
	Inpatient Services	$7,069	$221,467	$45,469	$0	$93,439	$46,660	$0	$414,104
	Outpatient Services	$12,721	$267,020	$231,300	$0	$282,037	$74,411	$0	$867,489
	Physician Services	$479	$32,552	$9,170	$0	$8,970	$2,972	$0	$54,143
	Sub-Total Fee-For-Service	$20,269	$521,039	$285,939	$0	$384,446	$124,043	$0	$1,335,736
	Total FY 2007-08 Expenditures	**$5,805,825**	**$83,141,085**	**$14,810,246**	**$0**	**$37,950,054**	**$55,579,381**	**$60,178**	**$197,346,769**
FY 2008-09	Capitations	$6,149,782	$92,132,599	$17,026,544	$0	$43,714,042	$56,764,896	$73,074	$215,860,937
	Fee-For-Service								
	Inpatient Services	$22,235	$331,864	$107,478	$0	$171,764	$8,913	$0	$642,254
	Outpatient Services	$9,657	$284,108	$300,557	$0	$364,710	$103,091	$0	$1,062,123
	Physician Services	$285	$37,367	$12,386	$0	$13,685	$8,153	$0	$71,876
	Sub-Total Fee-For-Service	$32,177	$653,339	$420,421	$0	$550,159	$120,157	$0	$1,776,253
	Total FY 2008-09 Expenditures	**$6,181,959**	**$92,785,938**	**$17,446,965**	**$0**	**$44,264,201**	**$56,885,053**	**$73,074**	**$217,637,190**
	% Change from FY 2007-08	**6.48%**	**11.60%**	**17.80%**	**0.00%**	**16.64%**	**2.35%**	**21.43%**	**10.28%**
FY 2009-10 [1]	Capitations	$5,714,066	$98,475,008	$21,250,051	$0	$49,749,580	$51,334,158	$97,955	$226,620,818
	Fee-For-Service								
	Inpatient Services	$36,707	$327,355	$24,703	$0	$184,094	$23,702	$0	$596,561
	Outpatient Services	$18,805	$528,618	$623,741	$0	$601,664	$139,423	$0	$1,912,251
	Physician Services	$61	$45,659	$6,543	$0	$22,296	$4,291	$0	$78,850
	Sub-Total Fee-For-Service	$55,573	$901,632	$654,987	$0	$808,054	$167,416	$0	$2,587,662
	Total FY 2009-10 Expenditures	**$5,769,639**	**$99,376,640**	**$21,905,038**	**$0**	**$50,557,634**	**$51,501,574**	**$97,955**	**$229,208,480**
	% Change from FY 2007-08	**-6.67%**	**7.10%**	**25.55%**	**0.00%**	**14.22%**	**-9.46%**	**34.05%**	**5.32%**
FY 2010-11 [1]	Capitations	$6,265,262	$112,579,810	$31,142,656	$0	$57,953,130	$43,070,676	$134,493	$251,146,027
	Fee-For-Service								
	Inpatient Services	$26,281	$462,018	$73,357	$0	$209,493	$31,297	$0	$802,446
	Outpatient Services	$19,668	$838,729	$1,066,059	$0	$843,338	$204,022	$0	$2,971,816
	Physician Services	$44	$53,652	$13,543	$0	$19,019	$10,074	$0	$96,331
	Sub-Total Fee-For-Service	$45,993	$1,354,399	$1,152,959	$0	$1,071,850	$245,393	$0	$3,870,594
	Total FY 2010-11 Expenditures	**$6,311,255**	**$113,934,209**	**$32,295,615**	**$0**	**$59,024,980**	**$43,316,069**	**$134,493**	**$255,016,621**
	% Change from FY 2009-10	**9.39%**	**14.65%**	**47.43%**	**0.00%**	**16.75%**	**-15.89%**	**37.30%**	**11.26%**
FY 2011-12	Capitations	$6,501,731	$120,858,807	$37,302,066	$91,244	$67,777,256	$38,817,457	$158,074	$271,506,635
	Fee-For-Service								
	Inpatient Services	$21,297	$355,817	$66,514	$0	$176,653	$11,869	$0	$632,151
	Outpatient Services	$19,808	$762,862	$1,230,908	$13,232	$980,428	$156,434	$0	$3,163,672
	Physician Services	$0	$49,001	$18,279	$0	$23,508	$5,786	$0	$96,575
	Sub-Total Fee-For-Service	$41,105	$1,167,680	$1,315,702	$13,232	$1,180,589	$174,089	$0	$3,892,397
	Total FY 2011-12 Expenditures	**$6,542,836**	**$122,026,487**	**$38,617,768**	**$104,476**	**$68,957,845**	**$38,991,546**	**$158,074**	**$275,399,032**
	% Change from FY 2010-11	**3.67%**	**7.10%**	**19.58%**	**0.00%**	**16.83%**	**-9.98%**	**17.53%**	**7.99%**
FY 2012-13	Capitations	$6,533,297	$124,950,830	$41,769,895	$12,914,408	$76,537,197	$36,623,205	$152,344	$299,481,176
	Fee-For-Service								
	Inpatient Services	$23,759	$657,600	$61,481	$47,488	$147,305	$26,023	$0	$963,656
	Outpatient Services	$15,873	$737,252	$1,304,574	$270,481	$1,035,757	$140,576	$0	$3,504,514
	Physician Services	$0	$61,602	$8,361	$256	$9,712	$2,308	$0	$82,240
	Sub-Total Fee-For-Service	$39,632	$1,456,455	$1,374,416	$318,226	$1,192,774	$168,907	$0	$4,550,410
	Total FY 2012-13 Expenditures	**$6,572,929**	**$126,407,285**	**$43,144,311**	**$13,232,634**	**$77,729,971**	**$36,792,112**	**$152,344**	**$304,031,586**
	% Change from FY 2011-12	**0.46%**	**3.59%**	**11.72%**	**12565.72%**	**12.72%**	**-5.64%**	**-3.62%**	**10.40%**
FY 2013-14	Capitations	$6,794,071	$135,811,614	$52,617,174	$92,611,488	$88,922,742	$38,922,470	$253,774	$415,933,333
	Fee-For-Service								
	Inpatient Services	$12,637	$701,499	$147,802	$199,734	$181,770	$33,646	$0	$1,277,088
	Outpatient Services	$10,423	$555,506	$1,316,416	$1,113,265	$885,140	$75,378	$0	$3,956,128
	Physician Services	$50	$32,316	$9,050	$9,088	$10,754	$1,877	$0	$63,135
	Sub-Total Fee-For-Service	$23,110	$1,289,321	$1,473,269	$1,322,086	$1,077,664	$110,901	$0	$5,296,351
	Total FY 2013-14 Expenditures	**$6,817,181**	**$137,100,935**	**$54,090,443**	**$93,933,574**	**$90,000,406**	**$39,033,371**	**$253,774**	**$421,229,684**
	% Change from FY 2012-13	**3.72%**	**8.46%**	**25.37%**	**609.86%**	**15.79%**	**6.09%**	**66.58%**	**38.55%**

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

Exhibit DD - Medicaid Mental Health Community Programs Expenditures Historical Summary

Expanded Annual Total Expenditures

	Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	MAGI Adults	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Breast & Cervical Cancer Program	MENTAL HEALTH TOTAL
	Capitations	$5,785,556	$8,604,645	$74,015,401	$0	$13,045,420	$0	$1,478,887	$0	$0	$37,565,608	$0	$55,455,338	$60,178	$196,011,033
	Fee-For-Service														
	Inpatient Services	$7,069	$13,110	$208,357	$0	$45,469	$0	$0	$0	$0	$93,439	$0	$46,660	$0	$414,104
FY 2007-08	*Outpatient Services*	$12,721	$14,262	$252,758	$0	$225,351	$0	$5,949	$0	$0	$282,037	$0	$74,411	$0	$867,489
	Physician Services	$479	$2,275	$30,277	$0	$7,745	$0	$1,425	$0	$0	$8,970	$0	$2,972	$0	$54,143
	Sub-Total Fee-For-Service	$20,269	$29,647	$491,392	$0	$278,565	$0	$7,374	$0	$0	$384,446	$0	$124,043	$0	$1,335,736
	Total FY 2007-08 Expenditures	**$5,805,825**	**$8,634,292**	**$74,506,793**	**$0**	**$13,323,985**	**$0**	**$1,486,261**	**$0**	**$0**	**$37,950,054**	**$0**	**$55,579,381**	**$60,178**	**$197,346,769**
	Capitations	$6,149,782	$9,745,116	$82,387,483	$0	$15,504,797	$0	$1,521,747	$0	$0	$43,714,042	$0	$56,764,896	$73,074	$215,860,937
	Fee-For-Service														
	Inpatient Services	$22,235	$9,653	$322,211	$0	$107,478	$0	$0	$0	$0	$171,764	$0	$8,913	$0	$642,254
FY 2008-09	*Outpatient Services*	$9,657	$19,613	$264,495	$0	$291,393	$0	$9,164	$0	$0	$364,710	$0	$103,091	$0	$1,062,123
	Physician Services	$285	$1,580	$35,787	$0	$10,873	$0	$1,513	$0	$0	$13,685	$0	$8,153	$0	$71,876
	Sub-Total Fee-For-Service	$32,177	$30,846	$622,493	$0	$409,744	$0	$10,677	$0	$0	$550,159	$0	$120,157	$0	$1,776,253
	Total FY 2008-09 Expenditures	**$6,181,959**	**$9,775,962**	**$83,009,976**	**$0**	**$15,914,541**	**$0**	**$1,532,424**	**$0**	**$0**	**$44,264,201**	**$0**	**$56,885,053**	**$73,074**	**$217,637,190**
	% Change from FY 2007-08	**6.48%**	**13.22%**	**11.41%**	**0.00%**	**0.00%**	**0.00%**	**3.11%**	**0.00%**	**0.00%**	**16.64%**	**0.00%**	**2.35%**	**21.43%**	**10.28%**
	Capitations	$5,714,066	$10,837,828	$87,637,180	$0	$19,027,843	$643,078	$1,579,130	$0	$0	$49,749,580	$0	$51,334,158	$97,955	$226,620,818
	Fee-For-Service														
	Inpatient Services	$36,707	$0	$327,355	$0	$23,679	$1,024	$0	$0	$0	$184,094	$0	$23,702	$0	$596,561
FY 2009-10 [1]	*Outpatient Services*	$18,805	$35,433	$493,185	$0	$575,312	$24,891	$23,538	$0	$0	$601,664	$0	$139,423	$0	$1,912,251
	Physician Services	$61	$631	$45,028	$0	$4,747	$205	$1,591	$0	$0	$22,296	$0	$4,291	$0	$78,850
	Sub-Total Fee-For-Service	$55,573	$36,064	$865,568	$0	$603,738	$26,120	$25,129	$0	$0	$808,054	$0	$167,416	$0	$2,587,662
	Total FY 2009-10 Expenditures	**$5,769,639**	**$10,873,892**	**$88,502,748**	**$0**	**$19,631,581**	**$669,198**	**$1,604,259**	**$0**	**$0**	**$50,557,634**	**$0**	**$51,501,574**	**$97,955**	**$229,208,480**
	% Change from FY 2008-09	**-6.67%**	**11.23%**	**6.62%**	**0.00%**	**0.00%**	**0.00%**	**4.69%**	**0.00%**	**0.00%**	**14.22%**	**0.00%**	**-9.46%**	**34.05%**	**5.32%**
	Capitations	$6,265,262	$12,890,748	$99,689,062	$0	$21,770,317	$7,654,920	$1,717,419	$0	$0	$57,953,130	$0	$43,070,676	$134,493	$251,146,027
	Fee-For-Service														
	Inpatient Services	$26,281	$0	$462,018	$0	$54,952	$18,405	$0	$0	$0	$209,493	$0	$31,297	$0	$802,446
FY 2010-11 [1]	*Outpatient Services*	$19,668	$54,047	$784,682	$0	$778,402	$260,702	$26,955	$0	$0	$843,338	$0	$204,022	$0	$2,971,816
	Physician Services	$44	$559	$53,093	$0	$8,634	$2,892	$2,017	$0	$0	$19,019	$0	$10,074	$0	$96,331
	Sub-Total Fee-For-Service	$45,993	$54,606	$1,299,792	$0	$841,988	$281,999	$28,972	$0	$0	$1,071,850	$0	$245,393	$0	$3,870,594
	Total FY 2010-11 Expenditures	**$6,311,255**	**$12,945,354**	**$100,988,854**	**$0**	**$22,612,305**	**$7,936,919**	**$1,746,391**	**$0**	**$0**	**$59,024,980**	**$0**	**$43,316,069**	**$134,493**	**$255,016,621**
	% Change from FY 2009-10	**9.39%**	**19.05%**	**14.11%**	**0.00%**	**0.00%**	**1086.03%**	**8.86%**	**0.00%**	**0.00%**	**16.75%**	**0.00%**	**-15.89%**	**37.30%**	**11.26%**
	Capitations	$6,501,731	$14,198,785	$106,568,343	$91,679	$25,412,054	$10,138,129	$1,751,883	$0	$91,244	$67,777,256	$0	$38,817,457	$158,074	$271,506,635
	Fee-For-Service														
	Inpatient Services	$21,297	$12,590	$343,228	$0	$48,185	$18,329	$0	$0	$0	$176,653	$0	$11,869	$0	$632,151
FY 2011-12	*Outpatient Services*	$19,808	$66,220	$696,219	$423	$873,401	$332,229	$25,278	$0	$13,232	$980,428	$0	$156,434	$0	$3,163,672
	Physician Services	$0	$580	$48,421	$0	$12,402	$4,718	$1,159	$0	$0	$23,508	$0	$5,786	$0	$96,575
	Sub-Total Fee-For-Service	$41,105	$79,389	$1,087,868	$423	$933,988	$355,276	$26,438	$0	$13,232	$1,180,589	$0	$174,089	$0	$3,892,397
	Total FY 2011-12 Expenditures	**$6,542,836**	**$14,278,174**	**$107,656,211**	**$92,102**	**$26,346,042**	**$10,493,405**	**$1,778,321**	**$0**	**$104,476**	**$68,957,845**	**$0**	**$38,991,546**	**$158,074**	**$275,399,032**
	% Change from FY 2010-11	**3.67%**	**10.30%**	**6.60%**	**0.00%**	**16.51%**	**32.21%**	**1.83%**	**0.00%**	**0.00%**	**16.83%**	**0.00%**	**-9.98%**	**17.53%**	**7.99%**
	Capitations	$6,533,297	$15,283,706	$109,667,124	$1,821,870	$27,973,392	$11,805,595	$1,990,908	$0	$12,914,408	$76,537,197	$0	$36,623,205	$152,344	$301,303,046
	Fee-For-Service														
	Inpatient Services	$23,759	$89,128	$568,472	$9,972	$56,164	$5,318	$0	$0	$47,488	$147,305	$0	$26,023	$0	$973,629
FY 2012-13	*Outpatient Services*	$15,873	$70,123	$667,130	$8,815	$977,747	$301,289	$25,538	$0	$270,481	$1,035,757	$0	$140,576	$0	$3,513,329
	Physician Services	$0	$355	$61,247	$0	$5,234	$2,561	$566	$0	$256	$9,712	$0	$2,308	$0	$82,240
	Sub-Total Fee-For-Service	$39,632	$159,606	$1,296,849	$18,788	$1,039,144	$309,168	$26,104	$0	$318,226	$1,192,774	$0	$168,907	$0	$4,569,198
	Total FY 2012-13 Expenditures	**$6,572,929**	**$15,443,312**	**$110,963,973**	**$1,840,658**	**$29,012,536**	**$12,114,763**	**$2,017,012**	**$0**	**$13,232,634**	**$77,729,971**	**$0**	**$36,792,112**	**$152,344**	**$305,872,244**
	% Change from FY 2011-12	**0.46%**	**8.16%**	**3.07%**	**1898.50%**	**10.12%**	**15.45%**	**13.42%**	**0.00%**	**12565.72%**	**12.72%**	**0.00%**	**-5.64%**	**-3.62%**	**11.07%**
	Capitations	$6,794,071	$16,991,711	$113,813,015	$5,006,888	$38,834,657	$10,148,824	$3,584,933	$48,760	$92,611,488	$87,866,710	$1,056,032	$38,922,470	$253,774	$415,933,333
	Fee-For-Service														
	Inpatient Services	$12,637	$19,104	$626,179	$56,216	$138,091	$9,711	$0	$0	$199,734	$169,677	$12,092	$33,646	$0	$1,277,088
FY 2013-14	*Outpatient Services*	$10,423	$38,587	$501,652	$15,268	$987,859	$276,800	$49,120	$2,637	$1,113,265	$820,427	$64,713	$75,378	$0	$3,956,128
	Physician Services	$50	$1,324	$30,834	$158	$6,611	$1,262	$1,176	$0	$9,088	$10,578	$176	$1,877	$0	$63,135
	Sub-Total Fee-For-Service	$23,110	$59,015	$1,158,665	$71,641	$1,132,562	$287,773	$50,296	$2,637	$1,322,086	$1,000,682	$76,982	$110,901	$0	$5,296,351
	Total FY 2013-14 Expenditures	**$6,817,181**	**$17,050,726**	**$114,971,680**	**$5,078,529**	**$39,967,219**	**$10,436,597**	**$3,635,229**	**$51,397**	**$93,933,574**	**$88,867,392**	**$1,133,014**	**$39,033,371**	**$253,774**	**$421,229,684**
	% Change from FY 2012-13	**3.72%**	**10.41%**	**3.61%**	**175.91%**	**37.76%**	**-13.85%**	**80.23%**	**0.00%**	**609.86%**	**14.33%**	**0.00%**	**6.09%**	**66.58%**	**37.71%**

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

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

Mental Health Capitation Payments Per Capita History

Item	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	TOTAL PER CAPITA
FY 2007-08 Actuals	$159.45	$1,473.28	$243.04	-	$184.13	$3,235.25	$222.88	$524.72
FY 2008-09 Actuals	$163.48	$1,593.93	$247.30	-	$185.92	$3,147.83	$230.52	$516.72
% Change from FY 2007-08	2.53%	8.19%	1.75%	-	0.97%	-2.70%	3.43%	-1.52%
FY 2009-10 Actuals	$148.47	$1,632.73	$247.36	-	$180.47	$2,792.78	$230.48	$472.93
% Change from FY 2008-09	-9.18%	2.43%	0.03%	-	-2.93%	-11.28%	-0.02%	-8.47%
FY 2010-11 Actuals	$161.15	$1,757.63	$268.13	-	$191.64	$2,341.69	$253.28	$464.73
% Change from FY 2009-10	8.54%	7.65%	8.39%	-	6.19%	-16.15%	9.89%	-1.73%
FY 2011-12 Actuals	$163.61	$1,780.77	$273.65	$80.46	$202.54	$2,152.46	$264.78	$453.78
% Change from FY 2010-11	1.53%	1.32%	2.06%	-	5.69%	-8.08%	4.54%	-2.36%
FY 2012-13 Actuals	$160.02	$1,764.19	$279.76	$1,214.44	$207.94	$2,060.15	$244.53	$457.14
% Change from FY 2011-12	-2.19%	-0.93%	2.24%	1409.37%	2.66%	-4.29%	-7.65%	0.74%
FY 2013-14 Actuals	$162.40	$1,767.53	$282.92	$1,061.53	$209.54	$2,130.75	$453.98	$498.07
% Change from FY 2012-13	1.49%	0.19%	1.13%	-12.59%	0.77%	3.43%	85.65%	8.95%
FY 2014-15 Projection	$163.73	$1,779.38	$329.30	$690.56	$227.07	$2,552.24	$329.18	$500.05
% Change from FY 2013-14	0.82%	0.67%	16.39%	-34.95%	8.37%	19.78%	-27.49%	0.40%
FY 2015-16 Projection	$166.23	$1,828.69	$349.49	$735.12	$237.17	$2,615.17	$342.28	$521.57
% Change from FY 2014-15	1.53%	2.77%	6.13%	4.45%	4.45%	2.47%	3.98%	4.30%
FY 2016-17 Projection	$169.84	$1,855.21	$368.85	$775.84	$247.30	$2,656.89	$351.83	$540.20
% Change from FY 2015-16	2.17%	1.45%	5.54%	5.54%	4.27%	1.60%	$0.03	3.57%

Expanded Medicaid Per Capita Summary for Mental Health Capitation Payments

Item	Adults 65 and Older (OAP-A)	Disabled Adults 60 to 64 (OAP-B)	Disabled Individuals to 59 (AND/AB)	Disabled Buy-In	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Pregnant Adults	SB 11-250 Eligible Pregnant Adults	MAGI Adults	Eligible Children (AFDC-C/BC)	SB 11-008 Eligible Children	Foster Care	Breast & Cervical Cancer Program	TOTAL PER CAPITA
FY 2007-08 Actuals	$159.45	$1,400.04	$1,482.29	-	$243.96	-	$235.19	-	-	$184.13	-	$3,235.25	$222.88	$524.72
FY 2008-09 Actuals	$163.48	$1,511.57	$1,604.27	-	$250.59	-	$218.14	-	-	$185.92	-	$3,147.83	$230.52	$516.72
% Change from FY 2007-08	2.53%	7.97%	8.23%	-	2.72%	-	-7.25%	-	-	0.97%	-	-2.70%	3.43%	-1.52%
FY 2009-10 Actuals	$148.47	$1,537.50	$1,645.34	-	$254.25	$198.60	$201.68	-	-	$180.47	-	$2,792.78	$230.48	$472.93
% Change from FY 2008-09	-9.18%	1.72%	2.56%	-	1.46%	-	-7.55%	-	-	-2.93%	-	-11.28%	-0.02%	-8.47%
FY 2010-11 Actuals	$161.15	$1,659.68	$1,771.15	-	$268.39	$281.77	$218.28	-	-	$191.64	-	$2,341.69	$253.28	$464.73
% Change from FY 2009-10	8.54%	7.95%	7.65%	-	5.56%	41.88%	8.23%	-	-	6.19%	-	-16.15%	9.89%	-1.73%
FY 2011-12 Actuals	$163.61	$1,693.76	$1,793.05	$1,763.06	$272.59	$285.90	$229.60	-	$80.46	$202.54	-	$2,152.46	$264.78	$453.78
% Change from FY 2010-11	1.53%	2.05%	1.24%	-	1.56%	1.47%	5.19%	-	-	5.69%	-	-8.08%	4.54%	-2.36%
FY 2012-13 Actuals	$160.02	$1,688.62	$1,771.11	$2,051.66	$281.45	$284.16	$248.12	$0.00	$1,214.44	$212.70	$0.00	$2,060.15	$244.53	$457.14
% Change from FY 2011-12	-2.19%	-0.30%	-1.22%	16.37%	3.25%	-0.61%	8.07%	-	1409.37%	5.02%	-	-4.29%	-7.65%	0.74%
FY 2013-14 Actuals	$162.40	$1,724.52	$1,766.62	$1,955.82	$311.47	$215.56	$272.41	$46.13	$1,061.53	$221.13	$39.09	$2,130.75	$453.98	$498.07
% Change from FY 2012-13	1.49%	2.13%	-0.25%	-4.67%	10.67%	-24.14%	9.79%	-	-12.59%	3.96%	-	3.43%	85.65%	8.95%
FY 2014-15 Projection	$163.73	$1,779.38	$1,779.38	$1,779.38	$329.30	$329.30	$329.30	$329.30	$690.56	$227.07	$227.07	$2,552.24	$329.18	$500.05
% Change from FY 2013-14	0.82%	3.18%	0.72%	-9.02%	5.72%	52.76%	20.88%	613.85%	-34.95%	2.69%	480.89%	19.78%	-27.49%	0.40%
FY 2015-16 Projection	$166.23	$1,828.69	$1,828.69	$1,828.69	$349.49	$349.49	$349.49	$349.49	$735.12	$237.17	$237.17	$2,615.17	$342.28	$521.57
% Change from FY 2014-15	1.53%	2.77%	2.77%	2.77%	6.13%	6.13%	6.13%	6.13%	6.45%	4.45%	4.45%	2.47%	3.98%	4.30%
FY 2016-17 Projection	$169.84	$1,855.21	$1,855.21	$1,855.21	$368.85	$368.85	$368.85	$368.85	$775.84	$247.30	$247.30	$2,656.89	$351.83	$540.20
% Change from FY 2015-16	2.17%	1.45%	1.45%	1.45%	5.54%	5.54%	5.54%	5.54%	5.54%	4.27%	4.27%	1.60%	2.79%	3.57%

Exhibit EE - Expenditure Calculations by Eligibility Category

Behavioral Health Capitation Calculations by Eligibility Category for FY 2014-15

FY 2014-15 Q1 and Q2 Calculation

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Weighted Capitation Rate	$13.85	$149.05	$27.59	$57.99	$18.96	$212.92	$27.59	
Estimated Monthly Caseload [1]	41,761	79,891	231,294	212,704	479,792	20,453	413	1,066,308
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Costs for FY 2014-15 Q1 and Q2 Capitated Payments	$3,470,339	$71,446,521	$38,288,409	$74,008,230	$54,581,138	$26,129,117	$68,368	$267,992,122
Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	98.86%	98.12%	97.77%	98.48%	98.73%	99.50%	98.88%	
Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,430,777	$70,103,326	$37,434,577	$72,883,305	$53,887,958	$25,998,471	$67,602	$263,806,016
Expenditures for Prior Period Dates of Service	$36,405	$1,090,439	$492,440	$99,452	$514,589	$87,837	$915	$2,322,077
Total Estimated Expenditures in FY 2014-15 Q1 and Q2	**$3,467,182**	**$71,193,765**	**$37,927,017**	**$72,982,757**	**$54,402,547**	**$26,086,308**	**$68,517**	**$266,128,093**

FY 2014-15 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Weighted Capitation Rate	$13.85	$149.05	$27.59	$57.99	$18.96	$212.92	$27.59	
Estimated Monthly Caseload [1]	42,102	82,479	242,946	234,845	503,009	20,775	322	1,126,478
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2014-15 Q3 and Q4 Capitated Payments	$3,498,676	$73,760,970	$40,217,281	$81,711,969	$57,222,304	$26,540,478	$53,304	$283,004,982
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	98.86%	98.12%	97.77%	98.48%	98.73%	99.50%	98.88%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,458,791	$72,374,264	$39,320,436	$80,469,947	$56,495,581	$26,407,776	$52,707	$278,579,502
Estimated Expenditures for Prior Period Dates of Service	$39,296	$1,297,753	$848,971	$1,124,925	$690,371	$125,943	$782	$4,128,041
Total Estimated Expenditures in FY 2014-15 Q3 and Q4	**$3,498,087**	**$73,672,017**	**$40,169,407**	**$81,594,872**	**$57,185,952**	**$26,533,719**	**$53,489**	**$282,707,543**
Total Estimated FY 2014-15 Expenditures	**$6,965,269**	**$144,865,782**	**$78,096,424**	**$154,577,629**	**$111,588,499**	**$52,620,027**	**$122,006**	**$548,835,636**
Estimated Date of Death Retractions	($99,949)	($405,336)	($13,076)	($46,662)	($5,177)	($8,150)	($868)	($579,218)
Total Estimated FY 2014-15 Expenditures Including Date of Death Retractions	**$6,865,320**	**$144,460,446**	**$78,083,348**	**$154,530,967**	**$111,583,322**	**$52,611,877**	**$121,138**	**$548,256,418**
Estimated FY 2014-15 Monthly Caseload	41,932	81,186	237,121	223,775	491,401	20,614	368	1,096,397
Estimated FY 2014-15 Per Capita Expenditure	**$163.73**	**$1,779.38**	**$329.30**	**$690.56**	**$227.07**	**$2,552.24**	**$329.18**	**$500.05**

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

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

Exhibit EE - Expenditure Calculations by Eligibility Category

Behavioral Health Capitation Calculations by Eligibility Category for FY 2015-16

FY 2015-16 Q1 and Q2 Calculation

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$13.89	$151.83	$28.38	$59.67	$19.36	$216.29	$28.38	
Estimated Monthly Caseload [1]	42,681	84,256	253,721	248,628	519,723	20,915	213	1,170,137
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2015-16 Q1 and Q2 Capitated Payments	$3,557,035	$76,755,531	$43,203,612	$89,013,797	$60,371,024	$27,142,232	$36,270	$300,079,501
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	98.86%	98.12%	97.77%	98.48%	98.73%	99.50%	98.88%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,516,485	$75,312,527	$42,240,171	$87,660,787	$59,604,312	$27,006,521	$35,864	$295,376,667
Estimated Expenditures for Prior Period Dates of Service	$39,779	$1,360,496	$896,267	$1,242,022	$726,195	$130,888	$620	$4,396,267
Total Estimated Expenditures in FY 2015-16 Q1 and Q2	**$3,556,264**	**$76,673,023**	**$43,136,438**	**$88,902,809**	**$60,330,507**	**$27,137,409**	**$36,484**	**$299,772,934**

FY 2015-16 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$14.17	$153.94	$29.95	$62.96	$20.19	$219.71	$29.95	
Estimated Monthly Caseload [1]	43,439	85,429	263,902	263,219	531,497	20,923	123	1,208,532
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2015-16 Q3 and Q4 Capitated Payments	$3,693,184	$78,905,642	$47,423,189	$99,433,609	$64,385,547	$27,581,954	$22,103	$321,445,228
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	98.86%	98.12%	97.77%	98.48%	98.73%	99.50%	98.88%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,651,082	$77,422,216	$46,365,652	$97,922,218	$63,567,851	$27,444,044	$21,855	$316,394,918
Estimated Expenditures for Prior Period Dates of Service	$40,452	$1,421,470	$962,544	$1,353,010	$766,082	$135,268	$287	$4,679,113
Total Estimated Expenditures in FY 2015-16 Q3 and Q4	**$3,691,534**	**$78,843,686**	**$47,328,196**	**$99,275,228**	**$64,333,933**	**$27,579,312**	**$22,142**	**$321,074,031**
Total Estimated FY 2015-16 Expenditures	**$7,247,798**	**$155,516,709**	**$90,464,634**	**$188,178,037**	**$124,664,440**	**$54,716,721**	**$58,626**	**$620,846,965**
Estimated Date of Death Retractions	($89,954)	($364,802)	($11,768)	($41,996)	($4,659)	($7,335)	($781)	($521,295)
Total Estimated FY 2015-16 Expenditures Including Date of Death Retractions	**$7,157,844**	**$155,151,907**	**$90,452,866**	**$188,136,041**	**$124,659,781**	**$54,709,386**	**$57,845**	**$620,325,670**
Estimated FY 2015-16 Monthly Caseload	43,060	84,843	258,812	255,924	525,610	20,920	169	1,189,338
Estimated FY 2015-16 Per Capita Expenditure	**$166.23**	**$1,828.69**	**$349.49**	**$735.12**	**$237.17**	**$2,615.17**	**$342.28**	**$521.57**

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

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

Exhibit EE - Expenditure Calculations by Eligibility Category

Behavioral Health Capitation Calculations by Eligibility Category for FY 2016-17

FY 2016-17 Q1 and Q2 Calculation

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$14.17	$153.94	$29.95	$62.96	$20.19	$219.71	$29.95	
Estimated Monthly Caseload [1]	43,901	87,102	274,979	278,667	548,765	21,075	73	1,254,562
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2016-17 Q1 and Q2 Capitated Payments	$3,732,463	$80,450,891	$49,413,726	$105,269,246	$66,477,392	$27,782,330	$13,118	$333,139,166
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	98.86%	98.12%	97.77%	98.48%	98.73%	99.50%	98.88%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,689,913	$78,938,414	$48,311,800	$103,669,153	$65,633,129	$27,643,418	$12,971	$327,898,798
Estimated Expenditures for Prior Period Dates of Service	$41,875	$1,465,565	$1,056,271	$1,511,391	$816,893	$137,526	$269	$5,029,790
Total Estimated Expenditures in FY 2016-17 Q1 and Q2	**$3,731,788**	**$80,403,979**	**$49,368,071**	**$105,180,544**	**$66,450,022**	**$27,780,944**	**$13,240**	**$332,928,588**

FY 2016-17 Q3 and Q4 Calculation

Service Expenditures	Adults 65 and Older	Disabled Individuals	Low Income Adults	MAGI Adults	Eligible Children	Foster Care	Breast and Cervical Cancer Program	Totals
Estimated Weighted Capitation Rate	$14.45	$156.08	$31.59	$66.43	$21.04	$223.19	$31.59	
Estimated Monthly Caseload [1]	44,148	89,159	286,881	295,022	570,439	21,332	43	1,307,024
Number of Months Rate is Effective	6	6	6	6	6	6	6	
Total Estimated Costs for FY 2016-17 Q3 and Q4 Capitated Payments	$3,827,632	$83,495,620	$54,375,425	$117,589,869	$72,012,219	$28,566,534	$8,150	$359,875,449
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	98.86%	98.12%	97.77%	98.48%	98.73%	99.50%	98.88%	
Estimated Expenditures for Claims Paid in Current Period with Current Period Dates of Service	$3,783,997	$81,925,902	$53,162,853	$115,802,503	$71,097,664	$28,423,701	$8,059	$354,204,679
Estimated Expenditures for Prior Period Dates of Service	$42,437	$1,499,645	$1,101,329	$1,600,093	$843,844	$138,703	$162	$5,226,213
Total Estimated Expenditures in FY 2016-17 Q3 and Q4	**$3,826,434**	**$83,425,547**	**$54,264,182**	**$117,402,596**	**$71,941,508**	**$28,562,404**	**$8,221**	**$359,430,892**
Total Estimated FY 2016-17 Expenditures	**$7,558,222**	**$163,829,526**	**$103,632,253**	**$222,583,140**	**$138,391,530**	**$56,343,348**	**$21,461**	**$692,359,480**
Estimated Date of Death Retractions	($80,959)	($328,322)	($10,591)	($37,796)	($4,193)	($6,602)	($703)	($469,166)
Total Estimated FY 2016-17 Expenditures Including Date of Death Retractions	**$7,477,263**	**$163,501,204**	**$103,621,662**	**$222,545,344**	**$138,387,337**	**$56,336,746**	**$20,758**	**$691,890,314**
Estimated FY 2016-17 Monthly Caseload	44,025	88,131	280,931	286,845	559,602	21,204	59	1,280,797
Estimated FY 2016-17 Per Capita Expenditure	**$169.84**	**$1,855.21**	**$368.85**	**$775.84**	**$247.30**	**$2,656.89**	**$351.83**	**$540.20**

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

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

Exhibit EE - Incurred But Not Reported Runout by Fiscal Period

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

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	0.15%	0.04%	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	0.99%	0.11%	0.04%	-	-	-
Incurred in FY 2014-15 Q1 and Q2	98.86%	0.99%	0.11%	0.04%	-	-
Incurred in FY 2014-15 Q3 and Q4	-	98.86%	0.99%	0.11%	0.04%	-
Incurred in FY 2015-16 Q1 and Q2	-	-	98.86%	0.99%	0.11%	0.04%
Incurred in FY 2015-16 Q3 and Q4	-	-	-	98.86%	0.99%	0.11%
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	98.86%	0.99%
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	98.86%

Incurred But Not Reported (IBNR) Estimate for Disabled Individuals

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	0.58%	0.18%	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	1.30%	0.40%	0.18%	-	-	-
Incurred in FY 2014-15 Q1 and Q2	98.12%	1.30%	0.40%	0.18%	-	-
Incurred in FY 2014-15 Q3 and Q4	-	98.12%	1.30%	0.40%	0.18%	-
Incurred in FY 2015-16 Q1 and Q2	-	-	98.12%	1.30%	0.40%	0.18%
Incurred in FY 2015-16 Q3 and Q4	-	-	-	98.12%	1.30%	0.40%
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	98.12%	1.30%
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	98.12%

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

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	0.03%	-	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	2.20%	0.03%	-	-	-	-
Incurred in FY 2014-15 Q1 and Q2	97.77%	2.20%	0.03%	-	-	-
Incurred in FY 2014-15 Q3 and Q4	-	97.77%	2.20%	0.03%	-	-
Incurred in FY 2015-16 Q1 and Q2	-	-	97.77%	2.20%	0.03%	-
Incurred in FY 2015-16 Q3 and Q4	-	-	-	97.77%	2.20%	0.03%
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	97.77%	2.20%
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	97.77%

Incurred But Not Reported (IBNR) Estimate for MAGI Adults

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	0.00%	-	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	1.52%	0.00%	-	-	-	-
Incurred in FY 2014-15 Q1 and Q2	98.48%	1.52%	0.00%	-	-	-
Incurred in FY 2014-15 Q3 and Q4	-	98.48%	1.52%	0.00%	-	-
Incurred in FY 2015-16 Q1 and Q2	-	-	98.48%	1.52%	0.00%	-
Incurred in FY 2015-16 Q3 and Q4	-	-	-	98.48%	1.52%	0.00%
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	98.48%	1.52%
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	98.48%

Exhibit EE - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Eligible Children

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	0.02%	-	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	1.25%	0.02%	-	-	-	-
Incurred in FY 2014-15 Q1 and Q2	98.73%	1.25%	0.02%	-	-	-
Incurred in FY 2014-15 Q3 and Q4	-	98.73%	1.25%	0.02%	-	-
Incurred in FY 2015-16 Q1 and Q2	-	-	98.73%	1.25%	0.02%	-
Incurred in FY 2015-16 Q3 and Q4	-	-	-	98.73%	1.25%	0.02%
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	98.73%	1.25%
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	98.73%

Incurred But Not Reported (IBNR) Estimate for Foster Care

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	0.06%	0.02%	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	0.44%	0.04%	0.02%	-	-	-
Incurred in FY 2014-15 Q1 and Q2	99.50%	0.44%	0.04%	0.02%	-	-
Incurred in FY 2014-15 Q3 and Q4	-	99.50%	0.44%	0.04%	0.02%	-
Incurred in FY 2015-16 Q1 and Q2	-	-	99.50%	0.44%	0.04%	0.02%
Incurred in FY 2015-16 Q3 and Q4	-	-	-	99.50%	0.44%	0.04%
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	99.50%	0.44%
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	99.50%

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

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	0.11%	0.04%	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	1.01%	0.07%	0.04%	-	-	-
Incurred in FY 2014-15 Q1 and Q2	98.88%	1.01%	0.07%	0.04%	-	-
Incurred in FY 2014-15 Q3 and Q4	-	98.88%	1.01%	0.07%	0.04%	-
Incurred in FY 2015-16 Q1 and Q2	-	-	98.88%	1.01%	0.07%	0.04%
Incurred in FY 2015-16 Q3 and Q4	-	-	-	98.88%	1.01%	0.07%
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	98.88%	1.01%
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	98.88%

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

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

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	$3,621	$1,297	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	$32,784	$3,643	$1,325	-	-	-
Incurred in FY 2014-15 Q1 and Q2	$3,430,777	$34,356	$3,817	$1,388	-	-
Incurred in FY 2014-15 Q3 and Q4	-	$3,458,791	$34,637	$3,849	$1,399	-
Incurred in FY 2015-16 Q1 and Q2	-	-	$3,516,485	$35,215	$3,913	$1,423
Incurred in FY 2015-16 Q3 and Q4	-	-	-	$3,651,082	$36,563	$4,063
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	$3,689,913	$36,951
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	$3,783,997
Total Paid in Current Period	$3,430,777	$3,458,791	$3,516,485	$3,651,082	$3,689,913	$3,783,997
Total IBNR Amount	$36,405	$39,296	$39,779	$40,452	$41,875	$42,437
Total Paid for All Incurred Dates	$3,467,182	$3,498,087	$3,556,264	$3,691,534	$3,731,788	$3,826,434

Incurred But Not Reported (IBNR) Estimate for Disabled Individuals

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	$253,980	$111,576	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	$836,459	$257,372	$115,817	-	-	-
Incurred in FY 2014-15 Q1 and Q2	$70,103,326	$928,805	$285,786	$128,604	-	-
Incurred in FY 2014-15 Q3 and Q4	-	$72,374,264	$958,893	$295,044	$132,770	-
Incurred in FY 2015-16 Q1 and Q2	-	-	$75,312,527	$997,822	$307,022	$138,160
Incurred in FY 2015-16 Q3 and Q4	-	-	-	$77,422,216	$1,025,773	$315,623
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	$78,938,414	$1,045,862
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	$81,925,902
Total Paid in Current Period	$70,103,326	$72,374,264	$75,312,527	$77,422,216	$78,938,414	$81,925,902
Total IBNR Amount	$1,090,439	$1,297,753	$1,360,496	$1,421,470	$1,465,565	$1,499,645
Total Paid for All Incurred Dates	$71,193,765	$73,672,017	$76,673,023	$78,843,686	$80,403,979	$83,425,547

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

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	$6,534	-	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	$485,906	$6,626	-	-	-	-
Incurred in FY 2014-15 Q1 and Q2	$37,434,577	$842,345	$11,487	-	-	-
Incurred in FY 2014-15 Q3 and Q4	-	$39,320,436	$884,780	$12,065	-	-
Incurred in FY 2015-16 Q1 and Q2	-	-	$42,240,171	$950,479	$12,961	-
Incurred in FY 2015-16 Q3 and Q4	-	-	-	$46,365,652	$1,043,310	$14,227
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	$48,311,800	$1,087,102
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	$53,162,853
Total Paid in Current Period	$37,434,577	$39,320,436	$42,240,171	$46,365,652	$48,311,800	$53,162,853
Total IBNR Amount	$492,440	$848,971	$896,267	$962,544	$1,056,271	$1,101,329
Total Paid for All Incurred Dates	$37,927,017	$40,169,407	$43,136,438	$47,328,196	$49,368,071	$54,264,182

Incurred But Not Reported (IBNR) Estimate for MAGI Adults

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	-	-	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	$99,452	-	-	-	-	-
Incurred in FY 2014-15 Q1 and Q2	$72,883,305	$1,124,925	-	-	-	-
Incurred in FY 2014-15 Q3 and Q4	-	$80,469,947	$1,242,022	-	-	-
Incurred in FY 2015-16 Q1 and Q2	-	-	$87,660,787	$1,353,010	-	-
Incurred in FY 2015-16 Q3 and Q4	-	-	-	$97,922,218	$1,511,391	-
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	$103,669,153	$1,600,093
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	$115,802,503
Total Paid in Current Period	$72,883,305	$80,469,947	$87,660,787	$97,922,218	$103,669,153	$115,802,503
Total IBNR Amount	$99,452	$1,124,925	$1,242,022	$1,353,010	$1,511,391	$1,600,093
Total Paid for All Incurred Dates	$72,982,757	$81,594,872	$88,902,809	$99,275,228	$105,180,544	$117,402,596

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Eligible Children

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	$7,915	-	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	$506,674	$8,107	-	-	-	-
Incurred in FY 2014-15 Q1 and Q2	$53,887,958	$682,264	$10,916	-	-	-
Incurred in FY 2014-15 Q3 and Q4	-	$56,495,581	$715,279	$11,444	-	-
Incurred in FY 2015-16 Q1 and Q2	-	-	$59,604,312	$754,638	$12,074	-
Incurred in FY 2015-16 Q3 and Q4	-	-	-	$63,567,851	$804,819	$12,877
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	$65,633,129	$830,967
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	$71,097,664
Total Paid in Current Period	$53,887,958	$56,495,581	$59,604,312	$63,567,851	$65,633,129	$71,097,664
Total IBNR Amount	$514,589	$690,371	$726,195	$766,082	$816,893	$843,844
Total Paid for All Incurred Dates	$54,402,547	$57,185,952	$60,330,507	$64,333,933	$66,450,022	$71,941,508

Exhibit EE - Incurred But Not Reported Expenditures by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Foster Care

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	$7,362	$3,659	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	$80,475	$7,316	$3,658	-	-	-
Incurred in FY 2014-15 Q1 and Q2	$25,998,471	$114,968	$10,452	$5,226	-	-
Incurred in FY 2014-15 Q3 and Q4	-	$26,407,776	$116,778	$10,616	$5,308	-
Incurred in FY 2015-16 Q1 and Q2	-	-	$27,006,521	$119,426	$10,857	$5,428
Incurred in FY 2015-16 Q3 and Q4	-	-	-	$27,444,044	$121,361	$11,033
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	$27,643,418	$122,242
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	$28,423,701
Total Paid in Current Period	$25,998,471	$26,407,776	$27,006,521	$27,444,044	$27,643,418	$28,423,701
Total IBNR Amount	$87,837	$125,943	$130,888	$135,268	$137,526	$138,703
Total Paid for All Incurred Dates	$26,086,308	$26,533,719	$27,137,409	$27,579,312	$27,780,944	$28,562,404

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

	Paid in FY 2014-15 Q1 and Q2	Paid in FY 2014-15 Q3 and Q4	Paid in FY 2015-16 Q1 and Q2	Paid in FY 2015-16 Q3 and Q4	Paid in FY 2016-17 Q1 and Q2	Paid in FY 2016-17 Q3 and Q4
Incurred in all other previous periods	$57	$32	-	-	-	-
Incurred in FY 2013-14 Q3 and Q4	$858	$59	$34	-	-	-
Incurred in FY 2014-15 Q1 and Q2	$67,602	$691	$48	$27	-	-
Incurred in FY 2014-15 Q3 and Q4	-	$52,707	$538	$37	$21	-
Incurred in FY 2015-16 Q1 and Q2	-	-	$35,864	$223	$25	$15
Incurred in FY 2015-16 Q3 and Q4	-	-	-	$12,971	$223	$15
Incurred in FY 2016-17 Q1 and Q2	-	-	-	-	$12,971	$132
Incurred in FY 2016-17 Q3 and Q4	-	-	-	-	-	$8,059
Total Paid in Current Period	$67,602	$52,707	$35,864	$12,971	$12,971	$8,059
Total IBNR Amount	$915	$782	$620	$287	$269	$162
Total Paid for All Incurred Dates	$68,517	$53,489	$36,484	$13,258	$13,240	$8,221

Exhibit FF - Medicaid Mental Health Retroactivity Adjustment

Fiscal Year		Adults 65 and Older	Disabled Individuals	Low Income Adults [1]	MAGI Adults	Eligible Children	Foster Care
FY 2007-08	Average Monthly Claims	36,907	61,336	69,407	-	225,162	17,810
	Average Caseload	36,284	56,079	59,761	-	204,022	17,141
	Claims as a Percentage of Caseload	101.72%	109.37%	116.14%	-	110.36%	103.90%
FY 2008-09	Average Monthly Claims	37,865	62,496	77,211	-	251,445	18,597
	Average Caseload	37,619	57,802	68,850	-	235,129	18,033
	Claims as a Percentage of Caseload	100.65%	108.12%	112.14%	-	106.94%	103.13%
FY 2009-10	Average Monthly Claims	38,645	65,337	94,478	-	290,971	18,842
	Average Caseload	38,487	60,313	85,907	-	275,672	18,381
	Claims as a Percentage of Caseload	100.41%	108.33%	109.98%	-	105.55%	102.51%
FY 2010-11	Average Monthly Claims	38,337	68,739	127,056	-	323,244	18,792
	Average Caseload	38,879	64,052	116,149	-	302,410	18,393
	Claims as a Percentage of Caseload	98.61%	107.32%	109.39%	-	106.89%	102.17%
FY 2011-12	Average Monthly Claims	39,691	72,084	145,631	6,856	351,100	18,402
	Average Caseload	39,740	67,869	136,315	6,810	334,633	18,034
	Claims as a Percentage of Caseload	99.88%	106.21%	106.83%	100.68%	104.92%	102.04%
FY 2012-13	Estimated Average Monthly Claims	40,123	74,703	159,244	10,729	380,186	18,072
	Average Caseload	40,827	71,859	149,305	10,634	368,079	17,777
	Claims as a Percentage of Caseload	98.27%	103.96%	106.66%	100.89%	103.29%	101.66%
FY 2013-14	Estimated Average Monthly Claims	40,510	77,092	190,987	86,998	428,271	18,577
	Average Caseload	41,836	76,837	185,979	87,243	424,377	18,267
	Claims as a Percentage of Caseload	96.83%	100.33%	102.69%	99.72%	100.92%	101.70%
Weighted Average Claims as a Percentage of Caseload [2]		97.89%	101.80%	106.44%	104.74%	102.00%	101.22%
Retroactivity Adjustment Factor		-2.11%	1.80%	6.44%	4.74%	2.00%	1.22%

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

[2] The retroactivity adjustment captures the difference in total claims paid versus caseload due to retroactive eligibility. Beginning January 1, 2014, the Department has implemented a 3-month retroactivity policy at the guidance of CMS. Therefore, in order to get an accurate factor moving forward, the Department analyzed FY 2013-14 Q3 to assess current retroactivity due to the policy change.

Exhibit FF - Medicaid Mental Health Partial Month Adjustment Multiplier

Fiscal Year		Adults 65 and Older	Disabled Individuals	Low Income Adults [1]	MAGI Adults [4]	Eligible Children	Foster Care
FY 2007-08	Weighted Claims-Based Rate	$13.07	$113.61	$17.48	-	$13.87	$260.01
	Weighted Capitation Rate	$13.15	$114.07	$17.51	-	$13.94	$262.46
	Claims as a Percentage of Capitation	99.36%	99.60%	99.84%	-	99.49%	99.07%
FY 2008-09	Weighted Claims-Based Rate	$13.49	$122.69	$18.40	-	$14.47	$253.56
	Weighted Capitation Rate [2]	$13.57	$123.19	$18.47	-	$14.57	$255.41
	Claims as a Percentage of Capitation	99.42%	99.59%	99.62%	-	99.34%	99.27%
FY 2009-10	Weighted Claims-Based Rate	$13.21	$127.20	$18.74	-	$14.21	$225.86
	Weighted Capitation Rate [2]	$13.29	$127.70	$18.82	-	$14.29	$227.45
	Claims as a Percentage of Capitation	99.40%	99.61%	99.56%	-	99.44%	99.30%
FY 2010-11	Weighted Claims-Based Rate	$13.50	$136.46	$20.56	-	$15.11	$191.24
	Weighted Capitation Rate [2]	$13.58	$137.00	$20.64	-	$15.19	$192.53
	Claims as a Percentage of Capitation	99.39%	99.61%	99.63%	-	99.45%	99.33%
FY 2011-12	Weighted Claims-Based Rate	$13.69	$139.19	$21.46	$100.82	$16.12	$176.56
	Weighted Capitation Rate	$13.77	$139.69	$21.49	$100.83	$16.20	$177.70
	Claims as a Percentage of Capitation	99.42%	99.64%	99.84%	100.00%	99.53%	99.36%
FY 2012-13	Weighted Claims-Based Rate	$13.57	$139.85	$21.86	$100.67	$16.70	$171.02
	Weighted Capitation Rate	$13.65	$140.33	$21.90	$100.97	$16.76	$171.84
	Claims as a Percentage of Capitation	99.40%	99.66%	99.84%	99.70%	99.65%	99.52%
FY 2013-14	Weighted Claims-Based Rate	$13.90	$144.73	$22.64	$88.74	$17.18	$174.20
	Weighted Capitation Rate	$13.96	$144.99	$24.07	$79.38	$17.22	$174.80
	Claims as a Percentage of Capitation	99.56%	99.82%	94.07%	111.80%	99.79%	99.66%
Average Claims as a Percentage of Capitation [3]		99.40%	99.66%	99.84%	99.84%	99.65%	99.52%
Partial Month Adjustment Multiplier		-0.60%	-0.34%	-0.16%	-0.16%	-0.35%	-0.48%

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

[2] The Department has adjusted the rates paid to the BHOs in FY 2008-09 through FY 2010-11 due to budget actions. The numbers provided, here, reflects the actual paid rates and therefore do not match the numbers in Exhibit GG, which demonstrate the trend on the actuarial point estimates.

[3] The partial month adjustment captures the difference in the amount paid per claim versus the capitation rate due to paying an adjusted rate for clients enrolled for only part of a month. After analyzing the data and historical trends, the Department determined that the most recent year with adequate runout, which in this request is FY 2012-13, most accurately represents the relationship between the claims-based rate and the capitation rate for all eligibility categories.

[4] The partial month adjustment factor for MAGI Adults cannot be calculated in the same manner as the other categories because it does not have adequate runout. Therefore the Department has selected the Low Income Adults retroactivity adjustment factor for the MAGI Adults factor because both eligibilities are determined strictly on level of income.

Exhibit GG - Medicaid Behavioral Health Capitation Rate Trends and Forecasts

Capitation Rate Trends

Fiscal Year	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults [1]	MAGI Adults	Eligible Children	Foster Care	Weighted Mental Health Total [2]
FY 2007-08 Actuals	**$13.15**	**$114.07**	**$17.51**	**$0.00**	**$13.94**	**$262.46**	**$40.88**
FY 2008-09 Actuals [3]	**$13.37**	**$121.31**	**$18.18**	**$0.00**	**$14.34**	**$251.88**	**$39.96**
% Change from FY 2007-08	1.67%	6.35%	3.83%	-	2.87%	-4.03%	-2.25%
FY 2009-10 Actuals [3]	**$13.40**	**$131.64**	**$19.33**	**$0.00**	**$14.71**	**$220.67**	**$38.08**
% Change from FY 2008-09	0.22%	8.52%	6.33%	-	2.58%	-12.39%	-4.72%
FY 2010-11 Actuals [3]	**$13.79**	**$139.14**	**$20.94**	**$0.00**	**$15.41**	**$195.38**	**$37.29**
% Change from FY 2009-10	2.91%	5.70%	8.33%	-	4.76%	-11.46%	-2.06%
FY 2011-12 Actuals	**$13.89**	**$140.82**	**$21.69**	**$100.85**	**$16.33**	**$179.30**	**$36.60**
% Change from FY 2010-11	0.73%	1.21%	3.58%	-	5.97%	-8.23%	-1.85%
FY 2012-13 Actuals	**$13.66**	**$140.28**	**$21.89**	**$100.98**	**$16.75**	**$171.85**	**$36.74**
% Change from FY 2011-12	-1.66%	-0.38%	0.92%	0.13%	2.57%	-4.16%	0.38%
FY 2013-14 Actuals	**$13.96**	**$144.99**	**$24.07**	**$79.38**	**$17.21**	**$176.86**	**$40.34**
% Change from FY 2012-13	2.20%	3.36%	9.96%	-21.39%	2.75%	2.92%	9.78%
FY 2014-15 Q1 and Q2 Known Rate	$14.23	$146.92	$25.96	$55.45	$18.65	$211.36	$40.73
% Change from FY 2013-14	1.93%	1.33%	7.85%	-30.15%	8.37%	19.51%	0.97%
FY 2014-15 Q3 and Q4 Known Rate	$14.23	$146.92	$25.96	$55.45	$18.65	$211.36	$40.67
% Change from FY 2014-15 Q1 and Q2	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.15%
% Change from FY 2013-14	1.93%	1.33%	7.85%	-30.15%	8.37%	19.51%	0.82%
FY 2014-15 Estimated Weighted Average Rate [4]	**$14.23**	**$146.92**	**$25.96**	**$55.45**	**$18.65**	**$211.36**	**$40.70**
% Change from FY 2013-14	1.93%	1.33%	7.85%	-30.15%	8.37%	19.51%	0.90%
FY 2015-16 Q1 and Q2 Estimated Rate	$14.28	$149.66	$26.71	$57.06	$19.05	$214.70	$40.73
% Change from FY 2014-15 Q3 and Q4 Rate	0.35%	1.86%	2.89%	2.90%	2.14%	1.58%	0.15%
% Change from FY 2014-15 Average Rate	0.35%	1.86%	2.89%	2.90%	2.14%	1.58%	0.07%
FY 2015-16 Q3 and Q4 Estimated Rate	$14.56	$151.74	$28.18	$60.20	$19.86	$218.10	$40.67
% Change from FY 2015-16 Q1 and Q2 Rate	1.96%	1.39%	5.50%	5.50%	4.25%	1.58%	-0.15%
% Change from FY 2014-15 Average Rate	2.32%	3.28%	8.55%	8.57%	6.49%	3.19%	-0.08%
FY 2015-16 Estimated Weighted Average Rate [4]	**$14.42**	**$150.71**	**$27.46**	**$58.67**	**$19.46**	**$216.40**	**$40.70**
% Change from FY 2014-15 Average Rate	1.34%	2.58%	5.78%	5.81%	4.34%	2.38%	0.00%
FY 2016-17 Q1 and Q2 Estimated Rate	$14.56	$151.74	$28.18	$60.20	$19.86	$218.10	$41.52
% Change from FY 2015-16 Q3 and Q4 Rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.10%
% Change from FY 2015-16 Average Rate	0.97%	0.68%	2.62%	2.61%	2.06%	0.79%	2.02%
FY 2016-17 Q3 and Q4 Estimated Rate	$14.85	$153.85	$29.73	$63.52	$20.70	$221.55	$43.02
% Change from FY 2016-17 Q1 and Q2 Rate	1.99%	1.39%	5.50%	5.51%	4.23%	1.58%	3.62%
% Change from FY 2015-16 Average Rate	2.98%	2.08%	8.27%	8.27%	6.37%	2.38%	5.71%
FY 2016-17 Estimated Weighted Average Rate [4]	**$14.71**	**$152.81**	**$28.97**	**$61.91**	**$20.29**	**$219.84**	**$42.28**
% Change from FY 2015-16 Average Rate	2.01%	1.39%	5.50%	5.52%	4.27%	1.59%	3.88%

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

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

[3] The Department has adjusted the rates paid to the BHOs in FY 2008-09 through FY 2010-11 due to budget actions. The numbers provided, here, reflects the actuarial point estimates prior to budget actions and therefore do not match the numbers in Exhibit FF, which demonstrate the actual paid rates to the BHOs.

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

Exhibit GG - Medicaid Mental Health Capitation Rate Trends and Forecasts							
Capitation Rate Across Eligibility Categories							
Fiscal Year	**Adults 65 and Older**	**Disabled Individuals**	**Low Income Adults**	**MAGI Adults**	**Eligible Children**	**Foster Care**	**Total**
FY 2007-08 Caseload	36,284	56,079	59,761		204,022	17,141	373,287
Percentage of Total Caseload	9.72%	15.02%	16.01%		54.66%	4.59%	100.00%
FY 2007-08 Weighted Capitation Rate	$13.15	$114.07	$17.51		$13.94	$262.46	$40.88
FY 2008-09 Caseload	37,619	57,802	68,850		235,129	18,033	417433
Percentage of Total Caseload	9.01%	13.85%	16.49%		56.33%	4.32%	100.00%
FY 2008-09 Weighted Capitation Rate	$13.37	$121.31	$18.18		$14.34	$251.88	$39.96
FY 2009-10 Average Caseload	38,487	60,313	85,907		275,672	18,381	478760
Percentage of Total Caseload	8.04%	12.60%	17.94%		57.58%	3.84%	100.00%
FY 2009-10 Average Weighted Capitation Rate	$13.40	$131.64	$19.33		$14.71	$220.67	$38.08
FY 2010-11 Average Caseload	38,879	64,052	116,149		302,410	18,393	539883
Percentage of Total Caseload	7.20%	11.86%	21.51%		56.01%	3.41%	100.00%
FY 2010-11 Average Weighted Capitation Rate	$13.79	$139.14	$20.94		$15.41	$195.38	$37.29
FY 2011-12 Average Caseload	39,740	67,869	136,315	1,134	334,633	18,034	597725
Percentage of Total Caseload	6.65%	11.35%	22.81%	0.19%	55.98%	3.02%	100.00%
FY 2011-12 Average Weighted Capitation Rate	$13.89	$140.82	$21.69	$100.85	$16.33	$179.30	$36.60
FY 12-13 Average Caseload	40,827	71,859	149,305	10,634	368,079	17,777	658,481
Percentage of Total Caseload	6.20%	10.91%	22.67%	1.61%	55.90%	2.70%	100.00%
FY 2012-13 Average Weighted Capitation	$13.66	$140.28	$21.89	$100.98	$16.75	$171.85	$36.74
FY 2013-14 Average Caseload	41,836	76,837	185,979	87,243	424,377	18,267	834,539
Percentage of Total Caseload	5.01%	9.21%	22.29%	10.45%	50.85%	2.19%	100.00%
FY 2013-14 Average Weighted Capitation	$13.96	$144.99	$24.07	$79.38	$17.21	$176.86	$40.34
FY 2014-15 Average Estimated Caseload	41,932	81,186	237,121	223,775	491,401	20,614	1,096,029
Percentage of Total Caseload	3.83%	7.41%	21.63%	20.42%	44.83%	1.88%	100.00%
FY 2014-15 Average Weighted Capitation	$14.23	$146.92	$25.96	$55.45	$18.65	$211.36	$40.70
FY 2014-15 Q1 and Q2 Estimated Caseload	41,761	79,891	231,294	212,704	479,792	20,453	1,065,895
Percentage of Caseload	3.92%	7.50%	21.70%	19.96%	45.01%	1.92%	100.00%
FY 2014-15 Q1 and Q2 Weighted Capitation Rate	$14.23	$146.92	$25.96	$55.45	$18.65	$211.36	$40.73
FY 2014-15 Q3 and Q4 Estimated Caseload	42,102	82,479	242,946	234,845	503,009	20,775	1,126,156
Percentage of Caseload	3.74%	7.32%	21.57%	20.85%	44.67%	1.84%	100.00%
FY 2014-15 Q3 and Q4 Weighted Capitation Rate	$14.23	$146.92	$25.96	$55.45	$18.65	$211.36	$40.67
FY 2015-16 Average Estimated Caseload	43,060	84,843	258,812	255,924	525,610	20,920	1,189,169
Percentage of Total Caseload	3.62%	7.13%	21.76%	21.52%	44.20%	1.76%	100.00%
FY 2015-16 Average Weighted Capitation	$14.42	$150.71	$27.46	$58.67	$19.46	$216.40	$42.28
FY 2015-16 Q1 and Q2 Estimated Caseload	42,681	84,256	253,721	248,628	519,723	20,915	1,169,924
Percentage of Caseload	3.65%	7.20%	21.69%	21.25%	44.42%	1.79%	100.00%
FY 2015-16 Q1 and Q2 Weighted Capitation Rate	$14.28	$149.66	$26.71	$57.06	$19.05	$214.70	$41.52
FY 2015-16 Q3 and Q4 Estimated Caseload	43,439	85,429	263,902	263,219	531,497	20,923	1,208,409
Percentage of Caseload	3.59%	7.07%	21.84%	21.78%	43.98%	1.73%	100.00%
FY 2015-16 Q3 and Q4 Weighted Capitation Rate	$14.56	$151.74	$28.18	$60.20	$19.86	$218.10	$43.02
FY 2016-17 Average Estimated Caseload	44,025	88,131	280,931	286,845	559,602	21,204	1,280,738
Percentage of Total Caseload	3.44%	6.88%	21.94%	22.40%	43.69%	1.66%	100.00%
FY 2016-17 Average Weighted Capitation	$14.71	$152.81	$28.97	$61.91	$20.29	$219.84	$43.76
FY 2016-17 Q1 and Q2 Estimated Caseload	43,901	87,102	274,979	278,667	548,765	21,075	1,254,489
Percentage of Caseload	3.50%	6.94%	21.92%	22.21%	43.74%	1.68%	100.00%
FY 2016-17 Q1 and Q2 Weighted Capitation Rate	$14.56	$151.74	$28.18	$60.20	$19.86	$218.10	$42.94
FY 2016-17 Q3 and Q4 Estimated Caseload	44,148	89,159	286,881	295,022	570,439	21,332	1,306,981
Percentage of Caseload	3.38%	6.82%	21.95%	22.57%	43.65%	1.63%	100.00%
FY 2016-17 Q3 and Q4 Weighted Capitation Rate	$14.85	$153.85	$29.73	$63.52	$20.70	$221.55	$44.50

Exhibit HH - Forecast Model Comparisons - Final Forecasts Adjustment Factors for Forecasted Rates						
Model	**Adults 65 and Older (OAP-A)**	**Disabled Individuals**	**Low Income Adults [1]**	**MAGI Adults**	**Eligible Children**	**Foster Care**
FY 2014-15 Q1/Q2 Rate						
Weighted Capitation Point Estimate	**$14.23**	**$146.92**	**$25.96**	**$55.45**	**$18.65**	**$211.36**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.11%	1.80%	6.44%	4.74%	2.00%	1.22%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.60%	-0.34%	-0.16%	-0.16%	-0.35%	-0.48%
Final Adjustment Factor [3]	**-2.70%**	**1.45%**	**6.27%**	**4.58%**	**1.65%**	**0.74%**
FY 2014-15 Final Estimated Paid Q1/Q2 Rate [2]	**$13.85**	**$149.05**	**$27.59**	**$57.99**	**$18.96**	**$212.92**
FY 2014-15 Q3/Q4 Rate						
Weighted Capitation Point Estimate	**$14.23**	**$146.92**	**$25.96**	**$55.45**	**$18.65**	**$211.36**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.11%	1.80%	6.44%	4.74%	2.00%	1.22%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.60%	-0.34%	-0.16%	-0.16%	-0.35%	-0.48%
Final Adjustment Factor [3]	**-2.70%**	**1.45%**	**6.27%**	**4.58%**	**1.65%**	**0.74%**
FY 2014-15 Final Estimated Q3/Q4 Rate	**$13.85**	**$149.05**	**$27.59**	**$57.99**	**$18.96**	**$212.92**
FY 2015-16 Estimated Q1/Q2 Rate						
Weighted Capitation Point Estimate	**$14.28**	**$149.66**	**$26.71**	**$57.06**	**$19.05**	**$214.70**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.11%	1.80%	6.44%	4.74%	2.00%	1.22%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.60%	-0.34%	-0.16%	-0.16%	-0.35%	-0.48%
Final Adjustment Factor [3]	**-2.70%**	**1.45%**	**6.27%**	**4.58%**	**1.65%**	**0.74%**
FY 2015-16 Final Estimated Q1/Q2 Rate	**$13.89**	**$151.83**	**$28.38**	**$59.67**	**$19.36**	**$216.29**
FY 2015-16 Estimated Q3/Q4 Rate						
Weighted Capitation Point Estimate	**$14.56**	**$151.74**	**$28.18**	**$60.20**	**$19.86**	**$218.10**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.11%	1.80%	6.44%	4.74%	2.00%	1.22%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.60%	-0.34%	-0.16%	-0.16%	-0.35%	-0.48%
Final Adjustment Factor [3]	**-2.70%**	**1.45%**	**6.27%**	**4.58%**	**1.65%**	**0.74%**
FY 2015-16 Final Estimated Q3/Q4 Rate	**$14.17**	**$153.94**	**$29.95**	**$62.96**	**$20.19**	**$219.71**

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

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

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

Exhibit HH - Forecast Model Comparisons - Final Forecasts						
Adjustment Factors for Forecasted Rates						
Model	**Adults 65 and Older (OAP-A)**	**Disabled Individuals**	**Low Income Adults [1]**	**MAGI Adults**	**Eligible Children**	**Foster Care**
FY 2016-17 Estimated Q1/Q2 Rate [3]						
Weighted Capitation Point Estimate	**$14.56**	**$151.74**	**$28.18**	**$60.20**	**$19.86**	**$218.10**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.11%	1.80%	6.44%	4.74%	2.00%	1.22%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.60%	-0.34%	-0.16%	-0.16%	-0.35%	-0.48%
Final Adjustment Factor [2]	**-2.70%**	**1.45%**	**6.27%**	**4.58%**	**1.65%**	**0.74%**
FY 2016-17 Final Estimated Q1/Q2 Rate	**$14.17**	**$153.94**	**$29.95**	**$62.96**	**$20.19**	**$219.71**
FY 2016-17 Estimated Q3/Q4 Rate						
Weighted Capitation Point Estimate	**$14.85**	**$153.85**	**$29.73**	**$63.52**	**$20.70**	**$221.55**
Retroactivity Adjustment Multiplier (Exhibit FF)	-2.11%	1.80%	6.44%	4.74%	2.00%	1.22%
Partial Month Adjustment Multiplier (Exhibit FF)	-0.60%	-0.34%	-0.16%	-0.16%	-0.35%	-0.48%
Final Adjustment Factor [2]	**-2.70%**	**1.45%**	**6.27%**	**4.58%**	**1.65%**	**0.74%**
FY 2016-17 Final Estimated Q3/Q4 Rate	**$14.45**	**$156.08**	**$31.59**	**$66.43**	**$21.04**	**$223.19**

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

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

[3] The rate set for Q3 and Q4 of FY 2014-15 will be the same rate in effect for Q1 and Q2 of FY 2015-16.

Exhibit HH - Forecast Model Comparisons - Capitation Trend Models

Capitation Rate Forecast Model for FY 2014-15 Q3 and Q4

Model	Adults 65 and Older (OAP-A)	Disabled Individuals	Low Income Adults [1]	MAGI Adults	Eligible Children	Foster Care [2]
FY 2013-14 Actual Rate	$13.96	$144.99	$24.07	$79.38	$17.21	$176.86
FY 2014-15 Q1 and Q2 Weighted Average Rate	$14.23	$146.92	$25.96	$55.45	$18.65	$211.36
FY 2014-15 Q3 and Q4 Weighted Average Rate	$14.23	$146.92	$25.96	$55.45	$18.65	$211.36
FY 2014-15 Full Year Average Rate	$14.23	$146.92	$25.96	$55.45	$18.65	$211.36
FY 2015-16 Q1 and Q2 Weighted Average Rate	$14.28	$149.66	$26.71	$57.06	$19.05	$214.70
Recent Growth Rates						
% Growth from FY 2013-14 to FY 2014-15 Rate	1.93%	1.33%	7.85%	-30.15%	8.37%	19.51%
% Growth from CY 2014 to CY 2015 Rate	0.35%	1.86%	2.89%	2.90%	2.14%	1.58%
Selected Trend Models						
Average Growth Model	$14.38	$155.12	$28.23	$41.81	$19.84	$203.30
% Difference from FY 2015-16 Q1 and Q2 Rate	0.72%	3.65%	5.67%	-26.72%	4.16%	-5.31%
% Difference from FY 2014-15 Full Year Average Rate	1.07%	5.58%	8.73%	-24.59%	6.39%	-3.81%
Two Period Moving Average Model	$13.91	$142.34	$23.38	$83.74	$16.85	$179.74
% Difference from FY 2015-16 Q1 and Q2 Rate	-2.59%	-4.89%	-12.45%	46.75%	-11.52%	-16.28%
% Difference from FY 2014-15 Full Year Average Rate	-2.24%	-3.12%	-9.92%	51.02%	-9.63%	-14.96%
Exponential Growth Model	$14.32	$163.84	$27.00	$47.51	$18.98	$122.49
% Difference from FY 2015-16 Q1 and Q2 Rate	0.26%	9.48%	1.08%	-16.74%	-0.36%	-42.95%
% Difference from FY 2014-15 Full Year Average Rate	0.61%	11.52%	4.00%	-14.32%	1.78%	-42.05%
Linear Growth Model	$15.93	$188.72	$27.64	$38.58	$18.74	$130.87
% Difference from FY 2015-16 Q1 and Q2 Rate	11.56%	26.10%	3.48%	-32.39%	-1.61%	-39.04%
% Difference from FY 2014-15 Full Year Average Rate	11.95%	28.45%	6.47%	-30.42%	0.50%	-38.08%
CY 2016 Forecast Minimum	$13.91	$142.34	$23.38	$38.58	$16.85	$122.49
CY 2016 Forecast Maximum	$15.93	$188.72	$28.23	$83.74	$19.84	$203.30
% change from FY 2014-15 Rate to Selected FY 2015-16 Q1 & Q2 Capitaltion Rate [3]	0.36%	1.87%	2.90%	2.90%	2.12%	1.58%
FY 2015-16 Q1 & Q2 Forecast Point Estimate	**$14.28**	**$149.66**	**$26.71**	**$57.06**	**$19.05**	**$214.70**
% change from CY 2015 Rate to Selected CY 2016 Capitation Rate [4]	1.96%	1.39%	5.51%	5.51%	4.23%	1.58%
CY 2016 Forecast Point Estimate	**$14.56**	**$151.74**	**$28.18**	**$60.20**	**$19.86**	**$218.10**
% change from CY 2016 Rate to Selected CY 2017 Capitaltion Rate [5]	1.96%	1.39%	5.51%	5.51%	4.23%	1.58%
CY 2017 Forecast Point Estimate	**$14.85**	**$153.85**	**$29.73**	**$63.52**	**$20.70**	**$221.55**

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

[2] The rate methodology has changed beginning CY 2014 and we are using known values in the rate development. Therefore, the forecast point estimate for FY 2015-16 Q1 & Q2, CY 2016, and CY 2017 may not fit into the forecasted min and max range because the range is based on historical data and methodologies.

[3] Percentage selected to modify capitation rates for FY 2015-16 Q1 & Q2: Where applicable, percentage selections have been bolded for clarification.	Adults 65 and Older (OAP-A)	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	MAGI Adults	Due to lack of avaiable data, trend is equal to Low Income Adults
	Disabled Individuals	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Eligible Children	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.
	Low Income Adults	Trend is half of the projected percent growth for FY 2015-16 based on average annual percent growth from FY 2008-09 through FY 2014-15.	Foster Care	Trend is average growth from FY 2011-12 through the projected FY 2015-16 rate based on a linear average growth model.
[4] Percentage selected to modify capitation rates for CY 2016: Where applicable, percentage selections have been bolded for clarification.	Adults 65 and Older (OAP-A)	Trend is average annual percent growth from FY 2009-10 to FY 2011-12 and FY 2013-14.	MAGI Adults	Due to lack of avaiable data, trend is equal to Low Income Adults
	Disabled Individuals	Trend is average annual percent growth from FY 2011-12 through FY 2014-15.	Eligible Children	Trend is avearage growth in rates from FY 2008-09 through FY 2014-15
	Low Income Adults	Trend is avearage annual percent growth from FY 2008-09 through FY 2014-15	Foster Care	Trend is average growth from FY 2011-12 through the projected FY 2015-16 rate based on a linear average growth model.
[5] Percentage selected to modify capitation rates for CY 2017: Where applicable, percentage selections have been bolded for clarification.	Adults 65 and Older (OAP-A)	Trend is average annual percent growth from FY 2009-10 to FY 2011-12 and FY 2013-14.	MAGI Adults	Due to lack of avaiable data, trend is equal to Low Income Adults
	Disabled Individuals	Trend is average annual percent growth from FY 2011-12 through FY 2014-15.	Eligible Children	Trend is avearage growth in rates from FY 2008-09 through FY 2014-15
	Low Income Adults	Trend is avearage annual percent growth from FY 2008-09 through FY 2014-15	Foster Care	Trend is average growth from FY 2011-12 through the projected FY 2015-16 rate based on a linear average growth model.

Exhibit II - Reconciliations

Exhibit II - MAGI Adults Reconciliations

Total Reconciliations for MAGI Adults by Fiscal Year

	FY 2012-13 Actuals	FY 2013-14 Actuals	FY 2014-15 Estimate	FY 2015-16 Estimate	FY 2016-17 Estimate
Estimated Reconciliation for FY 2014-15 [(1)]	$0	$0	$0	$0	$0
Estimated Reconciliation for FY 2015-16	$0	$0	$0	$0	$0
Estimated Reconciliation for FY 2016-17	$0	$0	$0	$0	$0
Net Impact of Estimated Reconciliations	$0	$0	$0	$0	$0

[1] The reconciliation surrounding the MAGI Adults risk corridor from FY 2013-14 will take place in FY 2014-15. That reconciliation has not been finalized yet, but future iterations will reflrect actual reconciliation amounts. The Department will monitor the situation and reconcile as neccesary.

Reconciliation Fund Splits

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds
Estimated Reconciliation for FY 2014-15	$0	$0	$0	$0	$0
Estimated Reconciliation for FY 2015-16	$0	$0	$0	$0	$0
Estimated Reconciliation for FY 2016-17	$0	$0	$0	$0	$0

Exhibit JJ - Alternative Financing Populations [1]

FY 2014-15 Calculation

Capitations

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	4,686	$329.30	$1,543,100	$0	$759,822	$0	$783,278	50.76%
MAGI Parents and Caretakers 69% - 133% FPL	64,563	$329.30	$21,260,596	$0	$0	$0	$21,260,596	100.00%
MAGI Adults[2]	223,354	$690.56	$154,239,338	$0	$0	$0	$154,239,338	100.00%
Non Newly Eligible	421	$329.30	$138,635	$0	$68,264	$0	$70,371	50.76%
Buy-In for Disabled Individuals	3,700	$1,779.38	$6,583,706	$0	$3,241,817	$0	$3,341,889	50.76%
Total from Hospital Provider Fee Fund	-	-	**$183,765,375**	**$0**	**$4,069,903**	**$0**	**$179,695,472**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	52,304	$227.07	$11,876,669	$4,093,888	$0	$0	$7,782,781	65.53%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,767	$329.30	$581,873	$200,572	$0	$0	$381,301	65.53%

Fee-for-Service

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
Magi Parents and Caretakers 60% - 68% FPL	4,686	$9.93	$46,532	$0	$22,912	$0	$23,620	50.76%
MAGI Parents and Caretakers 69% - 133% FPL	64,563	$6.08	$392,799	$0	$0	$0	$392,799	100.00%
MAGI Adults[2]	223,354	$8.08	$1,804,595	$0	$0	$0	$1,804,595	100.00%
Non Newly Eligible	421	$30.33	$12,770	$0	$6,288	$0	$6,482	50.76%
Buy-In for Disabled Individuals	3,700	$26.43	$97,788	$0	$48,151	$0	$49,637	50.76%
Total from Hospital Provider Fee Fund	-	-	**$2,354,484**	**$0**	**$77,351**	**$0**	**$2,277,133**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	52,304	$2.01	$105,077	$36,220	$0	$0	$68,857	65.53%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,767	$2.04	$3,600	$1,241	$0	$0	$2,359	65.53%

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

Exhibit JJ - Alternative Financing Populations [1]

FY 2015-16 Calculation

Capitations

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	5,145	$349.49	$1,798,126	$0	$880,902	$0	$917,224	51.01%
MAGI Parents and Caretakers 69% - 133% FPL	70,573	$349.49	$24,664,558	$0	$0	$0	$24,664,558	100.00%
MAGI Adults	255,464	$735.12	$187,796,696	$0	$0	$0	$187,796,696	100.00%
Non Newly Eligible	460	$349.49	$160,765	$0	$78,759	$0	$82,006	51.01%
Buy-In for Disabled Individuals	4,359	$1,828.69	$7,971,260	$0	$3,905,120	$0	$4,066,140	51.01%
Total from Hospital Provider Fee Fund	-	-	**$222,391,405**	**$0**	**$4,864,781**	**$0**	**$217,526,624**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	56,726	$237.17	$13,453,705	$2,292,511	$0	$0	$11,161,194	82.96%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,971	$349.49	$688,845	$328,992	$0	$0	$359,853	52.24%

Fee-for-Service

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	5,145	$9.81	$50,476	$0	$24,728	$0	$25,748	51.01%
MAGI Parents and Caretakers 69% - 133% FPL	70,573	$6.04	$426,096	$0	$0	$0	$426,096	100.00%
MAGI Adults	255,464	$7.66	$1,957,569	$0	$0	$0	$1,957,569	100.00%
Non Newly Eligible	460	$30.33	$13,953	$0	$6,836	$0	$7,117	51.01%
Buy-In for Disabled Individuals	4,359	$24.34	$106,077	$0	$51,967	$0	$54,110	51.01%
Total from Hospital Provider Fee Fund	-	-	**$2,554,171**	**$0**	**$83,531**	**$0**	**$2,470,640**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	56,726	$2.01	$113,984	$19,423	$0	$0	$94,561	82.96%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	1,971	$1.98	$3,905	$1,865	$0	$0	$2,040	52.24%

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

Exhibit JJ - Alternative Financing Populations [1]

FY 2016-17 Calculation

Capitations

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	5,629	$368.85	$2,076,257	$0	$1,017,158	$0	$1,059,099	51.01%
MAGI Parents and Caretakers 69% - 133% FPL	76,305	$368.85	$28,145,099	$0	$0	$0	$28,145,099	100.00%
MAGI Adults	286,346	$775.84	$222,158,681	$0	$0	$0	$222,158,681	100.00%
Non Newly Eligible	499	$368.85	$184,056	$0	$90,169	$0	$93,887	51.01%
Buy-In for Disabled Individuals	4,951	$1,855.21	$9,185,145	$0	$4,499,803	$0	$4,685,342	51.01%
Total from Hospital Provider Fee Fund	**-**	**-**	**$261,749,238**	**$0**	**$5,607,130**	**$0**	**$256,142,108**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	61,422	$247.30	$15,189,661	$1,714,913	$0	$0	$13,474,748	88.71%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	2,120	$368.85	$781,962	$383,083	$0	$0	$398,879	51.01%

Fee-for-Service

DESCRIPTION OF ESTIMATE				CALCULATION OF MATCH				
Eligibility Category	**Caseload**	**Estimated Per Capita Cost**	**Total Estimate**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Hospital Provider Fee Cash Fund:								
MAGI Parents and Caretakers 60% - 68% FPL	5,629	$9.66	$54,358	$0	$26,630	$0	$27,728	51.01%
MAGI Parents and Caretakers 69% - 133% FPL	76,305	$6.01	$458,862	$0	$0	$0	$458,862	100.00%
MAGI Adults	286,346	$7.36	$2,108,104	$0	$0	$0	$2,108,104	100.00%
Non Newly Eligible	499	$30.33	$15,136	$0	$7,415	$0	$7,721	51.01%
Buy-In for Disabled Individuals	4,951	$23.07	$114,234	$0	$55,963	$0	$58,271	51.01%
Total from Hospital Provider Fee Fund	**-**	**-**	**$2,750,694**	**$0**	**$90,008**	**$0**	**$2,660,686**	
SB 11-008: Aligning Medicaid Eligibility for Children								
Former CHP+ Kids	61,422	$2.00	$122,750	$13,858	$0	$0	$108,892	88.71%
SB 11-250: Eligibility for Pregnant Women in Medicaid								
Former CHP+ Prenatal	2,120	$1.98	$4,205	$2,060	$0	$0	$2,145	51.01%

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

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

FY 2014-15 Calculation

Components	FY 2013-14 Actual	FY 2014-15 Appropriation	Estimated Change in Total Behavioral Health Caseload			FY 2014-15 Estimate [1]	FY 2014-15 Change from Appropriation
			FY 2013-14 Average Monthly Caseload	FY 2014-15 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$1,277,088	$1,713,695	835,098	1,096,397	31.29%	$1,743,174	$29,479
Outpatient Services	$3,956,128	$5,308,634	835,098	1,096,397	31.29%	$5,399,954	$91,320
Physician Services	$63,135	$84,720	835,098	1,096,397	31.29%	$86,177	$1,457
Total After Prior Year Adjustments	**$5,296,351**	$7,107,049				**$7,229,305**	**$122,256**

[1] FY 2014-15 estimates are adjusted to reflect 52 weeks and the 2.0% provider rate increase.

FY 2015-16 Calculation

Components	FY 2014-15 Estimate [2]	Estimated Change in Total Behavioral Health Caseload			FY 2015-16 Estimate	FY 2015-16 Change from FY 2014-15 Estimate
		FY 2014-15 Forecasted Average Monthly Caseload	FY 2015-16 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$1,743,174	1,096,397	1,189,338	8.48%	$1,890,942	$147,768
Outpatient Services	$5,399,954	1,096,397	1,189,338	8.48%	$5,857,705	$457,751
Physician Services	$86,177	1,096,397	1,189,338	8.48%	$93,482	$7,305
Total After Prior Year Adjustments	**$7,229,305**				**$7,842,129**	**$612,824**

[2] The FY 2014-15 estimates are the base for the FY 2015-16 estimates.

FY 2016-17 Calculation

Components	FY 2015-16 Estimate [3]	Estimated Change in Total Behavioral Health Caseload			FY 2016-17 Estimate	FY 2016-17 Change from FY 2015-16 Estimate
		FY 2015-16 Forecasted Average Monthly Caseload	FY 2016-17 Forecasted Average Monthly Caseload	Forecasted Change in Caseload		
Inpatient Services	$1,890,942	1,189,338	1,280,797	7.69%	$2,036,354	$145,412
Outpatient Services	$5,857,705	1,189,338	1,280,797	7.69%	$6,308,157	$450,452
Physician Services	$93,482	1,189,338	1,280,797	7.69%	$100,671	$7,189
Total After Prior Year Adjustments	**$7,842,129**				**$8,445,182**	**$603,053**

[3] The FY 2015-16 estimates are the base for the FY 2016-17 estimates.

Exhibit LL - Global Reasonableness Test for Medicaid Behavioral Health Capitation Payments [1]							
	Actual/Estimated Expenditures	**Percent Change**	**Dollar Change**	**Two-year Rolling Average**	**Percent Change Two-year Average**	**Three-year Rolling Average**	**Percent Change Three-year Average**
FY 2007-08 Actual	$197,346,769	-	-	-	-	-	-
FY 2008-09 Actual	$217,637,190	10.28%	$20,290,421	$207,491,980	-	-	-
FY 2009-10 Actual	$229,208,480	5.32%	$11,571,290	$223,422,835	7.68%	$214,730,813	-
FY 2010-11 Actual	$255,016,621	11.26%	$25,808,141	$242,112,551	8.37%	$233,954,097	8.95%
FY 2011-12 Actual	$275,399,032	7.99%	$20,382,411	$265,207,827	9.54%	$253,208,045	8.23%
FY 2012-13 Actual	$305,872,244	11.07%	$30,473,212	$290,635,638	9.59%	$278,762,633	10.09%
FY 2013-14 Actual	$421,229,684	37.71%	$115,357,440	$363,550,964	25.09%	$334,166,987	19.88%
FY 2014-15 Appropriation vs. FY 2013-14 Actual	$548,101,614	30.12%	$126,871,930	$484,665,649	33.31%	$425,067,847	27.20%
FY 2014-15 Estimate vs. FY 2013-14 Actual	$546,217,162	29.67%	$124,987,478	$483,723,423	33.06%	$424,439,697	27.01%
FY 2014-15 Estimate vs. 2014-15 Appropriation	$546,217,162	-0.34%	($1,884,452)	$547,159,388	12.89%	$505,182,820	18.85%
FY 2015-16 Estimate vs. FY 2014-15 Appropriation	$620,325,670	13.18%	$72,224,056	$584,213,642	20.54%	$529,885,656	24.66%
FY 2015-16 Estimate vs. FY 2014-15 Estimate	$620,325,670	13.57%	$74,108,508	$583,271,416	20.58%	$529,257,505	4.77%
FY 2016-17 Estimate vs. FY 2014-15 Appropriation	$691,890,314	26.23%	$143,788,700	$619,995,964	27.92%	$620,105,866	45.88%
FY 2016-17 Estimate vs. FY 2015-16 Estimate	$691,890,314	11.54%	$71,564,644	$656,107,992	12.49%	$619,477,715	17.05%

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

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-03

Request Titles

R-03 Children's Basic Health Plan Medical and Dental Costs

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$199,832,216	$0	$219,848,404	($15,392,141)	$6,846,915
	FTE	-	-	-	-	-
	GF	$22,299,001	$0	$21,502,903	($21,502,903)	($21,502,903)
	CF	$48,226,542	$0	$49,006,710	($12,922,721)	($21,980,075)
	RF	$0	$0	$0	$0	$0
	FF	$129,306,673	$0	$149,338,791	$19,033,483	$50,329,893

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
05. Indigent Care Program - Children's Basic Health Plan Medical and Dental Costs	Total	$199,832,216	$0	$219,848,404	($15,392,141)	$6,846,915
	CF	$48,226,542	$0	$49,006,710	($12,922,721)	($21,980,075)
	FF	$129,306,673	$0	$149,338,791	$19,033,483	$50,329,893
	GF	$22,299,001	$0	$21,502,903	($21,502,903)	($21,502,903)

Letternote Text Revision Required?	Yes	X	No	If Yes, describe the Letternote Text Revision: See Exhibit C2
Cash or Federal Fund Name and CORE Fund Number:	See Exhibit C2			
Reappropriated Funds Source, by Department and Line Item Name:	N/A			
Approval by OIT?	Yes		No	Not Required: X
Schedule 13s from Affected Departments:	N/A			
Other Information:	N/A			

Department of Health Care Policy and Financing
Children's Basic Health Plan

FY 2014-15, FY 2015-16, and FY 2016-17 Budget Request

November 1, 2014

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CHILDREN'S BASIC HEALTH PLAN

The following is a description of the budget projection for the Children's Basic Health Plan.

Changes from February 2014 Forecast

- Actual average monthly caseload in FY 2013-14 for children was 61,553, which was 5.45% under what was forecasted in February 2014. Actual average monthly caseload in FY 2013-14 for prenatal was 952, which was 5.74% under what was forecasted in February 2014. This has resulted in a decreased caseload forecast for FY 2014-15 and a lower estimated expenditure in FY 2014-15 than previously forecasted in February 2014.
- In the February 2014 forecast, the Department has predicted an increase in rates for prenatal clients in FY 2014-15. The contracted rates for prenatal clients in FY 2014-15 are unchanged from the contracted rates in FY 2013-14. This has resulted in a lower estimated expenditure in FY 2014-15 from what was previously forecasted in February 2014.
- In FY 2013-14, a budget amendment was passed to expand dental services in CHP+ in order to bring the program into compliance with the CHIPRA Legislation of 2009. While the contracted rates for FY 2014-15 are higher than the contracted rates in the previous fiscal year, the new dental rates are actually lower than what was estimated in the budget amendment. This has resulted in a lower estimated expenditure in FY 2014-15 than previously forecasted in February 2014.
- The February 2014 forecast includes a bottom line adjustment for the Eligible But Not Enrolled population to account for the population that was eligible for coverage, but only applied after the implementation of Medicaid Expansion either due to increased knowledge of coverage or the insurance mandate. This request refers to this adjustment as the Welcome-Mat Effect. In this request, the Department assumes that the Welcome-Mat effect is present in all three FPL categories for children, where in the February request the Welcome-Mat Effect was only present in CHP+ Children under 200% FPL.
- In FY 2014-15, the Department had submitted an estimate for the implementation of HB 09-1353, removing the 5 year bar on legal immigrant children and pregnant women. The 5 year bar had been removed for Medicaid eligible pregnant adults, but not for Medicaid Eligible Children and CHP+ clients. The Department's estimate in FY 2013-14 assumed implementation in FY 2014-15. After further review, the Department has decided that the implementation this bill for Medicaid eligible children and CHP+ clients cannot be done until FY 2015-16. The estimates for this have been moved out one fiscal year.

Points of Interest

- Beginning in January 2013, Medicaid eligibility expanded to include children ages 6 to 18 up to 133% Federal Poverty Level (FPL) per SB 11-008 and prenatal clients up to 185% FPL per SB 11-250. Senate bills 11-008 and 11-250 led to a significant decrease in caseload for CHP+ and the effects were previously reported as a bottom line adjustments in caseload. This Medicaid expansion is

no longer seen as a bottom line adjustment in CHP+ caseload, but former CHP+ children and prenatal clients are accounted for and forecasted separately in Medicaid caseload.

- The Modified Adjusted Gross Income (MAGI), required by the Affordable Care Act of 2010 (ACA) began in October 2013. States will be required to use this new income and a standardized household size definition to determine eligibility for low-income subsidies in Health Care Exchanges, as well as Medicaid and federal CHIP programs. Due to differences in household size and income calculations that currently exist between Colorado's Medicaid and CHP+ programs, a number of clients with reported household incomes within the official Medicaid eligibility range are actually eligible for CHP+. The anticipated changes from the implementation of MAGI were previously reported as bottom line adjustments and are now considered a part of the base caseload. As expected, the implementation of MAGI has resulted in a decrease in caseload. This decrease however, has been mitigated by the implementation of continuous eligibility in March 2014.
- As mentioned above, continuous eligibility was implemented for Medicaid Eligible Children and CHP+ Children in March 2014. The Department has forecasted aggressive growth trends to account for the anticipated increase in member months.
- The Department faces a potential disallowance due to the expiration of the prenatal waiver used to pay for prenatal clients within the 206%-250% FPL range. In order to be compliant with Federal regulation, the Department continued to provide coverage for these clients despite the expiration of the applicable waiver.
- Beginning in January 2013, systems issues created duplicate payments for CHP+ clients in the State Managed Care Network. The magnitude of these duplication errors has waned considerably, but the Department expects to recover $2,704,784 in FY 2014-15 for duplication that occurred in FY 2013-14.
- In FY 2013-14, prenatal capitations for some clients within 201%-260% FPL experienced systems issues. The issues have been tied to individual income rating codes that represent the following FPL brackets; 185%-200%, 201%-213%, and 214%-225%. There is an estimate for the missed capitations included as a bottom line adjustment to expenditure. The Department expects these issues to be resolved in FY 2014-15.
- After January 2014, an income rating code used to identify clients from 201%-205% changed to 201%-213% as part of the MAGI conversion. Clients under 205% FPL receive funding from the CHP Trust Fund while clients over 205% FPL receive funding from the Hospital Provider Fee (HB 09-1293). The Department is working to identify a discrete FPL for all CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-260% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.

History and Background Information

Children's Basic Health Plan (CBHP), also known as Children's Health Plan *Plus* (CHP+), provides affordable health insurance to children under the age of 19 and pregnant women in low-income families (up to 260% of the federal poverty level) who do not qualify for Medicaid and do not have private insurance. CHP+ offers a defined benefit package that uses privatized administration.

The federal government implemented this program in 1997, giving states an enhanced match on state expenditures for the program. Colorado began serving children in April of 1998. Where available, children enroll in a health maintenance organization. CHP+ also has an extensive self-insured managed care network that provides services to children until they enroll in a selected health maintenance organization, and to those children who do not have geographic access to a health maintenance organization. All pregnant women enrolled in CHP+ receive services through the State's self-funded network.

The number of CHP+ enrollees and their per capita costs fluctuate due to changes in economic conditions, federal and state policies, and a number of other factors, resulting in changes in CHP+ program expenditures. Changes in funding from sources such as the Tobacco Master Settlement Agreement and Tobacco Taxes also increase the volatility in funding needs. Thus, the Department periodically updates its caseload and expenditure forecast based on recent experience and submits funding requests to the General Assembly. This ensures that the Department has sufficient spending authority to cover expenditures for CHP+ clients and the program's administration. The Department will submit a separate supplemental request to true up its most recent estimates for FY 2014-15 in February 2015.

The eligible CHP+ populations are:

- Children to 200% FPL (Medical and Dental)
- Children 201%-205% FPL (Medical and Dental)
- Children 206%-260% FPL (Medical and Dental)
- Prenatal to 200% FPL
- Prenatal 201%-205% FPL
- Prenatal 206%-260% FPL

CBHP CAPITATION PAYMENTS

The CBHP Capitation Payments line item reflects the appropriation that funds CBHP services throughout Colorado through managed care providers contracted by the Department. CHP+ children are served by either a health maintenance organization (HMO) at a fixed monthly cost, or by the State's managed care network (SMCN), which is administered by a no-risk provider. Actual and estimated caseload ratios between HMOs and the self-funded network are used to develop blended capitation rates and per capita costs. All clients in the prenatal program are served by the self-funded program (SMCN) administered by Colorado Access and the costs of their services are billed in full directly to the State.

The CHP+ Third Party Administrator (TPA) contract was re-bid for FY 2008-09, and Colorado Access was selected as the new vendor.

The dental vendor contract was re-bid for FY 2007-08, and a new contract was executed with Delta Dental. As part of the re-bid process, Delta Dental was able to offer an increased benefits package. These changes included increasing the cap on dental benefits from $500 to $600 per year, removing the age limit on sealants and fluoride varnishes, and increasing the cap on fluoride varnishes from one to two per year. In FY 2013-14, there was a budget amendment passed (BA-11) to align the CHP+ oral health care benefits with the CHIPRA legislation of 2009. CHP+ dental coverage had been lacking periodontic care, orthodontic care, prosthodontic care, and the required coverage of all medically necessary oral health care. Such services were added to the scope of coverage and the dental program's annual maximum was increased from $600 to $1000. These changes in the oral health care benefits led to significant increases in the dental rates for FY 2014-15.

Effective July 1, 2010, the Department implemented a new reimbursement schedule for hospital payments. While the hospitals were paid 44% of billed charges in FY 2009-10, in FY 2010-11 they were paid 135% of the Colorado Medicaid Diagnosis Related Groups (DRGs) for inpatient services and 135% of the Colorado Medicaid Outpatient Cost-to-Charge ratio for outpatient services. This means that the program has essentially adopted the Medicaid reimbursement methodologies. This change in reimbursement methodologies resulted in significant savings in the SMCN, which is reflected in the negative trend in the children's per capita cost in FY 2010-11.

Analysis of Historical Expenditure Allocations across Eligibility Categories

Historical expenditure allocations across eligibility categories reflects the expenditures reported in the Colorado Financial Reporting System (COFRS). Beginning July 1, 2014, the Department will transition from COFRS to Colorado Operations Resource Engine (CORE). Historical expenditure for this November 1, 2014 request is from COFRS.

Description of Transition to New Methodology

As part of its ongoing efforts to continuously improve the projections, as well as to provide access to information more specific than overall per-capita rates, the Department has moved to a capitation trend forecast model beginning with the FY 2014-15 Request. In short, the methodology examines the trend in capitation rates across each eligibility category and applies that trend to the average per-claim, incurred expense rate. By examining the capitation rate trends for each eligibility category, rather than a weighted rate for all categories, future expenditures are forecasted per the characteristics of a specific eligibility category: the actuarially agreed-upon capitation rate and caseload for the 9 categories rather than the previous 3 (children's medical, children's dental, and prenatal). In addition to viewing the 9 eligibility categories separately, the Department has divided up the categories further to analyze each group that has a specific rate. This grouping separates by age as well as FPL. The different age groups apply only to children; 0-1, 2-5, and 6-18. The same FPL brackets apply to both children and prenatal; under 100%, 101%-150%, 151%-200%, 201%-205%, and 206%-260%. These individual analyses are then aggregated in the familiar FPL brackets 0%-200%, 201%-205%, and 206%-260%. By tying forecasted capitation rates directly to each category, the methodology may provide more accurate estimates of expenditures by eligibility category as well as provide an additional window of transparency into the forecasting process by presenting a clear link between total expenditure and the rates being paid to health maintenance organizations and the state managed care network.

In estimating the future per capitas, the Department has also started incorporating partial month and retroactivity adjustments to the projected rates beginning with the November 2013 request. The adjustments are described in further detail in Exhibit C8 (page R-3.11)

Additionally, the Department has incorporated an incurred but not reported methodology similar to the Medicaid Behavioral Health Program Request submitted by the Department. The Department is adjusting its request to capture the reality that some CBHP claims incurred in any one fiscal year may not be paid during that same fiscal year. Similarly, some portion of expenditure in any fiscal year will be payments on claims incurred in prior fiscal years.

The following narrative describes in greater detail the assumptions and calculations used in developing the current year and out-year for Medicaid Children's Basic Health Plan. It should be noted that the data and values in many of the exhibits are contained and/or calculated in one or more other exhibits which may come before or after the exhibit being described. When this occurs, the source exhibit will be noted.

EXHIBIT C1 - CALCULATION OF CURRENT TOTAL LONG BILL GROUP IMPACT

Effective with the November 1, 2013 Budget Request, the Department will include Exhibit C1 which presents a concise summary of spending authority affecting Children's Basic Health Plan. In this exhibit the Department sums the total spending authority by fund source, including the Long Bill and any special bills which have appropriations that affect the Department. The total spending authority is compared to the total projected estimated current year expenditures from Exhibit C2. The difference between the two figures is the Department's Supplemental Request for the current fiscal year.

For the request year, the Department starts with the prior year's appropriation including special bills and adds in any required annualizations. This total is the Base Amount for the Request year. The total Base Amount is compared to the total projected estimated request year expenditure from exhibit C2 (pages R-3.C2-1 through R-3.C2-3). The difference between the two figures is the Department's Funding Request in the November Budget Request and the Department's Budget Amendment in the February Supplemental Budget Request.

EXHIBIT C2 - CALCULATION OF FUND SPLITS

Exhibit C2 details fund splits for all Children's Basic Health Plan budget lines for the current fiscal year Supplemental and the out-year Budget Request. Capitation expenditures are split between traditional clients and expansion clients. The State share for the traditional clients (0%-205% FPL) is funded from the CBHP Trust fund and the State share for expansion clients (206%-260% FPL) is funded from Hospital Provider Fee funds (HB 09-1293).

Beginning October 2014, the enhanced CHP+ FMAP will be raised from 65% to 65.71%. The average for the State Fiscal Year is 65.53%. Per the Patient Protection and Affordable Care Act (Sec. 2101 (a)), the enhanced CHP+ FMAP will be raised 23 percentage from October 1, 2015 through September 30, 2019 (SSA 2105 (b)). The projected FMAP for FY 2015-16 is 82.96% and the projected FMAP for FY 2016-17 is 88.71%. Due to this 23 percentage point increase, the Department forecasts that the CBHP Trust Fund will be sufficient for the State share of CHP+ expenditures beginning in FY 2015-16 a there will be $0 General Fund expenditure.

Estimated recoveries from prior years for CHP+ capitation overpayments are also presented in exhibit C2. As discussed above, there were duplicate capitations paid to the State Managed Care Network beginning in January 2013. The Department recovered most of duplicate payments that occurred in FY 2013-14, but estimates a remaining $2,704,784 that needs to be recovered.

EXHIBIT C3 - CHILDREN'S BASIC HEALTH PLAN SUMMARY

Exhibit C3 presents a summary of Children's Basic Health Plan caseload and capitation expenditures itemized by eligibility category and a summary of the bottom line adjustments to expenditure, as well as expenditures for CBHP Administration. The net capitation payments include the impacts of the reconciliations for manual enrollments. Exhibit C6 illustrates the build to the final expenditure estimates presented in this exhibit.

EXHIBIT C4 - CBHP CASELOAD

Exhibit C4 contains the caseload history for each of the 6 eligibility categories. Each of the tables that comprise Exhibit C4 is described below. Forecast details for CHP+ caseload can be found starting on page R-3.22 of this narrative.

Children's Basic Health Plan Caseload by Fiscal Year

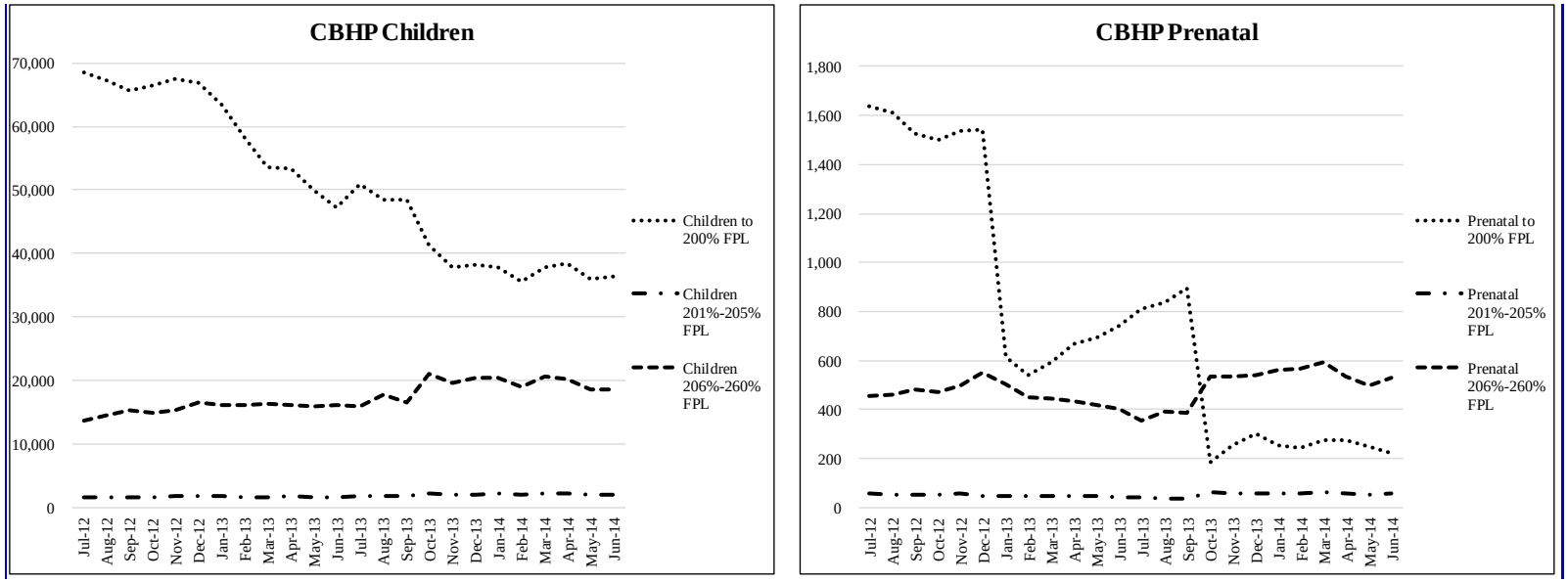
Caseload for the Children's Basic Health Plan is displayed in one table showing caseload by all CHP+ eligibility categories. Figures for fiscal years up to the present fiscal year are actual caseloads, while the current fiscal year and the request year caseloads are estimates. The caseload numbers are used in numerous exhibits throughout the Children's Basic Health Plan Exhibits and narrative. Caseload numbers for children are used twice, once for medical and once for dental.

Caseload forecast by fiscal year shows the final estimated caseload, caseload adjustments, and base caseload. Caseload adjustments in this request include the estimates for the Welcome-Mat Effect (formerly referred to as EBNE) and the estimates for the implementation of HB 09-1353 (which removes the 5 year bar on legal immigrant children and pregnant women).

This exhibit also includes a forecast comparison between this November 2014 request and the February 2014 request. There is a comparison for final caseload, caseload adjustments, and base caseload.

Children's Basic Health Plan Caseload by Month

These tables show the actual caseload by month as reported in the JBC monthly report for the 2 most recent fiscal years. As can be seen in the graphs shown below and on page R-3.C4-8, caseload has been steadily decreasing for populations under 200% FPL, due to the implementation of SB 11-008 and SB 11-250 and the MAGI conversion, and only slightly increasing for populations above 205% FPL.



Children's Basic Health Plan Per Capita Historical Summary

Medicaid Children's Basic Health Plan per capita is displayed in one table. The table displays per capita by all CBHP eligibility categories, children categories are displayed twice to show medical and dental per capitas. Figures for fiscal years up to the present fiscal year are actual per capitas, while the current fiscal year and the request year per capitas are estimates. Calculated per capitas in Exhibit C4-Per Capita Historical Summary represent the estimated per capita including all expenditure adjustments for the given fiscal year. Forecasted per capitas without bottom line adjustments can be found in exhibit C6, pages R-3.C6-1 through R-3.C6-3. Calculations are described in exhibits C6 through C10 (pages R-3.9 through R-3.16).

The final per capita for Children's Medical and Dental expenditures increased greatly for all FPL categories in FY 2013-14. This is due to a large increase in reconciliation payments for manual enrollments. In FY 2012-13, the Department paid approximately $8.5 million for reconciliation payments for manual enrollments. In FY 2013-14, these payments increased to $18.4 million. This resulted in a large increase in final per capitas for all children's expenditure categories.

For prenatal clients 201%-205% FPL, the actual per capita in FY 2013-14 decreased by 44.36%. This is due to a systems issue with capitation payments beginning in January 2014, discussed above. Similar capitation issues were also seen in clients within 186%-200%

and 214%-225%. The Department has included an adjustment for FY 2014-15 expenditure for the estimated capitations that were not been paid and are expected to be paid this fiscal year. Calculations for this estimate can be seen on page R-3.C7-3.

Children's Basic Health Plan Historical Expenditures Summary

The history of expenditures shows total capitation expenditures for all CBHP eligibility categories. Medical and dental expenditures are listed separately. Actual expenditures by eligibility category are available from the Colorado Financial Reporting System (COFRS) and actual expenditures for FY 2013-14 are also reported in exhibit C3-Expenditure Summary, page R-3.C3-1. This exhibit also includes a similar summary of expenditure for all forecast years.

EXHIBIT C5 - CHILDREN'S BASIC HEALTH PLAN FUNDING SOURCES

Traditional Population Expenditures and Funding

This exhibit shows expenditures for the traditional population in isolation and provides additional detail to the calculation of fund splits. Traditional populations include those from 0%-205% FPL. These populations receive the enhanced CHP+ Federal Match and receive cash funds from the CHP Trust Fund, CO Immunization Fund, and Health Care Expansion Fund. Once the available cash funds have been used, the General Fund covers the remaining State share of expenditures for clients under 205% FPL. The available funding from the CHP Trust Fund and the CO Immunization Fund is forecasted using the published projections in the 2014 Tobacco MSA Payment Forecast and the actual expenditures from prior years. Calculations can be seen in exhibit C5, page R-3.C5-2.

As described above for exhibit C2, the CHP+ Federal Match increases by 23 percentage points in October 2015. After this increased match, the Department forecasts that the CHP Trust Fund will have sufficient revenue to cover the expenditures of the CHP+ population under 205% FPL. This results in $0 General Fund expenditure. These calculations are shown on page R-3.C5-2.

Expansion Population Expenditures and Funding

HB 09-1293 established a funding mechanism for a series of expansion clients. The set of expansion clients that are funded through the bill are children and prenatal clients with income 206%-260% FPL. These populations also receive the enhanced CHP+ Federal Match. Services for these clients are funded through the Hospital Provider Fee Cash Fund. This exhibit shows expenditures for the expansion population in isolation and provides additional detail to the calculation of fund splits.

Children's Health Plan Plus Enrollment Fees

Clients above 157% FPL owe an enrollment fee prior to accessing benefits. There is a fee for enrolling one child, then there is one fee for enrolling more than one child. This exhibit shows the assumptions and calculations used to predict the collected enrollment fees. The amount accrued in enrollment fees is exempt from the federal match, so this amount is subtracted from the estimated CHP+ expenditures that can receive a federal match for fund split calculations seen in exhibits C2 and C5 (pages R-3.C2-1 through R-3.C2-3, R3.C5-2, and R3.C5-4).

EXHIBIT C6 - ESTIMATE AND REQUEST BY ELIGIBILITY CATEGORY

Exhibit C6 provides capitation expenditure calculations for the current fiscal year and the request year.

The Department has adopted a methodology based on forecasting a capitation rate, multiplying that rate by monthly caseload, multiplying again by the number of months that the forecasted rate will be in effect, and then adjusting for incurred claims that will be paid in subsequent years as well as for claims from former years that will be paid in the year of the request. The methodology is a zero-based budget tool that allows the Department to examine projected expenditures each year without building in inappropriate assumptions, estimates, or calculations from preceding years.

The forecasted capitation rate is derived from exhibits C8 through C10 and will be presented in more detail below. The caseload is the same as displayed in exhibit C4.

In order to adjust the calculations for cash accounting, the Department makes two adjustments to the calculation: first, the Department subtracts the incurred amount estimated to be paid in subsequent periods; then, the Department adds the claims incurred in prior periods expected to be paid in the forecast period. These adjustments transform the estimated incurred expenditure to a cash-based figure. The basis for these adjustments is described in this narrative below and is shown in the exhibits starting on page R-3.C6-1.

After calculating total expenditure for capitations, the anticipated reconciliation payments for manual enrollments for each fiscal year are estimated and added to total expenditure. The sum of expenditure for capitation payments and reconciliation payments for manual

enrollments is the total CBHP Capitation Payments summarized in exhibit C3. Following the addition of projected reconciliation payments for manual enrollments are any applicable bottom-line impacts to expenditure. Details are discussed below in exhibit C7.

Actuarially Certified Capitation Rates

Capitated rates for the health maintenance organizations are required to be actuarially certified and approved by CMS, thus actuarially certified rate increases could reasonably be expected to be good predictors of future costs. As such, the Department used trends on the historically certified capitation rates to derive the capitation rate presented in Exhibit C6. The methodology for determining the forecasted capitation rate is the subject of exhibits C8 through C10.

Incurred-but-not-Reported Estimates

In order to estimate the necessary adjustments to convert the projection to a cash basis, the Department estimates monthly incurred-but-not-reported (IBNR) adjustments based on historical data. Monthly adjustments are required because, for example, claims incurred in July of the current fiscal year have 11 more months of the fiscal year in which the claims can be paid; however, claims incurred in June of the fiscal year only have the remainder of that month in which to be paid before the payment becomes part of the next fiscal year's expenditure.

The Department examined historical data from the last five fiscal years and determined the prior fiscal years would provide a representative model for the likelihood of claims being paid in the year in which they are incurred. Pages R-3.C6-4 through R-3.C6-6 present the percentage of claims paid in a twelve-month period that come from that same period and those which come from previous periods. The previous four years of expenditure experience were examined and the average was applied to the forecast.

EXHIBIT C7 - CHILDREN'S BASIC HEALTH PLAN BOTTOM LINE IMPACTS TO EXPENDITURE

Reconciliation payments for manual enrollments

As mentioned above, the Department makes reconciliation payments for clients that were manually enrolled. These are projected by applying growth rates from projected caseload (exhibit C4) and rate inflation (exhibit C9) to the expenditure for reconciliation payments for manual enrollments in the previous fiscal year.

Payments to FQHC's/RHC's

The Department began making reconciliation payments to FQHC's/RHC's in FY 2013-14, this was referred to as CHP+ PPS Implementation in the February 2014 request. Services at FQHC's and RHC's are now taken into consideration in the rate setting process as of FY 2014-15, but there are still reconciliation payments to be made. The Department estimates a total of $10,725,000 will need to be made in FY 2014-15. Of this amount, approximately $6 million is for services provider prior to FY 2012-13. The Department is seeking approval for a good cause waiver in order to make payments for these services and hopes to complete this in FY 2014-15. Another reconciliation payment of approximately $2,250,000 will need to be made in FY 2015-16. After this, services provided by FQHC's/RHC's should be fully accounted for in the rate setting process and reconciliation payments should not be needed for these services.

Prenatal capitations

Due to systems issues discussed above, prenatal capitations for certain FPL brackets were not paid in FY 2013-14. The specific FPL brackets are 186%-200%, 201%-213%, and 214%-225%. The Department expects this issue to be resolved in FY 2014-15 and to pay these missed capitations this fiscal year. There is a bottom line adjustment to account for this in the budget. Calculations can be seen in exhibit C7, page R-3.C7-3.

Clients disenrolled with missing denial codes

In FY 2013-14, clients were disenrolled with a blank disenrollment reason code. The Department will retroactively cover medical services for these clients that were inappropriately disenrolled. The Department estimates $500,000 in services will need to be covered by CHP+ and has used the projected base expenditure distribution from FY 2013-14, seen on page R-3.C4-10, for this amount.

EXHIBIT C8 - CBHP RETROACTIVITY ADJUSTMENT AND PARTIAL MONTH ADJUSTMENT MULTIPLIER

Capitations are paid for clients from the date the client's eligibility is effective, resulting in claims paid retroactively. As such, any projection which derives expenditure by using non-retroactive caseload must take into account these retroactive claims. Since expenditures are calculated as the estimated capitation rate multiplied by the non-retroactive caseload, an adjustment for retroactivity can be applied to either the forecasted capitation rate or the caseload figure. In order to maintain the uniform presentation of caseload across all Departmental estimates and requests, the Department chose to make its retroactivity adjustment to the forecasted capitation rate itself.

Additionally, claims-based data (as it is derived from literally the money spent on each claim) is the actual driver of expenditure. Examining the capitation rate for forecasting allows the Department and policy makers to see the relationship of the capitation payments

paid to the health maintenance organizations (HMO's) and State Managed Care Network (SMCN) to total expenditure. Forecasting based on trends in the capitation rate will only be as accurate as the relationship between that capitation trend and any trends in the rates of per-claim expenditure. These two rates can trend similarly, but any difference in trends needs to be captured in order to ensure the accuracy of the forecast. The different trends are usually related to the incidence of payments for partial months of eligibility, which fluctuate for reasons unrelated to the CBHP Capitation program. This difference is captured through a partial-month adjustment multiplier.

Retroactivity Adjustment Multiplier

For the purpose of adjusting the forecasted capitation rate to capture the omission of retroactivity from caseload, the Department analyzed the last five years of claims and caseload data. Page R-3.C8-1 presents the average monthly claims as compared to the average monthly caseload for those years across eligibility categories. The retroactivity adjustment calculated in FY 2013-14 for medical services for Children is quite high compared to prior years. This is due to the duplicate payments made to the State Managed Care Network discussed above. The adjustments calculated for prenatal clients above 200% FPL in FY 2013-14 are low compared to prior years. This is a result of the systems issues with prenatal capitations described above. The Department believes these issues are either negligible in FY 2014-15 or will be resolved in FY 2014-15. Details on the selected retroactivity adjustment can be found on page R-3.C8-1. All categories above 206% FPL use the selected results for the 201%-205% category. This is because the 206%-250% populations are still relatively new and do not offer as many observations as the traditional populations.

Partial Month Adjustment Multiplier

To derive the partial month adjustment multiplier for the purpose of capturing any difference in trends between the capitation rate trends and the trends on per-claim expenditure, the last seven years of data were examined.

As presented on page R-3.C8-2, for each eligibility category, the weighted average claims-based rate (weighted by proportion of total claims within an eligibility category covered by an individual HMO or SMCN) was compared to the weighted capitation rate (similarly weighted). Then, the claims-based rate as a percentage of the capitation rate was calculated, providing a simple comparison of any trend in claims-based rates as compared to capitation rates. Details on the selected partial month adjustment for each eligibility can be found on page R-3.C8-2.

EXHIBIT C9 - CBHP CAPITATION RATE TRENDS AND FORECASTS

As presented above, the expenditure forecast was derived by examining the trend on the capitation rate and then applying that trend to the monthly cost per client (i.e., the claims-based rate). For the purpose of trend analysis, the weighted capitation rate (weighted by proportion of total claims within an eligibility category covered by an individual health maintenance organization or state managed care network) was examined. Exhibit C9 presents historical data as well as the forecasted weighted rates.

The weighted rate is presented along with the percentage change from the previous fiscal year. The multiple forecast trend models and the criteria for selecting the forecasted capitation rate point estimate are presented in Exhibit C10.

Based on the Department's calculations and rate-setting process and input from the health maintenance organizations, the Department's actuaries certify a capitation rate range for each HMO, SMCN, and eligibility type; the Department is permitted to pay any rate within this range and maintain an actuarially sound capitation payment. To develop the range, the actuaries calculate a single rate (the "point estimate") and the upper and lower bounds around this rate that maintain actuarial soundness.

It is important to note the overall weighted point estimate presented in the exhibit is weighted across several factors. First, the rate is weighted within an eligibility category. Within an eligibility category, the rate is weighted by the health maintenance organizations' and state managed care network's proportion of claims processed within that eligibility category, the proportion attributable to each FPL category (0%-100%, 101%-150%, 150%-200%, and above 200%), and for children the proportion for each age range (ages 0-1, 2-5, and 6-18). Next, that rate is then weighted across all eligibility categories (with the weight derived from the total number of claims processed within an eligibility category as a percentage of total claims processed across all eligibility categories). Because caseload can be increasing or decreasing independently of any one capitation rate, the weighted CBHP total rate may not be a clear indicator of the rate trends across all eligibility categories.

Exhibit C9 presents the weighted point estimate rates, and the trend of those rates is used for forecasting. The weighted point estimates differ from paid rates, which can change within the upper and lower bounds of the established rate range in response to new rate-setting processes and budget reduction measures. The paid rates, which are discussed below, are not presented in Exhibit C6 in order to allow for comparison across years and so as to not artificially inflate or deflate the rate trend and bias the estimated rate in future years. Below is a table showing the actual weighted rate for FY 2013-14, and the projected weighted rates through FY 2016-17.

Fiscal Year	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	Weighted CBHP Total
FY 2013-14 Actuals	**$148.46**	**$149.24**	**$150.29**	**$15.70**	**$15.45**	**$15.54**	**$982.46**	**$970.08**	**$970.08**	**$177.05**
FY 2014-15 Estimated Rate	**$150.39**	**$155.82**	**$155.02**	**$18.61**	**$17.73**	**$17.95**	**$981.79**	**$970.08**	**$970.08**	**$180.60**
% Change from FY 2013-14	1.30%	4.41%	3.15%	18.51%	14.75%	15.47%	-0.07%	0.00%	0.00%	2.00%
FY 2015-16 Estimated Rate	**$156.71**	**$163.64**	**$162.80**	**$19.84**	**$18.72**	**$18.95**	**$1,047.76**	**$1,030.42**	**$1,032.50**	**$189.10**
% Change from FY 2014-15	4.20%	5.02%	5.02%	6.61%	5.58%	5.57%	6.72%	6.22%	6.43%	4.70%
FY 2016-17 Estimated Rate	**$163.29**	**$171.85**	**$170.96**	**$21.16**	**$19.76**	**$20.01**	**$1,118.17**	**$1,094.51**	**$1,098.94**	**$198.41**
% Change from FY 2015-16	4.20%	5.02%	5.01%	6.65%	5.56%	5.59%	6.72%	6.22%	6.43%	4.92%

EXHIBIT C10 - FORECAST MODEL COMPARISONS

Exhibit C10 produces the final capitation rate estimates that are used as the source of the expenditure calculations provided in exhibit C6. Pages R-3.C10-1 and R-3.C10-2 present the final rate estimates in their entirety. The final rate estimates are a product of model selection (discussed below) and the necessary adjustments as presented in exhibit C8.

On page R-3.C10-2, a series of forecast models are presented for each eligibility category. From the models or from historical changes, a point estimate is selected as an input into page R-3.C10-1. Based on the point estimates, the adjustments presented in Exhibit C8 are then applied and the final, adjusted point estimate is then used in the expenditure calculations of exhibit C6.

On page R-3.C10-1, there is an adjustment to the rate for the passing of HB 14-1213, "Pharmacy Benefits Manager Maximum Allowable Cost," which currently has an expected implementation of January 2015. This is a tentative implementation date and the adjustment to the rate is a placeholder, the Department is still analyzing when would be most beneficial to implement HB 14-1213. There is a half year impact on the rate for FY 2014-15, and a full year impact for the remaining forecast years.

Final Forecasts

Page R-3.C10-1 begins by presenting the known rates from those already set through the actuarial process and the remaining point estimates of each eligibility category's rate as selected on page R-3.C10-2 (see below).

The forecasted rate is then adjusted by the partial month adjustment multiplier, calculated on page R-3.C8-2. The multiplier is applied to adjust for the fact that the full capitation rate is not paid for every member month. The rate for paid claims is impacted by payments made for partial months of eligibility; this type of payment will not be for a "whole" capitation payment at the current fiscal period's capitation rate. Therefore, the multiplier is applied to convert capitation rates to a figure which is more likely to reflect actual expenditure.

Then the claims-based rate is adjusted a second time, this time by the retroactivity adjustment. From exhibit C8, page R-3.C8-1, this second adjustment is made to capture the retroactivity not captured by the caseload figures. As described in the narrative for exhibit C8, since caseload does not capture retroactivity, and since projected total expenditure is equal to caseload times the projected rate, either the rate or the caseload must be adjusted to capture retroactivity. To keep CBHP caseload matched to other caseload figures presented by the Department, the adjustment is made to the projected rate yielding the final forecasted rate, which is the rate used to derive the expenditure calculation presented in exhibit C6. A similar methodology is applied to the rates in each eligibility category and for each fiscal period.

Capitation Trend Models

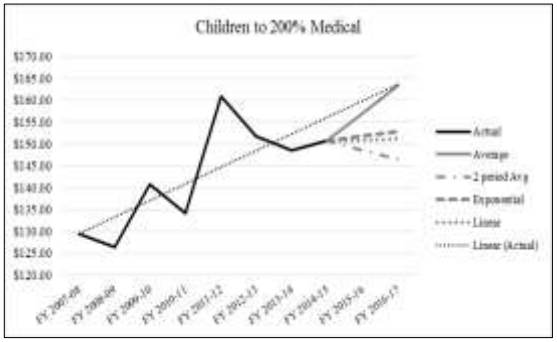
The forecasted capitation rates are the result of a point estimate selection from among several forecast trend models and historical information. These models are presented on page R-3.C10-2.

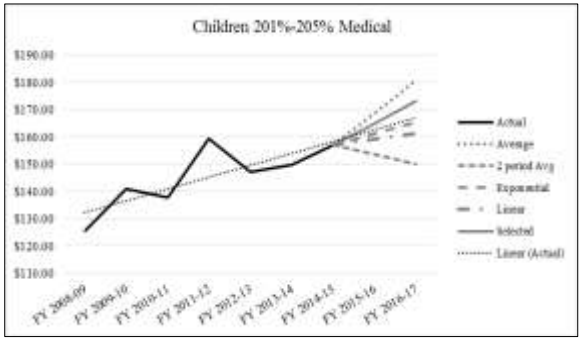
For each eligibility category, four different trend model forecasts were performed: an average growth model, a two-period moving average model, an exponential growth model, and a linear growth model. The average growth model examines the rate of change in the capitation rate and applies the average rate of change to the forecast period. The two-period moving average model projects the forecast period will see a change in the capitation rate that is the average of the last two changes in the capitation rate. The exponential growth model assumes the capitation rate is increasing faster as time moves forward (a best-fit exponential equation is applied to the historical data and trended into the future). The linear growth model is a regression model on time, fitting a linear equation line to the historical data and forecasting that line into the future. Each model in the exhibit also shows what the percent change would be from the prior period.

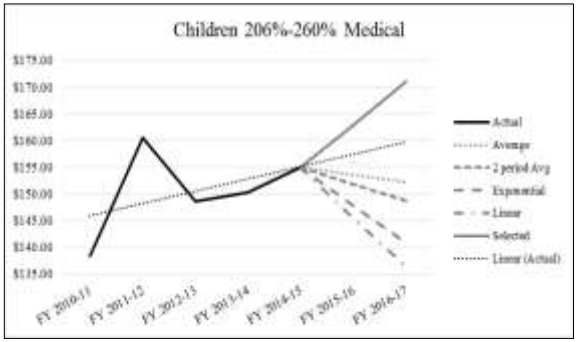
The Department's decisions for trend factors are informed, in part, by preliminary calculations from the actual rate setting process. Because those calculations remain preliminary, the Department does not explicitly use them in estimating trend factors.

Capitation rates are required to be actuarially sound and are built from a blend of historical rates. The trends models, as presented in this exhibit, are an attempt to predict the final outcome of this rate setting process. However, the use of historical, final rates as data points for predicting future rates is limited when future periods are likely to be fundamentally different than historical periods. Beginning with FY 2008-09 the Department has experienced unusual trends for the CBHP capitation program. This program, in its present state, has never existed in an economic climate like the one currently being experienced. As such, the various rate estimating models' reliance on historical performance for predicting future performance is limited. The Department has used the trend models to establish a range of reasonable rate values and has selected trends by considering the various factors that impact the respective eligibility populations as well as the impact that encounter data will have on the rate setting process. The tables below show the trends selected for the current and request years by eligibility category.

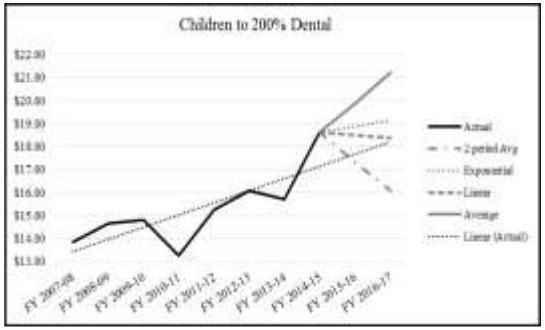
Aid Category	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
Children to 200% FPL Medical	**4.20%** Average Growth Model	**4.20%** Average Growth Model	The linear trend shows that the historical rates have been increasing over time. The Department has selected the average growth model to allow this increase to continue for FY 2015-16 and FY 2016-17.
Children 201%-205% FPL Medical	**5.02%** Average of the Average Growth Model and the Exponential Growth Model	**5.02%** Average of the Average Growth Model and the Exponential Growth Model	The average of the average growth model and the exponential growth model give a trend that is slightly higher than the linear growth trend. The 5.02% growth trend is relatively close with the estimated 4.41% trend for FY 2014-15.
Children 206%-260% FPL Medical	**5.02%** Trend selected for Children 201%-205% FPL Medical	**5.02%** Trend selected for Children 201%-205% FPL Medical	This expansion population is still relatively new. Due to the small number of observations, the Department has chosen the selected growth trend for Children 201%-205% Medical.

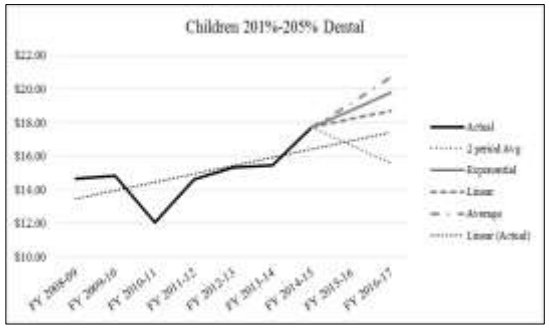


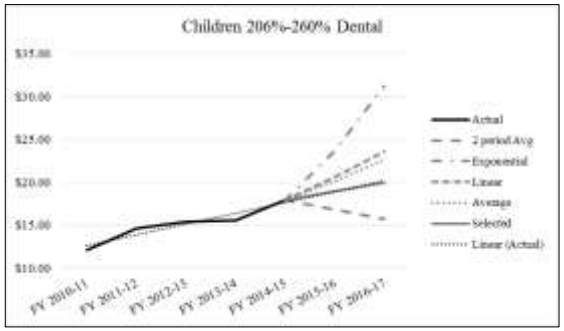




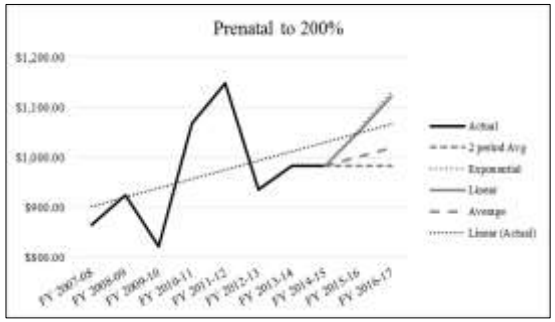
Aid Category	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
Children to 200% FPL Dental	**6.66%** Average Growth Model	**6.66%** Average Growth Model	The Department passed a budget action in FY 2013-14 that added services to the dental benefit in CHP+ in order to bring the dental program into compliance with the CHIPRA legislation of 2009, resulting in a large increase in the dental rate in FY 2014-15. The rates set in FY 2014-15 were beneath the Department's estimate for the budget action. For this reason, the Department has selected a relatively aggressive growth trend for this rate.
Children 201%-205% FPL Dental	**5.58%** Exponential Growth Model	**5.58%** Exponential Growth Model	The Department passed a budget action in FY 2013-14 that added services to the dental benefit in CHP+ in order to bring the dental program into compliance with the CHIPRA legislation of 2009, resulting in a large increase in the dental rate in FY 2014-15. The rates set in FY 2014-15 were beneath the Department's estimate for the budget action. For this reason, the Department has selected a relatively aggressive growth trend for this rate.
Children 206%-260% FPL Dental	**5.58%** Trend selected for Children 201-205% FPL Dental	**5.58%** Trend selected for Children 201-205% FPL Dental	This expansion population is still relatively new. Due to the small number of observations, the Department has chosen the selected growth trend for Children 201%-205% Dental.

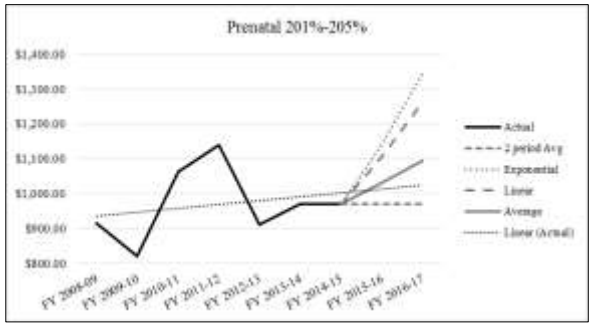


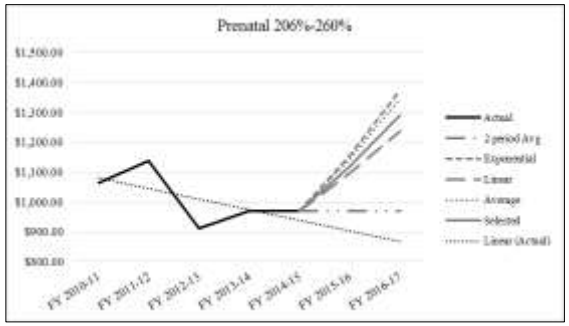




Aid Category	FY 2015-16 Trend Selection	FY 2016-17 Trend Selection	Justification
Prenatal to 200% FPL	**6.72%** Linear Growth Model	**6.72%** Linear Growth Model	The rates for Colorado Access State Managed Care Network (SMCN) remained constant in FY 2014-15, leaving the most recent growth trend close to zero. Due to the rates being held constant for the SMCN in FY 2014-15, the Department believes that the projected growth trend in FY 2015-16 will be much higher than what is projected in FY 2014-15.
Prenatal 201%-205% FPL	**6.22%** Average Growth Model	**6.22%** Average Growth Model	The rates for Colorado Access State Managed Care Network (SMCN) remained constant in FY 2014-15, leaving the most recent growth trend at zero. Due to the rates being held constant for the SMCN in FY 2014-15, the Department believes that the projected growth trend in FY 2015-16 will be much higher than what is seen in FY 2014-15.
Prenatal 206%-260% FPL	**6.44%** Average of the Average Growth Model and the Linear Growth Model	**6.44%** Average of the Average Growth Model and the Linear Growth Model	The rates for Colorado Access State Managed Care Network (SMCN) remained constant in FY 2014-15, leaving the most recent growth trend at zero. Due to the rates being held constant for the SMCN in FY 2014-15, the Department believes that the projected growth trend in FY 2015-16 will be much higher than what is seen in FY 2014-15.







CBHP CASELOAD

Length of Stay

CBHP caseload is not only affected by the number of individuals served but also the length of time they remain in the program. The Department has started tracking the average length of stay for each eligibility category to further the understanding the behavior of the CHP+ clients. Results for FY 2013-14 remain incomplete as there may not be sufficient run out to capture the true length of stay for all clients, FY 2012-13 (shaded) is also subject to change for the same reason. The Department anticipates an increase in the average length of stay as continuous eligibility for Medicaid Eligible Children and CHP+ Children was implemented March 1st, 2014.

		CHP Children 0%-200%	CHP Children 201%-205%	CHP Children 206%-260%	CHP Prenatal 0%-200%	CHP Prenatal 201%-205%	CHP Prenatal 206%-260%
FY 2007-08	Avg LOS Mo's	15.32	15.88	-	8.24	6.82	-
	% > 12 Mo's	61.99%	63.20%	-	12.00%	3.51%	-
FY 2008-09	Avg LOS Mo's	13.82	13.97	-	7.88	6.52	-
	% > 12 Mo's	52.92%	56.50%	-	6.43%	3.05%	-
FY 2009-10	Avg LOS Mo's	11.97	10.41	13.78	7.31	7.05	6.37
	% > 12 Mo's	43.85%	37.64%	50.56%	2.49%	3.39%	0.00%
FY 2010-11	Avg LOS Mo's	11.13	11.86	12.6	6.93	7.35	6.74
	% > 12 Mo's	39.97%	47.80%	50.73%	1.83%	1.27%	1.13%
FY 2011-12	Avg LOS Mo's	9.12	10.78	11.27	6.35	6.41	6.39
	% > 12 Mo's	32.59%	47.12%	49.33%	1.43%	0.00%	0.92%
FY 2012-13	Avg LOS Mo's	8.34	11.29	11.34	5.13	6.25	6.35
	% > 12 Mo's	26.20%	41.78%	42.59%	0.77%	1.12%	0.63%

CBHP Caseload Models

The Department's caseload projections utilize statistical forecasting methodologies to predict CBHP caseload by eligibility category. Historical monthly caseload data from July 2007 to June 2014. The following forecasting models are used to forecast CBHP caseload: trend and monthly seasonal dummy variables, ARIMA models, trend stationary, and difference stationary. The software the Department is now using to estimate these models is *EViews 6*.

Trend and Seasonality Model
CBHP caseload is a non-stationary series with a positive trend and many of the categories experience some level of seasonality. One of the models used will incorporate a time trend and monthly seasonal dummy variables.

ARIMA Model
ARIMA models, once referred to as Box-Jenkins models, rely on the past behavior of the series being forecasted. Relying on the past behavior of a series mandates that a series be stationary. Most of the eligibilities in Medicaid caseload have a positive growth trend (non-stationary) and require differencing to be made stationary.

Trend Stationary and Difference Stationary
Series that are stationary have a constant mean, caseload series frequently do not have this characteristic and often have a trending mean. Two popular models used for non-stationary series with a trending mean are trend stationary and difference stationary. The trend stationary serves as an effective model if the series has a deterministic trend. The difference stationary model proves effect should the trend be stochastic. Differencing the dependent variable gives a stationary series. The basic forms of the two models are listed below.

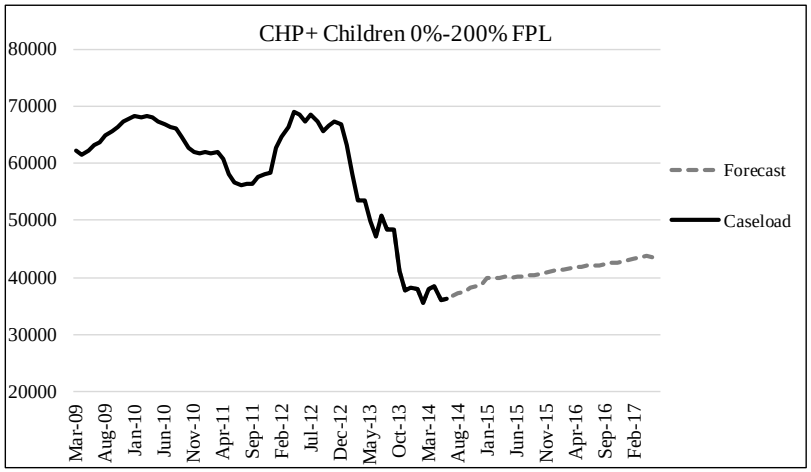
- Trend Stationary: $\log(y) = c + \text{trend} + \varepsilon$
- Difference Stationary: $\text{differenced}(\log(y)) = c + \varepsilon$

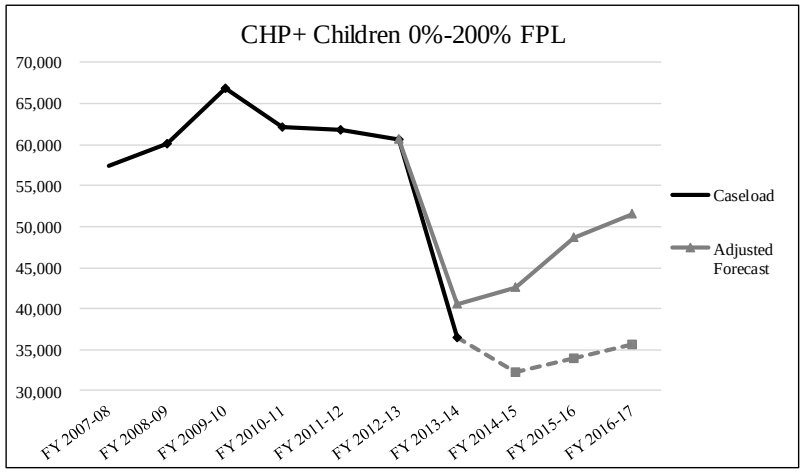
Model Selection

Models are created for each individual group that receives a separate rate. These groups are separated by FPL for both children and prenatal; under 100%, 101%-150%, 151%-200%, 201%-205%, and 206%-260%. Children's groups are also separated by age; ages 0-1, 2-5, and 6-18. A model is selected to forecast each group After several different forecasts are produced, the Department normally chooses one for each category and then aggregated to the familiar FPL categories for children and prenatal; under 200%, 201%-205%, and 206%-260%. When selecting a model, the Department closely analyzes the historical data as well as the goodness of fit of the model.

CHILDREN'S BASIC HEALTH PLAN CASELOAD FORECAST

Children's Caseload Projections (Exhibit C4)





- Average monthly caseload in FY 2013-14 for CHP+ Children 0%-200% FPL was 40,561, which was 3,111 clients, or 7.12% lower than what was forecasted in the February 2014 forecast. This has resulted in lower forecast trends for this November 2014 request.
- The February request accounted the effects of SB 11-008 and MAGI as bottom line adjustments. The Department believes these effects to be complete and is no longer including bottom line adjustments for the effects of SB 11-008 and MAGI.
- The selected trend for FY 2014-15 for Children to 200% FPL is slightly lower than the Department's February 2014 forecast and would result in average monthly growth of 622 per month. This lower forecast is reflective of the average monthly decreases over FY 2012-13 and FY 2013-14. The Department believes that base caseload will not continue to decrease in future months. Growth is forecasted to return to positive trends in FY 2014-15.
- The Department's existing Section 1115 waiver, which covers the Premium Assistance Program and pregnant women in CHP+, expired on December 31, 2012. Any eligible CHP+ at Work clients will transition to direct coverage in the CHP+ program beginning in January 2013.

- There are two bottom-line adjustments to the Children to 200% FPL caseload.
    - The first is from the estimated number of new clients that will seek out CHP+ coverage due to the new insurance mandate, referred to as Eligible But Not Enrolled in SB 13-200. The Department is now identifying this adjustment as the Welcome-Mat Effect. The Department believes that this Effect is present in all three FPL categories. The February request only showed a Welcome-Mat Effect for children under 200% FPL, this request allows the Welcome-Mat Effect to be present in all three FPL categories. The Department estimated the Welcome-Mat Effect for FY 2013-14 and found that clients appear to be responding more quickly than originally assumed in SB 13-200. To account for this response rate to the mandate, the estimated effect has been quickened by one fiscal year. For example, the February request estimated an adjustment of 15,871 clients in FY 2015-16 and this request estimates an adjustment of 15,871 clients in FY 2014-15.
    - The second bottom line impact is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ children in FY 2015-16.

CHP+ Children 0%-200%

	Actuals	Monthly Change	% Change
Jun-12	67,346		
Jul-12	68,486	1,140	1.69%
Aug-12	67,368	(1,118)	-1.63%
Sep-12	65,667	(1,701)	-2.52%
Oct-12	66,552	885	1.35%
Nov-12	67,410	858	1.29%
Dec-12	66,797	(613)	-0.91%
Jan-13	63,305	(3,492)	-5.23%
Feb-13	58,114	(5,191)	-8.20%
Mar-13	53,539	(4,575)	-7.87%
Apr-13	53,416	(123)	-0.23%
May-13	49,793	(3,623)	-6.78%
Jun-13	47,308	(2,485)	-4.99%
Jul-13	50,883	3,575	7.56%
Aug-13	48,436	(2,447)	-4.81%
Sep-13	48,373	(63)	-0.13%
Oct-13	41,212	(7,161)	-14.80%
Nov-13	37,802	(3,410)	-8.27%
Dec-13	38,117	315	0.83%
Jan-14	37,834	(283)	-0.74%
Feb-14	35,535	(2,299)	-6.08%
Mar-14	37,839	2,304	6.48%
Apr-14	38,360	521	1.38%
May-14	35,986	(2,374)	-6.19%
Jun-14	36,350	364	1.01%

February 2014 Forecast	
Forecasted June 2014 Level	43,884

Base trend from June level			
FY 2014-15	36,350	-10.38%	(4,211)
Base trend from Adjusted June level			
FY 2014-15	30,188	-17.31%	(6,318)

	Caseload	Level Change	% Change
FY 2007-08	57,466		
FY 2008-09	60,137	2,671	4.65%
FY 2009-10	66,940	6,803	11.31%
FY 2010-11	62,080	(4,860)	-7.26%
FY 2011-12	61,815	(265)	-0.43%
FY 2012-13	60,646	(1,169)	-1.89%
FY 2013-14	36,506	(24,140)	-39.80%
FY 2014-15	32,347	(4,159)	-11.39%
FY 2015-16	34,010	1,663	5.14%
FY 2016-17	35,594	1,584	4.66%

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	604
FY 2016-17	944

Welcome-Mat Effect	
FY 2013-14	4,055
FY 2014-15	10,293
FY 2015-16	13,970
FY 2016-17	14,908

November 2014 Projection			
FY 2013-14	40,561	(20,085)	-33.12%
FY 2014-15	42,640	2,079	5.13%
FY 2015-16	48,584	5,944	13.94%
FY 2016-17	51,446	2,862	5.89%

Monthly Average Growth Comparisons		
February 2014 Forecast	(46)	0.09%
FY 2013-14 Actuals	(895)	-1.86%
FY 2013-14 1st Half	(1,532)	-3.27%
FY 2013-14 2nd Half	61	0.26%
FY 2014-15 Base Forecast	309	0.82%
FY 2014-15 Adjusted Forecast	622	1.61%
February 2014 Forecast	(146)	-0.32%
FY 2015-16 Base Forecast	161	0.39%
FY 2015-16 Adjusted Forecast	472	1.04%

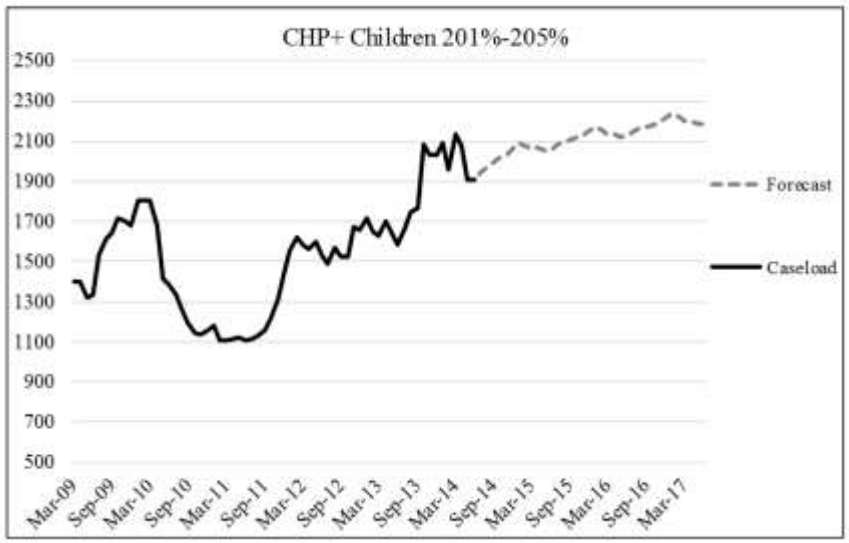
February 2014 Trend Selections Before Adjustments			
FY 2012-13	60,646	-1.89%	(1,168)
FY 2013-14	42,548	-29.84%	(18,098)
FY 2014-15	38,808	-8.79%	(3,741)
FY 2015-16	38,680	-0.33%	(128)

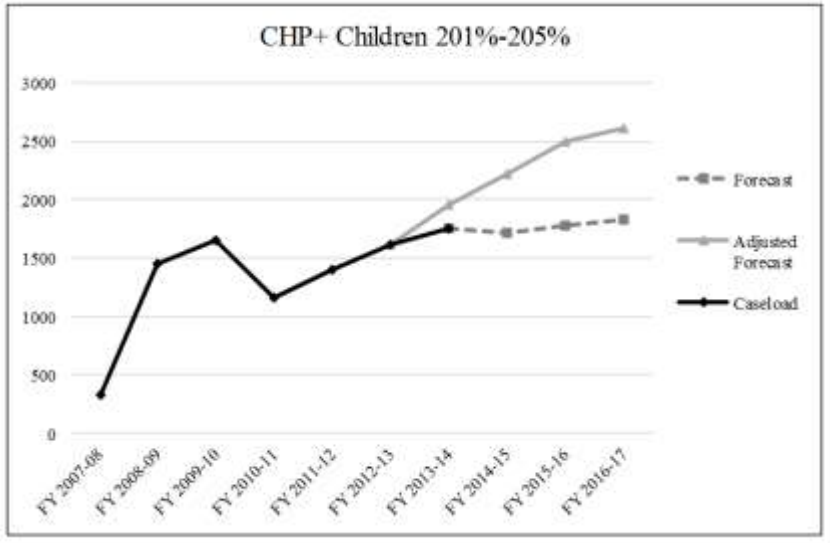
HB 09-1353 Fiscal Note Estimate	
FY 2012-13	-
FY 2013-14	-
FY 2014-15	945
FY 2015-16	1,493

February 2014 - Welcome-Mat Effect	
FY 2012-13	0
FY 2013-14	1,124
FY 2014-15	7,002
FY 2015-16	15,871

February 2014 Trend Selections After Adjustments			
FY 2012-13	60,646	(1,168)	-1.89%
FY 2013-14	43,672	-27.99%	(16,974)
FY 2014-15	46,755	7.06%	3,082
FY 2015-16	56,044	19.87%	9,289

Actuals		
	Monthly Change	% Change
6-month average	(295)	-0.69%
12-month average	(913)	-1.98%
18-month average	(1,691)	-3.17%
22-month average	(1,292)	-2.41%





- Average monthly caseload in FY 2013-14 for CHP+ Children 201%-205% FPL was 1,950, which was 81 clients, or 3.98% lower than what was forecasted in February 2014.
- This population was created through SB 07-097, and was implemented beginning March 1, 2008. Children in this population have family incomes between 201% and 205% FPL.
- This population is identified with an income rating code that represented 201%-205% FPL. After the MAGI conversion, this income rating code changed from 201%-205% to 201%-213%. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-260% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- There are two bottom-line adjustments to the Children 201%-205% FPL caseload:
    - The first bottom-line adjusment is from the estimated number of new clients that will seek out CHP+ coverage either due to increased knowledge about coverage or the new insurance mandate, referred to as Eligible But Not Enrolled in SB 13-200 and the February 2014 estimate. The Department is now identifying this adjustment as the Welcome-Mat Effect. The Department believes that this Effect is present in all three FPL categories. The February request only showed

a Welcome-Mat Effect for children under 200% FPL, this request allows the Welcome-Mat Effect to be present in all three FPL categories. The Department estimated the Welcome-Mat Effect for FY 2013-14 and found that clients appear to be responding more quickly than originally assumed in SB 13-200. To account for this response rate to the mandate, the estimated effect has been quickened by one fiscal year. For example, the February request estimated an adjustment of 15,871 clients in FY 2015-16 and this request estimates an adjustment of 15,871 clients in FY 2014-15.

- The second bottom-line impact is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ children in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.

CHP+ Children 201%-205%

	Actuals	Monthly Change	% Change
Jun-12	1,535		
Jul-12	1,491	(44)	-2.87%
Aug-12	1,570	79	5.30%
Sep-12	1,529	(41)	-2.61%
Oct-12	1,528	(1)	-0.07%
Nov-12	1,672	144	9.42%
Dec-12	1,656	(16)	-0.96%
Jan-13	1,717	61	3.68%
Feb-13	1,647	(70)	-4.08%
Mar-13	1,628	(19)	-1.15%
Apr-13	1,699	71	4.36%
May-13	1,645	(54)	-3.18%
Jun-13	1,587	(58)	-3.53%
Jul-13	1,665	78	4.91%
Aug-13	1,747	82	4.92%
Sep-13	1,770	23	1.32%
Oct-13	2,082	312	17.63%
Nov-13	2,030	(52)	-2.50%
Dec-13	2,033	3	0.15%
Jan-14	2,090	57	2.80%
Feb-14	1,955	(135)	-6.46%
Mar-14	2,133	178	9.10%
Apr-14	2,076	(57)	-2.67%
May-14	1,907	(169)	-8.14%
Jun-14	1,908	1	0.05%

February 2014 Forecast	
Forecasted June 2014 Level	2,270

Base trend from June level			
FY 2014-15	1,908	-2.15%	(42)

	Caseload	Level Change	% Change
FY 2007-08	330		
FY 2008-09	1,445	1,115	337.88%
FY 2009-10	1,649	204	14.12%
FY 2010-11	1,164	(485)	-29.41%
FY 2011-12	1,402	238	20.45%
FY 2012-13	1,614	212	15.12%
FY 2013-14	1,755	141	8.74%
FY 2014-15	1,709	(46)	-2.62%
FY 2015-16	1,778	69	4.04%
FY 2016-17	1,833	55	3.09%

Welcome-Mat Effect	
FY 2013-14	195
FY 2014-15	514
FY 2015-16	689
FY 2016-17	723

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	30
FY 2016-17	47

November 2014 Projection			
FY 2013-14	1,950	336	20.82%
FY 2014-15	2,223	273	14.00%
FY 2015-16	2,497	274	12.33%
FY 2016-17	2,603	106	4.25%

Monthly Average Growth Comparisons		
February 2014 Forecast	57	3.14%
FY 2013-14 Actuals	49	2.92%
FY 2013-14 1st Half	74	4.41%
FY 2013-14 2nd Half	11	0.69%
FY 2014-15 Base Forecast	12	-0.22%
FY 2014-15 Adjusted Forecast	14	0.65%
February 2014 Forecast	(16)	-0.73%
FY 2015-16 Base Forecast	6	0.26%
FY 2015-16 Adjusted Forecast	21	0.92%

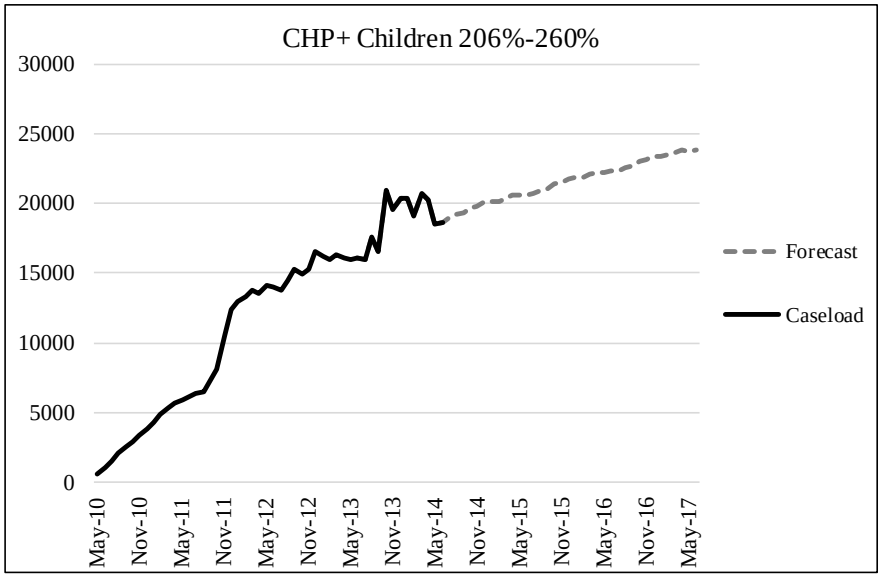
February 2014 Trend Selections Before Adjustments			
FY 2012-13	1,614	212	15.12%
FY 2013-14	2,031	417	25.82%
FY 2014-15	2,167	136	6.72%
FY 2015-16	2,216	49	2.25%

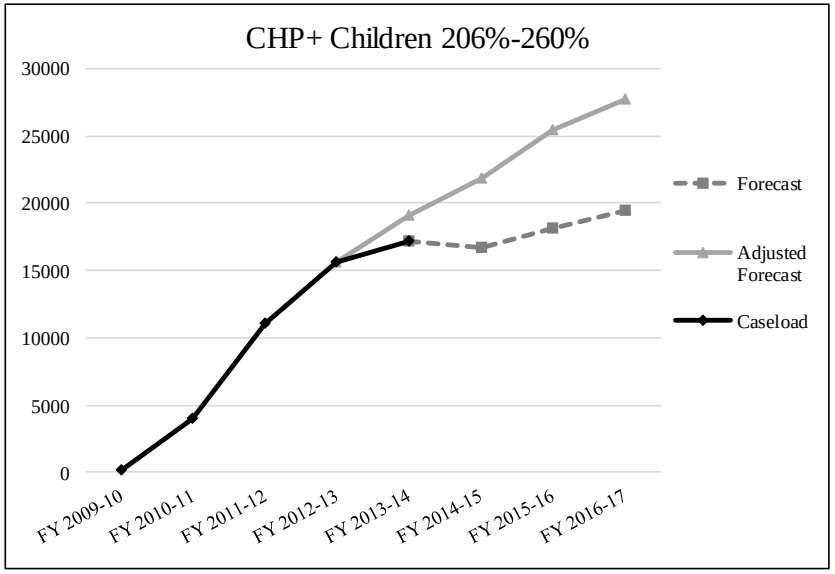
Welcome-Mat Effect	
FY 2012-13	-
FY 2013-14	-
FY 2014-15	-
FY 2015-16	-

HB 09-1353 Fiscal Note Estimate	
FY 2012-13	-
FY 2013-14	-
FY 2014-15	-
FY 2015-16	-

February 2014 Trend Selections			
FY 2012-13	1,614	212	15.13%
FY 2013-14	2,031	417	25.82%
FY 2014-15	2,167	136	6.72%
FY 2015-16	2,216	49	2.25%

Actuals		
	Monthly Change	% Change
6-month average	(21)	-0.89%
12-month average	27	1.76%
18-month average	14	0.96%
24-month average	16	1.06%





- Average monthly caseload in FY 2013-14 for CHP+ Children 206%-260% FPL was 19,043, which was 356 clients, or 1.84% lower than what was forecasted in February 2014.
- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Children in this population have family incomes between 206% and 260% of the federal poverty level.
- After the MAGI conversion, an income rating code used to identify clients from 201%-205% changed to 201%-213%. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-250% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- There are two bottom-line adjustments to the Children 206%-250% FPL caseload:
    - The first bottom-line adjustment is from the estimated number of new clients that will seek out CHP+ coverage either due to increased knowledge about coverage or the new insurance mandate, referred to as Eligible But Not Enrolled in SB 13-200 and the February 2014 forecast. The Department is now identifying this adjustment as the Welcome-Mat Effect. The Department believes that this Effect is present in all three FPL categories. The February request only showed a

Welcome-Mat Effect for children under 200% FPL, this request allows the Welcome-Mat Effect to be present in all three FPL categories. The Department estimated the Welcome-Mat Effect for FY 2013-14 and found that clients appear to be responding more quickly than originally assumed in SB 13-200. To account for this response rate to the mandate, the estimated effect has been quickened by one fiscal year. For example, the February request estimated an adjustment of 15,871 clients in FY 2015-16 and this request estimates an adjustment of 15,871 clients in FY 2014-15.

- The second bottom line impact is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ children in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.

CHP+ Children 206%-260%			
	Actuals	**Monthly Change**	**% Change**
Jun-12	13,975		
Jul-12	13,731	(244)	-1.75%
Aug-12	14,509	778	5.67%
Sep-12	15,267	758	5.22%
Oct-12	14,955	(312)	-2.04%
Nov-12	15,289	334	2.23%
Dec-12	16,575	1,286	8.41%
Jan-13	16,159	(416)	-2.51%
Feb-13	16,028	(131)	-0.81%
Mar-13	16,337	309	1.93%
Apr-13	16,091	(246)	-1.51%
May-13	15,914	(177)	-1.10%
Jun-13	16,047	133	0.84%
Jul-13	15,933	(114)	-0.71%
Aug-13	17,642	1,709	10.73%
Sep-13	16,564	(1,078)	-6.11%
Oct-13	20,972	4,408	26.61%
Nov-13	19,542	(1,430)	-6.82%
Dec-13	20,376	834	4.27%
Jan-14	20,324	(52)	-0.26%
Feb-14	19,050	(1,274)	-6.27%
Mar-14	20,690	1,640	8.61%
Apr-14	20,255	(435)	-2.10%
May-14	18,554	(1,701)	-8.40%
Jun-14	18,612	58	0.31%

February 2014 Forecast	
Forecasted June 2014 Level	20,193

Base trend from June level			
FY 2014-15	18,612	-2.26%	(431)

	Caseload	**Level Change**	**% Change**
FY 2007-08	-	-	-
FY 2008-09	-	-	-
FY 2009-10	136	136	-
FY 2010-11	4,023	3,887	2858.09%
FY 2011-12	11,049	7,026	174.65%
FY 2012-13	15,575	4,526	40.96%
FY 2013-14	17,139	1,564	10.04%
FY 2014-15	16,740	(399)	-2.33%
FY 2015-16	18,080	1,340	8.00%
FY 2016-17	19,439	1,359	7.52%

Welcome-Mat Effect	
FY 2013-14	1,904
FY 2014-15	5,064
FY 2015-16	7,047
FY 2016-17	7,709

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	311
FY 2016-17	502

November 2014 Projection			
FY 2013-14	19,043	3,468	22.27%
FY 2014-15	21,804	2,761	14.50%
FY 2015-16	25,438	3,634	16.67%
FY 2016-17	27,650	2,212	8.70%

Monthly Average Growth Comparisons		
February 2014 Forecast	346	2.27%
FY 2013-14 Actuals	421	2.79%
FY 2013-14 1st Half	722	4.66%
FY 2013-14 2nd Half	(30)	0.00%
FY 2014-15 Base Forecast	169	0.87%
FY 2014-15 Adjusted Forecast	322	1.63%
February 2014 Forecast	276	1.27%
FY 2015-16 Base Forecast	137	0.64%
FY 2015-16 Adjusted Forecast	298	1.27%

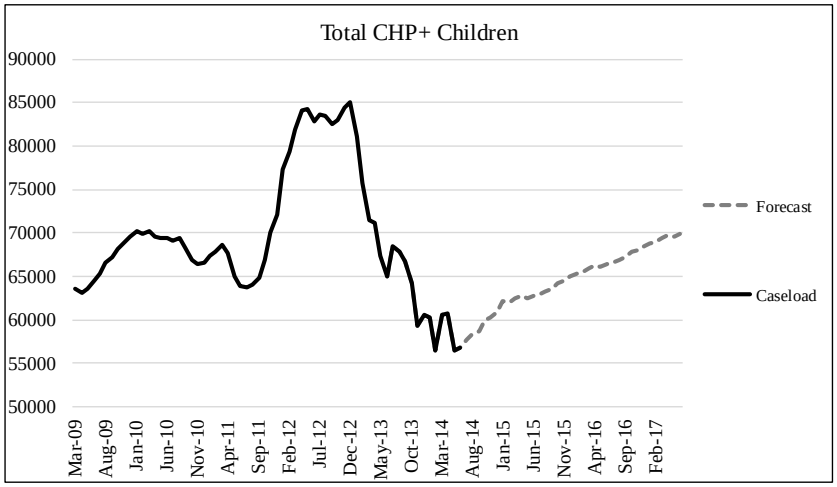
February 2014 Trend Selections			
FY 2012-13	15,575	4,526	40.96%
FY 2013-14	19,399	3,824	24.55%
FY 2014-15	21,989	2,590	13.35%
FY 2015-16	23,773	1,783	8.11%

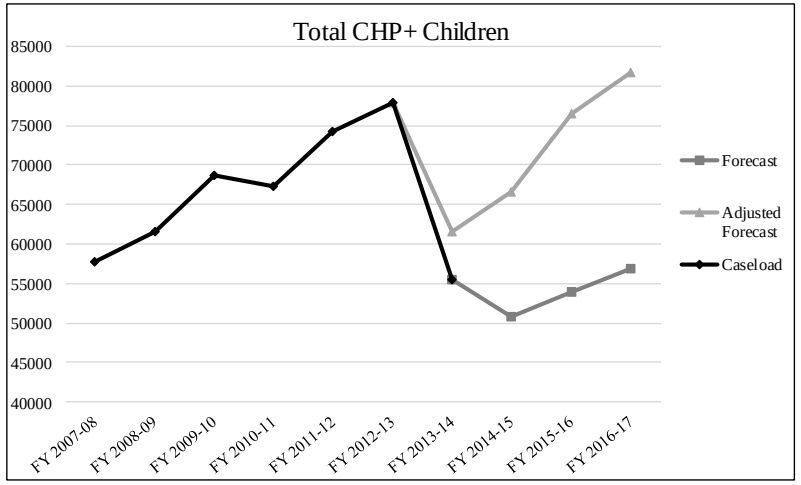
Welcome-Mat Effect	
FY 2012-13	-
FY 2013-14	-
FY 2014-15	-
FY 2015-16	-

HB 09-1353 Fiscal Note Estimate	
FY 2012-13	-
FY 2013-14	-
FY 2014-15	-
FY 2015-16	-

February 2014 Trend Selections			
FY 2012-13	15,575	4,526	40.96%
FY 2013-14	19,399	3,824	24.55%
FY 2014-15	21,989	2,590	13.35%
FY 2015-16	23,773	1,783	8.11%

Actuals		
	Monthly Change	**% Change**
6-month average	(294)	-1.35%
12-month average	214	1.66%
18-month average	113	0.93%
22-month average	193	1.44%





- The average monthly caseload in FY 2013-14 for CHP+ Children was 61,554, which was 3,549 clients, or 5.45% under the February 2014 forecast.
- Beginning in January 2013, the Department allowed the children of State employees eligible for CHP+ to enroll in the program. Although this policy change is anticipated to have a positive impact on children's caseload, the effects are difficult to anticipate. Per state statute at 25.5-8-109 (1) C.R.S. (2012), the newly eligible children must still comply with a waiting period that requires that they are not insured by a comparable health plan during the three months prior to enrolling in CHP+. The Department believes that the growth rates it has incorporated into the forecast will account for any increases due to this policy change.
- After the MAGI conversion, an income rating code used to identify clients from 201%-205% changed to 201%-213%. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-260% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- As described above, there are two bottom-line adjustment to the CHP+ children's caseload.
    - The first bottom-line adjustment is from the estimated number of new clients that will seek out CHP+ coverage either due to increased knowledge about coverage or the new insurance mandate, referred to as Eligible But Not Enrolled in SB 13-200 and the February 2014 request. The Department is now identifying this adjustment as the Welcome-Mat Effect.

The Department believes that this Effect is present in all three FPL categories. The February request only showed a Welcome-Mat Effect for children under 200% FPL, this request allows the Welcome-Mat Effect to be present in all three FPL categories. The Department estimated the Welcome-Mat Effect for FY 2013-14 and found that clients appear to be responding more quickly than originally assumed in SB 13-200. To account for this response rate to the mandate, the estimated effect has been quickened by one fiscal year. For example, the February request estimated an adjustment of 15,871 clients in FY 2015-16 and this request estimates an adjustment of 15,871 clients in FY 2014-15.

- The second bottom line impact is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ children in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.

Total CHP+ Children			
	Actuals	**Monthly Change**	**% Change**
Jun-12	82,856		
Jul-12	83,708	852	1.03%
Aug-12	83,447	(261)	-0.31%
Sep-12	82,463	(984)	-1.18%
Oct-12	83,035	572	0.69%
Nov-12	84,371	1,336	1.61%
Dec-12	85,028	657	0.78%
Jan-13	81,181	(3,847)	-4.52%
Feb-13	75,789	(5,392)	-6.64%
Mar-13	71,504	(4,285)	-5.65%
Apr-13	71,206	(298)	-0.42%
May-13	67,352	(3,854)	-5.41%
Jun-13	64,942	(2,410)	-3.58%
Jul-13	68,481	3,539	5.45%
Aug-13	67,825	(656)	-0.96%
Sep-13	66,707	(1,118)	-1.65%
Oct-13	64,266	(2,441)	-3.66%
Nov-13	59,374	(4,892)	-7.61%
Dec-13	60,526	1,152	1.94%
Jan-14	60,249	(277)	-0.46%
Feb-14	56,541	(3,708)	-6.15%
Mar-14	60,662	4,121	7.29%
Apr-14	60,691	29	0.05%
May-14	56,447	(4,244)	-6.99%
Jun-14	56,871	424	0.75%

	Caseload	**Level Change**	**% Change**
FY 2007-08	57,795		
FY 2008-09	61,582	3,787	6.55%
FY 2009-10	68,724	7,142	11.60%
FY 2010-11	67,267	(1,457)	-2.12%
FY 2011-12	74,266	6,999	10.40%
FY 2012-13	77,836	3,570	4.81%
FY 2013-14	55,399	(22,437)	-28.83%
FY 2014-15	50,796	(4,603)	-8.31%
FY 2015-16	53,868	3,072	6.05%
FY 2016-17	56,866	2,998	5.57%

February 2014 Trend Selections			
FY 2012-13	77,836	3,570	4.81%
FY 2013-14	63,979	(13,857)	-17.80%
FY 2014-15	62,964	(1,014)	-1.59%
FY 2015-16	64,668	1,704	2.71%

Welcome-Mat Effect	
FY 2013-14	6,154
FY 2014-15	15,871
FY 2015-16	21,706
FY 2016-17	23,340

Welcome-Mat Effect	
FY 2012-13	-
FY 2013-14	1,124
FY 2014-15	7,002
FY 2015-16	15,871

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	945
FY 2016-17	1,493

HB 09-1353 Fiscal Note Estimate	
FY 2012-13	-
FY 2013-14	-
FY 2014-15	945
FY 2015-16	1,493

November 2014 Projection			
FY 2013-14	61,554	(16,282)	-20.92%
FY 2014-15	66,667	5,113	8.31%
FY 2015-16	76,519	9,852	14.78%
FY 2016-17	81,699	5,180	6.77%

February 2014 Trend Selections			
FY 2012-13	77,836	3,570	4.81%
FY 2013-14	65,103	(12,733)	-16.36%
FY 2014-15	70,911	5,809	8.92%
FY 2015-16	82,032	11,121	15.68%

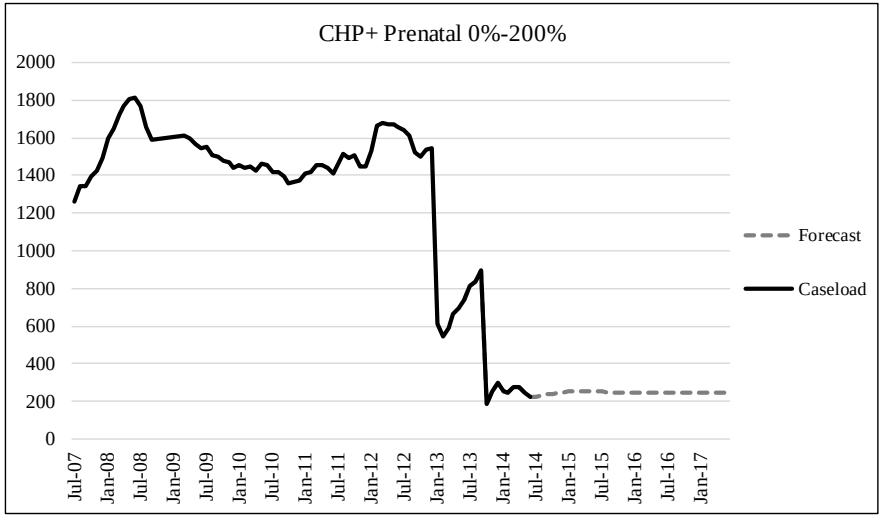
February 2014 Forecast	
Forecasted June 2014 Level	66,347

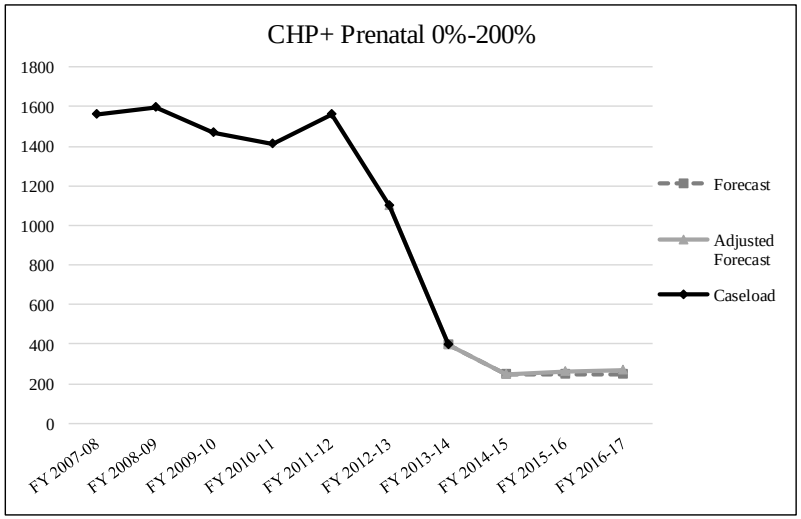
Base trend from June level			
FY 2014-15	56,871	2.66%	1,472
Base trend from Adjusted June level			
FY 2014-15	47,520	-11.78%	(6,348)

Monthly Average Growth Comparisons		
February 2014 Forecast	357	5.50%
FY 2013-14 Actuals	(425)	-0.58%
FY 2013-14 1st Half	(736)	-1.08%
FY 2013-14 2nd Half	41	0.18%
FY 2014-15 Base Forecast	490	0.83%
FY 2014-15 Adjusted Forecast	972	1.61%
February 2014 Forecast	113	0.16%
FY 2015-16 Base Forecast	304	0.47%
FY 2015-16 Adjusted Forecast	791	1.11%

Actuals		
	Monthly Change	**% Change**
6-month average	(609)	-0.92%
12-month average	(673)	-1.00%
18-month average	(1,564)	-2.12%
22-month average	(1,083)	-1.48%

Prenatal Caseload Projections (Exhibit C4)





- The average monthly caseload in FY 2013-14 for CHP+ Prenatal clients 0%-200% was 399, which was 39 clients, or 8.94% under what was forecasted in February 2014.
- There is one bottom-line adjustments to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ prenatal clients in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.
- The February request accounted the effects of SB 11-250 and MAGI as bottom line adjustments. The Department believes these effects to be complete and is no longer including bottom line adjustments for the effects of SB 11-250 and MAGI.

CHP+ Prenatal to 200%			
	Actuals	**Monthly Change**	**% Change**
Jun-12	1,660		
Jul-12	1,639	(21)	-1.27%
Aug-12	1,610	(29)	-1.77%
Sep-12	1,526	(84)	-5.22%
Oct-12	1,501	(25)	-1.64%
Nov-12	1,536	35	2.33%
Dec-12	1,542	6	0.39%
Jan-13	614	(928)	-60.18%
Feb-13	541	(73)	-11.89%
Mar-13	591	50	9.24%
Apr-13	666	75	12.69%
May-13	692	26	3.90%
Jun-13	740	48	6.94%
Jul-13	810	70	9.46%
Aug-13	835	25	3.09%
Sep-13	893	58	6.95%
Oct-13	185	(708)	-79.28%
Nov-13	255	70	37.84%
Dec-13	299	44	17.25%
Jan-14	252	(47)	-15.72%
Feb-14	243	(9)	-3.57%
Mar-14	272	29	11.93%
Apr-14	276	4	1.47%
May-14	247	(29)	-10.51%
Jun-14	222	(25)	-10.12%

February 2014 Forecast	
Forecasted June 2014 Level	352

Base trend from June level			
FY 2014-15	222	-44.36%	(177)

	Caseload	**Level Change**	**% Change**
FY 2007-08	1,557		
FY 2008-09	1,598	41	2.63%
FY 2009-10	1,470	(128)	-8.01%
FY 2010-11	1,410	(60)	-4.08%
FY 2011-12	1,563	153	10.85%
FY 2012-13	1,100	(463)	-29.62%
FY 2013-14	399	(701)	-63.73%
FY 2014-15	244	(155)	-38.85%
FY 2015-16	244	0	0.00%
FY 2016-17	244	0	0.00%

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	17
FY 2016-17	25

November 2014 Projections			
FY 2013-14	399	(701)	-63.73%
FY 2014-15	244	(155)	-38.85%
FY 2015-16	261	17	6.97%
FY 2016-17	269	8	3.07%

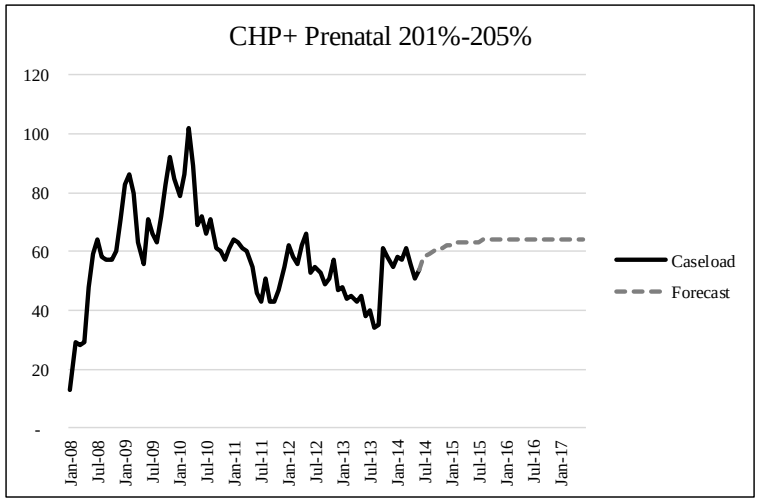
Monthly Average Growth Comparisons		
February 2014 Forecast	(32)	0.92%
FY 2013-14 Actuals	(46)	-1.06%
FY 2013-14 1st Half	(74)	-0.78%
FY 2013-14 2nd Half	(6)	-1.47%
FY 2014-15 Base Forecast	2	1.03%
FY 2014-15 Adjusted Forecast	2	1.03%
February 2014 Forecast	(17)	-5.39%
FY 2015-16 Base Forecast	(1)	-0.30%
FY 2015-16 Adjusted Forecast	1	0.28%

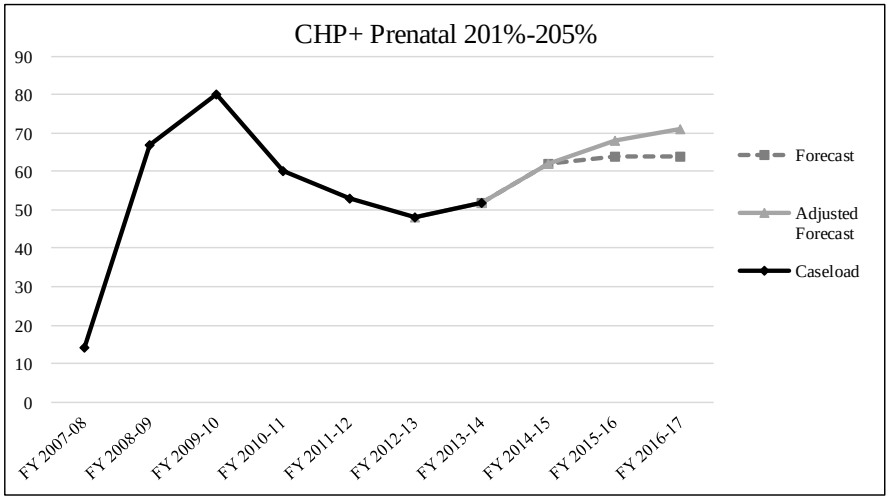
February 2014 Trend Selections			
FY 2012-13	1,100	(463)	-29.62%
FY 2013-14	438	(662)	-60.17%
FY 2014-15	141	(297)	-67.83%
FY 2015-16	175	34	23.80%

HB 09-1353 Fiscal Note Estimate	
FY 2012-13	-
FY 2013-14	-
FY 2014-15	63
FY 2015-16	96

February 2014 Trend Selections			
FY 2012-13	1,100	(463)	-29.63%
FY 2013-14	438	(662)	-60.17%
FY 2014-15	204	(234)	-53.45%
FY 2015-16	271	67	32.63%

Actuals		
	Monthly Change	**% Change**
6-month average	(13)	-4.42%
12-month average	(43)	-2.60%
18-month average	(73)	-3.92%
24-month average	(60)	-3.24%





- The average monthly caseload in FY 2013-14 for CHP+ Prenatal 201%-205% FPL was 52, which was 11 clients, or 17.7% under what was projected in the February 2014 forecast.

- Along with the children's expansion to 205% FPL, this population was created through SB 07-097 and was implemented beginning March 1, 2008. Prenatal women in this population have family incomes between 201 and 205% of the federal poverty level.
- Similar to children, this population is identified with an income rating code that represented 201%-205% FPL. After the MAGI conversion, this income rating code changed from 201%-205% to 201%-213% FPL. The Department is working to identify a discrete FPL for CHP+ clients, but until that option is available a distribution of clients over 200% FPL prior to January 2014 is being used to estimate the clients that are between 201%-205% and 206%-260% FPL after the MAGI conversion. Caseload for CHP+ clients above 200% FPL is therefore restated beginning in January 2014.
- There is one bottom-line adjustments to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ prenatal clients in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.

CHP+ Prenatal 201% to 205%

	Actuals	Monthly Change	% Change
Jun-12	53		
Jul-12	55	2	3.77%
Aug-12	53	(2)	-3.64%
Sep-12	49	(4)	-7.55%
Oct-12	51	2	4.08%
Nov-12	57	6	11.76%
Dec-12	47	(10)	-17.54%
Jan-13	48	1	2.13%
Feb-13	44	(4)	-8.33%
Mar-13	45	1	2.27%
Apr-13	43	(2)	-4.44%
May-13	45	2	4.65%
Jun-13	38	(7)	-15.56%
Jul-13	40	2	5.26%
Aug-13	34	(6)	-15.00%
Sep-13	35	1	2.94%
Oct-13	61	26	74.29%
Nov-13	58	(3)	-4.92%
Dec-13	55	(3)	-5.17%
Jan-14	58	3	5.45%
Feb-14	57	(1)	-1.72%
Mar-14	61	4	7.02%
Apr-14	56	(5)	-8.20%
May-14	51	(5)	-8.93%
Jun-14	54	3	5.88%

February 2014 Forecast	
Forecasted June Level	96

Base trend from June level			
FY 2014-15	54	3.85%	2

	Caseload	Level Change	% Change
FY 2007-08	14		
FY 2008-09	67	53	378.57%
FY 2009-10	80	13	19.40%
FY 2010-11	60	(20)	-25.00%
FY 2011-12	53	(7)	-11.67%
FY 2012-13	48	(5)	-9.43%
FY 2013-14	52	4	8.33%
FY 2014-15	62	10	19.23%
FY 2015-16	64	2	3.23%
FY 2016-17	64	0	0.00%

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	4
FY 2016-17	7

November 2014 Projection			
FY 2013-14	52	4	8.33%
FY 2014-15	62	10	19.23%
FY 2015-16	68	6	9.68%
FY 2016-17	71	3	4.41%

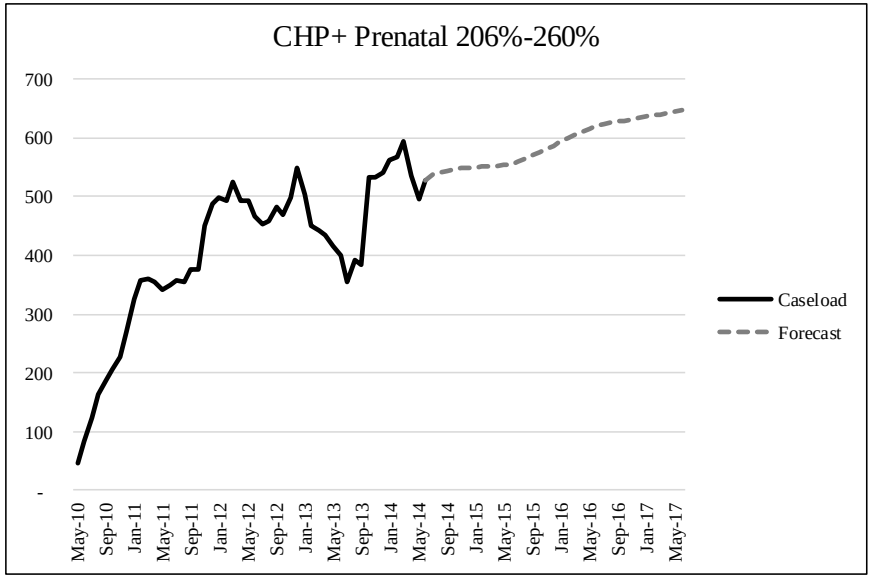
Monthly Average Growth Comparisons		
February Forecast	5	9.64%
FY 2013-14 Actuals	1	4.74%
FY 2013-14 1st Half	3	9.57%
FY 2013-14 2nd Half	(0)	-0.08%
FY 2014-15 Base Forecast	1	1.31%
FY 2014-15 Adjusted Forecast	1	1.31%
February 2014 Forecast	0	0.00%
FY 2015-16 Base Forecast	0	0.13%
FY 2015-16 Adjusted Forecast	0	0.65%

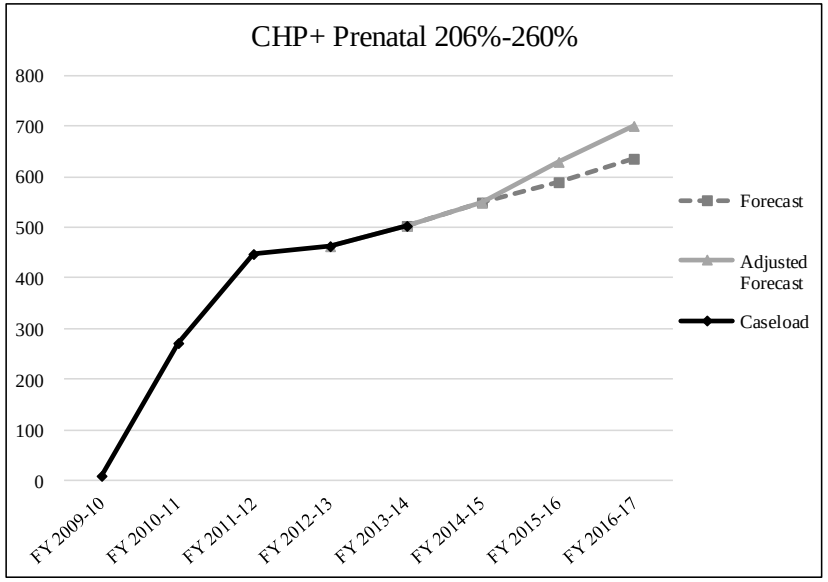
February Trend Selections			
FY 2012-13	48	(5)	-10.02%
FY 2013-14	63	15	31.86%
FY 2014-15	75	12	18.74%
FY 2015-16	82	7	8.89%

HB 09-1353 Fiscal Note Estimate	
FY 2012-13	-
FY 2013-14	-
FY 2014-15	-
FY 2015-16	-

February 2014 Trend Selections			
FY 2012-13	48	(5)	-10.02%
FY 2013-14	63	15	31.86%
FY 2014-15	75	12	18.74%
FY 2015-16	82	7	8.89%

Actuals		
	Monthly Change	% Change
6-month average	0	-0.08%
12-month average	1	4.74%
18-month average	0	2.09%
24-month average	0	1.19%





- The average monthly caseload in FY 2013-14 for CHP+ Prenatal 206%-260% FPL was 502, 7 clients or 1.42% under what was forecasted in February 2014.

- This population was created through HB 09-1293, and was implemented beginning May 1, 2010. Pregnant women in this population have family incomes between 206% and 260% of the federal poverty level.
- There is one bottom-line adjustments to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ prenatal clients in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.

CHP+ Prenatal 206% to 250%

	Actuals	Monthly Change	% Change
Jun-12	466		
Jul-12	452	(14)	-3.00%
Aug-12	459	7	1.55%
Sep-12	482	23	5.01%
Oct-12	470	(12)	-2.49%
Nov-12	498	28	5.96%
Dec-12	550	52	10.44%
Jan-13	504	(46)	-8.36%
Feb-13	451	(53)	-10.52%
Mar-13	442	(9)	-2.00%
Apr-13	435	(7)	-1.58%
May-13	417	(18)	-4.14%
Jun-13	399	(18)	-4.32%
Jul-13	354	(45)	-11.28%
Aug-13	393	39	11.02%
Sep-13	385	(8)	-2.04%
Oct-13	533	148	38.44%
Nov-13	534	1	0.19%
Dec-13	540	6	1.12%
Jan-14	561	21	3.89%
Feb-14	566	5	0.89%
Mar-14	593	27	4.77%
Apr-14	536	(57)	-9.61%
May-14	496	(40)	-7.46%
Jun-14	527	31	6.25%

February Forecast	
Forecasted June Level	574

Base trend from June level			
FY 2014-15	527	4.98%	25

	Caseload	Level Change	% Change
FY 2007-08	-	-	-
FY 2008-09	-	-	-
FY 2009-10	11	-	-
FY 2010-11	272	261	2372.73%
FY 2011-12	448	176	64.71%
FY 2012-13	463	15	3.35%
FY 2013-14	502	39	8.42%
FY 2014-15	548	46	9.16%
FY 2015-16	590	42	7.66%
FY 2016-17	635	45	7.63%

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	41
FY 2016-17	65

November 2014 Projection			
FY 2013-14	502	39	8.42%
FY 2014-15	548	46	9.16%
FY 2015-16	631	83	15.15%
FY 2016-17	700	69	10.94%

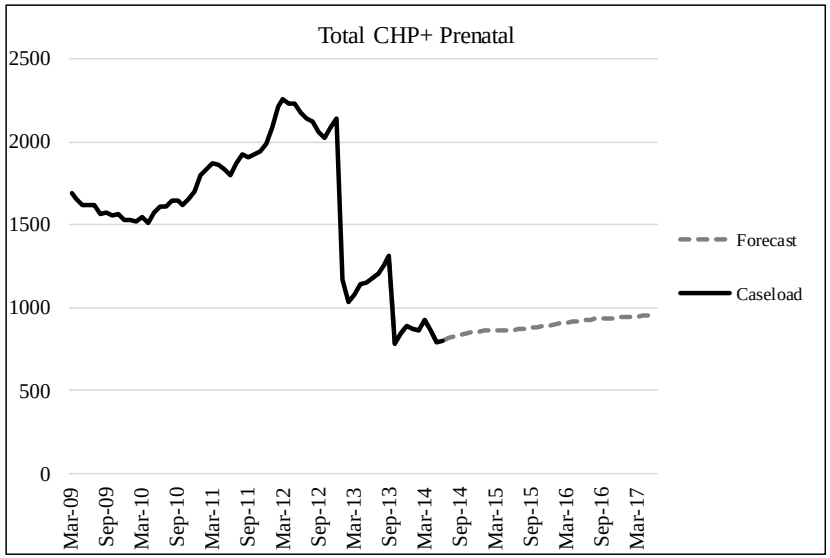
Monthly Average Growth Comparisons		
February Forecast	15	3.67%
FY 2013-14 Actuals	14	3.74%
FY 2013-14 1st Half	24	6.24%
FY 2013-14 2nd Half	(1)	-0.02%
FY 2014-15 Base Forecast	2	0.76%
FY 2014-15 Adjusted Forecast	2	0.40%
February 2014 Forecast	(0)	-0.04%
FY 2015-16 Base Forecast	6	0.64%
FY 2015-16 Adjusted Forecast	12	1.95%

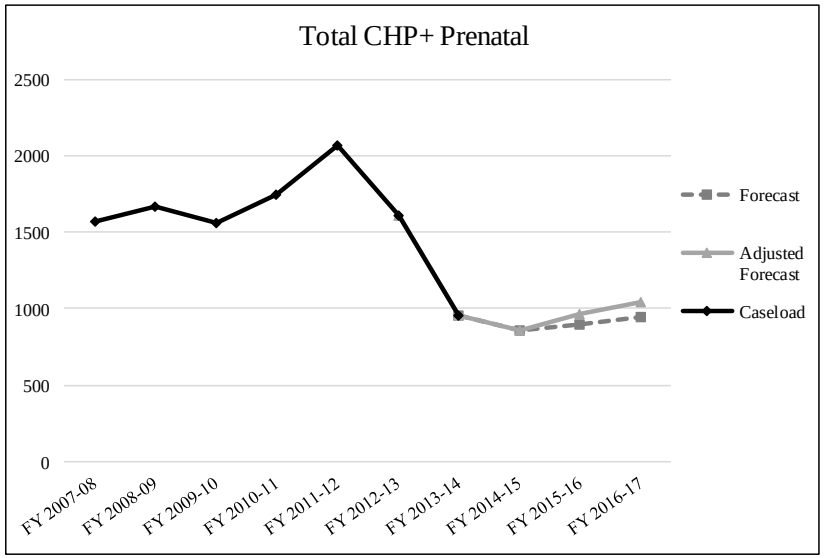
February Trend Selections			
FY 2012-13	463	15	3.40%
FY 2013-14	509	46	9.92%
FY 2014-15	573	64	12.59%
FY 2015-16	598	25	4.38%

HB 09-1353 Fiscal Note Estimate	
FY 2012-13	-
FY 2013-14	-
FY 2014-15	-
FY 2015-16	-

February Trend Selections			
FY 2012-13	463	15	3.40%
FY 2013-14	509	46	9.92%
FY 2014-15	573	64	12.59%
FY 2015-16	598	25	4.38%

Actuals		
	Monthly Change	% Change
6-month average	(2)	-0.21%
12-month average	11	3.02%
18-month average	(1)	0.29%
24-month average	3	0.95%





- The FY 2013-14 average monthly caseload for CHP+ prenatal was 953, which was 58 clients, or 5.7% under what was forecast in February 2014.
- There is one bottom-line adjustments to the CHP+ prenatal caseload. It is from the continued implementation of HB 09-1353, which removes the 5 year bar on legal immigrant children and pregnant adults. This 5 year bar was removed for pregnant adults in Medicaid, but not for Medicaid Eligible Children or CHP+ clients. The Department plans to implement this for CHP+ prenatal clients in FY 2015-16. The original calculation estimated an impact only for clients under 200%. The Department has changed this assumption and believes that the implementation of HB 09-1353 will affect all FPL categories in CHP+.
- The February request accounted the effects of SB 11-250 and MAGI as bottom line adjustments. The Department believes these effects to be complete and is no longer including bottom line adjustments for the effects of SB 11-250 and MAGI.

Total CHP+ Prenatal			
	Actuals	**Monthly Change**	**% Change**
Jun-12	2,179		
Jul-12	2,146	(33)	-1.51%
Aug-12	2,122	(24)	-1.12%
Sep-12	2,057	(65)	-3.06%
Oct-12	2,022	(35)	-1.70%
Nov-12	2,091	69	3.41%
Dec-12	2,139	48	2.30%
Jan-13	1,166	(973)	-45.49%
Feb-13	1,036	(130)	-11.15%
Mar-13	1,078	42	4.05%
Apr-13	1,144	66	6.12%
May-13	1,154	10	0.87%
Jun-13	1,177	23	1.99%
Jul-13	1,204	27	2.29%
Aug-13	1,262	58	4.82%
Sep-13	1,313	51	4.04%
Oct-13	779	(534)	-40.67%
Nov-13	847	68	8.73%
Dec-13	894	47	5.55%
Jan-14	871	(23)	-2.57%
Feb-14	866	(5)	-0.57%
Mar-14	926	60	6.93%
Apr-14	868	(58)	-6.26%
May-14	794	(74)	-8.53%
Jun-14	803	9	1.13%

February 2014 Forecast	
Forecasted June 2014 Level	1,022

Base trend from June level			
FY 2014-15	803	-15.74%	(150)

	Caseload	**Level Change**	**% Change**
FY 2007-08	1,571		
FY 2008-09	1,665	94	5.98%
FY 2009-10	1,561	(104)	-6.25%
FY 2010-11	1,742	181	11.60%
FY 2011-12	2,064	322	18.48%
FY 2012-13	1,611	(453)	-21.95%
FY 2013-14	953	(658)	-40.84%
FY 2014-15	854	(99)	-10.39%
FY 2015-16	898	44	5.15%
FY 2016-17	943	45	5.01%

HB 09-1353 Adjustment	
FY 2013-14	-
FY 2014-15	-
FY 2015-16	63
FY 2016-17	96

November 2014 Projection			
FY 2013-14	953	(658)	-40.84%
FY 2014-15	854	(99)	-10.39%
FY 2015-16	961	107	12.53%
FY 2016-17	1,039	78	8.12%

Monthly Average Growth Comparisons		
February 2014 Forecast	(13)	-0.15%
FY 2013-14 Actuals	(31)	-2.09%
FY 2013-14 1st Half	(47)	-2.54%
FY 2013-14 2nd Half	(15)	-1.65%
FY 2014-15 Base Forecast	5	0.65%
FY 2014-15 Adjusted Forecast	5	0.65%
February 2014 Forecast	(36)	-4.51%
FY 2015-16 Base Forecast	5	0.56%
FY 2015-16 Adjusted Forecast	14	1.53%

February 2014 Trend Selections			
FY 2012-13	1,611	(453)	-21.94%
FY 2013-14	1,011	(601)	-37.28%
FY 2014-15	789	(221)	-21.89%
FY 2015-16	855	65	8.28%

HB 09-1353 Fiscal Note Estimate	
FY 2012-13	-
FY 2013-14	-
FY 2014-15	63
FY 2015-16	96

February 2014 Trend Selections			
FY 2012-13	1,611	(453)	40.96%
FY 2013-14	1,011	(601)	-37.28%
FY 2014-15	852	(158)	-15.66%
FY 2015-16	951	98	11.54%

Actuals		
	Monthly Change	**% Change**
6-month average	(15)	-1.65%
12-month average	(31)	-2.09%
18-month average	(74)	-3.82%
22-month average	(57)	-2.93%

Exhibit	Title of Exhibit
Exhibit C1	Calculation of Current Total Long Bill Group Impact
Exhibit C2	Calculation of Fund Splits
Exhibit C2	Cash Fund Report
Exhibit C2	Recoveries
Exhibit C3	CBHP Expenditure Summary
Exhibit C4	CBHP Caseload by Fiscal Year
Exhibit C4	CBHP Caseload by Month
Exhibit C4	CBHP Capitation Payments Per Capita Historical Summary
Exhibit C4	CBHP Historical Expenditure Summary
Exhibit C5	CBHP Trust Fund Population Exhibit
Exhibit C5	Hospital Provider Fee Population Exhibit
Exhibit C5	Enrollment Fees Exhibit
Exhibit C6	Expenditure Calculations by Eligibility Category
Exhibit C6	Incurred But Not Reported Runout by Fiscal Period
Exhibit C6	Incurred But Not Reported Expenditures by Fiscal Period
Exhibit C7	Bottom Line Impact Summary
Exhibit C7	Bottom Line Impact Calculations
Exhibit C8	CBHP Retroactivity Adjustment
Exhibit C8	CBHP Partial Month Adjustment Multiplier
Exhibit C9	CBHP Capitation Rate Trends and Forecasts
Exhibit C10	Forecast Model Comparisons - Capitation Trend Models - Final Forecasts

Exhibit C1 - Calculation of Current Total Long Bill Group Impact

FY 2014-15 Children's Basic Health Plan Capitation

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2014-15 Chilldren's Basic Health Plan Capitation Appropriation						
FY 2014-15 Long Bill Appropriation (HB 14-1336)	$199,702,385	$21,830,882	$423,600	$48,226,542	$0	$129,221,361
Bill Annualizations						
HB 14-1213 "Pharmacy Benefits Manager Requirements"	$129,831	$44,519	$0	$0	$0	$85,312
Total Annualizations	**$129,831**	**$44,519**	**$0**	**$0**	**$0**	**$85,312**
FY 2014-15 Total Children's Basic Heath Plan Capitation Spending Authority	**$199,832,216**	**$21,875,401**	**$423,600**	**$48,226,542**	**$0**	**$129,306,673**
Projected Total FY 2014-15 CBHP Capitation Expenditure	**$183,909,178**	**$17,113,975**	**$423,600**	**$48,464,456**	**$0**	**$117,907,147**
FY 2014-15 Children's Basic Health Plan Capitation Estimated Change from Appropriation	**($15,923,038)**	**($4,761,426)**	**$0**	**$237,914**	**$0**	**($11,399,526)**
Percent Change from Spending Authority	-7.97%	-21.77%	0.00%	0.49%	-	-8.82%

FY 2014-15 CBHP External Admin

FY 2014-15 CBHP External Admin Appropriation						
FY 2014-15 Long Bill Appropriation (HB 14-1336)	$5,127,772	$0	$0	$2,404,035	$0	$2,723,737
FY 2014-15 Total CBHP External Admin Spending Authority	**$5,127,772**	**$0**	**$0**	**$2,404,035**	**$0**	**$2,723,737**
Projected Total FY 2014-15 CBHP External Admin Expenditure	**$5,127,772**	**$0**	**$0**	**$2,404,035**	**$0**	**$2,723,737**
Total FY 2014-15 CBHP External Admin Change from Appropriation	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Percent Change from Spending Authority	0.00%	-	-	0.00%	-	0.00%

Exhibit C1 - Calculation of Current Total Long Bill Group Impact

FY 2015-16 Children's Basic Health Plan Capitation

Item	Total Request	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds
FY 2014-15 CBHP Capitation Appropriation Plus Special Bills	**$199,832,216**	**$21,875,401**	**$423,600**	**$48,226,542**	**$0**	**$129,306,673**
Bill Annualizations						
HB 09-1353 Annualization "Removing 5 Year Bar for Legal Immigrant Pregnant Women and Children"	$1,822,218	($229,710)		$0	$0	$2,051,928
HB 14-1213 Annualization "Pharmacy Benefits Manager Requirements"	$189,164	$9,838		$0	$0	$179,326
FY 2014-15 BA#11 Annualization "CHP Oral Health Care Benefits"	$1,178,100	($1,334,347)	$0	$599,171	$0	$1,913,276
SB 13-200 Annualization "Expand Medicaid Eligibility"	$16,826,706	$758,121	$0	$180,997	$0	$15,887,588
Total Annualizations	**$20,016,188**	**($796,098)**	**$0**	**$780,168**	**$0**	**$20,032,118**
FY 2015-16 CBHP Capitation Base Amount	**$219,848,404**	**$21,079,303**	**$423,600**	**$49,006,710**	**$0**	**$149,338,791**
Projected Total FY 2015-16 CBHP Capitation Expenditure	**$204,456,263**	**$0**	**$0**	**$36,083,989**	**$0**	**$168,372,274**
Total FY 2015-16 CBHP Capitation Request	**($15,392,141)**	**($21,079,303)**	**($423,600)**	**($12,922,721)**	**$0**	**$19,033,483**
Percent Change from FY 2015-16 CBHP Capitation Base	-7.00%	-100.00%	-100.00%	-26.37%	-	12.75%
Percent Change from FY 2014-15 Estimated CBHP Capitation Expenditure	11.17%	-100.00%	-100.00%	-25.55%	-	42.80%

FY 2015-16 CBHP External Admin

FY 2014-15 CBHP External Admin Appropriation Plus Special Bills	**$5,127,772**	**$0**	**$0**	**$2,404,035**	**$0**	**$2,723,737**
Bill Annualizations						
FY 2014-15 R-12 Annualization "Administrative Contract Reprocurements"	($808,693)	$0		($384,453)	$0	($424,240)
SB 13-200 "Expand Medicaid Eligibility"	$714,195	$0		$344,242	$0	$369,953
Total Annualizations	**($94,498)**	**$0**	**$0**	**($40,211)**	**$0**	**($54,287)**
FY 2015-16 CBHP External Admin Base Amount	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
Projected Total FY 2015-16 CBHP External Admin Expenditure	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
Total FY 2015-16 CBHP External Admin Request	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Percent Change from FY 2015-16 CBHP External Admin Base	0.00%	0.00%	-	0.00%	-	0.00%
Percent Change from FY 2014-15 Estimated CBHP External Admin Expenditure	-1.84%	-	-	-1.67%	-	-1.99%

Exhibit C1 - Calculation of Current Total Long Bill Group Impact						
FY 2016-17 Children's Basic Health Plan Capitation						
Item	**Total Request**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**
FY 2015-16 CBHP Capitation Appropriation Plus Special Bills	**$219,848,404**	**$21,079,303**	**$423,600**	**$49,006,710**	**$0**	**$149,338,791**
FY 2016-17 CBHP Capitation Base Amount	**$219,848,404**	**$21,079,303**	**$423,600**	**$49,006,710**	**$0**	**$149,338,791**
Projected Total FY 2016-17 CBHP Capitation Expenditure	**$226,695,319**	**$0**	**$0**	**$27,026,635**	**$0**	**$199,668,684**
Total FY 2016-17 CBHP Capitation Continuation Amount	**$6,846,915**	**($21,079,303)**	**($423,600)**	**($21,980,075)**	**$0**	**$50,329,893**
Percent Change from FY 2016-17 CBHP Capitation Base	3.11%	-100.00%	-100.00%	-44.85%	-	33.70%
Percent Change from FY 2015-16 Estimated CBHP Capitation Expenditure	10.88%	-	-	-25.10%	-	18.59%
FY 2016-17 CBHP External Admin						
FY 2015-16 CBHP External Admin Appropriation Plus Special Bills	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
FY 2016-17 CBHP External Admin Base Amount	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
Projected Total FY 2016-17 CBHP External Admin Expenditure	**$5,033,274**	**$0**	**$0**	**$2,363,824**	**$0**	**$2,669,450**
Total FY 2016-17 CBHP External Admin Continuation Amount	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Percent Change from FY 2016-17 CBHP External Admin Base	0.00%	0.00%	-	0.00%	-	0.00%
Percent Change from FY 2015-16 Estimated CBHP External Admin Expenditure	0.00%	-	-	0.00%	-	0.00%

Exhibit C2 - Calculation of Fund Splits

Calculation of Fund Splits - FY 2014-15 Children's Basic Health Plan Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FMAP Rate[1]
CBHP Expenditure to be matched	$182,575,603	$62,933,811	$0	$0	$119,641,792	65.53%
Enrollment Fees CBHP Trust Fund	$498,187	$0	$498,187	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$799,288	$0	$799,288	$0	$0	0.00%
Total CBHP Expenditure	**$183,873,078**	**$62,933,811**	**$1,297,475**	**$0**	**$119,641,792**	65.07%
Cash Fund Financing						
CBHP Trust Fund	$0	($23,681,019)	$23,681,019	$0	$0	NA
CO Immunization Fund	$0	($229,694)	$229,694	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Hospital Provider Fee Fund	$0	($20,824,695)	$20,824,695	$0	$0	NA
Estimated FY 2014-15 Capitation Expenditure	**$183,873,078**	**$18,198,402**	**$46,032,884**	**$0**	**$119,641,792**	65.07%
Recoveries	$0	($673,462)	$2,431,572	$0	($1,758,110)	65.00%
Retainage Payments - CO Access	$36,100	$12,635	$0	$0	$23,465	65.00%
Final Estimated FY 2014-15 Capitation Expenditure	**$183,909,178**	**$17,537,575**	**$48,464,456**	**$0**	**$117,907,147**	64.11%
CBHP Admin Payments	**$5,127,772**	**$0**	**$2,404,035**	**$0**	**$2,723,737**	53.12%
Final Estimated FY 2014-15 CBHP Expenditure	**$189,036,950**	**$17,537,575**	**$50,868,491**	**$0**	**$120,630,884**	63.81%

[1]Starting October 1, 2014, CBHP programs will receive a federal match of 65.71% instead of the historical 65%. The weighted average federal match is 65.53%.

Exhibit C2 - Calculation of Fund Splits

Calculation of Fund Splits - FY 2015-16 Children's Basic Health Plan Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FMAP Rate[(1)]
CBHP Expenditure to be matched	$202,955,971	$34,583,697	$0	$0	$168,372,274	82.96%
Enrollment Fees CBHP Trust Fund	$567,789	$0	$567,789	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$932,503	$0	$932,503	$0	$0	0.00%
Total CBHP Expenditure	**$204,456,263**	**$34,583,697**	**$1,500,292**	**$0**	**$168,372,274**	82.35%
Cash Fund Financing						
CBHP Trust Fund	$0	($22,495,704)	$22,495,704	$0	$0	NA
CO Immunization Fund	$0	($229,297)	$229,297	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Hospital Provider Fee Fund	$0	($11,858,695)	$11,858,695	$0	$0	NA
Estimated FY 2015-16 Capitation Expenditure	**$204,456,263**	**$0**	**$36,083,989**	**$0**	**$168,372,274**	82.35%
CBHP Admin Payments	**$5,033,274**	**$0**	**$2,363,824**	**$0**	**$2,669,450**	53.04%
Final Estimated FY 2015-16 CBHP Expenditure	**$209,489,537**	**$0**	**$38,447,813**	**$0**	**$171,041,724**	81.65%

[(1)]Starting October 1, 2015, CBHP programs will receive an additional 23 percentage points on the federal match. The weighted average federal match is 82.96%.

Exhibit C2 - Calculation of Fund Splits

Calculation of Fund Splits - FY 2016-17 Children's Basic Health Plan Estimate

Item	Total Estimate	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FMAP Rate[(1)]
CBHP Expenditure to be matched	$225,080,243	$25,411,559	$0	$0	$199,668,684	88.71%
Enrollment Fees CBHP Trust Fund	$601,454	$0	$601,454	$0	$0	0.00%
Enrollment Fees Hospital Provider Fee	$1,013,622	$0	$1,013,622	$0	$0	0.00%
Total CBHP Expenditure	**$226,695,319**	**$25,411,559**	**$1,615,076**	**$0**	**$199,668,684**	88.08%
Cash Fund Financing						
CBHP Trust Fund	$0	($16,262,297)	$16,262,297	$0	$0	NA
CO Immunization Fund	$0	($212,548)	$212,548	$0	$0	NA
Health Care Expansion Fund	$0	($1)	$1	$0	$0	NA
Hospital Provider Fee Fund	$0	($8,936,713)	$8,936,713	$0	$0	NA
Final Estimated FY 2016-17 Capitation Expenditure	**$226,695,319**	**$0**	**$27,026,635**	**$0**	**$199,668,684**	88.08%
CBHP Admin Payments	**$5,033,274**	**$0**	**$2,363,824**	**$0**	**$2,669,450**	53.04%
Final Estimated FY 2016-17 CBHP Expenditure	**$231,728,593**	**$0**	**$29,390,459**	**$0**	**$202,338,134**	87.32%

[(1)]Starting October 1, 2015, CBHP programs will receive an additional 23 percentage points on the federal match. The new federal match is 88.71%.

Exhibit C2 - Cash Funds Report for CBHP

Cash Funds Report for CBHP Capitation Payments

Cash Fund	FY 2014-15			FY 2015-16			FY 2016-17		
	Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change
Cash Funds									
CBHP Trust Fund[1]	$24,779,986	$24,179,206	($600,780)	$25,803,278	$23,063,493	($2,739,785)	$25,803,278	$16,863,751	($8,939,527)
CO Immunization Fund	$234,000	$229,694	($4,306)	$234,000	$229,297	($4,703)	$234,000	$212,548	($21,452)
Health Care Expansion Fund	$1	$1	$0	$1	$1	$0	$1	$1	$0
Hospital Provider Fee Fund	$23,212,555	$21,350,771	($1,861,784)	$22,969,431	$12,791,198	($10,178,233)	$22,969,431	$9,950,335	($13,019,096)
Recoveries	$0	$2,704,784	$2,704,784	$0	$0	$0	$0	$0	$0
Total Cash Funds	**$48,226,542**	**$48,464,456**	**$237,914**	**$49,006,710**	**$36,083,989**	**($12,922,721)**	**$49,006,710**	**$27,026,635**	**($21,980,075)**

[1]Estimated revenues to the CBHP Trust Fund are based on the 2014 Tobacco MSA Payment Forecast. See Exhibit C5.

Cash Funds Report for CBHP Admin Payments

Cash Fund	FY 2014-15			FY 2015-16			FY 2016-17		
	Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change	Base Spending Authority	Estimate	Change
Cash Funds									
CBHP Trust Fund[1][2]	$2,394,674	$2,394,674	$0	$2,354,463	$2,354,463	$0	$2,354,463	$2,354,463	$0
CO Immunization Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Care Expansion Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0
Hospital Provider Fee Fund	$9,361	$9,361	$0	$9,361	$9,361	$0	$9,361	$9,361	$0
Total Cash Funds	**$2,404,035**	**$2,404,035**	**$0**	**$2,363,824**	**$2,363,824**	**$0**	**$2,363,824**	**$2,363,824**	**$0**

[1]Estimated revenues to the CBHP Trust Fund are based on the 2014 Tobacco MSA Payment Forecast. See Exhibit C5 for more details.

[2]SB 13-200 adds $344,242 to the General Fund in FY 2015-16. Due to the 23 percentage point increase in FMAP beginning October 2015, there is sufficient revenue in the CHP Trust Fund to cover this additional $344,242. The Department has increased the CHP Trust Fund appropriation and decreased the General Fund appropriation by the $344,242.

Exhibit C2-Estimated Recoveries				
Recovery Category	**Children to 200% FPL**	**Children 201%-205% FPL**	**Children 206%-260% FPL**	**Total**
CO Access Duplicate Payment[(1)]	$1,104,397	$51,714	$461,276	$1,617,387
CO Access Duplicate Payment[(2)]	$726,690	$41,377	$319,330	$1,087,397
Total Recoveries	$1,831,087	$93,091	$780,606	$2,704,784

[(1)] Beginning in January 2013, systems issues created duplicate payments for CHP+ clients in the State Managed Care Network. The Department anticipates a reimbursement for these duplicate payments in this fiscal year 2014-15. The Department also assumes the systems issue to be fully resolved in FY 2014-15. In FY 2013-14, $25 million dollars out of the estimated $27,391,762 for months April 2013 through February 2014 was recovered. The Department expects to recover the remaining $2,391,762 in FY 2014-15.

[(2)] The Department has estimated a total of $1,087,396 in duplication to CO Access for months March 2014 through June 2014 and expects this amount to be recovered in FY 2014-15.

Fund Splits						
Total CBHP Expenditure Impact	**Total Funds**	**General Fund**	**Hospital Provider Fee**	**Recoveries Funds**	**Federal Funds**	**FMAP**
Recoveries from Prior Years	$0	($673,462)	($273,212)	$2,704,784	($1,758,110)	65.00%

Exhibit C3 - Children's Basic Health Plan Programs Expenditure Summary
Actuals, Appropriations and Estimates Prior to Recoupments

ITEM	FY 2013-14 Actual		FY 2014-15 Appropriated		FY 2014-15 Estimate		FY 2014-15 Change from Appropriation		FY 2015-16 Estimate		FY 2015-16 Change from FY 2014-15 Estimate		FY 2015-16 Change from FY 2014-15 Appropriation		FY 2016-17 Estimate		FY 2016-17 Change from FY 2015-16 Estimate	
	Caseload	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**	**Caseload**	**Expenditure**
CHP+ Capitation Payments																		
Children to 200% FPL Medical	40,561	$88,927,881	45,810	$112,696,533	42,640	$93,360,712	(3,170)	($19,335,821)	48,584	$108,557,431	5,944	$15,196,719	2,774	($4,139,102)	51,446	$119,890,326	2,862	$11,332,895
Children 201%-205% FPL Medical	1,950	$5,580,800	2,167	$5,340,884	2,223	$4,819,620	56	($521,264)	2,497	$5,532,690	274	$713,070	330	$191,806	2,603	$6,073,447	106	$540,757
Children 206%-260% FPL Medical	19,043	$38,000,333	21,989	$48,816,926	21,804	$45,795,084	(185)	($3,021,842)	25,438	$55,664,301	3,634	$9,869,217	3,449	$6,847,375	27,650	$63,696,225	2,212	$8,031,924
Children to 200% FPL Dental	40,561	$7,701,614	45,810	$13,038,034	42,640	$11,247,314	(3,170)	($1,790,720)	48,584	$13,509,010	5,944	$2,261,696	2,774	$470,976	51,446	$15,230,482	2,862	$1,721,472
Children 201%-205% FPL Dental	1,950	$370,482	2,167	$536,681	2,223	$564,209	56	$27,528	2,497	$661,813	274	$97,604	330	$125,132	2,603	$731,500	106	$69,687
Children 206%-260% FPL Dental	19,043	$3,217,912	21,989	$5,325,979	21,804	$5,089,512	(185)	($236,467)	25,438	$6,242,554	3,634	$1,153,042	3,449	$916,575	27,650	$7,164,138	2,212	$921,584
Prenatal to 200% FPL	399	$2,157,413	141	$3,022,131	244	$3,003,437	103	($18,694)	261	$3,324,975	17	$321,538	120	$302,844	269	$3,661,244	8	$336,269
Prenatal 201%-205% FPL	52	$221,942	75	$948,577	62	$712,452	(13)	($236,125)	68	$842,551	6	$130,099	(7)	($106,026)	71	$938,692	3	$96,141
Prenatal 206%-260% FPL	502	$4,848,045	573	$7,359,086	548	$6,403,830	(25)	($955,256)	631	$7,870,938	83	$1,467,108	58	$511,852	700	$9,309,265	69	$1,438,327
Bottom Line Impacts																		
FQHC Payments		*$0*		*$2,747,385*		*$10,725,000*		*$7,977,615*		*$2,250,000*		*($8,475,000)*		*($497,385)*		*$0*		*($2,250,000)*
Prenatal Capitations		*$0*		*$0*		*$1,651,908*		*$1,651,908*		*$0*		*($1,651,908)*		*$0*		*$0*		*$0*
Clients disenrolled with missing denial codes		*$0*		*$0*		*$500,000*		*$500,000*		*$0*		*($500,000)*		*$0*		*$0*		*$0*
Recoveries		*$31,726,633*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*		*$0*
Retainage Payments - CO Access		*$0*		*$0*		*$36,100*		*$36,100*		*$0*		*($36,100)*		*$0*		*$0*		*$0*
Sub-total CBHP Program Expenditure	**62,507**	**$182,753,054**	**70,755**	**$199,832,216**	**67,521**	**$183,909,178**	**(3,234)**	**($15,923,038)**	**77,479**	**$204,456,263**	**9,958**	**$20,547,085**	**6,724**	**$4,624,047**	**82,739**	**$226,695,319**	**5,260**	**$22,239,056**
Enrollment Fees		$904,328		$2,333,911		$1,297,475		($1,036,436)		$1,500,292		$202,817		($833,619)		$1,615,076		$114,783
Children to 200%		*$494,993*		*$234,338*		*$472,198*		*$237,859*		*$538,600*		*$66,403*		*$304,262*		*$571,027*		*$32,427*
Children 201%-205%		*$47,681*		*$110,721*		*$25,989*		*($84,731)*		*$29,189*		*$3,200*		*($81,532)*		*$30,426*		*$1,238*
Children 206%-260%		*$361,653*		*$1,988,852*		*$799,288*		*($1,189,564)*		*$932,503*		*$133,215*		*($1,056,349)*		*$1,013,622*		*$81,119*
Total CBHP Program Expenditure	**62,507**	**$182,753,054**	**70,755**	**$199,832,216**	**67,521**	**$183,909,178**	**(3,234)**	**($15,923,038)**	**77,479**	**$204,456,263**	**9,958**	**$20,547,085**	**6,724**	**$4,624,047**	**82,739**	**$226,695,319**	**5,260**	**$22,239,056**
Incremental Percent Change							-4.57%	-7.97%			14.75%	11.17%	9.50%	2.31%			6.79%	10.88%
CBHP Admin Payments																		
External Admin		$4,013,739		$5,127,772		$5,127,772		$0		$5,033,274		($94,498)		($94,498)		$5,033,274		$0
Incremental Percent Change								0.00%				-1.84%						0.00%
Total CBHP Admin Payments		**$4,013,739**		**$5,127,772**		**$5,127,772**		**$0**		**$5,033,274**		**($94,498)**		**($94,498)**		**$5,033,274**		**$0**
Total CBHP Programs		**$186,766,793**		**$204,959,988**		**$189,036,950**		**($15,923,038)**		**$209,489,537**		**$20,452,587**		**$4,529,549**		**$231,728,593**		**$22,239,056**
Incremental Percent Change								-7.77%				10.82%		2.21%				10.62%

Exhibit C4 - Children's Basic Health Plan, Caseload

Children's Basic Health Plan Average Caseload By Fiscal Year

Item	Children to 200% FPL	Children 201%-205% FPL	Children 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	CBHP TOTAL
FY 2004-05 Actuals	38,255	-	-	484	-	-	38,739
FY 2005-06 Actuals	46,755	-	-	1,129	-	-	47,884
% Change from FY 2004-05	22.22%	-	-	133.41%	-	-	23.61%
FY 2006-07 Actuals	52,199	-	-	1,336	-	-	53,535
% Change from FY 2005-06	11.64%	-	-	18.27%	-	-	11.80%
FY 2007-08 Actuals	57,466	330	-	1,557	14	-	59,367
% Change from FY 2006-07	10.09%	-	-	16.57%	-	-	10.89%
FY 2008-09 Actuals	60,137	1,445	-	1,598	67	-	63,247
% Change from FY 2007-08	4.65%	337.88%	-	2.63%	378.57%	-	6.54%
FY 2009-10 Actuals	66,940	1,649	136	1,469	80	11	70,285
% Change from FY 2008-09	11.31%	14.12%	-	-8.07%	19.40%	-	11.13%
FY 2010-11 Actuals	62,080	1,164	4,023	1,409	60	272	69,008
% Change from FY 2009-10	-7.26%	-29.41%	2858.09%	-4.08%	-25.00%	2372.73%	-1.82%
FY 2011-12 Actuals	61,815	1,402	11,049	1,563	53	448	76,330
% Change from FY 2010-11	-0.43%	20.45%	174.65%	10.94%	-11.25%	64.61%	10.61%
FY 2012-13 Actuals	60,646	1,614	15,575	1,100	48	463	79,446
% Change from FY 2011-12	-1.89%	15.12%	40.96%	-29.63%	-9.86%	3.41%	4.08%
FY 2013-14 Actuals	40,561	1,950	19,043	399	52	502	62,505
% Change from FY 2012-13	-33.12%	20.82%	22.27%	-63.73%	8.33%	8.42%	-21.32%
FY 2014-15 Projection	42,640	2,223	21,804	244	62	548	67,521
% Change from FY 2013-14	5.13%	14.00%	14.50%	-38.85%	19.23%	9.16%	8.02%
FY 2015-16 Projection	48,584	2,497	25,438	261	68	631	77,479
% Change from FY 2014-15	13.94%	12.33%	16.67%	6.97%	9.68%	15.15%	14.75%
FY 2016-17 Projection	51,446	2,603	27,650	269	71	700	82,739
% Change from FY 2015-16	5.89%	4.25%	8.70%	3.07%	4.41%	10.94%	6.79%
FY 2014-15 Appropriation	45,810	2,167	21,989	141	75	573	70,755
Difference between the FY 2014-15 Appropriation and the FY 2014-15 Projection	(3,170)	56	(185)	103	(13)	(25)	(3,234)

Exhibit C4 - Children's Basic Health Plan, Caseload

Children's Basic Health Plan Caseload Adjustments By Fiscal Year

Item	Children to 200% FPL	Children 201%-205% FPL	Children 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	TOTAL
Medicaid Expansion - Welcome-Mat Effect	4,055	195	1,904	0	0	0	6,154
Total FY 2013-14 Adjustments	4,055	195	1,904	0	0	0	6,154
HB 09-1353 Removing 5 Year Bar on Legal Immigrants	0	0	0	0	0	0	0
Medicaid Expansion - Welcome-Mat Effect	10,293	514	5,064	0	0	0	15,871
Total FY 2014-15 Adjustments	10,293	514	5,064	0	0	0	15,871
HB 09-1353 Removing 5 Year Bar on Legal Immigrants	604	30	311	17	4	41	1,007
Medicaid Expansion - Welcome-Mat Effect	13,970	689	7,047	0	0	0	21,706
Total FY 2015-16 Adjustments	14,574	719	7,358	17	4	41	22,713
HB 09-1353 Removing 5 Year Bar on Legal Immigrants	944	47	502	25	7	65	1,590
Medicaid Expansion - Welcome-Mat Effect	14,908	723	7,709	0	0	0	23,340
Total FY 2016-17 Adjustments	15,852	770	8,211	25	7	65	24,930

Exhibit C4 - Children's Basic Health Plan, Caseload							
Expanded Medicaid Average Monthly Caseload for CBHP - Without Adjustments							
Item	**Children to 200% FPL**	**Children 201%-205% FPL**	**Children 206%-260% FPL**	**Prenatal to 200% FPL**	**Prenatal 201%-205% FPL**	**Prenatal 206%-260% FPL**	**CBHP TOTAL**
FY 2004-05 Actuals	38,255	-	-	484	-	-	
FY 2005-06 Actuals	46,755	-	-	1,129	-	-	
% Change from FY 2004-05	22.22%	-	-	133.41%	-	-	-
FY 2006-07 Actuals	52,199	-	-	1,336	-	-	
% Change from FY 2005-06	11.64%	-	-	18.27%	-	-	-
FY 2007-08 Actuals	57,466	330	-	1,557	14	-	
% Change from FY 2006-07	10.09%	-	-	16.57%	-	-	-
FY 2008-09 Actuals	60,137	1,445	-	1,598	67	-	63,247
% Change from FY 2007-08	4.65%	337.88%	-	2.63%	378.57%	-	-
FY 2009-10 Actuals	66,940	1,649	136	1,469	80	11	70,285
% Change from FY 2008-09	11.31%	14.12%	-	-8.07%	19.40%	-	11.13%
FY 2010-11 Actuals	62,080	1,164	4,023	1,409	60	272	69,008
% Change from FY 2009-10	-7.26%	-29.41%	2858.09%	-4.08%	-25.00%	2372.73%	-1.82%
FY 2011-12 Actuals	61,815	1,402	11,049	1,563	53	448	76,330
% Change from FY 2010-11	-0.43%	20.45%	174.65%	10.94%	-11.25%	64.61%	10.61%
FY 2012-13 Actuals	60,646	1,614	15,575	1,100	48	463	79,446
% Change from FY 2011-12	-1.89%	15.12%	40.96%	-29.63%	-9.86%	3.41%	4.08%
FY 2013-14 Actuals	36,506	1,755	17,139	399	52	502	56,351
% Change from FY 2012-13	-39.80%	8.74%	10.04%	-63.73%	8.33%	8.42%	-29.07%
FY 2014-15 Projection	32,347	1,709	16,740	244	62	548	51,650
% Change from FY 2013-14	-11.39%	-2.62%	-2.33%	-38.85%	19.23%	9.16%	-8.34%
FY 2015-16 Projection	34,010	1,778	18,080	244	64	590	54,766
% Change from FY 2014-15	5.14%	4.04%	8.00%	0.00%	3.23%	7.66%	6.03%
FY 2016-17 Projection	35,594	1,833	19,439	244	64	635	57,809
% Change from FY 2015-16	4.66%	3.09%	7.52%	0.00%	0.00%	7.63%	5.56%
FY 2014-15 Appropriation - No Adjustments	38,808	2,167	21,989	141	75	573	63,754
Difference between the FY 2014-15 Appropriation and the FY 2014-15 Projection	(6,461)	(458)	(5,249)	103	(13)	(25)	(12,104)

Exhibit C4 - Children's Basic Health Plan, Caseload

Forecast Comparisons With Adjustments

		Children to 200% FPL	Children 201%-205% FPL	Children 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	TOTAL
FY 2013-14 Actuals	FY 2013-14 Actual Caseload- November 2014	40,561	1,950	19,043	399	52	502	62,507
	FY 2013-14 Projected Caseload- February 2014	43,672	2,031	19,399	438	63	509	66,113
	FY 2013-14 Difference	(3,111)	(81)	(356)	(39)	(11)	(7)	(3,606)
	FY 2013-14 Actual Growth Rate- November 2014	-33.12%	20.82%	22.27%	-63.73%	8.33%	8.42%	-21.32%
	FY 2013-14 Projected Growth Rate- February 2014	-27.99%	25.82%	24.55%	-60.17%	31.63%	9.98%	-16.78%
FY 2014-15 Projections	FY 2014-15 Projected Caseload- November 2014	42,640	2,223	21,804	244	62	548	67,521
	FY 2014-15 Projected Caseload- February 2014	46,755	2,167	21,989	204	75	573	71,764
	FY 2014-15 Difference	(4,115)	56	(185)	40	(13)	(25)	(4,243)
	FY 2014-15 Projected Growth Rate- November 2014	5.13%	14.00%	14.50%	-38.85%	19.23%	9.16%	8.02%
	FY 2014-15 Projected Growth Rate- February 2014	7.06%	6.72%	13.35%	-53.44%	18.74%	12.59%	8.55%
FY 2015-16 Projections	FY 2015-16 Projected Caseload- November 2014	48,584	2,497	25,438	261	68	631	77,479
	FY 2015-16 Projected Caseload- February 2014	56,044	2,216	23,773	271	82	598	82,984
	FY 2015-16 Difference	(7,460)	281	1,665	(10)	(14)	33	(5,505)
	FY 2015-16 Projected Growth Rate- November 2014	13.94%	12.33%	16.67%	6.97%	9.68%	15.15%	14.75%
	FY 2015-16 Projected Growth Rate- February 2014	19.87%	2.25%	8.11%	32.84%	8.89%	4.38%	15.63%

Exhibit C4 - Children's Basic Health Plan, Caseload

Forecast Comparisons Without Adjustments

		Children to 200% FPL	Children 201%-205% FPL	Children 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	TOTAL
FY 2013-14 Actuals	FY 2013-14 Actual Caseload- November 2014	36,506	1,755	17,139	399	52	502	56,351
	FY 2013-14 Projected Caseload- February 2014	42,548	2,031	19,399	438	63	509	64,989
	FY 2013-14 Difference	(6,042)	(276)	(2,260)	(39)	(11)	(7)	(8,638)
	FY 2013-14 Actual Growth Rate- November 2014	-39.80%	8.74%	10.04%	-63.73%	8.33%	8.42%	-29.07%
	FY 2013-14 Projected Growth Rate- February 2014	-29.84%	25.82%	24.55%	-60.17%	31.63%	9.98%	-18.20%
FY 2014-15 Projections	FY 2014-15 Projected Caseload- November 2014	32,347	1,709	16,740	244	62	548	51,650
	FY 2014-15 Projected Caseload- February 2014	38,808	2,167	21,989	141	75	573	63,754
	FY 2014-15 Difference	(6,461)	(458)	(5,249)	103	(13)	(25)	(12,104)
	FY 2014-15 Projected Growth Rate- November 2014	-11.39%	-2.62%	-2.33%	-38.85%	19.23%	9.16%	-8.34%
	FY 2014-15 Projected Growth Rate- February 2014	-8.79%	6.72%	13.35%	-67.82%	18.74%	12.59%	-1.90%
FY 2015-16 Projections	FY 2015-16 Projected Caseload- November 2014	34,010	1,778	18,080	244	64	590	54,766
	FY 2015-16 Projected Caseload- February 2014	38,680	2,216	23,773	175	82	598	65,524
	FY 2015-16 Difference	(4,670)	(438)	(5,693)	69	(18)	(8)	(10,758)
	FY 2015-16 Projected Growth Rate- November 2014	5.14%	4.04%	8.00%	0.00%	3.23%	7.66%	6.03%
	FY 2015-16 Projected Growth Rate- February 2014	-0.33%	2.25%	8.11%	24.11%	8.89%	4.38%	2.78%

Exhibit C4 - Children's Basic Health Plan, Caseload

Children's Basic Health Plan Caseload Adjustment Comparison By Fiscal Year

	Item	Children to 200% FPL	Children 201%-205% FPL	Children 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	TOTAL
FY 2013-14 Adjustment Comparison	Welcome-Mat Effect Estimate Nov 2014	4,055	195	1,904	0	0	0	6,154
	Welcome-Mat Effect Estimate Feb 2014	1,124	0	0	0	0	0	1,124
	Difference	2,931	195	1,904	0	0	0	5,030
	FY 2013-14 Total Change in Adjustments	**2,931**	**195**	**1,904**	**0**	**0**	**0**	**5,030**
FY 2014-15 Adjustment Comparison	HB 09-1353 Removing 5 Year Bar on Legal Immigrants Nov 2014	0	0	0	0	0	0	0
	HB 09-1353 Removing 5 Year Bar on Legal Immigrants Feb 2014	945	0	0	63	0	0	1,008
	Difference	(945)	0	0	(63)	0	0	(1,008)
	Welcome-Mat Effect Estimate Nov 2014	10,293	514	5,064	0	0	0	15,871
	Welcome-Mat Effect Estimate Feb 2014	7,002	0	0	0	0	0	7,002
	Difference	3,291	514	5,064	0	0	0	8,869
	FY 2014-15 Total Change in Adjustments	**2,346**	**514**	**5,064**	**(63)**	**0**	**0**	**7,861**
FY 2015-16 Adjustment Comparison	HB 09-1353 Removing 5 Year Bar on Legal Immigrants Nov 2014	604	30	311	17	4	41	1,007
	HB 09-1353 Removing 5 Year Bar on Legal Immigrants Feb 2014	1,493	0	0	96	0	0	1,589
	Difference	(889)	30	311	(79)	4	41	(582)
	Welcome-Mat Effect Estimate Nov 2014	13,970	689	7,047	0	0	0	21,706
	Welcome-Mat Effect Estimate Feb 2014	15,871	0	0	0	0	0	15,871
	Difference	(1,901)	689	7,047	0	0	0	5,835
	FY 2015-16 Total Change in Adjustments	**(2,790)**	**719**	**7,358**	**(79)**	**4**	**41**	**5,253**

Exhibit C4 - Children's Basic Health Plan Monthly Caseload Historical Summary

CBHP CASELOAD FY 2012-13 without RETROACTIVITY

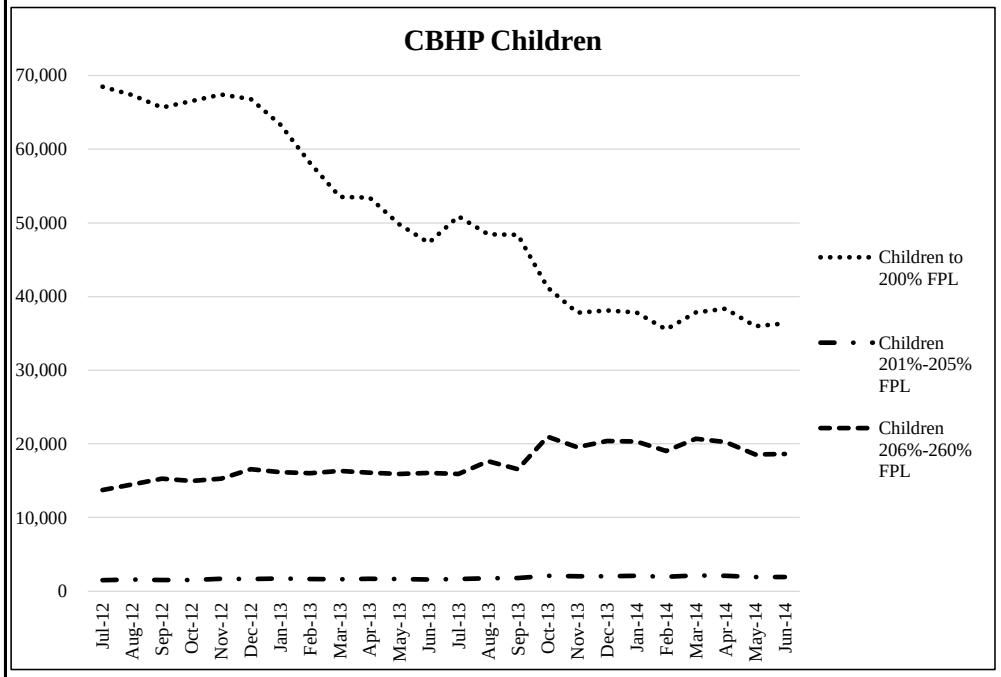
FY 2012-13	Children to 200% FPL	Children 201%-205% FPL	Children 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	TOTAL	Monthly Growth	Monthly Growth Rate
July 2012	68,486	1,491	13,731	1,639	55	452	85,854	819	0.96%
August 2012	67,368	1,570	14,509	1,610	53	459	85,569	(285)	-0.33%
September 2012	65,667	1,529	15,267	1,526	49	482	84,520	(1,049)	-1.23%
October 2012	66,552	1,528	14,955	1,501	51	470	85,057	537	0.64%
November 2012	67,410	1,672	15,289	1,536	57	498	86,462	1,405	1.65%
December 2012	66,797	1,656	16,575	1,542	47	550	87,167	705	0.82%
January 2013	63,305	1,717	16,159	614	48	504	82,347	(4,820)	-5.53%
February 2013	58,114	1,647	16,028	541	44	451	76,825	(5,522)	-6.71%
March 2013	53,539	1,628	16,337	591	45	442	72,582	(4,243)	-5.52%
April 2013	53,416	1,699	16,091	666	43	435	72,350	(232)	-0.32%
May 2013	49,793	1,645	15,914	692	45	417	68,506	(3,844)	-5.31%
June 2013	47,308	1,587	16,047	740	38	399	66,119	(2,387)	-3.48%
Year-to-Date Average	**60,646**	**1,614**	**15,575**	**1,100**	**48**	**463**	**79,447**	**(1,576)**	**-2.03%**

CBHP CASELOAD FY 2013-14 without RETROACTIVITY

FY 2013-14[(1)]	Children to 200% FPL	Children 201%-205% FPL	Children 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	TOTAL	Monthly Growth	Monthly Growth Rate
July 2013	50,883	1,665	15,933	810	40	354	69,685	3,566	5.39%
August 2013	48,436	1,747	17,642	835	34	393	69,087	(598)	-0.86%
September 2013	48,373	1,770	16,564	893	35	385	68,020	(1,067)	-1.54%
October 2013	41,212	2,082	20,972	185	61	533	65,045	(2,975)	-4.37%
November 2013	37,802	2,030	19,542	255	58	534	60,221	(4,824)	-7.42%
December 2013	38,117	2,033	20,376	299	55	540	61,420	1,199	1.99%
January 2014	37,834	2,090	20,324	252	58	561	61,119	(301)	-0.49%
February 2014	35,535	1,955	19,050	243	57	566	57,406	(3,713)	-6.08%
March 2014	37,839	2,133	20,690	272	61	593	61,588	4,182	7.28%
April 2014	38,360	2,076	20,255	276	56	536	61,559	(29)	-0.05%
May 2014	35,986	1,907	18,554	247	51	496	57,241	(4,318)	-7.01%
June 2014	36,350	1,908	18,612	222	54	527	57,673	432	0.75%
Year-to-Date Average	**40,561**	**1,950**	**19,043**	**399**	**52**	**502**	**62,505**	**(704)**	**-1.03%**

[(1)] Caseload has been restated for Children above 200% FPL and Prenatal above 200% FPL back to January 2014 and going forward. Due to the MAGI conversion in January 2014, clients that are 201%-205% FPL's can not be explicitly identified. The Department is using a rolling 6 month average (prior to the MAGI conversion) of the proportion of clients that are 201%-205% and 206%-260% FPL and applying this distribution to the total caseload that is above 200% FPL.

Exhibit C4 - Children's Basic Health Plan Monthly Caseload Historical Summary



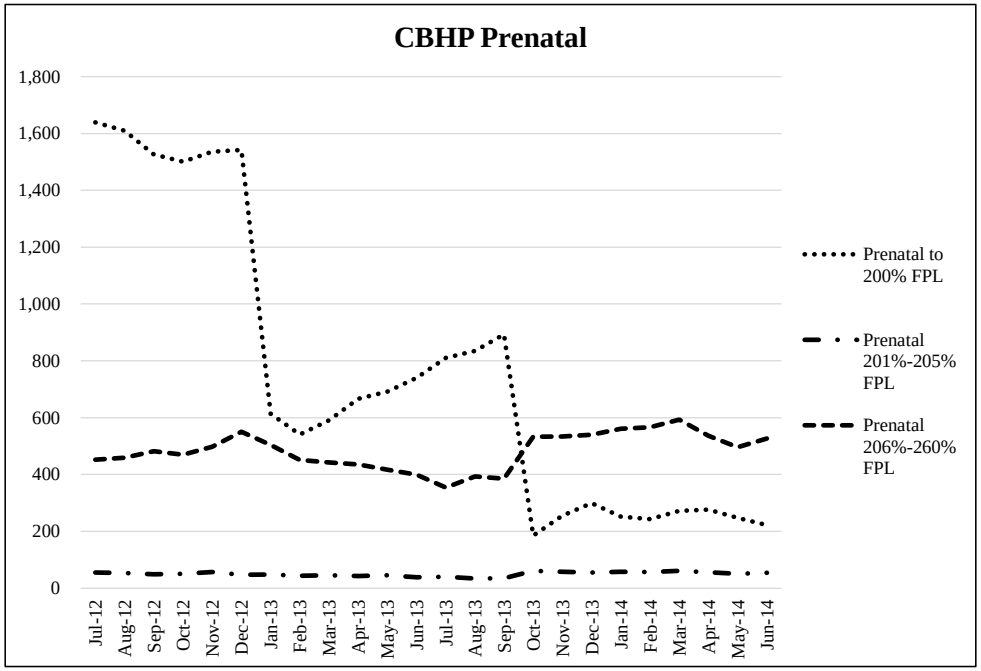


Exhibit C4 - Children's Basic Health Plan Capitation Payments Per Capita Historical Summary

Item	Children to 200% FPL Medical	Children 201%-205% FPL Medical	Children 206%-260% FPL Medical	Children to 200% FPL Dental[(1)]	Children 201%-205% FPL Dental[(1)]	Children 206%-260% FPL Dental[(1)]	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	TOTAL PER CAPITA
FY 2005-06 Actuals	$1,171.75	-	-	$113.07	-	-	$9,932.77	-	-	$1,488.77
FY 2006-07 Actuals	$1,364.61	-	-	$130.39	-	-	$13,816.37	-	-	$1,802.41
% Change from FY 2005-06	16.46%	-	-	15.32%	-	-	39.10%	-	-	21.07%
FY 2007-08 Actuals	$1,511.25	$1,437.26	-	$150.93	$139.07	-	$11,065.13	$9,541.29	-	$1,910.16
% Change from FY 2006-07	10.75%	-	-	15.75%	-	-	-19.91%	-	-	5.98%
FY 2008-09 Actuals	$1,668.48	$1,650.56	-	$160.34	$162.28	-	$10,876.59	$10,538.94	-	$2,066.29
% Change from FY 2007-08	10.40%	14.84%	-	6.24%	16.69%	-	-1.70%	10.46%	-	8.17%
FY 2009-10 Actuals	$2,206.65	$2,279.80	$1,540.48	$157.11	$158.43	$76.04	$10,339.84	$9,655.96	$5,651.89	$2,539.59
% Change from FY 2008-09	32.26%	38.12%	-	-2.01%	-2.37%	-	-4.93%	-8.38%	-	22.91%
FY 2010-11 Actuals	$2,125.84	$2,366.92	$2,439.89	$159.14	$160.88	$148.60	$12,517.45	$14,334.74	$13,159.54	$2,569.03
% Change from FY 2009-10	-3.66%	3.82%	58.38%	1.29%	1.55%	95.42%	21.06%	48.45%	132.83%	1.16%
FY 2011-12 Actuals	$2,012.99	$2,077.89	$1,926.19	$168.27	$169.47	$160.66	$10,519.90	$10,720.69	$9,819.60	$2,390.33
% Change from FY 2010-11	-5.31%	-12.21%	-21.05%	5.74%	5.33%	8.12%	-15.96%	-25.21%	-25.38%	-6.96%
FY 2012-13 Actuals	$2,064.59	$2,031.02	$1,817.94	$177.26	$159.93	$149.39	$14,307.81	$13,158.25	$10,936.88	$2,411.33
% Change from FY 2011-12	2.56%	-2.26%	-5.62%	5.34%	-5.62%	-7.01%	36.01%	22.74%	11.38%	0.88%
FY 2013-14 Actuals[(2)(3)]	$2,695.21	$3,136.21	$2,178.76	$232.16	$231.71	$207.37	$15,065.50	$7,321.87	$11,189.55	$2,923.81
% Change from FY 2012-13	30.54%	54.42%	19.85%	30.97%	44.88%	38.81%	5.30%	-44.36%	2.31%	21.25%
FY 2014-15 Projection	$2,357.40	$2,336.47	$2,266.39	$264.38	$254.36	$233.92	$17,063.40	$15,231.82	$12,220.15	$2,723.20
% Change from FY 2013-14	-12.53%	-25.50%	4.02%	13.88%	9.77%	12.80%	13.26%	108.03%	9.21%	-6.86%
FY 2015-16 Projection	$2,263.83	$2,245.14	$2,217.64	$278.05	$265.04	$245.40	$12,739.37	$12,390.46	$12,473.75	$2,638.86
% Change from FY 2014-15	-3.97%	-3.91%	-2.15%	5.17%	4.20%	4.91%	-25.34%	-18.65%	2.08%	-3.10%
FY 2016-17 Projection	$2,330.41	$2,333.25	$2,303.66	$296.05	$281.02	$259.10	$13,610.57	$13,221.01	$13,298.95	$2,739.88
% Change from FY 2015-16	2.94%	3.92%	3.88%	6.47%	6.03%	5.58%	6.84%	6.70%	6.62%	3.83%

[(1)]Dental per capitas experience a significant increase in FY 2014-15 due to a budget action passed in FY 2013-14 that added oral health care services to the CHP+ Dental program in order to bring the program into compliance with the CHIPRA legislation

[(2)]Per capitas in FY 2013-14 increased for Children's Medical and Children's Dental categories due to a substantial increase in reconciliation payments for manual enrollments.

[(3)]Due to systems issues, some capitations have not been made for some prenatal clients in all FPL categories. This results in a significant decrease in the per capita in FY 2013-14. The Department believes these capitations will be paid in the reconciliation process, creating a significant increase in the projected FY 2014-15 per capitas. Calculations can be seen in exhibit C7.

Exhibit C4 - Children's Basic Health Plan Program, Historical Expenditures Summary									
Annual Total Expenditures									
Item		Children to 200% FPL	Children 201%-205% FPL	Children 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	Recoveries	CBHP TOTAL
FY 2008-09 Actuals	*Medical Per Capita*	$1,668.48	$1,650.56	-	$10,876.59	$10,538.94	-		
	Dental Per Capita	$160.34	$162.28	-	-	-	-		
	Caseload	60,137	1,445	-	1,598	67	-		63,247
	Medical Expenditure	$100,337,641	$2,385,059	-	$17,380,795	$706,109	-		$120,809,604
	Dental Expenditure	$9,642,259	$234,495	-	-	-	-		$9,876,754
	Total FY 2008-09 Expenditures	**$109,979,900**	**$2,619,554**	**-**	**$17,380,795**	**$706,109**	**-**		**$130,686,358**
FY 2009-10 Actuals	*Medical Per Capita*	$2,206.65	$2,279.80	$1,540.48	$10,339.84	$9,655.96	$5,651.89		
	Dental Per Capita	$157.11	$158.43	$76.04	-	-	-		
	Caseload	66,940	1,649	136	1,469	80	11		70,285
	Medical Expenditure	$147,713,419	$3,759,383	$209,506	$15,189,230	$772,477	$62,171		$167,706,185
	Dental Expenditure	$10,517,236	$261,258	$10,342	-	-	-		$10,788,836
	Total FY 2009-10 Expenditures	**$158,230,655**	**$4,020,641**	**$219,847**	**$15,189,230**	**$772,477**	**$62,171**		**$178,495,021**
	% Change from FY 2008-09	**43.87%**	**53.49%**	**-**	**-12.61%**	**9.40%**	**-**		**36.58%**
FY 2010-11 Actuals	*Medical Per Capita*	$2,125.84	$2,366.92	$2,439.89	$12,517.45	$14,334.74	$13,159.54		
	Dental Per Capita	$159.14	$160.88	$148.60	-	-	-		
	Caseload	62,080	1,164	4,023	1,409	60	272		69,008
	Medical Expenditure	$131,972,069	$2,755,095	$9,815,685	$17,637,094	$860,085	$3,579,395		$166,619,422
	Dental Expenditure	$9,879,405	$187,270	$597,802	-	-	-		$10,664,477
	Total FY 2010-11 Expenditures	**$141,851,475**	**$2,942,365**	**$10,413,487**	**$17,637,094**	**$860,085**	**$3,579,395**		**$177,283,899**
	% Change from FY 2009-10	**-10.35%**	**-26.82%**	**4636.70%**	**16.12%**	**11.34%**	**5657.36%**		**-0.68%**
FY 2011-12 Actuals	*Medical Per Capita*	$2,012.99	$2,077.89	$1,926.19	$10,519.90	$10,720.69	$9,819.60		
	Dental Per Capita	$168.27	$169.47	$160.66	-	-	-		
	Caseload	61,815	1,402	11,049	1,563	53	448		76,330
	Medical Expenditure	$124,432,985	$2,913,206	$21,282,480	$16,443,475	$570,877	$4,396,724		$170,039,746
	Dental Expenditure	$10,401,614	$237,590	$1,775,172	-	-	-		$12,414,377
	Total FY 2011-12 Expenditures	**$134,834,599**	**$3,150,796**	**$23,057,652**	**$16,443,475**	**$570,877**	**$4,396,724**		**$182,454,123**
	% Change from FY 2010-11	**-4.95%**	**7.08%**	**121.42%**	**-6.77%**	**-33.63%**	**22.83%**		**2.92%**
FY 2012-13 Actuals	*Medical Per Capita*	$2,064.59	$2,031.02	$1,817.94	$14,307.81	$13,158.25	$10,936.88		
	Dental Per Capita	$177.26	$159.93	$149.39	-	-	-		
	Caseload	60,646	1,614	15,575	1,100	48	463		79,446
	Medical Expenditure	$125,209,014	$3,278,065	$28,314,344	$15,738,589	$631,596	$5,063,773		$178,235,380
	Dental Expenditure	$10,750,133	$258,132	$2,326,813	-	-	-		$13,335,077
	Total FY 2012-13 Expenditures	**$135,959,146**	**$3,536,197**	**$30,641,156**	**$15,738,589**	**$631,596**	**$5,063,773**		**$191,570,458**
	% Change from FY 2011-12	**0.83%**	**12.23%**	**32.89%**	**-4.29%**	**10.64%**	**15.17%**		**5.00%**
FY 2013-14 Actuals	*Medical Per Capita*	$2,695.21	$3,136.21	$2,178.76	$15,065.50	$7,321.87	$11,189.55		
	Dental Per Capita	$232.16	$231.71	$207.37	-	-	-		
	Caseload	40,561	1,950	19,043	399	52	502		62,507
	Medical Expenditure	$109,320,524	$6,115,603	$41,490,209	$6,011,136	$380,737	$5,617,155		$168,935,364
	Dental Expenditure	$9,416,810	$451,842	$3,949,038	-	-	-		$13,817,690
	Recoveries	($22,107,840)	($616,163)	($4,221,003)	($3,853,723)	($158,795)	($769,110)	$31,726,633	$0
	Total FY 2013-14 Expenditures	**$96,629,494**	**$5,951,282**	**$41,218,245**	**$2,157,413**	**$221,942**	**$4,848,045**	**$31,726,633**	**$182,753,054**
	% Change from FY 2012-13	**-28.93%**	**68.30%**	**34.52%**	**-86.29%**	**-64.86%**	**-4.26%**	**-**	**-4.60%**

Exhibit C4 - Children's Basic Health Plan Program, Historical Expenditures Summary									
Projected Total Expenditures									
Item		**Children to 200% FPL**	**Children 201%-205% FPL**	**Children 206%-260% FPL**	**Prenatal to 200% FPL**	**Prenatal 201%-205% FPL**	**Prenatal 206%-260% FPL**	**Recoveries**	**CBHP TOTAL**
FY 2014-15 Projection	*Medical Per Capita*	$2,357.40	$2,336.47	$2,266.39	$17,063.40	$15,231.82	$12,220.15		
	Dental Per Capita	$264.38	$254.36	$233.92	-	-	-		
	Caseload	42,640	2,223	21,804	244	62	548		67,521
	Medical Expenditure	$100,519,482	$5,193,975	$49,416,299	$4,163,469	$944,373	$6,696,641		$166,934,239
	Dental Expenditure	$11,273,078	$565,445	$5,100,316	-	-	-		$16,938,839
	Recoveries	($1,831,087)	($93,091)	($780,606)	$0	$0	$0	$2,704,784	$0
	Total FY 2014-15 Expenditures	**$109,961,473**	**$5,666,329**	**$53,736,009**	**$4,163,469**	**$944,373**	**$6,696,641**	**$2,704,784**	**$183,873,078**
	% Change from FY 2013-14	**13.80%**	**-4.79%**	**30.37%**	**92.98%**	**325.50%**	**38.13%**		**0.61%**
FY 2015-16 Projection	*Medical Per Capita*	$2,263.83	$2,245.14	$2,217.64	$12,739.37	$12,390.46	$12,473.75		
	Dental Per Capita	$278.05	$265.04	$245.40	-	-	-		
	Caseload	48,584	2,497	25,438	261	68	631		77,479
	Medical Expenditure	$109,986,017	$5,606,113	$56,412,292	$3,324,975	$842,551	$7,870,938		$184,042,886
	Dental Expenditure	$13,509,010	$661,813	$6,242,554	-	-	-		$20,413,377
	Total FY 2015-16 Expenditures	**$123,495,027**	**$6,267,926**	**$62,654,846**	**$3,324,975**	**$842,551**	**$7,870,938**		**$204,456,263**
	% Change from FY 2014-15	**12.31%**	**10.62%**	**16.60%**	**-20.14%**	**-10.78%**	**17.54%**		**11.19%**
FY 2016-17 Projection	*Medical Per Capita*	$2,330.41	$2,333.25	$2,303.66	$13,610.57	$13,221.01	$13,298.95		
	Dental Per Capita	$296.05	$281.02	$259.10	-	-	-		
	Caseload	51,446	2,603	27,650	269	71	700		82,739
	Medical Expenditure	$119,890,326	$6,073,447	$63,696,225	$3,661,244	$938,692	$9,309,265		$203,569,199
	Dental Expenditure	$15,230,482	$731,500	$7,164,138	-	-	-		$23,126,120
	Total FY 2016-17 Expenditures	**$135,120,808**	**$6,804,947**	**$70,860,363**	**$3,661,244**	**$938,692**	**$9,309,265**		**$226,695,319**
	% Change from FY 2015-16	**9.41%**	**8.57%**	**13.10%**	**10.11%**	**11.41%**	**18.27%**		**10.88%**

Exhibit C5 - Traditional Population Expenditures and Funding							
FY 2014-15 Projected Expenditures							
	Children 0%-200% Medical	**Children 201%-205% Medical**	**Children 0%-200% Dental**	**Children 201%-205% Dental**	**Prenatal 0%-200%**	**Prenatal 201%-205%**	**Totals**
Caseload	42,640	2,223	42,640	2,223	244	62	45,169
Estimated Per Capita Cost	$2,357.40	$2,336.47	$264.38	$254.36	$17,063.40	$15,231.82	$2,715.58
Total Estimated Expenditures FY 2014-15	**$100,519,482**	**$5,193,975**	**$11,273,078**	**$565,445**	**$4,163,469**	**$944,373**	**$122,659,822**
FY 2015-16 Projected Expenditures							
	Children 0%-200% Medical	**Children 201%-205% Medical**	**Children 0%-200% Dental**	**Children 201%-205% Dental**	**Prenatal 0%-200%**	**Prenatal 201%-205%**	**Totals**
Caseload	48,584	2,497	48,584	2,497	261	68	51,410
Estimated Per Capita Cost	$2,263.83	$2,245.14	$278.05	$265.04	$12,739.37	$12,390.46	$2,605.14
Total Estimated Expenditures FY 2015-16	**$109,986,017**	**$5,606,113**	**$13,509,010**	**$661,813**	**$3,324,975**	**$842,551**	**$133,930,479**
FY 2016-17 Projected Expenditures							
	Children 0%-200% Medical	**Children 201%-205% Medical**	**Children 0%-200% Dental**	**Children 201%-205% Dental**	**Prenatal 0%-200%**	**Prenatal 201%-205%**	**Totals**
Caseload	51,446	2,603	51,446	2,603	269	71	54,389
Estimated Per Capita Cost	$2,330.41	$2,333.25	$296.05	$281.02	$13,610.57	$13,221.01	$2,694.03
Total Estimated Expenditures FY 2016-17	**$119,890,326**	**$6,073,447**	**$15,230,482**	**$731,500**	**$3,661,244**	**$938,692**	**$146,525,691**

Exhibit C5 - Traditional Population Expenditures and Funding								
Cash Funds Forecast[1]								
Row		**FY 2011-12 Actuals**	**FY 2012-13 Actuals**	**FY 2013-14 Actuals**	**FY 2014-15 Forecast**	**FY 2015-16 Forecast**	**FY 2016-17 Forecast**	**Notes**
A	Tier 1 CHP+ Trust Fund	$24,100,000	$24,500,000	$24,500,000	$24,500,000	$24,400,000	$24,400,000	2014 Tobacco MSA Payment Forecast[1]
B	Tier 2 CHP+ Trust Fund	$4,300,000	$4,200,000	$4,100,000	$3,900,000	$3,800,000	$3,800,000	2014 Tobacco MSA Payment Forecast[1]
C	Projected Amount	$28,400,000	$28,700,000	$28,600,000	$28,400,000	$28,200,000	$28,200,000	Row A + Row B
D	**Total Trust Fund Expenditure**	**$27,652,698**	**$26,465,326**	**$26,062,316**	**$26,573,880**	**$26,028,600**	**$26,037,060**	Actuals: Reported in COFRS Forecast: Row D * Row G
E	CHP Premiums	$25,718,442	$24,588,447	$24,562,287	$24,179,206	$23,674,137	$23,682,597	Actuals: Reported in COFRS Forecast: Row D - Row F
F	CHP+ Admin	$1,934,256	$1,876,879	$1,500,029	$2,394,674	$2,354,463	$2,354,463	Actuals: Reported in COFRS Forecast: Exhibit C1
G	% of Projection	97.37%	92.21%	91.13%	93.57%	92.30%	92.33%	Actuals: Row D / Row C Forecast: Rolling 3 year average
H	Tier 2 Immunizations	$1,200,000	$1,200,000	$1,100,000	$1,200,000	$1,200,000	$1,100,000	2014 Tobacco MSA Payment Forecast[1]
I	% Appropriated to CHP+	39.00%	19.50%	19.50%	19.50%	19.50%	19.50%	Percentage appropriated to CHP+
J	Projected Amount	$468,000	$234,000	$214,500	$234,000	$234,000	$214,500	Row H * Row I
K	**Total CO Immunization Fund Expenditure**	**$461,700**	**$221,635**	**$216,871**	**$229,694**	**$229,297**	**$212,548**	Actuals: Reported in COFRS Forecast: Row J * Row L
L	% of Projection	98.65%	94.72%	101.11%	98.16%	97.99%	99.09%	Actuals: Row K / Row J Forecast: Rolling 3 year average

[1] http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251933728166&ssbinary=true

Exhibit C5 - Traditional Population Expenditures and Funding

FY 2014-15 - Calculation of Fund Splits

Item	Total Funds	General Fund	CBHP Trust Fund[1]	CO Immunization Fund[2]	Health Care Expansion Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$122,161,635	$42,109,116	$0	$0	$0	$0	$80,052,519	65.53%
Estimated Enrollment Fees	*$498,187*	*$0*	*$498,187*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$122,659,822**	**$42,109,116**	**$498,187**	**$0**	**$0**	**$0**	**$80,052,519**	65.26%
Offsetting Cash Funds	*$0*	*($23,910,714)*	*$23,681,019*	*$229,694*	*$1*	*$0*	*$0*	NA
Total Estimated Expenditures FY 2014-15	**$122,659,822**	**$18,198,402**	**$24,179,206**	**$229,694**	**$1**	**$0**	**$80,052,519**	65.26%

[1]Forecasted above Cash Funds Forecast Table, Row E

[2]Forecasted above in Cash Funds Forecast Table, Row K

FY 2015-16 - Calculation of Fund Splits

Item	Total Funds	General Fund	CBHP Trust Fund[1]	CO Immunization Fund[2]	Health Care Expansion Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$133,362,690	$22,725,002	$0	$0	$0	$0	$110,637,688	82.96%
Estimated Enrollment Fees	*$567,789*	*$0*	*$567,789*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$133,930,479**	**$22,725,002**	**$567,789**	**$0**	**$0**	**$0**	**$110,637,688**	82.61%
Offset From Cash Funds [3]	*$0*	*($23,335,646)*	*$23,106,348*	*$229,297*	*$1*	*$0*	*$0*	NA
Total Estimated Expenditures FY 2015-16	**$133,930,479**	**($610,644)**	**$23,674,137**	**$229,297**	**$1**	**$0**	**$110,637,688**	82.61%
Offset from General Fund [3]	*$0*	*$610,644*	*($610,644)*	*$0*	*$0*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2015-16	**$133,930,479**	**$0**	**$23,063,493**	**$229,297**	**$1**	**$0**	**$110,637,688**	82.61%

[1]Forecasted above Cash Funds Forecast Table, Row E

[2]Forecasted above in Cash Funds Forecast Table, Row K

[3]Due to the increased FMAP, the projected funds from the CHP Trust Fund are sufficient to cover forecasted expenditures without funding from the General Fund.

FY 2016-17 - Calculation of Fund Splits

Item	Total Funds	General Fund	CBHP Trust Fund[1]	CO Immunization Fund[2]	Health Care Expansion Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$145,924,237	$16,474,846	$0	$0	$0	$0	$129,449,391	88.71%
Estimated Enrollment Fees	*$601,454*	*$0*	*$601,454*	*$0*	*$0*	*$0*	*$0*	0.00%
Expenditures/No Cash Funds	**$146,525,691**	**$16,474,846**	**$601,454**	**$0**	**$0**	**$0**	**$129,449,391**	88.35%
Offset From Cash Funds [3]	*$0*	*($23,293,692)*	*$23,081,143*	*$212,548*	*$1*	*$0*	*$0*	NA
Estimated Expenditures FY 2016-17	**$146,525,691**	**($6,818,846)**	**$23,682,597**	**$212,548**	**$1**	**$0**	**$129,449,391**	88.35%
Offset from General Fund [3]	*$0*	*$6,818,846*	*($6,818,846)*	*$0*	*$0*	*$0*	*$0*	NA
Total Estimated Expenditures FY 2016-17	**$146,525,691**	**$0**	**$16,863,751**	**$212,548**	**$1**	**$0**	**$129,449,391**	88.35%

[1]Forecasted above Cash Funds Forecast Table, Row E

[2]Forecasted above in Cash Funds Forecast Table, Row K

[3]Due to the increased FMAP Rate, the projected funds from the CHP Trust Fund are sufficient to cover forecasted expenditures without funding from the General Fund.

Exhibit C5 - Expansion Population Expenditures and Funding				
FY 2014-15 Projected Expenditures				
	Children 206%-260% Medical	**Children 206%-260% Dental**	**Prenatal 206%-260%**	**Totals**
Caseload	21,804	21,804	548	22,352
Estimated Per Capita Cost	$2,266.39	$233.92	$12,220.15	$2,738.60
Total Estimated Expenditures FY 2014-15	$49,416,299	$5,100,316	$6,696,641	$61,213,256
FY 2015-16 Projected Expenditures				
	Children 206%-260% Medical	**Children 206%-260% Dental**	**Prenatal 206%-260%**	**Totals**
Caseload	25,438	25,438	631	26,069
Estimated Per Capita Cost	$2,217.64	$245.40	$12,473.75	$2,705.35
Total Estimated Expenditures FY 2015-16	$56,412,292	$6,242,554	$7,870,938	$70,525,784
FY 2016-17 Projected Expenditures				
	Children 206%-260% Medical	**Children 206%-260% Dental**	**Prenatal 206%-260%**	**Totals**
Caseload	27,650	27,650	700	28,350
Estimated Per Capita Cost	$2,303.66	$259.10	$13,298.95	$2,827.85
Total Estimated Expenditures FY 2016-17	$63,696,225	$7,164,138	$9,309,265	$80,169,628

Exhibit C5 - Expansion Population Expenditures and Funding

FY 2014-15 - Calculation of Fund Splits

Item	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$60,413,968	$0	$20,824,695	$0	$39,589,273	65.53%
Estimated Enrollment Fees	*$799,288*	*$0*	*$799,288*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2014-15	$61,213,256	$0	$21,623,983	$0	$39,589,273	64.67%

FY 2015-16 - Calculation of Fund Splits

Item	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$69,593,281	$0	$11,858,695	$0	$57,734,586	82.96%
Estimated Enrollment Fees	*$932,503*	*$0*	*$932,503*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2015-16	$70,525,784	$0	$12,791,198	$0	$57,734,586	81.86%

FY 2016-17 - Calculation of Fund Splits

Item	Total Funds	General Fund	Hospital Provider Fee Cash Fund	Reappropriated Funds	Federal Funds	FMAP
Expenditures to be matched	$79,156,006	$0	$8,936,713	$0	$70,219,293	88.71%
Estimated Enrollment Fees	*$1,013,622*	*$0*	*$1,013,622*	*$0*	*$0*	*NA*
Total Estimated Expenditures FY 2016-17	$80,169,628	$0	$9,950,335	$0	$70,219,293	87.59%

Exhibit C5 - Enrollment Fees Historical Summary and Projection					
Historical Enrollment Fees and Projections					
	Children 157%-200%	**Children 201%-205%**	**Children 206%-260%**	**Enrollment Fees[(1)]**	**Average Enrollment Fee[(2)]**
FY 2008-09 Actuals	17,752	1,445	-	$328,499	$17.11
FY 2009-10 Actuals	19,259	1,649	136	$346,589	$16.47
% Change from FY 2008-09	8.49%	14.12%	-	5.51%	-3.75%
FY 2010-11 Actuals	18,265	1,164	4,023	$428,326	$18.26
% Change from FY 2009-10	-5.16%	-29.41%	2858.09%	23.58%	10.89%
FY 2011-12 Actuals	19,517	1,402	11,049	$620,097	$19.40
% Change from FY 2010-11	6.85%	20.45%	174.65%	44.77%	6.21%
FY 2012-13 Actuals	22,168	1,614	15,575	$932,439	$23.69
% Change from FY 2011-12	13.58%	15.12%	40.96%	50.37%	22.14%
FY 2013-14 Actuals	25,507	2,457	18,636	$904,328	$19.41
% Change from FY 2012-13	15.06%	52.23%	19.65%	-3.01%	-18.09%
FY 2014-15 Projection	35,667	2,223	21,804	$1,297,475	$21.74
% Change from FY 2013-14	39.83%	-9.52%	17.00%	43.47%	12.00%
FY 2015-16 Projection	40,681	2,497	25,438	$1,500,292	$21.87
% Change from FY 2014-15	14.06%	12.33%	16.67%	15.63%	0.60%
FY 2016-17 Projection	43,131	2,603	27,650	$1,615,076	$22.01
% Change from FY 2015-16	6.02%	4.25%	8.70%	7.65%	0.66%

[(1)]Enrollment Fees collected is amount reported in COFRS

[(2)]This is the total enrollment fees collected reported in COFRS divided by children's caseload over 157% FPL

Exhibit C5 - Enrollment Fees Historical Summary and Projection

Projected Number of Enrollment Fees Calculations

		Children 157%-200%	Children 201%-205%	Children 206%-260%	Total
FY 2014-15	Projected New Enrollees[1]	22,341	1,213	12,350	35,904
	Projected New Cases[2]	15,552	861	8,868	25,281
	Projected Average Fee[3]	$30.36	$30.18	$90.13	$51.32
	Total Estimated Paid	$472,198	$25,989	$799,288	$1,297,475
FY 2015-16	Projected New Enrollees[1]	25,482	1,363	14,408	41,253
	Projected New Cases[2]	17,739	967	10,346	29,052
	Projected Average Fee[3]	$30.36	$30.18	$90.13	$51.64
	Total Estimated Paid	$538,600	$29,189	$932,503	$1,500,292
FY 2016-17	Projected New Enrollees[1]	27,017	1,421	15,661	44,099
	Projected New Cases[2]	18,807	1,008	11,246	31,061
	Projected Average Fee[3]	$30.36	$30.18	$90.13	$52.00
	Total Estimated Paid	$571,027	$30,426	$1,013,622	$1,615,076

[1] This is the number of new enrollees in FY 2013-14 with the projected growth trend for FY 2014-15, FY 2015-16, and FY 2016-17

[2] This is estimated by applying FY 2013-14 distribution of the number of children one parent or caretaker has enrolled in the CHP+ program to the projected number of newly enrolled clients.

[3]This is estimated by applying FY 2013-14 distribution of the number of children one parent or caretaker has enrolled in the CHP+ program to the known enrollment fee.

Assumptions Used in Estimations

	Children 157%-200%	Children 201%-205%	Children 206%-260%
Fee to enroll one child[4]	$25.00	$25.00	$75.00
Fee to enroll more than one child[4]	$35.00	$35.00	$105.00

Distribution of household size in CHP+ in FY 2013-14[5]

HH Size	157%-200%	201%-205%	206%-260%
1	46.37%	48.15%	49.56%
2	34.97%	35.12%	34.61%
3	13.85%	13.13%	12.28%
4	3.81%	2.99%	2.87%
5	0.74%	0.45%	0.54%
6	0.19%	0.17%	0.12%
7	0.03%	0.00%	0.01%
8	0.04%	0.00%	0.01%

[4] http://www.chpplus.org/Materials/IncomeGuidelinesWithEnrollmentFee201404.pdf

[5] This is the average distribution of the number of children one parent or caretaker has enrolled in the CHP+ program in FY 2013-14, applied to all forecasted fiscal years.

Exhibit C6 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2014-15

FY 2014-15 Calculation

Service Expenditure	Children to 200% FPL Medical	Children 201%-205% FPL Medical	Children 206%-260% FPL Medical	Children to 200% FPL Dental	Children 201%-205% FPL Dental	Children 206%-260% FPL Dental	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	Totals
Weighted Capitation Rate	$158.39	$166.07	$164.71	$18.57	$17.67	$17.89	$998.75	$986.36	$986.36	$189.29
Estimated Monthly Caseload[1]	42,640	2,223	21,804	42,640	2,223	21,804	244	62	548	67,521
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	12	12
Total Estimated Costs for FY 2014-15 Capitated Payments	$81,044,995	$4,430,083	$43,096,042	$9,501,898	$471,365	$4,680,883	$2,924,340	$733,852	$6,486,303	$153,369,761
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	95.93%	94.58%	94.46%	99.41%	99.22%	98.94%	96.66%	89.67%	94.55%	95.72%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$77,748,752	$4,190,050	$40,707,335	$9,446,221	$467,675	$4,631,287	$2,826,545	$658,021	$6,133,110	$146,808,996
Estimated Expenditure for Prior Period Dates of Service	$3,889,471	$314,087	$2,136,677	$42,136	$43,411	$30,439	$176,892	$54,431	$270,720	$6,958,264
Total Estimated Expenditure in FY 2014-15	**$81,638,223**	**$4,504,137**	**$42,844,012**	**$9,488,357**	**$511,086**	**$4,661,726**	**$3,003,437**	**$712,452**	**$6,403,830**	**$153,767,260**
Estimated FY 2014-15 Per Capita Expenditure without Adjustments	$1,914.59	$2,026.15	$1,964.96	$222.52	$229.91	$213.80	$12,309.17	$11,491.16	$11,685.82	$2,277.32
Total Estimated Expenditure in FY 2014-15	**$81,638,223**	**$4,504,137**	**$42,844,012**	**$9,488,357**	**$511,086**	**$4,661,726**	**$3,003,437**	**$712,452**	**$6,403,830**	**$153,767,260**
Reconciliation Payments	$11,722,489	$315,483	$2,951,072	$1,758,957	$53,123	$427,786	$0	$0	$0	$17,228,910
FQHC Payments	$6,859,676	$357,623	$3,507,701	$0	$0	$0	$0	$0	$0	$10,725,000
Prenatal Capitations	-	$0	$0	$0	$0	$0	$1,143,586	$230,879	$277,443	$1,651,908
Clients disenrolled with missing denial codes	$299,094	$16,732	$113,514	$25,764	$1,236	$10,804	$16,446	$1,042	$15,368	$500,000
Total Estimated FY 2014-15 Expenditure Including Bottom Line Impacts[3]	**$100,519,482**	**$5,193,975**	**$49,416,299**	**$11,273,078**	**$565,445**	**$5,100,316**	**$4,163,469**	**$944,373**	**$6,696,641**	**$183,873,078**
Estimated FY 2014-15 Monthly Caseload [1]	42,640	2,223	21,804	42,640	2,223	21,804	244	62	548	67,521
Estimated FY 2014-15 Per Capita Expenditure	**$2,357.40**	**$2,336.47**	**$2,266.39**	**$264.38**	**$254.36**	**$233.92**	**$17,063.40**	**$15,231.82**	**$12,220.15**	**$2,723.20**

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

[2] Exhibit C6, pages 4, 5, and 6 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

[3] Calculations and explanations for bottom line impacts can be found on pages R-3.C7-1 through R-3.C7-3.

Exhibit C6 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2015-16

FY 2015-16 Calculation

Service Expenditure	Children to 200% FPL Medical	Children 201%-205% FPL Medical	Children 206%-260% FPL Medical	Children to 200% FPL Dental	Children 201%-205% FPL Dental	Children 206%-260% FPL Dental	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	Totals
Weighted Capitation Rate	$165.24	$174.59	$173.16	$19.81	$18.66	$18.89	$1,066.04	$1,047.89	$1,050.01	$198.38
Estimated Monthly Caseload[1]	48,584	2,497	25,438	48,584	2,497	25,438	261	68	631	77,479
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	12	12
Total Estimated Costs for FY 2015-16 Capitated Payments	$96,336,242	$5,231,415	$52,858,129	$11,549,388	$559,128	$5,766,286	$3,338,837	$855,078	$7,950,676	$184,445,179
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	95.93%	94.58%	94.46%	99.41%	99.22%	98.94%	96.66%	89.67%	94.55%	95.72%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$92,418,078	$4,947,964	$49,928,334	$11,481,713	$554,751	$5,705,189	$3,227,180	$766,720	$7,517,745	$176,547,674
Estimated Expenditure for Prior Period Dates of Service	$3,296,243	$240,033	$2,388,707	$55,677	$48,708	$49,596	$97,795	$75,831	$353,193	$6,605,783
Total Estimated Expenditure in FY 2015-16	**$95,714,321**	**$5,187,997**	**$52,317,041**	**$11,537,390**	**$603,459**	**$5,754,785**	**$3,324,975**	**$842,551**	**$7,870,938**	**$183,153,457**
Estimated FY 2015-16 Per Capita Expenditure without Adjustments	$1,970.08	$2,077.69	$2,056.65	$237.47	$241.67	$226.23	$12,739.37	$12,390.46	$12,473.75	$2,363.91
Total Estimated Expenditure in FY 2015-16	**$95,714,321**	**$5,187,997**	**$52,317,041**	**$11,537,390**	**$603,459**	**$5,754,785**	**$3,324,975**	**$842,551**	**$7,870,938**	**$183,153,457**
Reconciliation Payments	$12,843,110	$344,693	$3,347,260	$1,971,620	$58,354	$487,769	$0	$0	$0	$19,052,806
FQHC Payments	$1,428,586	$73,423	$747,991	$0	$0	$0	$0	$0	$0	$2,250,000
Prenatal Capitations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Clients disenrolled with missing denial codes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Estimated FY 2015-16 Expenditure Including Adjustments[3]	**$109,986,017**	**$5,606,113**	**$56,412,292**	**$13,509,010**	**$661,813**	**$6,242,554**	**$3,324,975**	**$842,551**	**$7,870,938**	**$204,456,263**
Estimated FY 2015-16 Monthly Caseload [1]	48,584	2,497	25,438	48,584	2,497	25,438	261	68	631	77,479
Estimated FY 2015-16 Per Capita Expenditure	**$2,263.83**	**$2,245.14**	**$2,217.64**	**$278.05**	**$265.04**	**$245.40**	**$12,739.37**	**$12,390.46**	**$12,473.75**	**$2,638.86**

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

[2] Exhibit C6, pages 4, 5, and 6 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

[3] Calculations and explanations for bottom line impacts can be found on pages R-3.C7-1 through R-3.C7-3.

Exhibit C6 - Expenditure Calculations by Eligibility Category

CBHP Capitation Calculations by Eligibility Category for FY 2016-17

FY 2016-17 Calculation

Service Expenditure	Children to 200% FPL Medical	Children 201%-205% FPL Medical	Children 206%-260% FPL Medical	Children to 200% FPL Dental	Children 201%-205% FPL Dental	Children 206%-260% FPL Dental	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	Totals
Weighted Capitation Rate	$172.17	$183.35	$181.83	$21.12	$19.69	$19.95	$1,137.67	$1,113.06	$1,117.56	$208.11
Estimated Monthly Caseload[1]	51,446	2,603	27,650	51,446	2,603	27,650	269	71	700	82,739
Number of Months Rate is Effective	12	12	12	12	12	12	12	12	12	12
Total Estimated Costs for FY 2016-17 Capitated Payments	$106,289,494	$5,727,121	$60,331,194	$13,038,474	$615,037	$6,619,410	$3,672,399	$948,327	$9,387,504	$206,628,960
Estimated Percentage of Claims Paid in Current Period with Current Period Dates of Service [2]	95.93%	94.58%	94.46%	99.41%	99.22%	98.94%	96.66%	89.67%	94.55%	95.71%
Estimated Expenditure for Claims Paid in Current Period with Current Period Dates of Service	$101,966,513	$5,416,811	$56,987,185	$12,962,074	$610,223	$6,549,274	$3,549,587	$850,334	$8,876,334	$197,768,335
Estimated Expenditure for Prior Period Dates of Service	$3,918,164	$283,451	$2,929,795	$67,675	$57,776	$61,097	$111,657	$88,358	$432,931	$7,950,904
Total Estimated Expenditure in FY 2016-17	**$105,884,677**	**$5,700,262**	**$59,916,980**	**$13,029,749**	**$667,999**	**$6,610,371**	**$3,661,244**	**$938,692**	**$9,309,265**	**$205,719,239**
Estimated FY 2016-17 Per Capita Expenditure without Adjustments	$2,058.17	$2,189.88	$2,166.98	$253.27	$256.63	$239.07	$13,610.57	$13,221.01	$13,298.95	$2,486.36
Total Estimated Expenditure in FY 2016-17	**$105,884,677**	**$5,700,262**	**$59,916,980**	**$13,029,749**	**$667,999**	**$6,610,371**	**$3,661,244**	**$938,692**	**$9,309,265**	**$205,719,239**
Reconciliation Payments	$14,005,649	$373,185	$3,779,245	$2,200,733	$63,501	$553,767	$0	$0	$0	$20,976,080
FQHC Payments	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prenatal Capitations	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Clients disenrolled with missing denial codes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Estimated FY 2016-17 Expenditure Including Reconciliations[3]	**$119,890,326**	**$6,073,447**	**$63,696,225**	**$15,230,482**	**$731,500**	**$7,164,138**	**$3,661,244**	**$938,692**	**$9,309,265**	**$226,695,319**
Estimated FY 2016-17 Monthly Caseload [1]	51,446	2,603	27,650	51,446	2,603	27,650	269	71	700	82,739
Estimated FY 2016-17 Per Capita Expenditure	**$2,330.41**	**$2,333.25**	**$2,303.66**	**$296.05**	**$281.02**	**$259.10**	**$13,610.57**	**$13,221.01**	**$13,298.95**	**$2,739.88**

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

[2] Exhibit C6, pages 4, 5, and 6 present the estimated percentage of incurred claims from any six month period that will be paid in that same six month period.

[3] Calculations and explanations for bottom line impacts can be found on pages R-3.C7-1 through R-3.C7-3.

Exhibit C6 - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Children Medical to 200% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	*0.00%*	-	-
Incurred in FY 2013-14	*4.07%*	*0.00%*	-
Incurred in FY 2014-15	*95.93%*	*4.07%*	*0.00%*
Incurred in FY 2015-16	-	*95.93%*	*4.07%*
Incurred in FY 2016-17	-	-	*95.93%*

Incurred But Not Reported (IBNR) Estimate for Children Medical 201%-205% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	*0.00%*		-
Incurred in FY 2013-14	*5.42%*	*0.00%*	
Incurred in FY 2014-15	*94.58%*	*5.42%*	*0.00%*
Incurred in FY 2015-16	-	*94.58%*	*5.42%*
Incurred in FY 2016-17	-	-	*94.58%*

Incurred But Not Reported (IBNR) Estimate for Children Medical 206%-260% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	*0.00%*	-	-
Incurred in FY 2013-14	*5.54%*	*0.00%*	-
Incurred in FY 2014-15	*94.46%*	*5.54%*	*0.00%*
Incurred in FY 2015-16	-	*94.46%*	*5.54%*
Incurred in FY 2016-17	-	-	*94.46%*

Exhibit C6 - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Children Dental to 200% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	*0.00%*	-	-
Incurred in FY 2013-14	*0.59%*	*0.00%*	-
Incurred in FY 2014-15	*99.41%*	*0.59%*	*0.00%*
Incurred in FY 2015-16	-	*99.41%*	*0.59%*
Incurred in FY 2016-17	-	-	*99.41%*

Incurred But Not Reported (IBNR) Estimate for Children Dental 201%-205% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	*0.00%*		-
Incurred in FY 2013-14	*0.78%*	*0.00%*	
Incurred in FY 2014-15	*99.22%*	*0.78%*	*0.00%*
Incurred in FY 2015-16	-	*99.22%*	*0.78%*
Incurred in FY 2016-17	-	-	*99.22%*

Incurred But Not Reported (IBNR) Estimate for Children Dental 206%-260% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	*0.00%*	-	-
Incurred in FY 2013-14	*1.06%*	*0.00%*	-
Incurred in FY 2014-15	*98.94%*	*1.06%*	*0.00%*
Incurred in FY 2015-16	-	*98.94%*	*1.06%*
Incurred in FY 2016-17	-	-	*98.94%*

Exhibit C6 - Incurred But Not Reported Runout by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Prenatal to 200% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	*0.00%*	-	-
Incurred in FY 2013-14	*3.34%*	*0.00%*	-
Incurred in FY 2014-15	*96.66%*	*3.34%*	*0.00%*
Incurred in FY 2015-16	-	*96.66%*	*3.34%*
Incurred in FY 2016-17	-	-	*96.66%*

Incurred But Not Reported (IBNR) Estimate for Prenatal 201%-205% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	*0.00%*	-	-
Incurred in FY 2013-14	*10.33%*	*0.00%*	-
Incurred in FY 2014-15	*89.67%*	*10.33%*	*0.00%*
Incurred in FY 2015-16	-	*89.67%*	*10.33%*
Incurred in FY 2016-17	-	-	*89.67%*

Incurred But Not Reported (IBNR) Estimate for Prenatal 206%-260% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	*0.00%*	-	-
Incurred in FY 2013-14	*5.45%*	*0.00%*	-
Incurred in FY 2014-15	*94.55%*	*5.45%*	*0.00%*
Incurred in FY 2015-16	-	*94.55%*	*5.45%*
Incurred in FY 2016-17	-	-	*94.55%*

Exhibit C6 - Incurred But Not Reported Expenditure by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Children Medical to 200% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	$0	-	-
Incurred in FY 2013-14	$3,889,471	$0	-
Incurred in FY 2014-15	$77,748,752	$3,296,243	$0
Incurred in FY 2015-16	-	$92,418,078	$3,918,164
Incurred in FY 2016-17	-	-	$101,966,513
Total Paid in Current Period	$77,748,752	$92,418,078	$101,966,513
Total IBNR Amount	$3,889,471	$3,296,243	$3,918,164
Total Paid for All Incurred Dates	$81,638,223	$95,714,321	$105,884,677

Incurred But Not Reported (IBNR) Estimate for Children Medical 201%-205% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	$0	-	-
Incurred in FY 2013-14	$314,087	$0	-
Incurred in FY 2014-15	$4,190,050	$240,033	$0
Incurred in FY 2015-16	-	$4,947,964	$283,451
Incurred in FY 2016-17	-	-	$5,416,811
Total Paid in Current Period	$4,190,050	$4,947,964	$5,416,811
Total IBNR Amount	$314,087	$240,033	$283,451
Total Paid for All Incurred Dates	$4,504,137	$5,187,997	$5,700,262

Incurred But Not Reported (IBNR) Estimate for Children Medical 206%-260% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	$0	-	-
Incurred in FY 2013-14	$2,136,677	$0	-
Incurred in FY 2014-15	$40,707,335	$2,388,707	$0
Incurred in FY 2015-16	-	$49,928,334	$2,929,795
Incurred in FY 2016-17	-	-	$56,987,185
Total Paid in Current Period	$40,707,335	$49,928,334	$56,987,185
Total IBNR Amount	$2,136,677	$2,388,707	$2,929,795
Total Paid for All Incurred Dates	$42,844,012	$52,317,041	$59,916,980

Exhibit C6 - Incurred But Not Reported Expenditure by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Children Dental to 200% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	$0	-	-
Incurred in FY 2013-14	$42,136	$0	-
Incurred in FY 2014-15	$9,446,221	$55,677	$0
Incurred in FY 2015-16	-	$11,481,713	$67,675
Incurred in FY 2016-17	-	-	$12,962,074
Total Paid in Current Period	$9,446,221	$11,481,713	$12,962,074
Total IBNR Amount	$42,136	$55,677	$67,675
Total Paid for All Incurred Dates	$9,488,357	$11,537,390	$13,029,749

Incurred But Not Reported (IBNR) Estimate for Children Dental 201%-205% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	$0	$0	-
Incurred in FY 2013-14	$43,411	$0	$0
Incurred in FY 2014-15	$422,657	$48,708	$0
Incurred in FY 2015-16	-	$501,352	$57,776
Incurred in FY 2016-17	-	-	$551,483
Total Paid in Current Period	$422,657	$501,352	$551,483
Total IBNR Amount	$43,411	$48,708	$57,776
Total Paid for All Incurred Dates	$466,068	$550,060	$609,259

Incurred But Not Reported (IBNR) Estimate for Children Dental 206%-260% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	$0	-	-
Incurred in FY 2013-14	$30,439	$0	-
Incurred in FY 2014-15	$4,631,287	$49,596	$0
Incurred in FY 2015-16	-	$5,705,189	$61,097
Incurred in FY 2016-17	-	-	$6,549,274
Total Paid in Current Period	$4,631,287	$5,705,189	$6,549,274
Total IBNR Amount	$30,439	$49,596	$61,097
Total Paid for All Incurred Dates	$4,661,726	$5,754,785	$6,610,371

Exhibit C6 - Incurred But Not Reported Expenditure by Fiscal Period

Incurred But Not Reported (IBNR) Estimate for Prenatal to 200% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	$0	-	-
Incurred in FY 2013-14	$176,892	$0	-
Incurred in FY 2014-15	$2,826,545	$97,795	$0
Incurred in FY 2015-16	-	$3,227,180	$111,657
Incurred in FY 2016-17	-	-	$3,549,587
Total Paid in Current Period	$2,826,545	$3,227,180	$3,549,587
Total IBNR Amount	$176,892	$97,795	$111,657
Total Paid for All Incurred Dates	$3,003,437	$3,324,975	$3,661,244

Incurred But Not Reported (IBNR) Estimate for Prenatal 201%-205% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	$0	-	-
Incurred in FY 2013-14	$54,431	$0	-
Incurred in FY 2014-15	$658,021	$75,831	$0
Incurred in FY 2015-16	-	$766,720	$88,358
Incurred in FY 2016-17	-	-	$850,334
Total Paid in Current Period	$658,021	$766,720	$850,334
Total IBNR Amount	$54,431	$75,831	$88,358
Total Paid for All Incurred Dates	$712,452	$842,551	$938,692

Incurred But Not Reported (IBNR) Estimate for Prenatal 206%-260% FPL

	Paid in FY 2014-15	Paid in FY 2015-16	Paid in FY 2016-17
Incurred in all other previous periods	$0	-	-
Incurred in FY 2013-14	$270,720	$0	-
Incurred in FY 2014-15	$6,133,110	$353,193	$0
Incurred in FY 2015-16	-	$7,517,745	$432,931
Incurred in FY 2016-17	-	-	$8,876,334
Total Paid in Current Period	$6,133,110	$7,517,745	$8,876,334
Total IBNR Amount	$270,720	$353,193	$432,931
Total Paid for All Incurred Dates	$6,403,830	$7,870,938	$9,309,265

Exhibit C7 - Bottom Line Impacts Summary

	Item	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	Total
FY 2013-14 Actuals	Reconciliation Payments[1]	$13,060,128	$310,297	$2,929,187	$1,675,130	$47,539	$379,302	$0	$0	$0	$18,401,583
	FQHC Payments[2]	$2,222,064	$1,133,515	$0	$0	$0	$0	($177,462)	($123,711)	$0	$3,054,406
	Total Bottom Line Adjustments for FY 2013-14	**$15,282,192**	**$1,443,812**	**$2,929,187**	**$1,675,130**	**$47,539**	**$379,302**	**($177,462)**	**($123,711)**	**$0**	**$21,455,989**
FY 2014-15 Projections	Reconciliation Payments[1]	$11,722,489	$315,483	$2,951,072	$1,758,957	$53,123	$427,786	$0	$0	$0	$17,228,910
	FQHC Payments[2]	$6,859,676	$357,623	$3,507,701	$0	$0	$0	$0	$0	$0	$10,725,000
	Prenatal Capitations[3]	$0	$0	$0	$0	$0	$0	$1,143,586	$230,879	$277,443	$1,651,908
	Clients disenrolled with missing denial codes[4]	$299,094	$16,732	$113,514	$25,764	$1,236	$10,804	$16,446	$1,042	$15,368	$500,000
	Total Bottom Line Adjustments for FY 2014-15	**$18,881,259**	**$689,838**	**$6,572,287**	**$1,784,721**	**$54,359**	**$438,590**	**$1,160,032**	**$231,921**	**$292,811**	**$30,105,818**
FY 2015-16 Projections	Reconciliation Payments[1]	$12,843,110	$344,693	$3,347,260	$1,971,620	$58,354	$487,769	$0	$0	$0	$19,052,806
	FQHC Payments[2]	$1,428,586	$73,423	$747,991	$0	$0	$0	$0	$0	$0	$2,250,000
	Prenatal Capitations[3]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Clients disenrolled with missing denial codes[4]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Bottom Line Adjustments for FY 2015-16	**$14,271,696**	**$418,116**	**$4,095,251**	**$1,971,620**	**$58,354**	**$487,769**	**$0**	**$0**	**$0**	**$21,302,806**
FY 2016-17 Projections	Reconciliation Payments[1]	$14,005,649	$373,185	$3,779,245	$2,200,733	$63,501	$553,767	$0	$0	$0	$20,976,080
	FQHC Payments[2]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Prenatal Capitations[3]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Clients disenrolled with missing denial codes[4]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total Bottom Line Adjustments for FY 2016-17	**$14,005,649**	**$373,185**	**$3,779,245**	**$2,200,733**	**$63,501**	**$553,767**	**$0**	**$0**	**$0**	**$20,976,080**

[1]There exists a manual reconciliation process for CHP+ clients. These claims are accounted for as expenditure adjustments, calculations can be found on page R-3.C7-2

[2]FQHC Payments were implemented in FY 2013-14. The expenditure adjustments is the current estimate for what is owed to FQHC's from previous years applied to the projected distribution for children's caseload.

[3]In FY 2013-14, prenatal capitations for clients in 201%-260% experienced systems issues for some clients. These issues can be seen in the abnormally low retroactivity adjustment in FY 2013-14. The Department assumes these systems issues will be fixed in FY 2014-15 and the services accrued but not paid in FY 2013-14 will be paid in FY 2014-15. This is accounted for as an expenditure adjustment in FY 2014-15, and has been calculated using the FY 2013-14 retroactivity adjustment in Exhibit C8.

[4]In FY 2013-14, some Medicaid and CHP+ clients were disenrolled with a blank disenrollment reason code. The Department has notified the clients on this termination and will retroactively enroll the clients for the period of unexplained disenrollment. The Department estimates a $500,000 impact for CHP+ clients.

Exhibit C7 - Bottom Line Impact Calculations

Projected Reconciliation Payments Calculations

Estimated FY 2014-15 Reconciliations

	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	Average Total
Actual FY 2013-14 Reconciliation Payments	$13,060,128	$310,297	$2,929,187	$1,675,130	$47,539	$379,302	$0	$0	$0	$18,401,583
FY 2014-15 Projected Rate Inflation Exhibit C9	1.30%	4.41%	3.15%	18.51%	14.75%	15.47%	-0.07%	0.00%	0.00%	3.54%
Estimated Reconciliations After Rate Inflation	$13,229,702	$323,975	$3,021,411	$1,985,114	$54,553	$437,982	$0	$0	$0	$19,052,737
FY 2014-15 Projected Base Caseload Growth Exhibit C4	-11.39%	-2.62%	-2.33%	-11.39%	-2.62%	-2.33%	-38.85%	19.23%	9.16%	-9.57%
Final Estimated FY 2014-15 Reconciliations	**$11,722,489**	**$315,483**	**$2,951,072**	**$1,758,957**	**$53,123**	**$427,786**	**$0**	**$0**	**$0**	**$17,228,910**

Estimated FY 2015-16 Reconciliations

	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	Average Total
FY 2014-15 Projected Reconciliation Payments	$11,722,489	$315,483	$2,951,072	$1,758,957	$53,123	$427,786	$0.00	$0.00	$0.00	$17,228,910
FY 2015-16 Projected Rate Inflation Exhibit C9	4.20%	5.02%	5.02%	6.61%	5.58%	5.57%	6.72%	6.22%	6.43%	4.64%
Estimated Reconciliations After Rate Inflation	$12,215,116	$331,316	$3,099,178	$1,875,213	$56,089	$451,618	$0.00	$0.00	$0.00	$18,028,530
FY 2015-16 Projected Base Caseload Growth Exhibit C4	5.14%	4.04%	8.00%	5.14%	4.04%	8.00%	0.00%	3.23%	7.66%	5.68%
Final Estimated FY 2015-16 Reconciliations	**$12,843,110**	**$344,693**	**$3,347,260**	**$1,971,620**	**$58,354**	**$487,769**	**$0**	**$0**	**$0**	**$19,052,806**

Estimated FY 2016-17 Reconciliations

	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	Average Total
FY 2015-16 Projected Reconciliation Payments	$12,843,110	$344,693	$3,347,260	$1,971,620	$58,354	$487,769	$0.00	$0.00	$0.00	$19,052,806
FY 2016-17 Projected Rate Inflation Exhibit C9	4.20%	5.02%	5.01%	6.65%	5.56%	5.59%	6.72%	6.22%	6.43%	4.65%
Estimated Reconciliations After Rate Inflation	$13,382,371	$361,987	$3,515,034	$2,102,796	$61,596	$515,053	$0.00	$0.00	$0.00	$19,938,837
FY 2016-17 Projected Base Caseload Growth Exhibit C4	4.66%	3.09%	7.52%	4.66%	3.09%	7.52%	0.00%	0.00%	7.63%	5.20%
Final Estimated FY 2016-17 Reconciliations	**$14,005,649**	**$373,185**	**$3,779,245**	**$2,200,733**	**$63,501**	**$553,767**	**$0**	**$0**	**$0**	**$20,976,080**

Exhibit C7 - Bottom Line Impact Calculations

Projected Impact of Prenatal Capitation Systems Issues Calculation

Estimated FY 2014-15 Prenatal Capitations Impact

	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL	Average Total
Total Member Months within affected FPL Bracket[(1)]	-	-	-	-	-	-	1,164	620	2,316	4,100
Adjustment[(2)]	-	-	-	-	-	-	100.00%	38.46%	12.35%	41.17%
Estimated Member Months without Capitations	-	-	-	-	-	-	1,164	238	286	1,688
Weighted Rate for FY 2013-14 Exhibit C9	-	-	-	-	-	-	$982.46	$970.08	$970.08	$978.62
Estimated FY 2014-15 Expenditures	**-**	**-**	**-**	**-**	**-**	**-**	**$1,143,586**	**$230,879**	**$277,443**	**$1,651,908**

[(1)]Total Member Months within affected FPL Bracket is the sum of each monthly caseload in FY 2013-14 for the individual FPL bracket that is experiencing the systems issues. The individual FPL brackets are 185%-200%, 201%-205%, and 206%-225%.

[(2)]In FY 2013-14, capitations for prenatal clients within specific FPL brackets experienced systems issues. The Department has used claims data from the MMIS to estimate the number of member months that did not receive a capitation. No capitations were made for clients from 185%-200% FPL and the adjustment is 100%. Prenatal clients from 201%-225% FPL only had a portion of capitations paid. The adjustment is 1 minus the retroactivity adjusment from FY 2013-14 (Exhibit C8).

Exhibit C8 - Children's Basic Health Plan Retroactivity Adjustment[1]

Fiscal Year		Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL
FY 2007-08	Average Monthly Claims	63,158	412	-	52,975	308	-	1,733	18	-
	Average Caseload	57,466	330	-	57,466	330	-	1,557	14	-
	Claims as a Percentage of Caseload	109.90%	124.85%	-	92.18%	93.33%	-	111.30%	128.57%	-
FY 2008-09	Average Monthly Claims	63,657	1,598	-	54,368	1,334	-	1,290	50	-
	Average Caseload	60,137	1,445	-	60,137	1,445	-	1,598	67	-
	Claims as a Percentage of Caseload	105.85%	110.59%	-	90.41%	92.32%	-	80.73%	74.63%	-
FY 2009-10	Average Monthly Claims	68,517	1,669	186	59,381	1,423	66	1,310	69	8
	Average Caseload	66,940	1,649	136	66,940	1,649	136	1,469	80	11
	Claims as a Percentage of Caseload	102.36%	101.21%	136.76%	88.71%	86.29%	48.53%	89.18%	86.25%	72.73%
FY 2010-11	Average Monthly Claims	63,690	1,273	4,789	54,529	1,099	3,608	1,238	57	248
	Average Caseload	62,080	1,164	4,023	62,080	1,164	4,023	1,409	60	272
	Claims as a Percentage of Caseload	102.59%	109.36%	119.04%	87.84%	94.42%	89.68%	87.86%	95.00%	91.18%
FY 2011-12	Average Monthly Claims	50,680	1,112	8,042	54,038	1,278	9,310	1,200	41	303
	Average Caseload	61,815	1,402	11,049	61,815	1,402	11,049	1,563	53	448
	Claims as a Percentage of Caseload	81.99%	79.32%	72.78%	87.42%	91.16%	84.26%	76.77%	77.00%	67.67%
FY 2012-13	Average Monthly Claims	63,518	1,700	13,949	54,792	1,431	12,751	1,271	52	426
	Average Caseload	60,646	1,614	15,575	60,646	1,614	15,575	1,100	48	463
	Claims as a Percentage of Caseload	104.74%	105.33%	89.56%	90.35%	88.66%	81.87%	115.55%	108.33%	92.01%
FY 2013-14	Average Monthly Claims	49,815	2,485	19,237	40,489	1,870	17,390	448	32	440
	Average Caseload	40,561	1,950	19,043	40,561	1,950	19,043	399	52	502
	Claims as a Percentage of Caseload[2]	122.82%	127.44%	101.02%	99.82%	95.90%	91.32%	112.28%	61.54%	87.65%
Weighted Average Claims as a Percentage of Caseload[3]		103.67%	105.30%	105.30%	99.82%	99.82%	99.82%	101.71%	101.67%	101.67%
Retroactivity Adjustment Factor		3.67%	5.30%	5.30%	-0.18%	-0.18%	-0.18%	1.71%	1.66%	1.66%

[1] The retroactivity adjustment captures the difference in total claims paid versus caseload due to retroactive eligibility.

[2] Prenatal capitations for some clients within 201%-250% FPL experienced systems issues, resulting in a retroactivity adjustment below 100%. The Department assumes this issue will be resolved in FY 2014-15 and has included an expenditure adjustment (see Exhibit C7) to account for these capitations.

[3]Percentage selected to modify capitation rates	Children Medical	Children Medical to 200% - Average of FY 2010-11 and FY 2012-13; Children Medical 201%-205% - Average of FY 2009-10, FY 2010-11, and FY 2012-13; Children Medical 206%-260% - Estimated percentage for Children Medical 201%-205%
	Children Dental	Children Dental to 200% - FY 2013-14; Children Dental 201%-205% - Estimated percentage for Children Dental to 200%; Children Dental 206%-260% - Estimated percentage for Children Dental to 200%
	Prenatal	Prenatal to 200% - Average of FY 2010-11 and FY 2012-13; Prenatal 201%-205% - Average of FY 2010-11 and FY 2012-13; Prenatal 206%-260% - Estimated percentage for Prenatal 201%-205%

Exhibit C8 - Children's Basic Health Plan Partial Month Adjustment Multiplier[1]

Fiscal Year		Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL
FY 2007-08	Weighted Claims-Based Rate	$116.59	-	-	$13.68	-	-	$828.30	-	-
	Weighted Capitation Rate	$129.38	-	-	$13.84	-	-	$864.09	-	-
	Claims as a Percentage of Capitation	90.12%	-	-	98.87%	-	-	95.86%	-	-
FY 2008-09	Weighted Claims-Based Rate	$140.69	$154.32	-	$14.66	$14.66	-	$868.97	$679.00	-
	Weighted Capitation Rate	$126.41	$125.59	-	$14.66	$14.66	-	$924.68	$915.80	-
	Claims as a Percentage of Capitation	111.30%	122.87%	-	100.00%	100.00%	-	93.98%	74.14%	-
FY 2009-10	Weighted Claims-Based Rate	$149.25	$151.02	$186.11	$14.81	$14.81	$14.64	$827.81	$827.81	$827.08
	Weighted Capitation Rate	$140.69	$140.79	-	$14.81	$14.81	-	$821.42	$821.35	-
	Claims as a Percentage of Capitation	106.08%	107.27%	-	99.98%	99.98%	-	100.78%	100.79%	-
FY 2010-11	Weighted Claims-Based Rate	$156.55	$165.50	$170.55	$14.56	$13.54	$13.67	$1,184.97	$1,185.01	$1,185.01
	Weighted Capitation Rate	$134.21	$137.71	$138.42	$13.25	$12.05	$12.12	$1,067.97	$1,062.97	$1,062.97
	Claims as a Percentage of Capitation	116.65%	120.18%	123.21%	109.82%	112.33%	112.80%	110.95%	111.48%	111.48%
FY 2011-12	Weighted Claims-Based Rate	$164.20	$166.62	$168.28	$15.26	$14.31	$14.34	$1,147.65	$1,138.60	$1,138.60
	Weighted Capitation Rate	$160.91	$159.28	$160.47	$15.25	$14.62	$14.66	$1,147.62	$1,138.60	$1,138.60
	Claims as a Percentage of Capitation	102.04%	104.61%	104.87%	100.11%	97.88%	97.83%	100.00%	100.00%	100.00%
FY 2012-13	Weighted Claims-Based Rate	$158.06	$155.16	$152.43	$16.07	$15.29	$15.40	$935.52	$912.11	$912.11
	Weighted Capitation Rate	$151.75	$147.24	$148.62	$16.07	$15.32	$15.42	$935.27	$912.11	$912.11
	Claims as a Percentage of Capitation	104.16%	105.38%	102.56%	100.01%	99.84%	99.86%	100.03%	100.00%	100.00%
FY 2013-14	Weighted Claims-Based Rate	$150.65	$150.89	$151.48	$14.81	$14.68	$14.44	$983.87	$969.78	$969.71
	Weighted Capitation Rate	$148.46	$149.24	$150.29	$15.70	$15.45	$15.54	$982.46	$970.08	$970.08
	Claims as a Percentage of Capitation	101.48%	101.10%	100.79%	94.36%	95.00%	92.92%	100.14%	99.97%	99.96%
Average Claims as a Percentage of Capitation [2]		101.48%	101.10%	100.79%	100.01%	99.84%	99.86%	100.00%	100.00%	100.00%
Partial Month Adjustment Multiplier		1.48%	1.10%	0.79%	0.01%	-0.16%	-0.14%	0.00%	0.00%	0.00%

[1] The partial month adjustment captures the difference in the amount paid per claim versus the capitation rate due to paying an adjusted rate for clients enrolled for only part of a month.

[2] Percentage selected to modify capitation rates		
	Children Medical	Children Medical to 200% - FY 2013-14; Children Medical 201%-205% - FY 2013-14; Children Medical 206%-260% - FY 2013-14
	Children Dental	Children Dental to 200% - FY 2012-13; Children Dental 201%-205% - FY 2012-13; Children Dental 206%-260% - FY 2012-13
	Prenatal	Prenatal to 200% - FY 2011-12; Prenatal 201%-205% - FY 2012-13; Prenatal 206%-260% - FY 2012-13

Exhibit C9 - Children's Basic Health Plan Capitation Rate Trends and Forecasts										
Capitation Rate Trends										
Fiscal Year	**Children Medical to 200% FPL**	**Children Medical 201%-205% FPL**	**Children Medical 206%-260% FPL**	**Children Dental to 200% FPL**	**Children Dental 201%-205% FPL**	**Children Dental 206%-260% FPL**	**Prenatal to 200% FPL**	**Prenatal 201%-205% FPL**	**Prenatal 206%-260% FPL**	**Weighted CBHP Total**
FY 2007-08 Actuals	**$129.38**	-	-	**$13.84**	-	-	**$864.09**	-	-	**$161.30**
FY 2008-09 Actuals	**$126.41**	**$125.59**	-	**$14.66**	**$14.66**	-	**$924.68**	**$915.80**	-	**$161.67**
% Change from FY 2007-08	-2.30%	-	-	5.92%	-	-	7.01%	-	-	0.23%
FY 2009-10 Actuals	**$140.69**	**$140.79**	-	**$14.81**	**$14.81**	-	**$821.42**	**$821.35**	-	**$169.86**
% Change from FY 2008-09	11.30%	12.10%	-	1.02%	1.02%	-	-11.17%	-10.31%	-	5.07%
FY 2010-11 Actuals	**$134.21**	**$137.71**	**$138.42**	**$13.25**	**$12.05**	**$12.12**	**$1,067.97**	**$1,062.97**	**$1,062.97**	**$170.88**
% Change from FY 2009-10	-4.61%	-2.19%	-	-10.51%	-18.64%	-	30.02%	29.42%	-	0.60%
FY 2011-12 Actuals	**$160.91**	**$159.28**	**$160.47**	**$15.25**	**$14.62**	**$14.66**	**$1,147.62**	**$1,138.60**	**$1,138.60**	**$202.18**
% Change from FY 2010-11	19.90%	15.67%	15.93%	15.03%	21.31%	21.00%	7.46%	7.11%	7.11%	18.32%
FY 2012-13 Actuals	**$151.75**	**$147.24**	**$148.62**	**$16.07**	**$15.32**	**$15.42**	**$935.27**	**$912.11**	**$912.11**	**$182.39**
% Change from FY 2011-12	-5.69%	-7.56%	-7.38%	5.42%	4.78%	5.14%	-18.50%	-19.89%	-19.89%	-9.79%
FY 2013-14 Actuals	**$148.46**	**$149.24**	**$150.29**	**$15.70**	**$15.45**	**$15.54**	**$982.46**	**$970.08**	**$970.08**	**$177.05**
% Change from FY 2012-13	-2.17%	1.36%	1.12%	-2.31%	0.89%	0.83%	5.05%	6.36%	6.36%	-2.92%
FY 2014-15 Projected Weighted Rate	**$150.39**	**$155.82**	**$155.02**	**$18.61**	**$17.73**	**$17.95**	**$981.79**	**$970.08**	**$970.08**	**$180.60**
% Change from FY 2013-14	1.30%	4.41%	3.15%	18.51%	14.75%	15.47%	-0.07%	0.00%	0.00%	2.00%
FY 2015-16 Estimated Rate	**$156.71**	**$163.64**	**$162.80**	**$19.84**	**$18.72**	**$18.95**	**$1,047.76**	**$1,030.42**	**$1,032.50**	**$189.10**
% Change from FY 2014-15 Estimated Rate	4.20%	5.02%	5.02%	6.61%	5.58%	5.57%	6.72%	6.22%	6.43%	4.70%
FY 2016-17 Estimated Rate	**$163.29**	**$171.85**	**$170.96**	**$21.16**	**$19.76**	**$20.01**	**$1,118.17**	**$1,094.51**	**$1,098.94**	**$198.41**
% Change from FY 2015-16 Estimated Rate	4.20%	5.02%	5.01%	6.65%	5.56%	5.59%	6.72%	6.22%	6.43%	4.92%

Exhibit C10 - Forecast Model Comparisons - Final Forecasts

Adjustment Factors for Forecasted Rates

Model	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL
FY 2014-15 Known Rate									
Weighted Capitation Point Estimate	***$150.39***	***$155.82***	***$155.02***	***$18.61***	***$17.73***	***$17.95***	***$981.79***	***$970.08***	***$970.08***
Estimated Rate Impact of HB 14-1213 "Pharmacy Benefits Manager Maximum Allowable Cost"[1]	*$0.35*	*$0.35*	*$0.35*	*$0.00*	*$0.00*	*$0.00*	*$0.35*	*$0.35*	*$0.35*
Half year impact for HB 14-1213 "Pharmacy Benefits Manager Maximum Allowable Cost"	*50.00%*	*50.00%*	*50.00%*	*50.00%*	*50.00%*	*50.00%*	*50.00%*	*50.00%*	*50.00%*
FY 2014-15 Estimated Rate	***$150.56***	***$156.00***	***$155.20***	***$18.61***	***$17.73***	***$17.95***	***$981.96***	***$970.26***	***$970.26***
Retroactivity Adjustment Multiplier (Exhibit C8)	3.67%	5.30%	5.30%	-0.18%	-0.18%	-0.18%	1.71%	1.66%	1.66%
Partial Month Adjustment Multiplier (Exhibit C8)	1.48%	1.10%	0.79%	0.01%	-0.16%	-0.14%	0.00%	0.00%	0.00%
Final Adjustment Factor	**5.20%**	**6.46%**	**6.13%**	**-0.17%**	**-0.34%**	**-0.32%**	**1.71%**	**1.66%**	**1.66%**
FY 2014-15 Final Estimated Rate	**$158.39**	**$166.07**	**$164.71**	**$18.57**	**$17.67**	**$17.89**	**$998.75**	**$986.36**	**$986.36**

[1]This is a placeholder for a potential amendment to the rate. The Department is still analyzing the most advantageous implementation date for HB 14-1213.

Model	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL
FY 2015-16 Estimated Rate									
Weighted Capitation Point Estimate	***$156.71***	***$163.64***	***$162.80***	***$19.84***	***$18.72***	***$18.95***	***$1,047.76***	***$1,030.42***	***$1,032.50***
Estimated Rate Impact of HB 14-1213 "Pharmacy Benefits Manager Maximum Allowable Cost"[1]	*$0.36*	*$0.36*	*$0.36*	*$0.00*	*$0.00*	*$0.00*	*$0.36*	*$0.36*	*$0.36*
Full year impact for HB 14-1213 "Pharmacy Benefits Manager Maximum Allowable Cost"	*100.00%*	*100%*	*100%*	*100.00%*	*100.00%*	*100.00%*	*100.00%*	*100.00%*	*100.00%*
FY 2014-15 Estimated Rate	***$157.07***	***$164.00***	***$163.16***	***$19.84***	***$18.72***	***$18.95***	***$1,048.12***	***$1,030.78***	***$1,032.86***
Retroactivity Adjustment Multiplier (Exhibit C8)	3.67%	5.30%	5.30%	-0.18%	-0.18%	-0.18%	1.71%	1.66%	1.66%
Partial Month Adjustment Multiplier (Exhibit C8)	1.48%	1.10%	0.79%	0.01%	-0.16%	-0.14%	0.00%	0.00%	0.00%
Final Adjustment Factor [1]	**5.20%**	**6.46%**	**6.13%**	**-0.17%**	**-0.34%**	**-0.32%**	**1.71%**	**1.66%**	**1.66%**
FY 2015-16 Final Estimated Rate	**$165.24**	**$174.59**	**$173.16**	**$19.81**	**$18.66**	**$18.89**	**$1,066.04**	**$1,047.89**	**$1,050.01**

[1]This is a placeholder for a potential amendment to the rate. The Department is still analyzing the most advantageous implementation date for HB 14-1213.

Model	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL
FY 2016-17 Estimated Rate									
Weighted Capitation Point Estimate	**$163.29**	**$171.85**	**$170.96**	**$21.16**	**$19.76**	**$20.01**	**$1,118.17**	**$1,094.51**	**$1,098.94**
Estimated Rate Impact of HB 14-1213 "Pharmacy Benefits Manager Maximum Allowable Cost"[1]	*$0.37*	*$0.37*	*$0.37*	*$0.00*	*$0.00*	*$0.00*	*$0.37*	*$0.37*	*$0.37*
Full year impact for HB 14-1213 "Pharmacy Benefits Manager Maximum Allowable Cost"	*100.00%*	*100%*	*100%*	*100.00%*	*100.00%*	*100.00%*	*100.00%*	*100.00%*	*100.00%*
FY 2014-15 Estimated Rate	***$163.66***	***$172.22***	***$171.33***	***$21.16***	***$19.76***	***$20.01***	***$1,118.54***	***$1,094.88***	***$1,099.31***
Retroactivity Adjustment Multiplier (Exhibit C8)	3.67%	5.30%	5.30%	-0.18%	-0.18%	-0.18%	1.71%	1.66%	1.66%
Partial Month Adjustment Multiplier (Exhibit C8)	1.48%	1.10%	0.79%	0.01%	-0.16%	-0.14%	0.00%	0.00%	0.00%
Final Adjustment Factor [2]	**5.20%**	**6.46%**	**6.13%**	**-0.17%**	**-0.34%**	**-0.32%**	**1.71%**	**1.66%**	**1.66%**
FY 2016-17 Final Estimated Rate	**$172.17**	**$183.35**	**$181.83**	**$21.12**	**$19.69**	**$19.95**	**$1,137.67**	**$1,113.06**	**$1,117.56**

[1]This is a placeholder for a potential amendment to the rate. The Department is still analyzing the most advantageous implementation date for HB 14-1213.

Exhibit C10 - Forecast Model Comparisons - Capitation Trend Models

Capitation Rate Forecast Model for FY 2013-14

Model	Children Medical to 200% FPL	Children Medical 201%-205% FPL	Children Medical 206%-260% FPL	Children Dental to 200% FPL	Children Dental 201%-205% FPL	Children Dental 206%-260% FPL	Prenatal to 200% FPL	Prenatal 201%-205% FPL	Prenatal 206%-260% FPL
FY 2012-13 Actual Rate	$151.75	$147.24	$148.62	$16.07	$15.32	$15.42	$935.27	$912.11	$912.11
FY 2013-14 Full Year Average Rate	$148.46	$149.24	$150.29	$15.70	$15.45	$15.54	$982.46	$970.08	$970.08
FY 2014-15 Estimated Average Rate	$150.39	$155.82	$155.02	$18.61	$17.73	$17.95	$981.79	$970.08	$970.08
Recent Growth Rates									
% Growth from FY 2012-13 to FY 2013-14 Rate	-2.17%	1.36%	1.12%	-2.31%	0.89%	0.83%	5.05%	6.36%	6.36%
% Growth from FY 2013-14 to FY 2014-15 Rate	1.30%	4.41%	3.15%	18.51%	14.75%	15.47%	-0.07%	0.00%	0.00%
Selected Trend Models									
Average Growth Model	**$156.70**	**$167.03**	**$153.58**	**$19.85**	**$19.16**	**$20.16**	**$999.30**	**$1,030.47**	**$1,141.57**
% Difference from FY 2014-15 Rate	4.20%	7.19%	-0.93%	6.66%	8.03%	12.33%	1.78%	6.22%	17.68%
Two Period Moving Average Model	**$148.38**	**$152.69**	**$151.83**	**$17.28**	**$16.62**	**$16.80**	**$981.78**	**$970.08**	**$970.08**
% Difference from FY 2014-15 Rate	-1.33%	-2.01%	-2.06%	-7.10%	-6.29%	-6.40%	0.00%	0.00%	0.00%
Exponential Growth Model	**$151.61**	**$160.25**	**$147.80**	**$18.85**	**$18.72**	**$23.66**	**$1,051.63**	**$1,141.43**	**$1,154.29**
% Difference from FY 2014-15 Rate	0.81%	2.84%	-4.66%	1.31%	5.58%	31.81%	7.11%	17.66%	18.99%
Linear Growth Model	**$150.75**	**$158.35**	**$145.42**	**$18.47**	**$18.21**	**$20.58**	**$1,047.75**	**$1,105.81**	**$1,094.95**
% Difference from FY 2014-15 Rate	0.24%	1.62%	-6.19%	-0.73%	2.71%	14.67%	6.72%	13.99%	12.87%
FY 2015-16 Forecast Minimum	$148.38	$152.69	$145.42	$17.28	$16.62	$16.80	$981.78	$970.08	$970.08
FY 2015-16 Forecast Maximum	$156.70	$167.03	$153.58	$19.85	$19.16	$23.66	$1,051.63	$1,141.43	$1,154.29
% change from FY 2014-15 Rate to Selected FY 2015-16 Capitation Rate [1]	4.20%	5.02%	5.02%	6.66%	5.58%	5.58%	6.72%	6.22%	6.44%
FY 2015-16 Forecast Point Estimate	**$156.71**	**$163.64**	**$162.80**	**$19.84**	**$18.72**	**$18.95**	**$1,047.76**	**$1,030.42**	**$1,032.50**
% change from FY 2015-16 Rate to Selected FY 2016-17 Capitation Rate [2]	4.20%	5.02%	5.02%	6.66%	5.58%	5.58%	6.72%	6.22%	6.44%
FY 2016-17 Forecast Point Estimate	**$163.29**	**$171.85**	**$170.96**	**$21.16**	**$19.76**	**$20.01**	**$1,118.17**	**$1,094.51**	**$1,098.94**

[1] Percentage selected to modify capitation rates for FY 2015-16	Children Medical	Children Medical to 200% - Average Growth Model; Children Medical 201%-205% - Average of the Average Growth Model and the Exponential Growth Model; Children Medical 206%-260% - Trend selected for Children Medical 201%-205%
	Children Dental	Children Dental to 200% - Average Growth Model; Children Dental 201%-205 - Exponential Growth Model; Children Dental 206%-260% - Trend selected for Children Dental 201%-205%
	Prenatal	Prenatal to 200% - Linear Growth Model; Prenatal 201%-205% - Average Growth Model; Prenatal 206%-260% - Average of the Average Growth Model and the Linear Growth Model

[2] Percentage selected to modify capitation rates for FY 2016-17	Children Medical	Children Medical to 200% - Average Growth Model; Children Medical 201%-205% - Average of the Average Growth Model and the Exponential Growth Model; Children Medical 206%-260% - Trend selected for Children Medical 201%-205%
	Children Dental	Children Dental to 200% - Average Growth Model; Children Dental 201%-205 - Exponential Growth Model; Children Dental 206%-260% - Trend selected for Children Dental 201%-205%
	Prenatal	Prenatal to 200% - Linear Growth Model; Prenatal 201%-205% - Average Growth Model; Prenatal 206%-260% - Average of the Average Growth Model and the Linear Growth Model

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-04

Request Titles

R-04 Medicare Modernization Act of 2003 State Contr. Payment

Dept. Approval By:	Josh Block	___	Supplemental FY 2014-15
		X	Change Request FY 2015-16
		___	Base Reduction FY 2015-16
OSPB Approval By:		___	Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$104,007,505	$0	$104,007,505	$15,613,436	$29,170,390
	FTE	-	-	-	-	-
	GF	$99,304,985	$0	$99,304,985	$20,315,956	$33,872,910
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$4,702,520	$0	$4,702,520	($4,702,520)	($4,702,520)

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
	Total	$104,007,505	$0	$104,007,505	$15,613,436	$29,170,390
06. Other Medical Services - Medicare Modernization Act State Contribution Payment	FF	$4,702,520	$0	$4,702,520	($4,702,520)	($4,702,520)
	GF	$99,304,985	$0	$99,304,985	$20,315,956	$33,872,910

Letternote Text Revision Required?	Yes ___	No X	**If Yes, describe the Letternote Text Revision:**	
Cash or Federal Fund Name and CORE Fund Number:	FF: CHIPRA Bonus Payment			
Reappropriated Funds Source, by Department and Line Item Name:	N/A			
Approval by OIT?	Yes ___	No ___	**Not Required:**	X
Schedule 13s from Affected Departments:	N/A			
Other Information:	N/A			

Cost and FTE

- $5,765,582 total funds, including an increase of $10,038,677 General Fund and a reduction of $4,273,095 federal funds for FY 2014-15; and $15,613,436 total funds, including an increase of $20,315,956 General Fund and a reduction of $4,702,520 federal funds for FY 2015-16, for the Medicare Modernization Act of 2003 State Contribution Payment line item to make the mandatory reimbursement payments to the federal government for the States' share of the cost of outpatient prescription drugs for clients that are eligible for both Medicaid and Medicare, referred to as dual-eligible clients.

Current Program

- The Department serves clients who are eligible for both Medicaid and Medicare.
- These dual-eligible clients are provided prescription drug coverage through the federal Medicare program.
- The State is required to reimburse the federal government for the amount the federal Centers for Medicare and Medicaid Services (CMS) determines is the State's obligation for such prescription drug coverage, which is also called the "clawback" payment.

Problem or Opportunity

- The State's obligation varies from year to year and is affected by changes in caseload and the per member per month (PMPM) rate, which is also determined by CMS.
- The Department must annually forecast both anticipated caseload and PMPM rate to ensure the State is adequately funded to meet its reimbursement obligation to the federal government.

Consequences of Problem

- If this request is not approved and the State is unable to meet its reimbursement obligation to the federal government, the Department would be at risk of having the amount due for the clawback payment – plus interest – deducted from the federal funds received for the Medicaid program, generating overexpenditures on other line items.

Proposed Solution

- The Department would be able to meet the State's obligation to the federal government for prescription drug coverage for dual-eligible clients; thus avoiding the additional cost of accumulating interest on the amount owed to the federal government and deductions from the federal funds owed to the State for the Medicaid program.

Department Priority: R-4
Request Detail: Medicare Modernization Act of 2003 State Contribution Payment

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
MMA State Contribution Payment	$15,613,436	$20,315,956

Problem or Opportunity:

On January 1, 2006, the federal Centers for Medicare and Medicaid Services (CMS) assumed responsibility for the Medicare Part D prescription-drug benefit that replaced the Medicaid prescription-drug coverage for dual-eligible clients, who are individuals eligible for both Medicare and Medicaid. States are required to make mandatory state payments to the federal government, known as the "clawback" payment, to help finance the Medicaid Part D benefit for the dual-eligible population for the states' share of the costs of outpatient prescription drugs. The amount of each state's clawback payment roughly reflects the expenditures of its own funds that the state would make if it continued to pay for outpatient prescription drugs through Medicaid on behalf of dual-eligible clients. These clawback payments, if left unpaid, are subject to automatic deduction – plus interest – from the federal funds the State receives for the Medicaid program.

Proposed Solution:

The Department requests to increase the Medicare Modernization Act of 2003 State Contribution Payment line item to cover the State's share of the costs of the Medicare Part D outpatient prescription drug benefit for dual-eligible clients as follows:

- FY 2014-15: $5,765,582 total funds, including an increase of $10,038,677 General Fund and a reduction of $4,273,095 federal funds;
- FY 2015-16: $15,613,436 total funds, including an increase of $20,315,956 General Fund and a reduction of $4,702,520 federal funds; and
- FY 2016-17: $29,170,390 total funds, including an increase of $33,872,910 General Fund and a reduction of $4,702,520 federal funds.

The Department estimates the clawback payment will total $109,773,087 for FY 2014-15; $119,620,941 for FY 2015-16; and $133,177,895 for FY 2016-17, based on the Department's most recent caseload projections and projections of the per member per month (PMPM) rate paid by the State as required by federal regulations (see row O of tables 2.1, 2.3, and 2.5 of the appendix). Typically, the Medicare Modernization Act of 2003 State Contribution Payment line item is entirely General Fund, as it is a reimbursement to the federal

government and is not eligible to receive a federal match. However, from FY 2011-12 to FY 2014-15, the Department elected to utilize federal funds received from the Children's Health Insurance Program Reauthorization Act (CHIPRA) performance bonus to offset General Fund in this line item. The federal funding for the CHIPRA bonus was awarded annually for qualifying states in federal fiscal years 2009 through 2013. The Department will receive the final supplemental payment for the 2013 CHIPRA performance bonus in FY 2014-15, which was announced by CMS in September to be $429,425. This is a much lower supplemental payment than in years past, due to retroactive caseload being much lower in FFY 2013 than in prior years.

If the Department does not receive the requested appropriations and subsequently cannot make the required federal payment within the Department's existing spending authority, the Department would be required to use overexpenditure authority to make the payment, pursuant to section 24-75-109(1)(a.6), C.R.S. Without overexpenditure authority, the Department would be at risk of having the amount due for the clawback payment – plus interest – deducted from the federal funds received for the Medicaid program, generating overexpenditures on other line items.

Anticipated Outcomes:

One of the Department's top priorities in its Performance Plan is to "ensure sound stewardship of financial resources." The approval of this request would be a direct implementation of this goal by allowing the Department to meet its obligation to the federal government, and ensuring that no amount of federal funds owed to the State for Medicaid would be subject to deduction plus interest.

Assumptions and Calculations:

A summary of the Medicare Modernization Act of 2003 State Contribution Payment line item request by fund type is provided for FY 2014-15, FY 2015-16, and FY 2016-17 in tables 1.1, 1.2, and 1.3, respectively. Row E in each of these tables provides the incremental changes by fiscal year and fund type of the cost due to projected caseload growth and the impact in fund splits related to the change in availability of federal funds from the CHIPRA bonus to offset part of the General Fund obligation.

The State´s clawback payment is calculated according to three factors:

1. The number of dual-eligible clients enrolled in a Part D plan;
2. A per capita estimate of the amount the State otherwise would have spent on Medicaid prescription drugs for dual-eligible clients; and
3. A "phasedown" percentage of the State's obligation for the PMPM rate set forth by the MMA which declines 1.67% each year, starting from 90% in 2006 and declining to 75% in 2015, where it will remain.

The total caseload estimates for FY 2014-15, FY 2015-16, and FY 2016-17 are calculated in tables 2.1, 2.3, and 2.5, respectively, in the appendix. To estimate caseload, the Department analyzed data from January 2006 through June 2014 and applied a 6.92% annual growth trend, based upon a monthly average over the past two years. This method estimates caseload by increasing the total caseload incurred each month by 0.60% to forecast the total caseload for the following month. Because clients are able to be retroactively

enrolled and disenrolled for up to 24 months, retroactivity is also considered in this forecast. Rows A through L on tables 2.1, 2.3 and 2.5 show the breakdown of actual and projected caseload for a given month by the calendar year of which the caseload is attributed to. Due to a two-month delay between when the Department receives an invoice from CMS and when the invoice is paid, the amount paid in the state fiscal year are actually invoices received between May and April. Therefore, rows A through L in tables 2.1, 2.3 and 2.5 show invoice actuals and projections for this time period. Tables 2.2, 2.4, and 2.6 provide a calculation of caseload total expenditures for dual-eligible clients covered in CY 2014 who will receive a PMPM rate of $125.50 during January through September and a PMPM rate of $122.97 during October through December (CY 2014 rates are found in table 3.1 rows R and V, respectively). The change in CY 2014 rates is caused by a change in the Federal Medicaid Assistance Percentage (FMAP) from 50% to 51.01%.

The Department assumes the changes in the PMPM rate paid by the Department will be based on the formula established by CMS. PMPM rates for CY 2015, CY 2016, and CY 2017 are calculated in tables 3.2, 3.3, and 3.4, respectively in the appendix. To calculate the PMPM rate, CMS first uses 2013 and 2014 annual National Health Expenditure (NHE) Projections of the average growth rate of per capita prescription drug expenditure between years 2003 and 2006 to calculate the percentage change in growth rate estimates, shown in row G. Then, CMS calculates the average percentage increase (API) in average per capita aggregate Part D expenditures for the current year by multiplying the annual percentage trend for the current year by the revision of the previous year's annual percentage trend, shown in row J. CMS aggregates these growth rates, shown in row I, and uses this aggregate growth rate to trend out next year's PMPM rate using the prior year's PMPM rate, shown in row N. Finally, this figure is multiplied by the state share and the phasedown percentage, shown in rows O and Q, respectively. This approach yields a PMPM rate of $124.70 for CY 2015, shown in row R.

The PMPM rates for CY 2016 and CY 2017 are not yet known. Therefore, the Department has applied the current aggregate trend of 3.66% used to calculate the CY 2015 PMPM rate to trend forward the PMPM to produce estimates for CY 2016 and CY 2017 (the aggregate trend of 3.66% can be found in row I of table 3.1). This methodology produces PMPM rates of $129.26 for CY 2016 and $133.99 for CY 2017, shown in row R of tables 3.3 and 3.4, respectively.

The Department notes that this methodology is in contrast to the 4.03% decrease in the CY 2014 PMPM rate from the previous year (table 3.1 row K). This significant dip in the CY 2014 PMPM rate is a result of CMS trending out a one-time decrease in prescription drug costs that occurred in 2012 induced by the expiration of multiple brand-name drug patents which allowed more generic brands to flood the market. However, CMS anticipates the current generic-brand dispensing rates to level off while prescription drug utilization increases due to projected income growth and drug usage earlier in treatment. According to the most recent National Health Expenditure projections, the average annual growth in prescription drug spending is projected to be 6.5% for 2015 through 2022 (National Health Expenditure Projections 2012-2022). This report and the current upward trend in the CY 2014 PMPM rate support the Department's decision to continue using an aggregate trend of 3.66% to forecast CY 2016 and CY 2017 PMPM rates.

The product of the State's PMPM rate and the projected caseload for a given fiscal year produce the total projected expenditure for this line item, which can be found in row O of tables 2.1, 2.3, and 2.5 of the

appendix. Historical caseload and PMPM rate data can be found in tables 6.1-6.3 of the appendix. Historical total expenditures for the Medicare Modernization Act of 2003 State Contribution Payment line item can be found in table 6.4.

Table 1.1
FY 2014-15 Summary by Incremental Funding Request

Row	Item	Total Funds	General Fund	Federal Funds	Source
A	Projected FY 2014-15 Expenditures	$109,773,087	$109,773,087	$0	Table 2.1 Row O
B	Supplemental CHIPRA Bonus Payment FY 2014-15	$0	($429,425)	$429,425	Table 4.1 Row C
C	Projected FY 2014-15 Expenditures with CHIPRA Bonus Offset	$109,773,087	$109,343,662	$429,425	Row A + Row B
D	FY 2014-15 Spending Authority	$104,007,505	$99,304,985	$4,702,520	Long Bill Appropriation
E	**FY 2014-15 Incremental** [(1)]	**$5,765,582**	**$10,038,677**	**($4,273,095)**	Row C - Row D

(1) Incremental requests impact Line Item: (6) Other Medical Services, Medicare Modernization Act of 2003 State Contribution Payment

Table 1.2
FY 2015-16 Summary of Incremental Funding Request

Row	Item	Total Funds	General Fund	Federal Funds	Source
A	Projected FY 2015-16 Expenditures	$119,620,941	$119,620,941	$0	Table 2.3 Row O
B	Supplemental CHIPRA Bonus Payment FY 2015-16	$0	$0	$0	Table 4.1 Row C
C	Projected FY 2015-16 Expenditures with CHIPRA Bonus Offset	$119,620,941	$119,620,941	$0	Row A + Row B
D	FY 2014-15 Spending Authority	$104,007,505	$99,304,985	$4,702,520	Long Bill Appropriation
E	**FY 2015-16 Incremental** [(1)]	**$15,613,436**	**$20,315,956**	**($4,702,520)**	Row C - Row D

(1) Incremental requests impact Line Item: (6) Other Medical Services, Medicare Modernization Act of 2003 State Contribution Payment

Table 1.3
FY 2016-17 Summary of Incremental Funding Request

Row	Item	Total Funds	General Fund	Federal Funds	Source
A	Projected FY 2016-17 Expenditures	$133,177,895	$133,177,895	$0	Table 2.5 Row O
B	Supplemental CHIPRA Bonus Payment FY 2016-17	$0	$0	$0	Table 4.1 Row C
C	Projected FY 2016-17 Expenditures with CHIPRA Bonus Offset	$133,177,895	$133,177,895	$0	Row A + Row B
D	FY 2014-15 Spending Authority	$104,007,505	$99,304,985	$4,702,520	Long Bill Appropriation
E	**FY 2016-17 Incremental** [(1)]	**$29,170,390**	**$33,872,910**	**($4,702,520)**	Row C - Row D

(1) Incremental requests impact Line Item: (6) Other Medical Services, Medicare Modernization Act of 2003 State Contribution Payment

Table 2.1
FY 2014-15 Caseload and Expenditures

Row	Month	CY 2012	CY 2013	CY 2014	CY 2015	FY 2014-15 TOTAL
A	May 2014	(55)	30	70,685	0	70,660
B	June 2014	(120)	(198)	71,014	0	70,696
C	July 2014	188	477	71,297	0	71,962
D	August 2014	153	448	71,789	0	72,390
E	September 2014	117	431	72,274	0	72,822
F	October 2014	79	427	72,758	0	73,264
G	November 2014	40	425	73,232	0	73,697
H	December 2014	0	436	73,708	0	74,144
I	January 2015	0	408	3,249	70,933	74,590
J	February 2015	0	374	1,871	72,792	75,037
K	March 2015	0	337	1,178	73,972	75,487
L	April 2015	0	301	853	74,785	75,939
M	CY Client Total	402	3,896	583,908	292,482	880,688
N	CY PMPM Rate [1]	$132.41	$133.62	Varies [2]	$124.70	
O	**Expenditures [3]**	**$53,229**	**$520,584**	**$72,726,769**	**$36,472,505**	**$109,773,087**

(1) PMPM Rates in row N are calculated in tables 3.1-3.5
(2) In CY 2014, Q1-Q3 PMPM is $125.50, whereas Q4 is $122.97 due to FMAP increasing from 50.0% to 51.01%. Expenditure for CY 2014 in row O is calculated in table 2.2
(3) Expenditures are calculated by summing the caseload of rows A through L for a given CY and then multiplying that sum (row M) by its respective CY PMPM rate (row N) to get total CY expenditures (row O) for FY 2014-15.

Table 2.2
Caseload Breakdown for FY 2014-15 by CY 2014 Rates

Row	Rate Period	FY 2014-15 Dual Eligible Count	CY 2014 Rates	Total	Source
A	January - September 2014	365,060	$125.50	$45,815,030	
B	October - December 2014	218,848	$122.97	$26,911,739	
C	**Total**			**$72,726,769**	**Row A + Row B**

Table 2.3
FY 2015-16 Caseload and Expenditures

Row	Month	CY 2013	CY 2014	CY 2015	CY 2016	FY 2015-16 TOTAL
A	May 2015	271	673	75,456	0	76,400
B	June 2015	233	566	76,056	0	76,855
C	July 2015	199	524	76,595	0	77,318
D	August 2015	164	496	77,129	0	77,789
E	September 2015	126	472	77,654	0	78,252
F	October 2015	84	469	78,170	0	78,723
G	November 2015	43	470	78,684	0	79,197
H	December 2015	0	476	79,194	0	79,670
I	January 2016	0	450	3,486	76,213	80,149
J	February 2016	0	409	2,013	78,210	80,632
K	March 2016	0	372	1,265	79,478	81,115
L	April 2016	0	331	916	80,351	81,598
M	CY Client Total	1,120	5,708	626,618	314,252	947,698
N	CY PMPM Rate [1]	$133.62	Varies [2]	$124.70	$129.26	
O	**Expenditures [3]**	**$149,654**	**$711,808**	**$78,139,265**	**$40,620,214**	**$119,620,941**

(1) PMPM Rates in row N are calculated in tables 3.1-3.5
(2) In CY 2014, Q1-Q3 PMPM is $125.50, whereas Q4 is $122.97 due to FMAP increasing from 50.0% to 51.01%. Expenditure for CY 2014 in row O is calculated in table 2.4
(3) Expenditures are calculated by summing the caseload of rows A through L for a given CY and then multiplying that sum (row M) by its respective CY PMPM rate (row N) to get total CY expenditures (row O) for FY 2015-16.

Table 2.4
Caseload Breakdown for FY 2015-16 by CY 2014 Rates

Row	Rate Period	FY 2015-16 Dual Eligible Count	CY 2014 Rates	Total	Source
A	January - September 2014	3,911	$125.50	$490,831	
B	October - December 2014	1,797	$122.97	$220,977	
C	**Total**			**$711,808**	**Row A + Row B**

Table 2.5
FY 2016-17 Caseload and Expenditures

Row	Month	CY 2014	CY 2015	CY 2016	CY 2017	FY 2016-17 TOTAL
A	May 2016	296	719	81,073	0	82,088
B	June 2016	257	607	81,716	0	82,580
C	July 2016	218	563	82,295	0	83,076
D	August 2016	179	528	82,870	0	83,577
E	September 2016	136	508	83,430	0	84,074
F	October 2016	92	503	83,989	0	84,584
G	November 2016	46	503	84,539	0	85,088
H	December 2016	0	511	85,086	0	85,597
I	January 2017	0	482	3,748	81,883	86,113
J	February 2017	0	441	2,160	84,029	86,630
K	March 2017	0	396	1,358	85,390	87,144
L	April 2017	0	358	984	86,329	87,671
M	CY Client Total	1,224	6,119	673,248	337,631	1,018,222
N	CY PMPM Rate (1)	Varies (2)	$124.70	$129.26	$133.99	
O	**Expenditures (3)**	**$151,642**	**$763,039**	**$87,024,036**	**$45,239,178**	**$133,177,895**

(1) PMPM Rates in row N are calculated in tables 3.1-3.5
(2) In CY 2014, Q1-Q3 PMPM is $125.50, whereas Q4 is $122.97 due to FMAP increasing from 50.0% to 51.01%. Expenditure for CY 2014 in row O is calculated in table 2.6
(3) Expenditures are calculated by summing the caseload of rows A through L for a given CY and then multiplying that sum (row M) by its respective CY PMPM rate (row N) to get total CY expenditures (row O) for FY 2016-17.

Table 2.6
Caseload Breakdown for FY 2016-17 by CY 2014 Rates

Row	Rate Period	FY 2016-17 Dual Eligible Count	CY 2014 Rates	Total	Source
A	January - September 2014	445	$125.50	$55,848	
B	October - December 2014	779	$122.97	$95,794	
C	**Total**			**$151,642**	**Row A + Row B**

Table 3.1
CY 2014 PMPM Rate Calculation

Row	Item		Source
	From 2012 NHE Estimates		
A	Estimated 2003 Per Capita Rx Drug Expenditures	$607	
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	
C	Percentage Growth	23.89%	(Row B ÷ Row A) - 1
	From 2013 NHE Estimates		
D	Estimated 2003 Per Capita Rx Drug Expenditures	$607	
E	Estimated 2006 Per Capita Rx Drug Expenditures	$752	
F	Percentage Growth	23.89%	(Row E ÷ Row D) - 1
G	Change in Percentage Growth	0.00%	(1 + Row F) ÷ (1 + Row C) - 1
	From Announcement of CY 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies 4/1/13		
H	Annual percentage trend for July 2013	-2.76%	
I	Revisions of Annual percentage trend for July 2012	-1.31%	
J	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2014 (Attachment VI, Table IV-2)	-4.03%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2013**	**-4.03%**	Row G + Row H
L	CY 2013 PMPM Rate Prior to FMAP and Phasedown	$341.15	
M	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2014	-4.03%	Row K
N	Projected CY 2014 PMPM Rate Prior to FMAP and Phasedown	$327.40	Row L × (1 + Row M)
O	FMAP State Share (January-September)	50.00%	
P	Projected CY 2014 PMPM Rate Prior to Phasedown	$163.70	Row N × Row O
Q	CY 2014 Phasedown Percentage	76.67%	
R	**CY 2014 PMPM Rate (January-September)**	**$125.50**	Row P × Row Q
S	FMAP State Share (October-December)	48.99%	
T	Projected CY 2014 PMPM Rate Prior to Phasedown	$160.39	Row N × Row S
U	CY 2014 Phasedown Percentage	76.67%	
V	**CY 2014 PMPM Rate (October-December)**	**$122.97**	Row T × Row U

Source: Centers for Medicare and Medicaid Services (CMS), 2012 and 2013 NHE estimates; and Announcement of CY 2014 Medicare Advantage Capitation Rates and Medicare Advantage Part D Payment Policies, Attachment VI, Table IV-2.

Table 3.2
Estimated CY 2015 PMPM Rate Calculation

Row	Item		Source
	From 2013 NHE Estimates		
A	Estimated 2003 Per Capita Rx Drug Expenditures	$607	
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	
C	Percentage Growth	23.89%	(Row B ÷ Row A) - 1
	From 2014 NHE Estimates		
D	Estimated 2003 Per Capita Rx Drug Expenditures	$610	
E	Estimated 2006 Per Capita Rx Drug Expenditures	$753	
F	Percentage Growth	23.44%	(Row E ÷ Row D) - 1
G	Change in Percentage Growth	-0.36%	(1 + Row F) ÷ (1 + Row C) - 1
	From Announcement of CY 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies 4/7/14		
H	Annual percentage trend for July 2014	4.07%	
I	Revisions of Annual percentage trend for July 2013	-0.05%	
J	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2015 (Attachment V, Table V-3)	4.02%	(1 + Row H) × (1 + Row I) - 1
K	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2015**	**3.66%**	Row G + Row H
L	CY 2014 PMPM Rate Prior to FMAP and Phasedown	$327.40	Table 4.1 Row N
M	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2015	3.66%	Row K
N	Projected CY 2015 PMPM Rate Prior to FMAP and Phasedown	$339.38	Row L × (1 + Row M)
O	FMAP State Share	48.99%	
P	Projected CY 2015 PMPM Rate Prior to Phasedown	$166.26	Row N × Row O
Q	CY 2015 Phasedown Percentage	75.00%	
R	**CY 2015 PMPM Rate**	**$124.70**	Row P × Row Q

Source: Centers for Medicare and Medicaid Services (CMS), 2013 and 2014 NHE estimates; and Announcement of CY 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table V-3.

Table 3.3
Estimated CY 2016 PMPM Rate Calculation

Row	Item		Source
	From 2014 NHE Estimates		
A	Estimated 2003 Per Capita Rx Drug Expenditures	$607	
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	
C	Percentage Growth	23.89%	(Row B ÷ Row A) - 1
	Projected 2015 NHE Estimates		
D	Estimated 2003 Per Capita Rx Drug Expenditures	$610	
E	Estimated 2006 Per Capita Rx Drug Expenditures	$753	
F	Percentage Growth	23.44%	(Row E ÷ Row D) - 1
G	Change in Percentage Growth	-0.36%	(1 + Row F) ÷ (1 + Row C) - 1
	From Announcement of CY 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies 4/7/14		
H	Projected Annual percentage trend for July 2015	4.07%	
I	Projected Revisions of Annual percentage trend for July 2014	-0.05%	
J	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2015 (Attachment V, Table V-3)	4.02%	(1 + Row H) × (1 + Row I) - 1
I	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2016**	**3.66%**	Row G + Row H
L	CY 2015 PMPM Rate Prior to FMAP and Phasedown	$339.38	Table 4.2 Row N
M	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2016	3.66%	Row K
N	Projected CY 2016 PMPM Rate Prior to FMAP and Phasedown	$351.81	Row L × (1 + Row M)
O	FMAP State Share	48.99%	
P	Projected CY 2016 PMPM Rate Prior to Phasedown	$172.35	Row N × Row O
Q	CY 2016 Phasedown Percentage	75.00%	
R	**CY 2016 PMPM Rate**	**$129.26**	Row P × Row Q

Source: Centers for Medicare and Medicaid Services (CMS), 2013 and 2014 NHE estimates; and Announcement of CY 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table V-3.

Table 3.4
Estimated CY 2017 PMPM Rate Calculation

Row	Item		Source
	Projected 2015 NHE Estimates		
A	Estimated 2003 Per Capita Rx Drug Expenditures	$607	
B	Estimated 2006 Per Capita Rx Drug Expenditures	$752	
C	Percentage Growth	23.89%	(Row B ÷ Row A) - 1
	Projected 2016 NHE Estimates		
D	Estimated 2003 Per Capita Rx Drug Expenditures	$610	
E	Estimated 2006 Per Capita Rx Drug Expenditures	$753	
F	Percentage Growth	23.44%	(Row E ÷ Row D) - 1
G	Change in Percentage Growth	-0.36%	(1 + Row F) ÷ (1 + Row C) - 1
	From Announcement of CY 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies 4/7/14		
H	Projected Annual percentage trend for July 2016	4.07%	
I	Projected Revisions of Annual percentage trend for July 2015	-0.05%	
J	Annual Percentage Increase in Average Per Capita Aggregate Part D Expenditures for 2015 (Attachment V, Table V-3)	4.02%	(1 + Row H) × (1 + Row I) - 1
I	**FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2017**	**3.66%**	Row G + Row H
L	CY 2016 PMPM Rate Prior to FMAP and Phasedown	$351.81	Table 4.3 Row N
M	FINAL Percentage Change in Rate Prior to Applying Phasedown for CY 2017	3.66%	Row K
N	Projected CY 2017 PMPM Rate Prior to FMAP and Phasedown	$364.69	Row L × (1 + Row M)
O	FMAP State Share	48.99%	
P	Projected CY 2017 PMPM Rate Prior to Phasedown	$178.66	Row N × Row O
Q	CY 2017 Phasedown Percentage	75.00%	
R	**CY 2017 PMPM Rate**	**$133.99**	Row P × Row Q

Source: Centers for Medicare and Medicaid Services (CMS), 2013 and 2014 NHE estimates; and Announcement of CY 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, Attachment V, Table V-3.

Table 4.1: CHIPRA Bonus Payments by State Fiscal Year

Row	Description	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Source
A	Initial CHIPRA Bonus Payment Awarded	$13,671,043	$26,141,052	$42,909,585	$58,489,650	$0	$0	$0	
B	Supplemental Payment Awarded from Prior FFY	$0	$4,502,230	$6,765,450	$4,581,212	$429,425	$0	$0	
C	**Total Payment Awarded by SFY**	**$13,671,043**	**$30,643,282**	**$49,675,035**	**$63,070,862**	**$429,425**	**$0**	**$0**	Row A + Row B

** The supplemental payment for FFY 2010 received in SFY 2011-12 was reduced by $30,000 for IDEA awards.*

Table 5.1
CHIPRA Bonus Calculation

Row	Item	FFY 2013	Notes
Caseload for Initial Bonus Payment Calculation			
A	Baseline Enrollment	300,158	
B	Colorado Children Annual Population Growth	0.25%	U.S. Census Bureau
C	Additional Percentage in Statute	3.00%	Provided by CMS
D	Child Population Growth Factor	3.25%	Row B + Row C
E	Tier 1 Bonus Target Enrollment	309,903	Row A * (1 + Row D)
F	Tier 2 Bonus Target Enrollment	340,893	Row E * 110%
G	Initial Enrollment	416,404	Submitted in November 2013
H	**Initial Tier 1 Bonus Enrollment**	**30,990**	Row E * 10%
I	**Initial Tier 2 Bonus Enrollment**	**75,511**	Row G - Row F
Per Capita for Initial Bonus Payment Calculation			
J	Per-Capita	$2,125.19	Provided by CMS
K	Pecent Growth Factor	6.18%	Provided by CMS
L	State FMAP Rate	50.00%	
M	**Applicable Per Capita**	**$1,128.21**	Row J * (1 + Row K) * Row L
Initial Bonus Payment Calculation			
N	Tier 1 Percent Factor	15.00%	Provided by CMS
O	Initial Tier 1 Bonus Enrollment	30,990	Row H
P	Applicable Per Capita	$1,128.21	Row M
Q	**Initial Tier 1 Bonus Payment**	**$5,244,484**	Row N * Row O * Row P
R	Tier 2 Percent Factor	62.50%	Provided by CMS
S	Initial Tier 2 Bonus Enrollment	75,511	Row I
T	Applicable Per Capita	$1,128.21	Row M
U	**Initial Tier 2 Bonus Payment**	**$53,245,166**	Row R * Row S * Row T
V	**Initial CHIPRA Bonus Payment**	**$58,489,650**	Row Q + Row U
Caseload for Supplemental Bonus Payment Calculation			
W	Initial Enrollment	416,404	Row G
X	Enrollment with Retroactivity	417,013	Submitted in April 2014
Y	**Enrollment with Estimated Retroactivity**	**N/A**	
Z	Tier 1 Bonus Enrollment with Retroactivity	30,990	Row H
AA	Tier 2 Bonus Enrollment with Retroactivity	76,120	Row Y - Row F
Final Bonus Payment Calculation			
AB	Tier 1 Percent Factor	15.00%	Provided by CMS
AC	Tier 1 Bonus Enrollment	30,990	Row Z
AD	Applicable Per Capita	$1,128.21	Row M
AE	**Projected Tier 1 Bonus Payment**	**$5,244,484**	Row AB * Row AC * Row AD
AF	Tier 2 Percent Factor	62.50%	Provided by CMS
AG	Tier 2 Bonus Enrollment	76,120	Row AA
AH	Applicable Per Capita	$1,128.21	Row M
AI	**Tier 2 Bonus Payment**	**$53,674,591**	Row AF * Row AG * Row AH
AJ	**Total CHIPRA Bonus Payment**	**$58,919,075**	Row AE + Row AI
AK	**Initial CHIPRA Bonus Payment**	**$58,489,650**	Row V
AL	**Supplemental CHIPRA Bonus Payment**	**$429,425**	Row AJ - Row AK

Table 6.1 Invoice Caseload History		
Item	**Total Member Months Caseload**	**Average Monthly Caseload**
FY 2006-07	611,212	50,934
FY 2007-08	642,840	53,570
% Change from FY 2006-07	5.17%	5.18%
FY 2008-09	651,968	54,331
% Change from FY 2007-08	1.42%	1.42%
FY 2009-10	664,292	55,358
% Change from FY 2008-09	1.89%	1.89%
FY 2010-11	697,817	58,151
% Change from FY 2009-10	5.05%	5.05%
FY 2011-12	725,075	60,423
% Change from FY 2010-11	3.91%	3.91%
FY 2012-13	750,509	62,542
% Change from FY 2011-12	3.51%	3.51%
FY 2013-14	812,812	67,734
% Change from FY 2012-13	8.30%	8.30%
FY 2014-15 Projection	880,688	73,391
% Change from FY 2013-14	8.35%	8.35%
FY 2015-16 Projection	947,698	78,975
% Change from FY 2014-15 Projection	7.61%	7.61%
FY 2016-17 Projection	1,018,222	84,852
% Change from FY 2015-16 Projection	7.44%	7.44%

Table 6.2 Aggregate Monthly Caseload History		
Item	**Total Member Months Caseload**	**Average Monthly Caseload**
FY 2006-07	618,862	51,572
FY 2007-08	630,715	52,560
% Change from FY 2006-07	1.92%	1.92%
FY 2008-09	621,662	51,805
% Change from FY 2007-08	-1.44%	-1.44%
FY 2009-10	665,732	55,478
% Change from FY 2008-09	7.09%	7.09%
FY 2010-11	693,267	57,772
% Change from FY 2009-10	4.14%	4.13%
FY 2011-12	728,875	60,740
% Change from FY 2010-11	5.14%	5.14%
FY 2012-13 Projection	759,756	63,313
% Change from FY 2011-12	4.24%	4.24%
FY 2013-14 Projection	811,900	67,658
% Change from FY 2012-13	6.86%	6.86%
FY 2014-15 Projection	883,466	73,622
% Change from FY 2013-14	8.81%	8.81%
FY 2015-16 Projection	948,975	79,081
% Change from FY 2014-15 Projection	7.41%	7.41%
FY 2016-17 Projection	1,019,587	84,966
% Change from FY 2015-16 Projection	7.44%	7.44%

Table 6.3
PMPM Rate History

Item	Q1	Q2	Q3	Q4	Average PMPM Rate
CY 2006	$114.71	$114.71	$114.71	$114.71	**$114.71**
CY 2007	$120.30	$120.30	$120.30	$120.30	**$120.30**
% Change from CY 2006					4.87%
CY 2008	$120.03	$120.03	$120.03	$98.95	**$114.76**
% Change from CY 2007					-4.61%
CY 2009	$106.03	$98.81	$98.81	$98.81	**$100.62**
% Change from CY 2008					-12.33%
CY 2010	$101.49	$101.49	$101.49	$101.49	**$101.49**
% Change from CY 2009					0.87%
CY 2011	$107.07	$111.97	$129.84	$129.84	**$119.68**
% Change from CY 2010					17.92%
CY 2012	$132.41	$132.41	$132.41	$132.41	**$132.41**
% Change from CY 2011					10.64%
CY 2013	$133.62	$133.62	$133.62	$133.62	**$133.62**
% Change from CY 2013-14					0.91%
CY 2014	$125.50	$125.50	$125.50	$122.97	**$124.87**
% Change from CY 2014-15					-6.55%
CY 2015	$124.70	$124.70	$124.70	$124.70	**$124.70**
% Change from CY 2014					-0.13%
CY 2016 Projection	$129.26	$129.26	$129.26	$129.26	**$129.26**
% Change from CY 2015-16 Projection					3.66%
CY 2017 Projection	$133.99	$133.99	$133.99	$133.99	**$133.99**
% Change from CY 2016-17 Projection					3.66%

Table 6.4 MMA Expenditures by State Fiscal Year			
Item	**Total Funds**	**General Fund**	**Federal Funds**
FY 2005-06	$31,461,626	$31,461,626	$0
FY 2006-07	$72,494,301	$72,494,301	$0
FY 2007-08	$71,350,801	$71,350,801	$0
FY 2008-09	$73,720,837	$73,720,837	$0
FY 2009-10	$57,624,126	$57,624,126	$0
FY 2010-11	$72,377,768	$58,706,725	$13,671,043
FY 2011-12	$93,582,494	$62,939,212	$30,643,282
FY 2012-13	$101,817,855	$52,136,848	$49,681,007
FY 2013-14	$106,376,992	$68,306,130	$38,070,862

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-05

Request Titles

R-05 Office of Community Living Cost and Caseload Adjustment

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
OSPB Approval By:			Base Reduction FY 2015-16
			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$520,641,049	$0	$525,122,354	$22,459,283	$34,349,342
	FTE	-	-	-	-	-
	GF	$241,232,921	$0	$245,142,118	$11,002,803	$16,827,743
	CF	$35,494,443	$0	$32,664,857	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$243,913,685	$0	$247,315,379	$11,456,480	$17,521,599

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
04. Office of Community Living - Adult Comprehensive Services	Total	$347,106,514	$0	$346,283,894	$10,985,874	$19,086,511
	CF	$33,628,301	$0	$30,798,715	$0	$0
	FF	$160,845,358	$0	$161,214,181	$5,603,894	$9,736,029
	GF	$152,632,855	$0	$154,270,998	$5,381,980	$9,350,482
04. Office of Community Living - Adult Supported Living Services	Total	$70,648,433	$0	$74,777,870	$11,621,429	$13,824,974
	FF	$31,938,485	$0	$34,150,260	$5,928,091	$7,052,119
	GF	$38,709,948	$0	$40,627,610	$5,693,338	$6,772,855
04. Office of Community Living - Children's Extensive Support Services	Total	$24,610,892	$0	$24,665,461	($2,500,441)	($1,633,264)
	FF	$12,530,479	$0	$12,605,609	($1,275,475)	($833,128)
	GF	$12,080,413	$0	$12,059,852	($1,224,966)	($800,136)
04. Office of Community Living - Case Management	Total	$29,300,733	$0	$29,095,579	$2,352,421	$3,071,121
	FF	$13,706,137	$0	$13,665,625	$1,199,970	$1,566,579
	GF	$15,594,596	$0	$15,429,954	$1,152,451	$1,504,542

	Total	**$0**	**$0**	**$0**	**$21,525,353**	**$21,525,353**
04. Office of Community Living - Eligibility Determination and Waiting List Management	FF	$0	$0	$0	$10,980,083	$10,980,083
	GF	$0	$0	$0	$10,545,270	$10,545,270
	Total	**$48,974,477**	**$0**	**$50,299,550**	**($21,525,353)**	**($21,525,353)**
07. Department of Human Services Medicaid-Funded Programs - Regional Centers	CF	$1,866,142	$0	$1,866,142	$0	$0
	FF	$24,893,226	$0	$25,679,704	($10,980,083)	($10,980,083)
	GF	$22,215,109	$0	$22,753,704	($10,545,270)	($10,545,270)

Letternote Text Revision Required?	Yes		No	X	**If Yes, describe the Letternote Text Revision:**
Cash or Federal Fund Name and CORE Fund Number:	FF:Title XIX				
Reappropriated Funds Source, by Department and Line Item Name:	**N/A**				
Approval by OIT?	Yes		No	**Not Required:**	X
Schedule 13s from Affected Departments:	N/A				
Other Information: N/A					

Cost and FTE

- In FY 2014-15, the Department requests a reduction of $22,428,708 total funds, including a decrease of $9,650,608 General Fund and a decrease of $2,829,586 cash funds. For FY 2015-16, the Department requests an increase of $22,459,283 total funds, including an increase of $11,002,803 General Fund. For FY 2016-17, the Department requests an increase of $34,349,342 total funds, including an increase of $16,827,743 General Fund.

Current Program

- Effective March 2014, the Department manages three Medicaid – Home and Community Based Services (HCBS) waiver programs for people with developmental disabilities, Adult Comprehensive Services (DD), Supported Living Services (SLS) and Children's Extensive Services (CES).
- These programs ensure delivery of services such as residential care, day habilitation services and behavioral services, as well as case management, and are delivered through a variety of approved providers.

Problem or Opportunity

- Appropriations do not accurately reflect the estimated number of enrollments, full program equivalents (FPE), or cost per FPE, based upon current enrollment and spending trends as well as input from program information.
- This issue poses the problem of under-expenditure in the current year because the Department estimates that newly authorized enrollments will not be filled as quickly as originally forecasted.
- In the request and out years, based on current policies, this issue poses the problem of over-expenditure because the Department estimates that the current appropriated enrollment levels will not be sufficient to cover the number of individuals needing services.

Consequences of Problem

- If the appropriations are not adjusted, the Department would likely revert a significant amount of funding in the current year. Additionally, in the request and out years, over-expenditure is expected if additional funding is not appropriated through this request.
- Reverting funds in the current year and over-expending funds in the request and out years would compromise the Department's ability to provide services the maximum number of people with developmental disabilities.

Proposed Solution

- The Department requests to adjust existing expenditure and enrollment appropriations and designated full program equivalents (FPE) within three Medicaid waiver programs for people with developmental disabilities to maintain the current policy of having no waiting lists for the HCBS-SLS and HCBS-CES waivers and to accommodate emergency enrollments, foster care transitions, and institutional care transitions.
- The outcomes of this proposed solution would be a more accurate budget that would be measured by comparing estimated expenditure to actual expenditure once the data is available.

Department Priority: R-5
Request Detail: Office of Community Living Cost and Caseload Adjustments

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Office of Community Living Cost and Caseload Adjustments	$22,459,283	$11,002,803

Problem or Opportunity:

Each year, the Department's appropriations for programs serving individuals with intellectual and developmental disabilities are set in advance of the fiscal year, based on prior year utilization and expenditure. As more recent data becomes available, the appropriation needs to be adjusted to account for the most recent projections of expenditure and caseload, in order to minimize any potential over or under-expenditures. The Department requests to adjust existing appropriations and designated full program equivalents (FPE) within three Medicaid waiver programs for people with developmental disabilities: Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD), Supported Living Services (HCBS-SLS), and Children's Extensive Services (HCBS-CES); further, the Department's request accounts for associated changes to targeted case management (TCM). Adjustments to targeted appropriations accurately reflect the current cost per FPE, based upon current spending trends, and maximize the number of individuals that can be served in the programs.

The Home and Community Based Services for Persons with Developmental Disabilities program (HCBS-DD) provides services to adults with developmental disabilities who require extensive supports to live safely in the community and who do not have the resources available to meet their needs. The Home and Community Based Services - Supported Living Services program (HCBS-SLS) is for adults who can either live independently with limited to moderate supports or who need more extensive support provided by other persons, such as their family. The Home and Community Based Services - Children's Extensive Services program (HCBS-CES) provides benefits to children who have a developmental disability or delay, and who need near constant line of sight supervision due to behavioral or medical needs.

In FY 2012-13, the Department of Human Services requested and received funding to eliminate the waiting list for the HCBS-CES program. In FY 2013-14, the Department of Health Care Policy and Financing requested and receiving funding to eliminate the waiting list for the HCBS-SLS program. In order to prevent new waiting lists, the General Assembly must provide new funding each year to allow for growth in both programs. In contract, the HCBS-DD program continues to have a waiting list for services; as of the June

30, 2014 Medicaid Funding Requested Waiting List Report, there are 1,287 people currently waiting to receive HCBS-DD waiver services. The waiting lists may include those requiring emergency enrollments as well as those transitioning out of institutional settings. Additionally, the list may include current Medicaid recipients being served in an alternative waiver that does not fully meet their needs, and may also include individuals being served in nursing facilities or hospitals that are not as cost-effective as the HCBS waivers.

Each year, additional enrollments in the HCBS-DD waiver are needed to provide resources for emergency placements and individuals transitioning out of foster care, a youth waiver, or an institutional setting. Without additional enrollments each year, people with intellectual and developmental disabilities would transition to other less appropriate, more costly settings or become vulnerable to abuse, neglect or homelessness as an increasing number of people continue to wait on the list to receive the services they need.

Proposed Solution:

In order to adjust the current appropriations for the programs administered by the Office of Community Living, the Department requests a reduction of $22,428,708 in FY 2014-15, including a decrease of $9,650,608 General Fund and a decrease of $2,829,586 cash funds; an increase of $22,459,283 in FY 2015-16, including an increase of $11,002,803 General Fund; and, an increase of $34,349,342 in FY 2016-17, including an increase of $16,827,743 General Fund.

To maintain the current policy of having no waiting lists for the HCBS-SLS and HCBS-CES waivers, the Department requests an additional 90 HCBS-SLS and 47 HCBS-CES enrollments for FY 2014-15, and 92 HCBS-SLS and 49 HCBS-CES enrollments for FY 2015-16. The Department also projects a need for 95 HCBS-SLS and 51 HCBS-CES enrollments in FY 2016-17. Additionally, the Department requests 125 new HCBS-DD enrollments to accommodate emergency enrollments, foster care transitions, and institutional care transitions and 61 HCBS-SLS enrollments to accommodate youth transitions from the HCBS-CES due to age for FY 2015-16 and FY 2016-17.

Based on the assumptions used in this request, the Department calculated maximum enrollment figures for each waiver program (and targeted case management services) and the number of full-program equivalents (FPE) for each fiscal year. If this request is approved, the Department calculates that by the end of FY 2014-15 it would serve: 5,093 people on the HCBS-DD waiver (including people in Regional Centers); 5,408 people on the HCBS-SLS waiver; and, 1,251 people on the HCBS-CES waiver. For the years covered in the request, the Department would limit HCBS-DD enrollments to the maximum enrollment figure. However, for the HCBS-SLS and HCBS-CES programs, the Department would adhere to the policy of maintaining no waiting lists; therefore, the maximum enrollment numbers are for information only, and the Department would exceed those figures if necessary and use the regular budget process to account for any change in the estimates. The number of associated FPE for each fiscal year is shown in exhibit B of the appendix.[1]

As part of this request, the Department has included the estimated expenditure associated with HCBS-DD waiver clients that receive services at Regional Centers in the totals for the Office of Community Living.

[1] Although not specifically identified as part of this request, these figures allow for any necessary transitions that occur from nursing facilities or regional centers as part of the Colorado Choice Transitions program.

Although this does not change the amount of funding received by the Regional Centers, this change would streamline reporting and management of enrollment and expenditure, without any effect on the operation of the program.[2] Managing the budget and expenditure for all HCBS-DD clients under the same line and process would improve transparency by showing the overall impact of the HCBS-DD waiver in one budget line.

Anticipated Outcomes:

The Office of Community Living finances long term services and supports in the community to adults and children with developmental disabilities who would otherwise receive services in more restrictive and expensive institutional settings or who would be without services altogether. As part of the Triple Aim, the Department strives to provide the right services to the right people at the right time and place.

The Department's request includes funding to provide needed services for the highest number as well as most at-risk eligible people as possible. If the Department's request is approved, the Department would have resources to cover 10,343 people on average per month in FY 2014-15, and 11,930 people on average per month in FY 2015-16, thereby improving their physical, mental, and social well-being and quality of life.

Assumptions and Calculations:

The Department's calculations are contained in the appendix. The appendix is organized into a series of exhibits, providing both calculation information and historical cost and caseload detail. The section below describes each exhibit individually. In many cases, the specific assumptions and calculations are contained in the exhibits directly; the narrative information below provides additional information and clarification where necessary. The Department's calculations for this request only cover the Medicaid portions of these programs. The Department is not requesting any adjustment to General Fund-only programs at this time.

Exhibit A: Calculation of Fund Splits

This exhibit provides the final calculation of the incremental request, by line item. Values in the total request column are taken from calculations in exhibit C which relates to projected expenditure. The Department applies the effective federal medical assistance percentage to calculate the total request by fund source. The appropriation amounts are for Medicaid funded individuals only and do not include State-Only funded individuals. The Federal Medical Assistance Percentage (FMAP) is set to increase for Colorado in October 2014 to 51.01%. For FY 2014-15 the Department uses a blended rate to account for the implementation of the new match rate in the middle of the fiscal year. The Department assumes the FMAP rate will remain constant through FY 2016-17.

The Department was appropriated funds in FY 2014-15 from the Child Welfare Transition cash fund to transition clients from the Child Welfare program to the Adult Comprehensive HCBS Waiver (HCBS-DD). However, given that the cash fund was simultaneously appropriated to the Department of Human Services

[2] Specifically, the Department requests that funding for HCBS-DD clients in Regional Centers be moved in Department's Long Bill from the "Department of Human Services Medicaid-Funded Programs" Long Bill group to the "Office of Community Living" Long Bill group. Because this change does not reduce or change the total amount of funding going to the Regional Centers, no changes are needed to the Long Bill line item for Regional Centers in the Department of Human Services' Long Bill.

(DHS) to transition these clients, the Department assumes it would not utilize cash funds for HCBS-DD services and would instead utilize General Fund to reimburse for the transitioned clients' waiver services.

Exhibit B: Summary of Program Costs

This exhibit provides a summary of historical program expenditure, as paid for through the Department's Medicaid Management Information System (MMIS), and projected totals as calculated in exhibit C.

Exhibit C: Calculation of Projected Expenditure

This exhibit provides the calculation of projected expenditure using revised assumptions about caseload and per FPE cost (calculated in exhibits D and E, respectively). The exhibit then calculates the difference between the appropriated or base request amounts which results in the estimated over/under-expenditure for each waiver, by fiscal year. In fiscal years where systemic under-expenditure exists, this exhibit would also calculate an additional number of people that could be enrolled within existing resources, and converts the total enrollment figures into new paid enrollments, and calculate the new cost for additional enrollments for each fiscal year.

Exhibit D.1: Calculation of Maximum Enrollment

To forecast the number of enrollments, the Department took the appropriated enrollments from the Long Bill and estimates a base trend. Selection of trends for each waiver are discussed below. Once the base enrollments are determined, the Department adds in additional enrollments authorized through special bills or other initiatives, as Bottom Line Adjustments, to reach the final estimated maximum enrollment. This process is repeated for the request year and the out year. Information on trend selection and Bottom Line Adjustments for each program are provided below.

Adult Comprehensive Waiver (DD)

For FY 2014-15 the Department was appropriated 4,820 enrollments through HB 14-1336 "2014-15 Long Appropriations Bill". To forecast maximum enrollments, the Department selected a base trend of 0.00% because current policy requires that maximum enrollment not exceed the appropriated number of enrollments, regardless of the existence or growth rate of a waiting list for waiver services.

For Bottom Line Adjustments, the Department added 150 enrollments to the Long Bill enrollment level for FY 2014-15 as HB 14-1368 "Transition Youth with Developmental Disabilities to Adult Services" authorized the Department of Human Services (DHS) to transition youth 18 to 21 years of age from the Child Welfare program managed by DHS to the Department's HCBS-DD waiver. In order to fully transition these clients, waiver enrollments must be created to ensure services are available upon transition. In estimating the fiscal note for HB 14-1368 "Transition Youth with Developmental Disabilities to Adult Services", both departments identified 114 clients that were likely to reach, or had already reached the transition age by the bill's effective date; it was later estimated that at least 36 more youth will have met the criteria for transition during the fiscal year that the bill is effective.

In addition to the enrollments mentioned above, the Department added 125 enrollments to the estimated FY 2014-15 maximum enrollment level to arrive at the estimated maximum enrollment level for the request year and out year. The additional enrollments account for emergency enrollments, foster care transitions, and institutional care transitions and reflect an extension of the policy approved in the Department's FY 2014-15 R-8 "Developmental Disabilities New Full Program Equivalents" budget request to enroll a number of emergency, foster care and institutional care transition clients each year.

Adult Comprehensive Waiver (DD) – Regional Centers

The Department has included HCBS-DD – Regional Center enrollments and expenditure to streamline reporting and management of enrollment and expenditure as well as improve transparency. For the purpose of this forecast, the Department assumes that the HCBS-DD – Regional Center enrollment level will remain constant in the future because there is regular enrollment churn and continuing efforts to serve clients in the community. To forecast maximum enrollment, the Department held constant the final enrollment level of FY 2013-14 (as of June 2014) for the current year, request year, and out year.

Supported Living Services Waiver (SLS)

For FY 2014-15 the Department was appropriated 5,318 enrollments through HB 14-1336 "2014-15 Long Appropriations Bill". To forecast maximum enrollments for FY 2015-16 the Department selected a base trend of 1.70%. The selected trend was set equal to the average monthly HCBS-SLS waiting list growth rate during FY 2013-14 to maintain consistency with current policy of having no waiting list for HCBS-SLS waiver services.

As a Bottom Line Adjustment, the Department added 61 enrollments to the estimated FY 2014-15 maximum enrollment level plus trend to arrive at the estimated maximum enrollment level for the request year and out year. The additional enrollments account for youth transitions from the CES waiver related to individuals on that waiver reaching the maximum eligible age, therefore requiring adult services as the policy was originally approved in the Department's FY 2014-15 R-8 "Developmental Disabilities New Full Program Equivalents" budget request.

Children's Extensive Services Waiver (CES)

For FY 2014-15 the Department was appropriated 1,204 enrollments through HB 14-1336 "2014-15 Long Appropriations Bill". To forecast maximum enrollments the Department selected a base trend of 3.90%. The selected trend was based on the average annual HCBS-CES waiting list growth rate between FY 2010-11 and FY 2013-14; the base trend was then set equal to half of the average annual growth rate for the request and out year as the waiting list has been, on average, growing at a decreasing rate.

Targeted Case Management (TCM)

For FY 2014-15 the Department was appropriated 11,342 enrollments through HB 14-1336 "2014-15 Long Appropriations Bill". To forecast actual enrollments the Department selected an average trend of 1.20%

which is a direct result of the DIDD waiver enrollment increase trends; each waiver client should receive TCM services therefore enrollment in TCM services should increase in accordance with waiver enrollments.

Additionally, the Department included enrollments from HB 14-1368 "Transition Youth with Developmental Disabilities to Adult Services", FY 2014-15 R-7 "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase" and the Department of Human Services FY 2013-14 R-1 "Developmental Disabilities Services for New Resources" budget request as Bottom Line Adjustments. Any time there are additional enrollments in any of the DIDD waivers, there is a subsequent increase in TCM services as each client authorized for the waivers receives this service. Including a base trend increase of 1.19% and a bottom line adjustment of 150 enrollments, a total of 287 enrollments were added to the FY 2014-15 TCM enrollment forecast.

Exhibit D.2: Conversion of Enrollment to Full Program Equivalent (FPE)

In order to properly calculate expenditure, the Department must use a consistent caseload metric that directly ties to expenditure. In this exhibit, and throughout the request, the Department uses average monthly paid enrollment to determine the number of clients for which it anticipates paying claims for in each fiscal year. This caseload metric is referred to as "full-program equivalents," or FPE. The Department notes, however, that the number of FPE is not always equal to the allowable maximum enrollment for each waiver. For example, if new enrollments were staggered throughout the year, the number of FPE would be a fraction of the allowable maximum enrollment. The relationship of FPE to maximum enrollment can vary based on a large number of factors including lag between enrollment and delivery of services and the lag between delivery of services and billing of claims; however, in order to accurately set the appropriation and manage the program, it is critical to explicitly identify both the number of FPE, the maximum enrollment level, and the interaction between the two.

The Department's methodology to account for the above mentioned variation includes the selection of an FPE adjustment factor which is based on the ratio of average monthly enrollments (as calculated in Exhibit D.3) to FPE in historical data. Enrollments are derived from the number of unique waiver clients in a given month with an active prior authorization request (PAR) which means that these clients have been authorized by the Community Center Boards (CCBs) to receive services. The Department then uses this metric to convert the average monthly enrollment forecast to projected FPE in Exhibit D.3.

For all waivers except HCBS-CES, the Department selected one adjustment factor per waiver, which is held constant for the current year, request year, and out year. The selected FPE Conversion Factor is the average FPE as a percentage of average monthly enrollment for FY 2012-13 and FY 2013-14. An adjustment factor lower than that of the request and out years was selected for the current year for HCBS-CES to reflect the anticipated impact of rapid enrollment growth. Ideally, the distribution of enrollments should translate directly into timely paid claims for services and supports. However, there are two key issues that can affect full utilization of distributed enrollments. A major consideration for enrollment is the process of authorizing the enrollments, enrolling clients, planning for services, and building provider capacity meet each individual's specific needs.

Within the current system, the Department is unable to identify HCBS-DD Regional Center clients using the PAR methodology that is used to determine average monthly enrollment for the other waiver programs. Therefore, the FPE as a percentage of average monthly enrollment factor for these clients is 100% as the clients can only be identified using paid claims.

Exhibit D.3: Calculation of Average Monthly Enrollment and FPE

This exhibit provides a summary of historical average monthly enrollment and estimates average monthly enrollment and FPE for the years covered in this request. The Department's methodology involves three steps and begins with the enrollment level at the end of the prior fiscal year. First, the final estimated average monthly enrollment under current policy is calculated by adding the additional enrollments described in the maximum enrollment exhibit to the enrollment level at the end of the prior fiscal year; these enrollments are adjusted based on a linear enrollment ramp-up over the fiscal year. The Department assumes that by the end of each fiscal year, enrollment will be at the maximum appropriated level and that the increase in enrollments from the beginning of the fiscal year to the end will happen evenly across 12 months.

Next, if gross under-expenditure across the waivers and request and out years exists, requested enrollments from reallocation of existing resources would be added to arrive at the final estimated average monthly enrollment; these enrollments would be in addition to those based on current policy. At this time, the Department is not requesting additional enrollments from reallocation of existing resources, but may reassess based on actual current year expenditure during the supplemental process.

Finally, the FPE adjustment factor, described in the conversion of enrollment to FPE, Exhibit D.2, is applied to the final estimated average monthly enrollment to arrive at the estimated FPE for the fiscal year. The steps described above are repeated for each waiver and fiscal year with the request and out years beginning with the estimated FY 2014-15 and FY 2015-16 maximum enrollment levels, respectively.

Exhibit E: Calculation of Per FPE Expenditure

This exhibit provides a summary of historical per FPE expenditure, and calculates estimated per FPE expenditure for the years covered in this request.

The Department's methodology begins with per FPE expenditure calculated using final FY 2013-14 expenditure. The calculation of per FPE expenditure for the current year and request years includes three components. The first component is a base trend adjustment which accounts for factors including shifts in the service-level mix, changes in billing patterns or utilization, and other factors. For the purposes of the current request, the Department has not identified major changes in the factors mentioned above to initiate a trend.

The second component accounts for provider rate adjustments. For FY 2013-14 and FY 2014-15, the General Assembly appropriated funding to implement 4.00% and 2.50% provider rate increases, respectively, to DIDD waiver programs. These rate increases were effective July 1 of each respective fiscal year. Because the programs operate on a cash-accounting basis, the rate increase affects per FPE expenditure across multiple

fiscal years, as some claims incurred in FY 2013-14 will not be paid until FY 2014-15, and similarly for claims incurred in FY 2014-15.

The third component accounts for the expected effect of approved policy in the Long Bill and any special bills through Bottom Line Adjustments. For 2014-15, the General Assembly appropriated funding to increase the service plan authorization limits (SPAL) for the HCBS-SLS waiver. The Department calculated the impact to per FPE expenditure by dividing the total appropriated amount of $6,959,536 associated with the SPAL increase by the projected number of FPE. Similar to the provider rate increase above, the SPAL increase affects per FPE expenditure across multiple fiscal years and will not be fully realized until FY 2015-16.

Table A.1 - FY 2014-15 Estimated Cost Summary by Line Item									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds [3]**	**Reappropriated Funds**	**Federal Funds**	**Federal Medical Assistance Percentage (FMAP) [2]**	**Source/Calculation**
A	**Total Request**	**($22,428,708)**	**0.0**	**($9,650,608)**	**($2,829,586)**	**$0**	**($9,948,514)**		**Row B + Row C + Row I**
B	**(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**50.76%**	**Table C.1, Row G**
C	**(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs;**	**($903,355)**	**0.0**	**$948,476**	**($2,829,586)**	**$0**	**$977,755**	**50.76%**	**Sum Row D through H**
D	Adult Comprehensive Services	($8,611,211)	0.0	($2,846,872)	($2,829,586)	$0	($2,934,753)	50.76%	Table C.1, Row G
E	NEW ITEM Adult Comprehensive Services; Regional Centers	$21,525,353	0.0	$10,599,084	$0	$0	$10,926,269	50.76%	Table C.1, Row G
F	Adult Supported Living Services [1]	($5,028,513)	0.0	($2,476,040)	$0	$0	($2,552,473)	50.76%	Table C.1, Row G
G	Children's Extensive Support Services	($7,627,354)	0.0	($3,755,709)	$0	$0	($3,871,645)	50.76%	Table C.1, Row G
H	Case Management [1]	($1,161,630)	0.0	($571,987)	$0	$0	($589,643)	50.76%	Table C.1, Row G
I	**(7) Department of Human Services Medicaid-Funded Programs; (H) Services for People with Disabilities - Medicaid Funding; Regional Centers**	**($21,525,353)**	**0.0**	**($10,599,084)**	**$0**	**$0**	**($10,926,269)**	**50.76%**	**Table C.1, Row G**

Table A.2 - FY 2015-16 Estimated Cost Summary by Line Item									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Federal Medical Assistance Percentage (FMAP) [2]**	**Source/Calculation**
A	**Total Request**	**$22,459,283**	**0.0**	**$11,002,803**	**$0**	**$0**	**$11,456,480**		**Row B + Row C + Row I**
B	**(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**51.01%**	**Table C.2, Row G**
C	**(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs;**	**$43,984,636**	**0.0**	**$21,548,073**	**$0**	**$0**	**$22,436,563**	**51.01%**	**Sum Row D through H**
D	Adult Comprehensive Services	$10,985,874	0.0	$5,381,980	$0	$0	$5,603,894	51.01%	Table C.2, Row G
E	NEW ITEM Adult Comprehensive Services; Regional Centers	$21,525,353	0.0	$10,545,270	$0	$0	$10,980,083	51.01%	Table C.2, Row G
F	Adult Supported Living Services [1]	$11,621,429	0.0	$5,693,338	$0	$0	$5,928,091	51.01%	Table C.2, Row G
G	Children's Extensive Support Services	($2,500,441)	0.0	($1,224,966)	$0	$0	($1,275,475)	51.01%	Table C.2, Row G
H	Case Management [1]	$2,352,421	0.0	$1,152,451	$0	$0	$1,199,970	51.01%	Table C.2, Row G
I	**(7) Department of Human Services Medicaid-Funded Programs; (H) Services for People with Disabilities - Medicaid Funding; Regional Centers**	**($21,525,353)**	**0.0**	**($10,545,270)**	**$0**	**$0**	**($10,980,083)**	**51.01%**	**Table C.2, Row G**

Table A.3 - FY 2016-17 Estimated Cost Summary by Line Item									
Row	**Item**	**Total Funds**	**FTE**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**Federal Medical Assistance Percentage (FMAP) [2]**	**Source/Calculation**
A	**Total Request**	**$34,349,342**	**0.0**	**$16,827,743**	**$0**	**$0**	**$17,521,599**		**Row B + Row C + Row I**
B	**(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**51.01%**	**Table C.3, Row G**
C	**(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs;**	**$55,874,695**	**0.0**	**$27,373,013**	**$0**	**$0**	**$28,501,682**	**51.01%**	**Sum Row D through H**
D	Adult Comprehensive Services	$19,086,511	0.0	$9,350,482	$0	$0	$9,736,029	51.01%	Table C.3, Row G
E	NEW ITEM Adult Comprehensive Services; Regional Centers	$21,525,353	0.0	$10,545,270	$0	$0	$10,980,083	51.01%	Table C.3, Row G
F	Adult Supported Living Services [1]	$13,824,974	0.0	$6,772,855	$0	$0	$7,052,119	51.01%	Table C.3, Row G
G	Children's Extensive Support Services	($1,633,264)	0.0	($800,136)	$0	$0	($833,128)	51.01%	Table C.3, Row G
H	Case Management [1]	$3,071,121	0.0	$1,504,542	$0	$0	$1,566,579	51.01%	Table C.3, Row G
I	**(7) Department of Human Services Medicaid-Funded Programs; (H) Services for People with Disabilities - Medicaid Funding; Regional Centers**	**($21,525,353)**	**0.0**	**($10,545,270)**	**$0**	**$0**	**($10,980,083)**	**51.01%**	**Table C.3, Row G**

(1) All appropriation amounts above are for Medicaid funded individuals only and do not include State-Only funded individuals.

(2) The Federal Medical Assistance Percentage (FMAP) is set to increase for Colorado in October 2014 to 51.01%. The Department assumes the FMAP rate will remain constant through FY 2016-17. For FY 2014-15 the Department uses a blended rate to account for the implementation of the new match rate in the middle of the fiscal year.

(3) The Department was appropriated funds in FY 2014-15 from the Child Welfare Transition cash fund to transition clients from the Child Welfare program to the Adult Comprehensive HCBS Waiver (HCBS-DD). However, given that the cash fund was simultaneously appropriated to the Department of Human Services (DHS) to transition these clients, the Department assumes it would not utilize cash funds for HCBS-DD services and would utilize General Fund to reimburse for the transitioned clients' waiver services.

Table B.1 - Division for Intellectual and Developmental Disabilities (DIDD) Total Program Expenditure and Forecast							
Row	**Fiscal Year**	**HCBS - Waiver for Persons with Developmental Disabilities (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Support Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Total**
A	FY 2007-08	$202,943,588	$19,814,222	$39,607,629	$5,894,263	$13,661,560	$281,921,262
B	FY 2008-09	$223,362,025	$26,028,730	$46,391,718	$6,913,410	$13,848,967	$316,544,850
C	FY 2009-10	$253,798,612	$28,360,034	$37,399,799	$7,158,025	$16,484,735	$343,201,205
D	FY 2010-11	$273,096,876	$24,142,015	$37,579,497	$7,956,073	$19,114,672	$361,889,133
E	FY 2011-12	$264,899,518	$25,276,720	$37,030,578	$7,361,601	$16,875,522	$351,443,939
F	FY 2012-13	$261,817,957	$24,167,096	$37,273,663	$7,015,707	$16,117,073	$346,391,496
G	FY 2013-14	$282,475,249	$22,225,364	$39,288,448	$9,125,302	$17,441,960	$370,556,323
H	Estimated FY 2014-15	$310,526,174	$21,525,353	$61,919,654	$17,038,107	$22,546,441	$433,555,729
I	Estimated FY 2015-16	$326,471,053	$21,525,353	$78,569,596	$22,165,020	$26,060,492	$474,791,515
J	Estimated FY 2016-17	$334,571,690	$21,525,353	$80,773,141	$23,032,197	$26,779,192	$486,681,574

Table B.2 - Percent Change in Division for Intellectual and Developmental Disabilities (DIDD) Total Program Expenditure							
Row	**Fiscal Year**	**HCBS - Waiver for Persons with Developmental Disabilities (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Support Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Total**
A	FY 2007-08						
B	FY 2008-09	10.06%	31.36%	17.13%	17.29%	1.37%	12.28%
C	FY 2009-10	13.63%	8.96%	-19.38%	3.54%	19.03%	8.42%
D	FY 2010-11	7.60%	-14.87%	0.48%	11.15%	15.95%	5.45%
E	FY 2011-12	-3.00%	4.70%	-1.46%	-7.47%	-11.71%	-2.89%
F	FY 2012-13	-1.16%	-4.39%	0.66%	-4.70%	-4.49%	-1.44%
G	FY 2013-14	7.89%	-8.03%	5.41%	30.07%	8.22%	6.98%
H	Estimated FY 2014-15	9.93%	-3.15%	57.60%	86.71%	29.27%	17.00%
I	Estimated FY 2015-16	5.13%	0.00%	26.89%	30.09%	15.59%	9.51%
J	Estimated FY 2016-17	2.48%	0.00%	2.80%	3.91%	2.76%	2.50%

R-5: Exhibit C - Projected Expenditure

Table C.1 - FY 2014-15 Projected Expenditure

Row	Item	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)[1]	New State Plan Costs	Total	Source/Calculation
A	HB 14-1336 "FY 2014-15 Long Bill Appropriation"	$316,307,799	$0	$66,948,167	$24,665,461	$23,708,071	$0	$431,629,498	See Footnote (2)
B	Appropriated Full Program Equivalents (FPE)	4,874.08	0.00	4,267.50	1,200.13	10,341.71	0.00		See Footnote (2)
C	Appropriated Per FPE Expenditure	$64,895.90	$0.00	$15,687.91	$20,552.32	$2,292.47	$0.00		Row A / Row B
D	Projected FPE	4,648.10	123.00	4,153.34	906.09	8,559.35	0.00		Table G.2.3, Row G
E	Projected Per FPE Expenditure	$66,807.12	$175,002.87	$14,908.40	$18,803.99	$2,634.13	$0.00		Table F.1, Row H
F	Total Projected Expenditure	$310,526,174	$21,525,353	$61,919,654	$17,038,107	$22,546,441	$0	$433,555,729	Row D * Row E
G	**Estimated Over/(Under-expenditure)**	**($5,781,625)**	**$21,525,353**	**($5,028,513)**	**($7,627,354)**	**($1,161,630)**	**$0**	**$1,926,231**	**Row F - Row A**

Table C.2 - FY 2015-16 Projected Expenditure

Row	Item	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)[1]	New State Plan Costs	Total	Source/Calculation
A	FY 2015-16 Base Request	$315,485,179	$0	$66,948,167	$24,665,461	$23,708,071	$0	$430,806,878	See Footnote (2)
B	Appropriated Full Program Equivalents (FPE)	4,874.08	0.00	4,267.50	1,200.13	10,341.71	0.00		See Footnote (2)
C	Appropriated Per FPE Expenditure	$64,727.12	$0.00	$15,687.91	$20,552.32	$2,292.47	$0.00		Row A / Row B
D	Projected FPE	4,876.53	123.00	5,210.41	1,176.27	9,872.67	0.00		Table G.2.4, Row G
E	Projected Per FPE Expenditure	$66,947.41	$175,002.87	$15,079.35	$18,843.48	$2,639.66	$0.00		Table F.1 Row I
F	Total Projected Expenditure	$326,471,053	$21,525,353	$78,569,596	$22,165,020	$26,060,492	$0	$474,791,514	Row D * Row E
G	**Estimated Over/(Under-expenditure)**	**$10,985,874**	**$21,525,353**	**$11,621,429**	**($2,500,441)**	**$2,352,421**	**$0**	**$43,984,636**	**Row F - Row A**

Table C.3 - FY 2016-17 Projected Expenditure

Row	Item	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)	HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers	HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)	HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)	HCBS - Targeted Case Management (TCM)[1]	New State Plan Costs	Total	Source/Calculation
A	FY 2016-17 Base Request	$315,485,179	$0	$66,948,167	$24,665,461	$23,708,071	$0	$430,806,878	See Footnote (2)
B	Appropriated Full Program Equivalents (FPE)	4,874.08	0.00	4,267.50	1,200.13	10,341.71	0.00		See Footnote (2)
C	Appropriated Per FPE Expenditure	$64,727.12	$0.00	$15,687.91	$20,552.32	$2,292.47	$0.00		Row A / Row B
D	Projected FPE	4,997.53	123.00	5,356.54	1,222.29	10,144.94	0.00		Table G.2.5, Row G
E	Projected Per FPE Expenditure	$66,947.41	$175,002.87	$15,079.35	$18,843.48	$2,639.66	$0.00		Table F.1 Row J
F	Total Projected Expenditure	$334,571,690	$21,525,353	$80,773,141	$23,032,197	$26,779,192	$0	$486,681,573	Row D * Row E
G	**Estimated Over/(Under-expenditure)**	**$19,086,511**	**$21,525,353**	**$13,824,974**	**($1,633,264)**	**$3,071,121**	**$0**	**$55,874,695**	**Row F - Row A**

(1) The Targeted Case Management Medicaid appropriation includes $2,900,000 for Utilization Review, Quality Assurance, and Supports Intensity Scale. These are distinct from Targeted Case Management services provided to individual clients. The $2,900,000 has therefore been taken out of the appropriation in each table (row A).

(2) All appropriation amounts above are for Medicaid funded individuals only and do not include State-only funded individuals or services provided to individuals in the Early Intervention program.

Table D.1.1 - FY 2014-15 Division for Intellectual and Developmental Disabilities (DIDD) Maximum Enrollment Forecast						
Row	**Fiscal Year**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers [(1)]**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	HB 14-1336 "FY 2014-15 Long Bill Appropriation"	4,820	123	5,318	1,204	11,465
B	Base Trend Increase	0.00%	0.00%	1.70%	3.90%	1.19%
C	Initial Estimated FY 2014-15 Enrollment	4,820	123	5,408	1,251	11,602
	Bottom Line Adjustments					
D	HB 14-1368 "Transition Youth with Developmental Disabilities to Adult Services"	150	0	0	0	150
E	Total Bottom Line Adjustments	150	0	0	0	150
F	**Estimated FY 2014-15 Maximum Enrollment**	**4,970**	**123**	**5,408**	**1,251**	**11,752**

Table D.1.2 - FY 2015-16 Division for Intellectual and Developmental Disabilities (DIDD) Maximum Enrollment Forecast						
Row	**Fiscal Year**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers [(1)]**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	Estimated FY 2014-15 Maximum Enrollment	4,970	123	5,408	1,251	11,752
B	Base Trend Increase	0.00%	0.00%	1.70%	3.90%	1.20%
C	Initial Estimated FY 2015-16 Enrollment	4,970	123	5,500	1,300	11,893
	Bottom Line Adjustments					
D	Emergency Enrollments	40	0	0	0	40
E	Foster Care Transitions	55	0	0	0	55
F	Youth Transitions	0	0	61	0	61
G	Institutional Care Transitions	30	0	0	0	30
H	Total Bottom Line Adjustments	125	0	61	0	186
I	**Estimated FY 2015-16 Maximum Enrollment**	**5,095**	**123**	**5,561**	**1,300**	**12,079**

Table D.1.3 - FY 2016-17 Division for Intellectual and Developmental Disabilities (DIDD) Maximum Enrollment Forecast						
Row	**Fiscal Year**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers [(1)]**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	Estimated FY 2015-16 Maximum Enrollment	5,095	123	5,561	1,300	12,079
B	Base Trend Increase	0.00%	0.00%	1.70%	3.90%	1.21%
C	Initial Estimated FY 2016-17 Enrollment	5,095	123	5,656	1,351	12,225
	Bottom Line Adjustments					
D	Emergency Enrollments	40	0	0	0	40
E	Foster Care Transitions	55	0	0	0	55
F	Youth Transitions	0	0	61	0	61
G	Institutional Care Transitions	30	0	0	0	30
H	Total Bottom Line Adjustments	125	0	61	0	186
I	**Estimated FY 2016-17 Maximum Enrollment**	**5,220**	**123**	**5,717**	**1,351**	**12,411**

(1) The Department assumes that HCBS-DD and HCBS-DD Regional Center waiver slots can be used interchangeably. For example, if an HCBS-DD Regional Center client transitions to the community, their waiver slot would follow them to the HCBS-DD community program. Additionally, if a client leaves the Regional Center program and does not move into the community program, the Department assumes either a new HCBS-DD Regional Center client or a new HCBS-DD community client could occupy the open waiver slot. The Department would account for any needed adjustment via the usual budget process.

Table D.2 - DIDD Average Monthly Enrollment vs. Full Program Equivalent (FPE)							
Row	**Fiscal Year**		**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers [1]**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2007-08	Average Monthly Enrollment	4,399	120	2,871	383	7,773
B		FPE	3,654.00	120.00	2,287.00	291.00	6,165.00
C		FPE as a Percentage of Average Monthly Enrollment	83.06%	100.00%	79.66%	75.98%	79.31%
D	FY 2008-09	Average Monthly Enrollment	4,390	129	2,992	400	7,911
E		FPE	3,854.00	129.00	2,369.00	328.00	6,420.00
F		FPE as a Percentage of Average Monthly Enrollment	87.79%	100.00%	79.18%	82.00%	81.15%
G	FY 2009-10	Average Monthly Enrollment	4,401	118	3,104	404	8,027
H		FPE	4,063.00	118.00	2,625.00	325.00	6,049.00
I		FPE as a Percentage of Average Monthly Enrollment	92.32%	100.00%	84.57%	80.45%	75.36%
J	FY 2010-11	Average Monthly Enrollment	4,397	122	3,116	385	8,020
K		FPE	4,123.00	122.00	2,848.00	358.00	7,045.00
L		FPE as a Percentage of Average Monthly Enrollment	93.77%	100.00%	91.40%	92.99%	87.84%
M	FY 2011-12	Average Monthly Enrollment	4,397	122	3,140	373	8,032
N		FPE	4,113.00	122.00	2,860.00	338.00	6,578.00
O		FPE as a Percentage of Average Monthly Enrollment	93.54%	100.00%	91.08%	90.62%	81.90%
P	FY 2012-13	Average Monthly Enrollment	4,384	135	3,178	377	8,074
Q		FPE	4,156.00	135.00	3,021.00	347.00	6,760.00
R		FPE as a Percentage of Average Monthly Enrollment	94.80%	100.00%	95.06%	92.04%	83.73%
S	FY 2013-14	Average Monthly Enrollment	4,392	127	3,183	607	8,309
T		FPE	4,339.00	127.00	3,015.00	498.00	6,795.00
U		FPE as a Percentage of Average Monthly Enrollment	98.79%	100.00%	94.72%	82.04%	81.78%
V	**FY 2014-15 Selected FPE Conversion Factor [2]**		**96.80%**	**100.00%**	**94.89%**	**87.04%**	**82.76%**
W	**FY 2015-16 and FY 2016-17 Selected FPE Conversion Factor [3]**		**96.80%**	**100.00%**	**94.89%**	**92.04%**	**82.76%**

(1) Within the current system, the Department is unable to identify HCBS-DD Regional Center clients using the Prior Authorization (PAR) methodology that is used to determine average monthly enrollment for the other waiver programs. Therefore, the FPE as a percentage of average monthly enrollment factor for these clients is 100% as the clients can only be identified using paid claims.

(2) The selected FPE Conversion Factor is the average FPE as a Percentage of Average Monthly Enrollment for FY 2012-13 and FY 2013-14.

(3) The FY 2015-16 and FY 2016-17 FPE conversion factor for the HCBS-CES waiver differs from the FY 2014-15 factor as the Department anticipates that as the waitlist is eliminated and clients are enrolled in the program, the percentage of paid claims is likely to increase as the new clients access services.

Table D.3.1 - Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment Forecast						
Row	**Fiscal Year**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2007-08	4,399	120	2,871	383	7,773
B	FY 2008-09	4,390	129	2,992	400	7,911
C	FY 2009-10	4,401	118	3,104	404	8,027
D	FY 2010-11	4,397	122	3,116	385	8,020
E	FY 2011-12	4,397	122	3,140	373	8,032
F	FY 2012-13	4,384	135	3,178	377	8,074
G	FY 2013-14	4,392	127	3,183	607	8,309
H	Estimated FY 2014-15	4,802	123	4,377	1,041	10,343
I	Estimated FY 2015-16	5,038	123	5,491	1,278	11,930
J	Estimated FY 2016-17	5,163	123	5,645	1,328	12,259

Table D.3.2 - Percent Change in Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment						
Row	**Fiscal Year**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2007-08					
B	FY 2008-09	-0.20%	7.50%	4.21%	4.44%	1.78%
C	FY 2009-10	0.25%	-8.53%	3.74%	1.00%	1.47%
D	FY 2010-11	-0.09%	3.39%	0.39%	-4.70%	-0.09%
E	FY 2011-12	0.00%	0.00%	0.77%	-3.12%	0.15%
F	FY 2012-13	-0.30%	10.66%	1.21%	1.07%	0.52%
G	FY 2013-14	0.18%	-5.93%	0.16%	61.01%	2.91%
H	Estimated FY 2014-15	9.34%	-3.15%	37.51%	71.50%	24.48%
I	Estimated FY 2015-16	4.91%	0.00%	25.45%	22.77%	15.34%
J	Estimated FY 2016-17	2.48%	0.00%	2.80%	3.91%	2.76%

Table D.3.3 - Calculation of FY 2014-15 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)							
Row	**FY 2014-15**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Source/Calculation**
A	FY 2013-14 Year-End Enrollment; June 2014	4,604	123	3,160	792	8,679	MMIS Prior Authorization Request Data; June 2014
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	198	0	1,217	249	1,664	See narrative
C	Final Estimated FY 2014-15 Average Monthly Enrollment Under Current Policy	4,802	123	4,377	1,041	10,343	Row A + Row B
D	Requested Enrollment from Reallocation of Existing Resources	0	0	0	0	0	
E	**Final Estimated FY 2014-15 Average Monthly Enrollment**	**4,802**	**123**	**4,377**	**1,041**	**10,343**	**Row C + Row D**
F	FPE Adjustment Factor	96.80%	100.00%	94.89%	87.04%	82.76%	Table D.2, Row V
G	**Estimated FY 2014-15 FPE**	**4,648.10**	**123.00**	**4,153.34**	**906.09**	**8,559.35**	**Row E * Row F**

Table D.3.4 - Calculation of FY 2015-16 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)							
Row	**FY 2015-16**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Source/Calculation**
A	Estimated FY 2014-15 Year-End Enrollment; June 2015	4,970	123	5,408	1,251	11,752	Table D.1.1, Row F
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	68	0	83	27	178	See narrative
C	Final Estimated FY 2015-16 Average Monthly Enrollment Under Current Policy	5,038	123	5,491	1,278	11,930	Row A + Row B
D	Requested Enrollment from Reallocation of Existing Resources	0	0	0	0	0	
E	**Final Estimated FY 2015-16 Average Monthly Enrollment**	**5,038**	**123**	**5,491**	**1,278**	**11,930**	**Row C + Row D**
F	FPE Adjustment Factor	96.80%	100.00%	94.89%	92.04%	82.76%	Table D.2, Row W
G	**Estimated FY 2015-16 FPE**	**4,876.53**	**123.00**	**5,210.41**	**1,176.27**	**9,872.67**	**Row E * Row F**

Table D.3.5 - Calculation of FY 2016-17 Division for Intellectual and Developmental Disabilities (DIDD) Average Monthly Enrollment and Full Program Equivalent (FPE)							
Row	**FY 2016-17**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**	**Source/Calculation**
A	Estimated FY 2015-16 Year-End Enrollment; June 2016	5,095	123	5,561	1,300	12,079	Table D.1.3, Row A
B	Additional Enrollments Adjusted for Linear Enrollment Ramp-up	68	0	84	28	180	See narrative
C	Final Estimated FY 2016-17 Average Monthly Enrollment Under Current Policy	5,163	123	5,645	1,328	12,259	Row A + Row B
D	Requested Enrollment from Reallocation of Existing Resources	0	0	0	0	0	
E	**Final Estimated FY 2016-17 Average Monthly Enrollment**	**5,163**	**123**	**5,645**	**1,328**	**12,259**	**Row C + Row D**
F	FPE Adjustment Factor	96.80%	100.00%	94.89%	92.04%	82.76%	Table D.2, Row W
G	**Estimated FY 2016-17 FPE**	**4,997.53**	**123.00**	**5,356.54**	**1,222.29**	**10,144.94**	**Row E * Row F**

Table E.1 - Division for Intellectual and Developmental Disabilities (DIDD) Per Full Program Equivalent (FPE) Expenditure and Forecast						
Row	**Fiscal Year**	**HCBS - Waiver for Persons with Developmental Disabilities (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Support Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2007-08	$55,540.12	$165,118.52	$17,318.60	$20,255.20	$2,215.99
B	FY 2008-09	$57,955.90	$201,773.10	$19,582.83	$21,077.47	$2,157.16
C	FY 2009-10	$62,465.82	$240,339.27	$14,247.54	$22,024.69	$2,725.20
D	FY 2010-11	$66,237.42	$197,885.37	$13,195.05	$22,223.67	$2,713.23
E	FY 2011-12	$64,405.43	$207,186.23	$12,947.75	$21,779.88	$2,565.45
F	FY 2012-13	$62,997.58	$179,015.53	$12,338.19	$20,218.18	$2,384.18
G	FY 2013-14	$65,101.46	$175,002.87	$13,030.99	$18,323.90	$2,566.88
H	Estimated FY 2014-15	$66,807.12	$175,002.87	$14,908.40	$18,803.99	$2,634.13
I	Estimated FY 2015-16	$66,947.41	$175,002.87	$15,079.35	$18,843.48	$2,639.66
J	Estimated FY 2016-17	$66,947.41	$175,002.87	$15,079.35	$18,843.48	$2,639.66

Table E.2 - Percent Change in Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure						
Row	**Fiscal Year**	**HCBS - Waiver for Persons with Developmental Disabilities (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Children's Extensive Support Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2007-08					
B	FY 2008-09	4.35%	22.20%	13.07%	4.06%	-2.65%
C	FY 2009-10	7.78%	19.11%	-27.24%	4.49%	26.33%
D	FY 2010-11	6.04%	-17.66%	-7.39%	0.90%	-0.44%
E	FY 2011-12	-2.77%	4.70%	-1.87%	-2.00%	-5.45%
F	FY 2012-13	-2.19%	-13.60%	-4.71%	-7.17%	-7.07%
G	FY 2013-14	3.34%	-2.24%	5.62%	-9.37%	7.66%
H	Estimated FY 2014-15	2.62%	0.00%	14.41%	2.62%	2.62%
I	Estimated FY 2015-16	0.21%	0.00%	1.15%	0.21%	0.21%
J	Estimated FY 2016-17	0.00%	0.00%	0.00%	0.00%	0.00%

Table E.3 - Calculation of FY 2014-15 Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure						
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2013-14 Per Full Program Equivalent (FPE) Expenditure	$65,101.46	$175,002.87	$13,030.99	$18,323.90	$2,566.88
B	Base Trend	0.00%	0.00%	0.00%	0.00%	0.00%
C	Estimated Base FY 2014-15 Per FPE Expenditure	$65,101.46	$175,002.87	$13,030.99	$18,323.90	$2,566.88
	Rate Adjustments (1)					
D	FY 2014-15 2.50% Rate Increase	2.29%	0.00%	2.29%	2.29%	2.29%
E	Annualization of FY 2013-14 4.00% Rate Increase	0.33%	0.00%	0.33%	0.33%	0.33%
F	Estimated Base FY 2014-15 Per FPE after Rate Adjustments	$66,807.12	$175,002.87	$13,372.40	$18,803.99	$2,634.13
	Bottom Line Adjustments					
G	FY 2014-15 R-7 "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase" (2)	$0.00	$0.00	$1,536.00	$0.00	$0.00
H	**Total Estimated FY 2014-15 Per FPE Expenditure**	**$66,807.12**	**$175,002.87**	**$14,908.40**	**$18,803.99**	**$2,634.13**

Table E.4 - Calculation of FY 2015-16 Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure						
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2014-15 Per Full Program Equivalent (FPE) Expenditure	$66,807.12	$175,002.87	$14,908.40	$18,803.99	$2,634.13
B	Base Trend	0.00%	0.00%	0.00%	0.00%	0.00%
C	Estimated Base FY 2015-16 Per FPE Expenditure	$66,807.12	$175,002.87	$14,908.40	$18,803.99	$2,634.13
	Rate Adjustments (1)					
D	Annualization of FY 2014-15 2.50% Rate Increase	0.21%	0.00%	0.21%	0.21%	0.21%
E	Annualization of FY 2013-14 4.00% Rate Increase	0.00%	0.00%	0.00%	0.00%	0.00%
F	Estimated Base FY 2015-16 Per FPE after Rate Adjustments	$66,947.41	$175,002.87	$14,939.71	$18,843.48	$2,639.66
	Bottom Line Adjustments					
G	Annualization of FY 2014-15 R-7 "Adult Supported Living Services Waiting List Reduction and Service Plan Authorization Limits Increase" (2)	$0.00	$0.00	$139.64	$0.00	$0.00
H	**Total Estimated FY 2015-16 Per FPE Expenditure**	**$66,947.41**	**$175,002.87**	**$15,079.35**	**$18,843.48**	**$2,639.66**

Table E.5 - Calculation of FY 2016-17 Division for Intellectual and Developmental Disabilities (DIDD) Per FPE Expenditure						
Row	**Item**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD)**	**HCBS - Developmental Disabilities Comprehensive Waiver (HCBS-DD) - Regional Centers**	**HCBS - Developmental Disabilities Supported Living Services Waiver (HCBS-SLS)**	**HCBS - Developmental Disabilities Children's Extensive Services Waiver (HCBS-CES)**	**HCBS - Targeted Case Management (TCM)**
A	FY 2015-16 Per Full Program Equivalent (FPE) Expenditure	$66,947.41	$175,002.87	$15,079.35	$18,843.48	$2,639.66
B	Base Trend	0.00%	0.00%	0.00%	0.00%	0.00%
C	Estimated Base FY 2016-17 Per FPE Expenditure	$66,947.41	$175,002.87	$15,079.35	$18,843.48	$2,639.66
	Rate Adjustments (1)					
D	None	0.00%	0.00%	0.00%	0.00%	0.00%
E	Estimated Base FY 2015-16 Per FPE after Rate Adjustments	$66,947.41	$175,002.87	$15,079.35	$18,843.48	$2,639.66
	Bottom Line Adjustments					
F	None	$0.00	$0.00	$0.00	$0.00	$0.00
G	**Total Estimated FY 2016-17 Per FPE Expenditure**	**$66,947.41**	**$175,002.87**	**$15,079.35**	**$18,843.48**	**$2,639.66**

(1) A 4.00% Provider Rate increase was added during FY 2013-14 and 2.50% for FY 2014-15. Because of lag between the dates services are provided and the dates claims are paid, the increases are realized gradually (i.e. some claims paid early in each fiscal year were for services provided in the prior year). This, likewise, will have a slight carryover effect into the request year and out year.

(2) A 25.00% service plan authorization limit (SPAL) increase was added for FY 2014-15. The amount appropriated for the SPAL increase was $6,959,536 which was divided by the number of project FPE for FY 2014-15 to calculate the impact to per FPE expenditure. Because of lag between the dates services are provided and the dates claims are paid, the increases are realized gradually (i.e. some claims paid early in each fiscal year were for services provided in the prior year). This, likewise, will have a slight carryover effect into the request year and out year.

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-06

Request Titles

R-06 Medicaid & CHP+ Enrollment Simplification

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$6,475,631,759	$0	$6,538,626,483	$1,050,191	$17,386,751
	FTE	-	-	-	-	-
	GF	$1,803,693,171	$0	$1,847,305,341	$147,729	$1,818,579
	CF	$675,722,073	$0	$682,275,581	$213,004	$299,241
	RF	$23,910	$0	$23,910	$0	$0
	FF	$3,996,192,605	$0	$4,009,021,651	$689,458	$15,268,931

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - Operating Expenses	Total	$3,345,159	$0	$1,946,037	$150,000	$0
	CF	$62,577	$0	$62,577	$0	$0
	FF	$1,681,676	$0	$976,139	$75,000	$0
	GF	$1,576,996	$0	$883,411	$75,000	$0
	RF	$23,910	$0	$23,910	$0	$0
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	Total	$5,724,352,770	$0	$5,768,568,225	$0	$12,281,696
	CF	$622,898,368	$0	$628,705,349	$0	$45,663
	FF	$3,492,641,948	$0	$3,485,278,253	$0	$10,825,525
	GF	$1,608,812,454	$0	$1,654,584,623	$0	$1,410,508
03. Behavioral Health Community Programs - Behavioral Health Capitation Payments	Total	$548,101,614	$0	$548,263,817	$0	$3,924,077
	CF	$4,534,586	$0	$4,500,945	$0	$0
	FF	$372,562,308	$0	$373,428,468	$0	$3,577,923
	GF	$171,004,720	$0	$170,334,404	$0	$346,154
05. Indigent Care Program - Children's Basic Health Plan Medical and Dental Costs	Total	$199,832,216	$0	$219,848,404	$900,191	$1,180,978
	CF	$48,226,542	$0	$49,006,710	$213,004	$253,578
	FF	$129,306,673	$0	$149,338,791	$614,458	$865,483
	GF	$22,299,001	$0	$21,502,903	$72,729	$61,917

Letternote Text Revision Required?	Yes	X	No		**If Yes, describe the Letternote Text Revision:**

In Medical Services Premiums $45,663 is from the Adult Dental Fund (28C0) in FY 2016-17. For Children's Basic Health Plan $40,396 is from the CHP Trust Fund (11G0) and $172,608 is from the Hospital Provider Fee (24A0) in FY 2015-16 and $50,875 is from the CHP Trust Fund and $202,703 is from the Hospital Provider Fee for FY 2016-17.

Cash or Federal Fund Name and CORE Fund Number:	CF: Adult Dental Fund (28C0), CHP Trust Fund (11G0), Hospital Provider Fee (24A0) FF: Title XIX, Title XXI
Reappropriated Funds Source, by Department and Line Item Name:	N/A

Approval by OIT?	Yes		No		**Not Required:**	X
Schedule 13s from Affected Departments:	N/A					
Other Information:	N/A					

Cost and FTE

- The Department requests $1,050,191 total funds, $147,729 General Fund, in FY 2015-16 and $17,386,751 total funds, $1,818,579 General Fund in FY 2016-17 to change income determination to an annualized income and implement a one-month grace period for CHP+ enrollment fees in order to reduce gaps in coverage and improve access to benefits.

Current Program

- Continuous eligibility has been made available for children enrolled in either Medicaid or CHP+, but not for Medicaid eligible adults.
- Both Medicaid and CHP+ eligibility are determined based on an individual's current or prior month income, rather than an annualized income.
- Clients that are eligible for CHP+ with incomes 157% above the federal poverty levels or higher are responsible for paying an enrollment fee. These clients are not enrolled immediately and benefits cannot be accessed until the enrollment fee is paid and processed.

Problem or Opportunity

- Clients lose and regain coverage from Medicaid and CHP+ due to changes in income. This is particularly difficult for clients with seasonal income, such as farmers. Clients with consistent seasonal changes in their income could have seasonal gaps in coverage as their income levels change each month. These gaps occur because State programs determine income eligibility based on prior or current month's income instead of an annualized income.
- Individuals that qualify for CHP+ cannot receive a real-time determination when they apply online because determination requires additional manual processing, noticing, and the enrollment fee calculation is based on income, which occurs after the client is otherwise eligible.

Consequences of Problem

- Continuing to determine clients eligible by monthly income means clients with seasonal income would continue to have seasonal gaps in coverage. This would perpetuate churn that is potentially harmful to the well-being of the client.
- Not allowing a one-month grace period for CHP+ clients prevents clients from receiving immediate access to benefits upon being determined eligible.

Proposed Solution

- While continuous eligibility for adults is not an immediate option, changing monthly income determination to an annualized income determination could greatly reduce the gaps in coverage and improve the client experience. Clients with seasonal income would gain more continuous coverage if their income were averaged for the year, rather than used for determination each month. This would also improve consistency between state programs and the Marketplace, since the Marketplace currently annualizes an applicant's income.
- Allow a one-month grace period for CHP+ clients owing an enrollment fee, giving clients immediate access to benefits upon being determined eligible.

Department Priority: R-6
Request Detail: Medicaid & CHP+ Enrollment Simplification

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Medicaid & CHP+ Enrollment Simplification	$1,050,191	$147,729

Problem or Opportunity:

Medicaid and the Children's Basic Health Plan Plus (CHP+) clients face unnecessary complexities when enrolled or when applying for benefits, resulting in either gaps in coverage or a delay in the clients' access to benefits. The Department has identified three sources of delayed access to benefits and significant burden for applicants. First, the treatment of income for Medicaid eligibility determinations is incongruent with other state processes and fails to adequately address issues related to seasonal variation in income. Second, clients churn on and off of Medicaid with fluctuations in income resulting in potential coverage gaps. Last, pregnant women and children have delayed access to care due to processes related to enrollment fee collection.

Both Medicaid and the CHP+ eligibility are determined based on an individual's current or prior month income. This methodology fails to account for applicants that have highly variable or seasonal incomes, such as farmers. Consequently, individuals must consistently make updates to their income based on the time of year that they work, which can result in interruption in benefits since they may be eligible in one month but over income the following month. Additionally, under the current methodology for evaluating income, individuals with very high, but seasonal, annual income can receive public assistance when it is genuinely not appropriate for them given their high income.

Monthly income determinations also create disconnects with other programs. Specifically, eligibility determination for Connect for Health Colorado (C4HCO), Colorado's insurance marketplace (the Marketplace), is based on projected annualized income. Having a different methodology for state programs causes eligibility for the Insurance Affordability Programs (IAPs), Marketplace tax subsidies and public assistance programs that ensure individuals have access to affordable coverage, to be out of sync. The implication is that individuals are potentially not receiving the correct subsidies or coverage to which they are entitled.

Fluctuations in income at any point in a year can result in loss of Medicaid eligibility. Moving back and forth between the Marketplace and public assistance can result in coverage gaps and excessive burden for clients needing to constantly reapply for different types of coverage when their income fluctuates. Further,

discontinuity in coverage, frequently referred to as "churn", can result in negative impacts on client health outcomes. Because different insurance providers contract with different provider networks, churn can result in breakage of critical connections between an individual and their primary care provider. To reduce churn and help ensure continuity of care, Colorado has implemented continuous eligibility for children. However, the Department would need a demonstration waiver to implement continuous eligibility for adults, which would require meeting federal budget neutrality requirements. Because the effects of churn on short and long run costs are not fully understood for adults in Medicaid, the Department perceives an opportunity to perform a study on the possible benefits of implementing a solution such as continuous eligibility for adults, as well as investigating other strategies for reducing disruptive churn in a cost effective manner.

The last factor identified by the Department as creating undue burden for clients is delayed eligibility for pregnant women and children pending processing of enrollment fees. After the CBMS Lawsuit in 2005 (Anna Davis et. al. v. Joan Henneberry and Karen Beye), the standard for CHP+ application processing was set at 45 days. Clients that are determined eligible for CHP+ with incomes 157% above the federal poverty levels (FPL) or higher are responsible for paying an enrollment fee within 30 days. With these time frames, an applicant may wait up to 75 days after submitting their application before they may access benefits. These clients with incomes above 157% FPL are not enrolled immediately and benefits cannot be accessed until the enrollment fee is paid and processed. As a result, individuals that will qualify for CHP+ will never receive a real time determination when they apply online because determination requires additional manual processing and noticing and the enrollment fee calculation is based on income, which occurs after the client is otherwise eligible.

Addressing the aforementioned issues presents a significant opportunity to improve client experience by reducing coverage gaps, reduce administrative burden, and improve consistency between state programs and the Marketplace.

Proposed Solution:

The Department requests $1,050,191 total funds, including $147,729 General Fund in FY 2015-16, and $17,386,751 total funds, including $1,818,579 General Fund in FY 2016-17 to address three critical issues impacting clients' eligibility to ensure seamless and efficient coverage and access to care.

The Department requests funding to implement standardization of Medicaid income calculation to align more closely with that of the Marketplace. This would essentially change the income assessment for public health care coverage from a monthly income determination to an annualized income determination. While the Marketplace annualizes income for the entire year, the State would annualize the applicant's income for the remainder of the year. Federal regulations at 42 CFR 435.603(h) do not allow the State to annualize for a full year, but the regulations do provide the option of annualizing for the remainder of the year. Basing income eligibility on an annualized income would prevent gaps in coverage for clients with seasonal income as well as maintain consistency for the IAPs by utilizing a similar methodology as the Marketplace.

To develop a long term solution for addressing churn, the Department requests funding to study on the potential benefits of implementing continuous eligibility for Medicaid eligible adults, as well as other options that could potentially reduce churn.

Lastly, to address delayed access to health care for pregnant women in need of prenatal care and children in CHP+, the Department requests funding to allow CHP+ eligible clients a one-month grace period to pay their enrollment fee; this would allow CHP+ clients immediate access to benefits. Should the applicant fail to pay enrollment fees by the end of the grace period, eligibility would be terminated.

Anticipated Outcomes:

Replacing monthly income determination with an annualized income determination would permit clients who have an annual income below the income threshold to maintain benefits continuously throughout the year. For clients remaining on Medicaid, they would do so without having to continuously reapply and enduring coverage gaps or potential churn between Medicaid and the Marketplace. Closing coverage gaps addresses the Department's FY 2014-15 performance goal for eligibility and enrollment by improving client access and supporting continuous enrollment. Supporting more continuous coverage could improve the client experience, has the potential to help client outcomes, which could lower per capita costs. Only those applicants with relatively high annual income will be determined ineligible for public assistance. Absent a change in methodology, populations with seasonal income would continue to churn on and off of Medicaid, and high income populations would remain enrolled. Lastly, inconsistencies between eligibility policy and IAPs through the Marketplace would remain unresolved.

Should income determination change from monthly to an annualized income, there would still be clients who churn on and off of Medicaid due to income changes. Through a study of options to address churn, the Department anticipates it would be able to develop a long term strategy that would support a seamless continuum of coverage in Colorado that significantly reduces the negative impacts of eligibility churn on costs and client outcomes.

Allowing a one-month grace period to pay enrollment fees will allow CHP+ clients immediate access to benefits, ensuring timely access to care for children. Implementing the one-month grace period for CHP+ clients addresses the Department's FY 2014-15 performance goal for client experience and timely eligibility determinations. The delayed access to benefits after eligibility determination can be reduced by up to 30 days by giving these clients a grace period for the enrollment fee. Failure to pay the enrollment fee within the first month would still result in termination of benefits.

Assumptions and Calculations:

The Department's calculations are shown in the appendix.

Fiscal impact of annualized income determinations:

The current system determines an applicant eligible base upon their monthly income, changes would need to be made for MAGI eligibilities so that income eligibility is based on the applicant's income that has been annualized for the remainder of the year. The Department assumes these hours can be covered by the current scheduled workload for CBMS changes.

In order to identify the number of clients that will be affected by the annualization of income, the Department has analyzed client history for Medicaid and CHP+ from FY 2012-13. The clients of interest are assumed to

be those that experienced gaps in their Medicaid or CHP+ eligibility of at least one month, but because not all clients would be affected, the Department has only considered clients who have an eligibility gap that is less than one standard deviation above the average gap in eligibility spans. These clients have a minimum gap in coverage of 1 month and a maximum gap in coverage of approximately 6 months, so the sample has a gap in coverage lasting half of the fiscal year or less. The Department assumes clients with coverage gaps lasting longer than 6 months are not facing predictable income changes since seasonal employment does not typically last longer than 6 months. A weighted average of the results for MAGI Parents/Caretakers to 68% FPL and MAGI Parents/Caretakers to 69% to 133% FPL was used to estimate the impact for MAGI Adults.

The Department assumes that MAGI Eligible Children and CHP+ Children would not be affected from the annualization of income because continuous eligibility has already been implemented for these categories. The Department also assumes that the annualization of income will have no impact on prenatal clients.

To account for the fact that per capita costs decline as clients are eligible for longer periods of time, the per capita costs used in the estimate are those projected in the FY 2014-15 S-1: "Medical Services Premiums" request, Exhibit C, multiplied by 50%. This is based on the analysis done to estimate the cost of implementing continuous eligibility for children. The estimated per capita used to predict the costs of continuous eligibility for children was approximately 50% of the actual per capita. This same proportion was applied to the per capita for MAGI Parents/Caretakers and MAGI Adults.

The Department assumes that this change could be implemented in July 2016.

Churn study:

After reviewing the costs of studies done in the past, the Department requests funding of $150,000 in FY 2015-16 to study the potential benefits of implementing continuous eligibility for Medicaid eligible adults, as well as other options that could potentially reduce churn.

One-month grace period for enrollment fees in CHP+:
Currently, CBMS determines a client ineligible for not paying the enrollment fee; the Department would require system changes to change system rules to allow a client to be enrolled immediately and only terminate for lack of payment after one month. The Department assumes these hours can be covered by the current scheduled workload for CBMS changes.

The Department identified a total of 5,383 clients (3,326 cases) that were denied eligibility in CY 2013 due to failure to pay the enrollment fee. This number was used to find the average monthly number of clients that did not qualify for benefits due to failure to pay enrollment fee. The Department assumes that 90% of cases that failed to pay the enrollment fee would have paid the fee within the one-month grace period, and would remain eligible for the remainder of the fiscal year. The remaining 10% of clients would fail to pay within the one-month grace period and would receive one month of coverage. The Department applied the projected growth trend for CHP+ caseload, from S-3 February 2014, to the average monthly clients and average monthly cases from CY 2013 to estimate the average monthly number of clients that will gain CHP+ eligibility when granted the one-month grace period and estimate the newly obtained enrollment fees.

While there is potential for clients to seek out their one month of benefits and still be terminated due to lack of payment, the Department assumes that this will not be a frequent occurrence as clients are more likely to be seeking continuous coverage and not simply one month of services. If implemented, the Department would track how often clients fail to pay the enrollment fee within the grace period to determine if additional policy changes would be necessary. For this analysis, the Department has assumed that 90% of all clients will have paid the enrollment fee within the one-month grace period.

The new enrollment fees collected after this change must be estimated in order to correctly calculate the federal match. The CHP+ program receives a federal match on all expenditures, minus the amount collected in enrollment fees. Enrollment fees are based on the FPL on the application and the number of children listed on the application, fees are listed in the table below. Because enrolling two or more children receives a flat fee, the Department uses the observed average fee owed in CY 2013 instead of estimating the number of children on each application. The Department assumes the average enrollment fee would equal the average observed fee in CY 2013 for all projected years. For clients under 205% FPL the average fee is $31.58, and the average enrollment fee for clients over 205% FPL is $94.42. The average enrollment fee is then multiplied by the projected number of cases (applications) that will pay the enrollment fee for the entire fiscal year. The projected number of cases is based on the 3,326 cases identified in CY 2013 as failing to pay the enrollment fee.

CHP+ Enrollment Fees		
	Children 150%-205%	**Children 206%-250%**
Fee to enroll one child[(1)]	$25.00	$75.00
Fee to enroll more than one child[(1)]	$35.00	$105.00

The Department assumes that this change could be implemented in September 2015.

R-6 Medicaid & CHP+ Enrollment Simplification - Summary of Request

Table 1.1
Summary of Request
FY 2015-16

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes
Total Request	**$1,050,191**	**$147,729**	**$213,004**	**$0**	**$689,458**	
(1) Executive Director's Office; (A) General Administration, Personal Services	$150,000	$75,000	$0	$0	$75,000	Narrative
(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	$900,191	$72,729	$213,004	$0	$614,458	Table 3.1 Row F

Table 1.2
Summary of Request
FY 2016-17

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Notes
Total Request	**$17,386,751**	**$1,818,579**	**$299,241**	**$0**	**$15,268,931**	
(2) Medical Services Premiums	$12,281,696	$1,410,508	$45,663	$0	$10,825,525	Table 2.1 Row E
(3) Behavioral Health Community Programs; Behavioral Health Capitation Payments	$3,924,077	$346,154	$0	$0	$3,577,923	Table 2.1 Row H
(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	$1,180,978	$61,917	$253,578	$0	$865,483	Table 3.2 Row F

R-6 Medicaid & CHP+ Enrollment Simplification - Summary of Request

Table 1.3
Request Components by Line Item
FY 2015-16

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**$1,050,191**	**$147,729**	**$213,004**	**$0**	**$689,458**	
(1) Executive Director's Office; (A) General Administration, Personal Services	**$150,000**	**$75,000**	**$0**	**$0**	**$75,000**	
Continuous Eligibility Study	$150,000	$75,000	$0	$0	$75,000	Narrative
(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	**$900,191**	**$72,729**	**$213,004**	**$0**	**$614,458**	
One-Month Grace Period for CHP+ Enrollment Fees	$900,191	$72,729	$213,004	$0	$614,458	Table 3.1 Row F

Table 1.4
Request Components by Line Item
FY 2016-17

	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
Total Request	**$17,386,751**	**$1,818,579**	**$299,241**	**$0**	**$15,268,931**	
(2) Medical Services Premiums	**$12,281,696**	**$1,410,508**	**$45,663**	**$0**	**$10,825,525**	
Annualization of Income	$12,281,696	$1,410,508	$45,663	$0	$10,825,525	Table 2.1 Row E
(3) Behavioral Health Community Programs	**$3,924,077**	**$346,154**	**$0**	**$0**	**$3,577,923**	
Annualization of Income	$3,924,077	$346,154	$0	$0	$3,577,923	Table 2.1 Row H
(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs	**$1,180,978**	**$61,917**	**$253,578**	**$0**	**$865,483**	
One-Month Grace Period for CHP+ Enrollment Fees	$1,180,978	$61,917	$253,578	$0	$865,483	Table 3.2 Row F

Determining Income Eligibility Through Annualized Income - Fund Splits

Table 2.1 Summary of Projected Expenditures for Annualized Income FY 2016-17

(2) Medical Services Premiums

Row		Total Funds	General Fund	Cash Funds*	Reappropriated Funds	Federal Funds	FMAP	Notes
A	Standard FMAP Expenditures - Medical	$2,846,061	$1,410,508	$0	$0	$1,435,553	*50.44%*	Table 2.4 Row I
B	Standard FMAP Expenditures - Dental	$92,136	$0	$45,663	$0	$46,473	*50.44%*	Table 2.4 Row L
C	Enhanced ACA FMAP Expenditures - Medical	$9,168,927	$0	$0	$0	$9,168,927	*100.00%*	Table 2.4 Row I
D	Enhanced ACA FMAP Expenditures - Dental	$174,572	$0	$0	$0	$174,572	*100.00%*	Table 2.4 Row L
E	**Total MSP Expenditure FY 2016-17**	**$12,281,696**	**$1,410,508**	**$45,663**	**$0**	**$10,825,525**	***88.14%***	**Row A + Row B + Row C + Row D**

*Of this amount, $45,663 is from the Adult Dental Fund.

(3) Behavioral Health Community Programs

Row		Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FMAP	Notes
F	Standard FMAP Expenditures	$698,455	$346,154	$0	$0	$352,301	*50.44%*	Table 2.4 Row O
G	Enhanced ACA FMAP Expenditures	$3,225,622	$0	$0	$0	$3,225,622	*100.00%*	Table 2.4 Row O
H	**Total BH Expenditure FY 2016-17**	**$3,924,077**	**$346,154**	**$0**	**$0**	**$3,577,923**	***91.18%***	**Row F + Row G**

Determining Income Eligibility Through Annualized Income - Calculations

Table 2.2 Projected Costs for Annualized Income FY 2016-17

Row	Item	MAGI Parents/ Caretakers to 68% FPL	MAGI Parents/ Caretakers 69% to 133% FPL	MAGI Adults	Total	Notes
A	FY 2016-17 Projected Caseload	187,003	65,764	209,346	462,113	Revised caseload estimates based on data through June 2014
B	Estimated Percentage of Clients Affected	3.81%	6.13%	4.43%	4.43%	Historical Medicaid and CHP+ Data
C	Estimated Clients Affected by Annualized Income	7,125	4,031	9,274	20,430	Row E * Row F
D	Estimated Months Added to Eligibility	3.45	3.54	3.48	3.48	Historical Medicaid and CHP+ Data
E	Annualize for Implementation Date	100.00%	100.00%	100.00%	100.00%	Projected Implementation of July 2016
F	Estimated Additional Member Months	24,581	14,270	32,304	71,155	Row C * Row D * Row E
G	Estimated PMPM for Medical Services Premiums - Medical	$115.78	$100.28	$239.53	$168.86	S-1 February 2014 Exhibit C1, divided by 12, multiplied by 50%
H	Estimated Additional Member Months	24,581	14,270	32,304	71,155	Row F
I	**Estimated MSP Expenditure - Medical**	**$2,846,061**	**$1,431,041**	**$7,737,886**	**$12,014,988**	**Row G * Row H**
J	Estimated PMPM for Medical Services Premiums - Dental	$3.75	$3.75	$3.75	$3.75	S-1 February 2014 Exhibit B1 & Exhibit D1, divided by 12, multiplied by 50%
K	Estimated Additional Member Months	24,581	14,270	32,304	71,155	Row F
L	**Estimated MSP Expenditure - Dental**	**$92,136**	**$53,488**	**$121,084**	**$266,708**	**Row J * Row K**
M	Estimated PMPM for Mental Health	$28.41	$28.41	$87.30	$55.15	S-2 February 2014 Exhibit DD, divided by 12, multiplied by 50%
N	Estimated Additional Member Months	24,581	14,270	32,304	71,155	Row F
O	**Estimated BH Expenditure**	**$698,455**	**$405,474**	**$2,820,148**	**$3,924,077**	**Row M * Row N**
P	**Total Expenditure FY 2016-17**	**$3,636,652**	**$1,890,003**	**$10,679,118**	**$16,205,773**	**Row I + Row L + Row O**

Implementing One-Month Grace Period for CHP+ Clients Owing Enrollment Fee - Fund Splits

Table 3.1 Summary of Costs of One-Month Grace Period FY 2015-16

(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs

Row	Item	Total Funds	General Fund	Cash Funds*	Reappropriated Funds	Federal Funds	FMAP	Notes
A	***FY 2015-16 Expenditure to be Matched***	***$740,668***	***$126,210***	***$0***	***$0***	***$614,458***	*82.96%*	Row D - (Row B + Row C)
B	*Children 0%-205% FPL Enrollment Fees*	*$40,396*	*$0*	*$40,396*	*$0*	*$0*	*NA*	Table 3.3 Row T
C	*Children 206%-250% FPL Enrollment Fees*	*$119,127*	*$0*	*$119,127*	*$0*	*$0*	*NA*	Table 3.3 Row T
D	**FY 2015-16 Total Expenditure**	**$900,191**	**$126,210**	**$159,523**	**$0**	**$614,458**	*68.26%*	Table 3.3 Row K
E	Children 206%-250% FPL	$0	($53,481)	$53,481	$0	$0	*NA*	Table 3.3 Row N
F	**Estimated CHP+ Expenditure FY 2015-16**	**$900,191**	**$72,729**	**$213,004**	**$0**	**$614,458**	*68.26%*	Row D + Row E

*Of this amount, $40,396 is from the CHP Trust Fund and $172,608 is from the Hospital Provider Fee.

Table 3.2 Summary of Costs of One-Month Grace Period FY 2016-17

(5) Indigent Care Program; Children's Basic Health Plan Medical and Dental Costs

Row	Item	Total Funds	General Fund	Cash Funds*	Reappropriated Funds	Federal Funds	FMAP	Notes
A	***FY 2016-17 Expenditure to be Matched***	***$975,632***	***$110,149***	***$0***	***$0***	***$865,483***	*88.71%*	Row D - (Row B + Row C)
B	*Children 0%-205% FPL Enrollment Fees*	*$50,875*	*$0*	*$50,875*	*$0*	*$0*	*NA*	Table 3.4 Row T
C	*Children 206%-250% FPL Enrollment Fees*	*$154,471*	*$0*	*$154,471*	*$0*	*$0*	*NA*	Table 3.4 Row T
D	**FY 2016-17 Total Expenditure**	**$1,180,978**	**$110,149**	**$205,346**	**$0**	**$865,483**	*73.29%*	Table 3.4 Row K
E	Children 206%-250% FPL	$0	($48,232)	$48,232	$0	$0	*NA*	Table 3.3 Row N
F	**Estimated CHP+ Expenditure FY 2016-17**	**$1,180,978**	**$61,917**	**$253,578**	**$0**	**$865,483**	*73.29%*	Row D + Row E

*Of this amount, $50,875 is from the CHP Trust Fund and $202,703 is from the Hospital Provider Fee.

Implementing One-Month Grace Period for CHP+ Clients Owing Enrollment Fee - Calculations

Table 3.3 Cost of Covering Clients Who Failed to Pay Enrollment Fee FY 2015-16

Projected Cost of Covering Clients

Row		CHP+ Children 0%-205% FPL	CHP+ Children 206%-250% FPL	Total	Source
A	Clients Denied Eligibility - Per Month	229	225	454	Historical CHP+ Data
B	Proportion of Clients That Will Pay the Fee	90.00%	90.00%	90.00%	See Narative
C	Clients That Will Maintain Eligibility After One Month	206	203	409	Row A * Row B
D	Projected Unadjusted Per Capita (Medical + Dental)	$2,696.51	$2,536.60	$2,617.14	S-3 February 2014 Exhibit C4
E	Annualize for Implementation Date	83.33%	83.33%	83.33%	Projected Implementation of September 2015
F	**Expenditure for clients that pay the fee FY 2015-16**	**$462,901**	**$429,108**	**$892,009**	**Row C * Row D * Row E**
G	Clients That Will Lose Eligibility After One Month	23	22	45	Row A - Row C
H	Projected Unadjusted Per Capita for One Month of Coverage	$224.71	$211.38	$218.19	Row D divided by 12
I	Annualize for Implementation Date	83.33%	83.33%	83.33%	Projected Implementation of September 2015
J	**Expenditure for clients that fail to pay the fee FY 2015-16**	**$4,307**	**$3,875**	**$8,182**	**Row G * Row H * Row I**
K	**Total Expenditure FY 2015-16**	**$467,208**	**$432,983**	**$900,191**	**Row F + Row J**
L	Projected Fees Collected	$40,396	$119,127	$159,523	Row T
M	Expenditures to be Matched	$426,812	$313,856	$740,668	Row K - Row L
N	State Funds / Hospital Provider Fee*	$72,729	$53,481	$126,210	Row M * (1-82.96%)

*Children 0%-205% FPL are funded with state funds, children 206%-250% FPL are funded with the Hospital Provider Fee.

Projected Enrollment Fees Collected

Row		CHP+ Cases 0%-205% FPL	CHP+ Cases 206%-250% FPL	Total	Source
O	Cases Denied Eligibility - Per Year	1,705	1,682	3,387	Projected Based on Historical CHP+ Data
P	Proportion that will pay fee	90.00%	90.00%	90.00%	Row B
Q	Cases that will pay the fee within one month	1,535	1,514	3,049	Row O * Row P
R	Average Fee	$31.58	$94.42	$62.79	Projected Based on Historical CHP+ Data
S	Annualize for Implementation Date	83.33%	83.33%	83.33%	Projected Implementation of September 2015
T	**Total Fees Collected FY 2015-16**	**$40,396**	**$119,127**	**$159,523**	**Row Q * Row R * Row S**

Implementing One-Month Grace Period for CHP+ Clients Owing Enrollment Fee - Calculations

Table 3.4 Cost of Covering Clients Who Failed to Pay Enrollment Fee FY 2016-17

Projected Cost of Covering Clients

Row		CHP+ Children 0%-205% FPL	CHP+ Children 206%-250% FPL	Total	Source
A	Clients Denied Eligibility	240	243	483	Historical CHP+ Data
B	Proportion of Clients that will pay the Fee	90.00%	90.00%	90.00%	See Narative
C	Clients that will maintain eligibility after one month	216	219	435	Row A * Row B
D	Projected Unadjusted Per Capita (Medical + Dental)	$2,749.07	$2,632.04	$2,690.19	S-3 February 2014 Exhibit C4
E	Annualize for Implementation Date	100.00%	100.00%	100.00%	Projected Implementation of September 2015
F	**Expenditure for clients that pay the fee FY 2015-16**	**$593,799**	**$576,417**	**$1,170,216**	**Row C * Row D * Row E**
G	Clients that will lose eligibility after one month	24	24	48	Row A - Row C
H	Projected Unadjusted Per Capita for one month of coverage	$229.09	$219.34	$224.22	Row D divided by 12
I	Annualize for Implementation Date	100.00%	100.00%	100.00%	Projected Implementation of September 2015
J	**Expenditure for clients that fail to pay the fee FY 2015-16**	**$5,498**	**$5,264**	**$10,762**	**Row G * Row H * Row I**
K	**Total Expenditure FY 2016-17**	**$599,297**	**$581,681**	**$1,180,978**	**Row F + Row J**
L	Projected Fees Collected	$50,875	$154,471	$205,346	Row T
M	Expenditures to be Matched	$548,422	$427,210	$975,632	Row K - Row L
N	State Funds / Hospital Provider Fee*	$61,917	$48,232	$110,149	Row K * (1-88.71%)

*Children 0%-205% FPL are funded with state funds, children 206%-250% FPL are funded with the Hospital Provider Fee.

Projected Enrollment Fees Collected

Row		CHP+ Cases 0%-205% FPL	CHP+ Cases 206%-250% FPL	Total	Source
O	Cases Denied Eligibility	1,790	1,818	3,608	Historical CHP+ Data
P	Proportion that will pay fee	90.00%	90.00%	90.00%	Row B
Q	Cases that will pay the fee within one month	1,611	1,636	3,247	Row O * Row P
R	Average Fee	$31.58	$94.42	$63.24	Historical CHP+ Data
S	Annualize for Implementation Date	100.00%	100.00%	100.00%	Projected Implementation of September 2015
T	**Total Fees Collected FY 2016-17**	**$50,875**	**$154,471**	**$205,346**	**Row Q * Row R * Row S**

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-07

Request Titles

R-07 Participant Directed Programs Expansion

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$5,865,388,449	$0	$5,912,519,045	$1,708,633	$2,769,835
	FTE	360.4	-	360.6	0.9	1.0
	GF	$1,667,971,843	$0	$1,715,143,064	$816,371	$1,360,259
	CF	$628,418,890	$0	$634,317,391	$0	$0
	RF	$2,405,009	$0	$2,532,436	$0	$0
	FF	$3,566,592,707	$0	$3,560,526,154	$892,262	$1,409,576

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - Personal Services	Total	$26,043,374	$0	$26,913,985	$58,479	$63,800
	CF	$2,676,189	$0	$2,746,161	$0	$0
	FF	$12,679,416	$0	$13,118,575	$29,239	$31,900
	FTE	360.4	-	360.6	0.9	1.0
	GF	$8,802,250	$0	$9,128,987	$29,240	$31,900
	RF	$1,885,519	$0	$1,920,262	$0	$0
01. Executive Director's Office - Health, Life, and Dental	Total	$2,476,612	$0	$2,764,474	$7,927	$7,927
	CF	$166,066	$0	$237,248	$0	$0
	FF	$1,284,665	$0	$1,396,951	$3,963	$3,963
	GF	$896,868	$0	$950,673	$3,964	$3,964
	RF	$129,013	$0	$179,602	$0	$0
01. Executive Director's Office - Short-term Disability	Total	$64,185	$0	$59,620	$115	$126
	CF	$4,955	$0	$4,521	$0	$0
	FF	$36,233	$0	$30,891	$57	$63
	GF	$21,082	$0	$21,545	$58	$63
	RF	$1,915	$0	$2,663	$0	$0

01. Executive Director's Office - Amortization Equalization Disbursement	**Total**	**$1,235,106**	**$0**	**$1,281,593**	**$2,306**	**$2,744**
	CF	$96,428	$0	$97,306	$0	$0
	FF	$696,733	$0	$664,020	$1,153	$1,372
	GF	$405,144	$0	$462,966	$1,153	$1,372
	RF	$36,801	$0	$57,301	$0	$0
01. Executive Director's Office - Supplemental Amortization Equalization Disbursement	**Total**	**$1,157,972**	**$0**	**$1,237,903**	**$2,227**	**$2,715**
	CF	$90,431	$0	$93,989	$0	$0
	FF	$653,218	$0	$641,383	$1,113	$1,357
	GF	$379,822	$0	$447,183	$1,114	$1,358
	RF	$34,501	$0	$55,348	$0	$0
01. Executive Director's Office - Operating Expenses	**Total**	**$3,345,159**	**$0**	**$1,946,037**	**$5,573**	**$950**
	CF	$62,577	$0	$62,577	$0	$0
	FF	$1,681,676	$0	$976,139	$2,786	$475
	GF	$1,576,996	$0	$883,411	$2,787	$475
	RF	$23,910	$0	$23,910	$0	$0
01. Executive Director's Office - General Professional Services and Special Projects	**Total**	**$6,151,808**	**$0**	**$5,481,508**	**$250,000**	**$250,000**
	CF	$727,500	$0	$727,500	$0	$0
	FF	$3,198,993	$0	$2,835,743	$125,000	$125,000
	GF	$2,225,315	$0	$1,918,265	$125,000	$125,000
01. Executive Director's Office - MMIS Maintenance and Projects	**Total**	**$29,913,030**	**$0**	**$29,487,830**	**$100,000**	**$0**
	CF	$1,696,376	$0	$1,642,740	$0	$0
	FF	$21,781,340	$0	$21,433,939	$75,000	$0
	GF	$6,141,964	$0	$6,117,801	$25,000	$0
	RF	$293,350	$0	$293,350	$0	$0
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	**Total**	**$5,724,352,770**	**$0**	**$5,768,568,225**	**($1,389,674)**	**($2,646,627)**
	CF	$622,898,368	$0	$628,705,349	$0	$0
	FF	$3,492,641,948	$0	$3,485,278,253	($708,872)	($1,350,044)
	GF	$1,608,812,454	$0	$1,654,584,623	($680,802)	($1,296,583)

	Total	**$70,648,433**	**$0**	**$74,777,870**	**$2,671,680**	**$5,088,200**
04. Office of Community Living - Adult Supported Living Services	FF	$31,938,485	$0	$34,150,260	$1,362,823	$2,595,490
	GF	$38,709,948	$0	$40,627,610	$1,308,857	$2,492,710

Letternote Text Revision Required?	Yes		No	X	**If Yes, describe the Letternote Text Revision:**
Cash or Federal Fund Name and CORE Fund Number:	FF: Title XIX				
Reappropriated Funds Source, by Department and Line Item Name:	N/A				
Approval by OIT?	Yes		No		**Not Required:** X
Schedule 13s from Affected Departments:	N/A				
Other Information:	N/A				

Cost and FTE

- The Department requests $1,708,633 total funds, including $816,371 General Fund, for FY 2015-16, to expand access to Consumer Directed Attendant Support Services (CDASS) in the Supported Living Services (SLS) Home and Community Based Services (HCBS) waiver, hire a contractor for technical assistance and cost modeling to further expand participant direction, and to hire 1.0 FTE to support program development for Community First Choice (CFC).

Current Program

- CDASS is available in four HCBS waivers, Elderly, Blind and Disabled (HCBS-EBD), Community Mental Health Supports (CMHS), Spinal Cord Injury (SCI) and Persons with Brain Injury waivers (BI).
- The Department conducted a feasibility study on the implementation of the Community First Choice (CFC) delivery system authorized in the Affordable Care Act to help determine the best methodology for the Department to expand participant directed care.

Problem or Opportunity

- HB 05-1243 authorized the Department to expand CDASS to all HCBS waivers. However, the Department's experience has shown that CDASS increases utilization which leads to increased cost so further implementation was delayed for waivers where the additional funding needed was not available, including HCBS-SLS.
- A preliminary report evaluating the feasibility of implementing CFC showed it would be costly and additional modeling is needed.

Consequences of Problem

- The Department would not be able to expand the CDASS service delivery option to HCBS-SLS. Clients in the HCBS-SLS waiver would not have the flexibility and choice in who can provide services and how they are delivered and would continue to receive the current benefits package.
- The Department would not be able to complete the analysis of the CFC option in a robust and timely manner.

Proposed Solution

- Include CDASS in the HCBS-SLS waiver to allow the expansion of participant direction to clients with intellectual and developmental disabilities.
- Hire third party contractors to provide technical assistance, more detailed cost modeling, and stakeholder engagement for continued CFC implementation planning.
- Increase personnel resources for the Department to fully develop and support a cost-effective and high quality participant directed program.

Department Priority: R-7
Request Detail: Participant Directed Programs Expansion

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Participant Directed Programs Expansion	$1,708,633	$816,371

Problem or Opportunity:

Providing access to participant directed service delivery options for all people who meet an institutional level of care is directly related to the Department's goal of improving client experience, health care access and health outcomes as it allows clients choice, control, and flexibility in who provides services and how they are received. Participant direction has also become an important initiative to the Department's federal partner, the Centers for Medicare and Medicaid Services (CMS) as demonstrated through the availability of a new service delivery option included in the Affordable Care Act (ACA). Consumer Directed Attendant Support Services (CDASS) are currently available in Colorado to certain populations through Medicaid Home and Community Based Services (HCBS) waivers. These services allow clients who have personal care, homemaker and/or health maintenance attendant service needs the flexibility to manage their individual budget allocation. This includes the ability to hire attendants who they may already know and who have been trained to provide the services, but who may not be licensed to provide skilled services through a home health agency. Participant direction allows clients to have more control over managing their services which can be especially beneficial to clients in rural areas that may live far from a home care agency. Participant directed programs also offer support for individuals who are employed, allowing them to set their own schedules for attendant services, and to be flexible to accommodate the changing demands associated with working.

After an initial pilot of participant directed services, HB 05-1243 authorized the Department to expand Consumer Directed Attendant Support Services (CDASS) to all HCBS waivers. To date, however, CDASS is only available in four HCBS waivers: the Elderly, Blind and Disabled (HCBS-EBD) waiver; the Community Mental Health Supports (HCBS-CMHS) waiver; the Spinal Cord Injury (HCBS-SCI) waiver; and, the Persons with Brain Injury (BI) waiver. The fiscal note for the authorizing legislation assumed that implementing CDASS would result in significant savings in service costs. However, the Department's experience from implementing the program in the HCBS-EBD waiver has shown that CDASS increases utilization of services which results in increased cost rather than the cost savings initially assumed. As a result, the Department slowed implementation of the program into other HCBS waivers as it strived to understand cost drivers, areas for program improvement and alternate program design possibilities prior to expansion.

One such effort has been the Department's work to analyze the feasibility of a new state plan option, Community First Choice (CFC), which was authorized in the Affordable Care Act (ACA) with final federal rules published by the Centers for Medicare and Medicaid Services (CMS) in February 2012. If the state elects to implement CFC, services are federally required to be available in the State Plan, therefore making them available to all Medicaid beneficiaries who meet an institutional level of care. CFC services are required to be available based upon functional need, and cannot be limited based on age or diagnosis like the current HCBS waivers are. In exchange for making these services widely available, states receive an additional six percentage points on their federal medical assistance percentage. Because of these requirements, CFC implementation would represent a redesign of hundreds of millions of dollars of home and community-based services provided to individuals with disabilities. A preliminary report evaluating the feasibility of implementing CFC[1] was completed in December 2013 for the Department by Mission Analytics and showed that implementing the program within Colorado's current long-term services and supports system would increase annual General Fund expenditure in a range between $46.7 and $79.2 million (between $133.9 and $212.3 million total funds).

Additionally, given the complexities of participant directed service options, and the uncertain implications of the new Department of Labor rule[2] that establishes new requirements for the payment of minimum wage, overtime, and travel time to personal care workers, including family members who are employed as caregivers, the report recommended that the state should seek more in depth technical assistance from experts in the financial, administrative, legal and regulatory complexities of participant directed service options. The report suggested the state would need to make several policy decisions about whether or not to provide health maintenance as a distinct service, and if so, how the Nurse Practice Act would apply, since the majority of skilled services are currently provided through long-term home health, which is a state plan benefit based upon medical necessity requirements, rather than based upon functional need. Additionally, the state would need to address inconsistencies and ambiguity in the current regulations and should conduct additional fiscal analysis based on policy options, which may include placing hard dollar limits on client budgets, changing payment rates, or placing a 120 day limit on the more expensive long-term home health services in order to control costs. The analysis also found that more work is needed to determine what other state plan or waiver services might decrease in utilization with the access to CFC services. While the Department continues to research this option within its current resources, additional funding would be needed in order to complete this analysis in a robust and timely manner.

As the Department continues to research and develop participant directed programs, it has become more apparent that, in addition to contractor funding, additional staff resources are needed to meet the demand of a changing participant direction program. The Department was appropriated 0.5 FTE in HB 05-1243 which

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[1] Feasibility Analysis of Community First Choice in Colorado
http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251923822425&ssbinary=true

[2] http://www.dol.gov/whd/homecare/final_rule.pdf.
In September 2013, the Department of Labor's Wage and Hour Division released a Final Rule entitled "Application of the Fair Labor Standards Act to Domestic Service." The rule amends the Department's prior rule at 29 CFR 552 to better reflect the intent of Congress to expand the class of workers covered by FLSA. At its most basic, the rule narrows the exemptions employers may claim for workers providing "companionship services."

has proven to be insufficient for expanding the program. Participant directed programs are complex and each HCBS waiver has different rules, service definitions and payment methodologies which the program must be designed to adhere to. Additional federal regulations exacerbates program complexity as the Department works to ensure the program meets the needs of the clients while maintaining federal and state regulatory requirements. As these regulations and participant directed programs have many complex elements, stakeholder outreach has proven paramount to the success of the programs over time. The Department meets frequently with stakeholders to understand the needs of the clients and to receive input on policy and programmatic changes.

Proposed Solution:

The Department requests $1,708,633 total funds, comprised of $816,371 General Fund and $892,262 federal funds to implement three initiatives: implement CDASS in the HCBS Supported Living Services (HCBS-SLS) waiver; hire third party contractors to provide technical assistance, cost modeling, and stakeholder engagement for continued CFC implementation planning; and, hire additional personnel resources for the Department to be able to fully implement a cost-effective and high quality participant direction program.

The Department's first initiative is to increase access to participant directed service delivery options for people with intellectual and developmental disabilities by adding CDASS as an available service delivery option for individuals enrolled in the HCBS-SLS waiver effective July 1, 2015. Providing CDASS in the HCBS-SLS waiver would make this participant directed delivery option available to people with intellectual and developmental disabilities who are enrolled in the HCBS-SLS waiver and would provide these clients more service delivery options allowing them to live in the communities in which they choose. The Department believes implementing CDASS in HCBS-SLS could address clients' needs that the traditional delivery option may not be meeting, such as limited providers in rural areas and provider capacity issues. Additionally, CDASS could improve client's quality of life by empowering them to select, train and manage the attendants of their choice and to have more control in scheduling their services.

Prioritizing CDASS availability in the HCBS-SLS waiver is important for several reasons. Most importantly, it would be an incremental step towards expanding participant direction to all populations as authorized by the General Assembly in 2005. Additionally, it would provide the Department with experience in implementing a participant directed program for people with intellectual and developmental disabilities (IDD), which would allow the Department to prepare for a larger expansion of participant direction for individuals with IDD. Understanding how participant directed services are successful, and where potential gaps might be, is imperative to understanding and developing the service for all adult IDD clients. The Department estimates that it would be able to implement CDASS on July 1st, 2015 because of its previous experience with adding CDASS as a service delivery option in other HCBS waivers. The Department plans to use existing funding to conduct outreach and training to individuals, families, case managers and providers prior to July 1st. Additionally, the Department is prepared to have rules, waiver amendments, and processes for operations in place by this date.

Additionally, the Department requests contractor resources for technical assistance, cost modeling and stakeholder engagement necessary for regulatory review of participant directed service delivery options, and continued CFC development and implementation planning. The contract would have multiple scopes of work

including regulatory review of CDASS and other participant directed programs and recommendations for improvement, which would be done through a modified Benefits Collaborative process. This process would encourage further stakeholder involvement in creating a coherent and consistent participant directed benefit prior to expansion to all populations, potentially through CFC. The Benefits Collaborative is a public process that ensures standards are based on the best available clinical evidence; outline the appropriate amount, duration, and scope of services; set reasonable service limits; and promote the health and functioning of clients. By defining regulations through the Benefits Collaborative process and including amount, scope and duration parameters in rule, the Department sets these standards in an effort to ensure appropriate utilization, equity, and consistency in the delivery of Medicaid services. Clearly defined standards help improve guidance for service providers, increase client understanding of their benefits and ensure responsible allocation of taxpayer dollars. This process would be modified slightly as the efficacy of home and community-based services are not based solely on clinical evidence and outcome measurement also needs to include national best practices and quality of life measurements.

The contractor would also collaborate with the Department and stakeholder groups on further policy analysis and technical assistance on participant direction related to the recommendations made in the CFC feasibility study. This includes stakeholder outreach and policy analysis related to health maintenance services and the Nurse Practice Act, quality improvement and participant directed service delivery options. This also includes work related to developing a consistent and financially sustainable policy for payment to family members who are paid to provide care for children, based upon national best practices. This scope of work would also include contracting with an actuary for more detailed pricing and financial modeling for expanding participant direction, possibly through CFC. The Department assumes the contracted work described above would be completed over a two year period, beginning in FY 2015-16.

Lastly, the Department requests funding for one additional program staff to support participant directed services implementation and operation efforts and to provide support to the CFC Development and Implementation Council. Staff resources are essential to plan and prepare for implementation of participant directed service delivery options to all populations, which may include CFC. Further, the Benefits Collaborative process is a labor intensive process on staff and to do this well, more staff would be needed. Detailed description of duties can be found below. Though 0.5 FTE were appropriated through HB 05-1243, the current Department staffing structure does not allow the significant program oversight that is required to run an expanded CDASS program. Currently there is one FTE responsible for all policy, program development and stakeholder engagement related to CDASS and In Home Support Services (IHSS), and a second staff position that manages the contract for Fiscal Management Services (FMS) for CDASS, among other responsibilities. Additionally, the Division for Intellectual and Developmental Disabilities has assigned one FTE to implementing participant direction. The current staffing structure and the associated work volume does not support program development, management and evaluation for participant directed options as they currently exist, nor does it support innovation or additional growth.

The Department's request for staffing resources also supports continuing the CFC Council meetings and to continue with CFC implementation planning efforts. The CFC Development and Implementation Council, established in 2012, meets federal requirements at 42 CFR § 441.575 that the state "consult and collaborate with this Council, made up of a majority of people with disabilities, the elderly and their representatives,

when writing the State Plan Amendment." Possible implementation of CFC, represents a redesign of the delivery of services and requires changes to all aspects of the HCBS system. Effective outreach and community involvement is imperative to ensure the program meets the needs of the clients and other stakeholders, while also creating an efficient and effective program.

In an effort to reduce inconsistencies and create a more robust program, the Department, in collaboration with stakeholders, has developed two work plans for CDASS and IHSS that require intensive deliberation and action. In order to fully implement these work plans more staff are needed. Additionally, there are two audits on participant directed services currently underway (by the Colorado Medicaid Fraud and Control Unit and the Office of State Auditor) and the Department anticipates staff would be needed to implement resulting audit recommendations and program improvements identified through these audits. While the Department's commitment to stakeholder engagement adds tremendous value to policies and decisions, it also requires additional time and staffing resources. The detailed job duties are provided below.

Descriptions of Requested Position

POSITION TITLE	FTE	JOB CLASS	JOB DUTIES
Participant Direction Policy Coordinator	1.0	General Professional IV	This position would oversee and manage the CFC implementation planning process, including: collaborating with staff across and outside the Department; planning for systems changes; benefits design; changes to case management; fiscal and policy analysis and recommendations; coordination with stakeholder groups and other state agencies; outreach and communications; communication with CMS; drafting state plan and waiver amendments; and, coordination regarding legislation. The position would collaborate with the CFC contractor to co-facilitate the CFC Development and Implementation Council and lead the administrative and policy support required for the Benefits Collaborative process. The position would coordinate policy and programmatic efforts between CFC, waiver services, and, other state plan services. This position would take the lead role in managing CFC contractor on cost analysis and program evaluation of current participant directed options.

Anticipated Outcomes:

Approval of this request would ensure that individuals with intellectual and developmental disabilities who are enrolled in the HCBS-SLS waiver have access to a participant directed service delivery option. The autonomy, choice, and control that comes with directing one's own services results in a more positive client

experience and has shown to improve quality of life. This is consistent with the Customer-Benefits/Program Design goal of "Improving health outcomes, client experiences and lower per capita costs" of the Department's Performance Plan.

Additionally, the Department anticipates contractor and staff resources to assist with defining the participant directed benefit through a modified Benefits Collaborative process would allow the Department to make changes to the rules that govern the benefit in order to provide consistency across populations. This, along with more detailed and in depth fiscal analysis would allow the Department to make a determination on whether or not to move forward with CFC, and would help clients, case managers and providers better understand the programs.

The requested FTE would allow the Department to focus resources on these programs for monitoring and ongoing programmatic development supporting participant directed programs and to make progress on expanding participant direction in a more cost-effective manner, which is consistent with the Department's financing goal of "Ensuring Sound Stewardship of Financial Resources" in the Department's FY 2014-15 Performance Plan.

Assumptions and Calculations:

Implement CDASS in the HCBS-SLS waiver:

In order to estimate the costs associated with implementing CDASS in the HCBS-SLS waiver, the Department made a number of assumptions about how the program would be implemented. These assumptions are narrated below.

Caseload Assumptions

The Department assumes clients would begin enrollment in the program on July 1, 2015. Given the experience of implementing CDASS in the HCBS-EBD waiver, the Department assumes a one year ramp-up period as it would take time for clients to be assessed, receive allocations, and hire attendants. The Department assumes a uniform enrollment increase over twelve months, reaching full enrollment in the twelfth month; the Department assumes full enrollment for the entire second year. The anticipated CDASS enrollment rate for HCBS-SLS is based on the CDASS enrollment rate for HCBS-EBD for FY 2012-13 of 12.65%. Detailed calculation documentation can be found in tables 6.1 and 6.2.

The Department anticipates that not all clients would utilize CDASS, based on its experience with participant directed programs in other waivers. To estimate the number of clients who would utilize CDASS, the Department assumes that the proportion of clients in the HCBS-SLS waiver who choose to utilize CDASS would be approximately equal to the proportion of clients who utilize CDASS in the HCBS-EBD waiver. CDASS has been included as a service delivery option in HCBS-EBD for several years and has become a mature benefit with stabilized enrollment and utilization which provides a good foundation for determining the potential impacts of implementation of CDASS in other waivers. The utilization proportion is applied to the anticipated CDASS enrollment figures for HCBS-SLS which are based on the HCBS-SLS caseload forecast from the Department's FY 2015-16 R-5 "Office of Community Living Cost and Caseload Adjustments" budget request.

CDASS Service Cost Assumptions

To estimate the cost of implementing CDASS in the HCBS-SLS waiver the Department assumed costs would be impacted in two areas: long-term home health and HCBS waiver services costs.

First, the Department assumes that clients would substitute long-term home health in the state plan with health maintenance services provided under CDASS as a service in the HCBS-SLS waiver. This would generate a cost shift between long-term home health services and waiver services. The Department assumes that the average cost of long-term home health services for clients that enroll in CDASS in HCBS-SLS would be $0 because long-term home health costs for HCBS-EBD clients that enrolled in CDASS were less than 1% of the cost compared with long-term home health costs for HCBS-EBD clients that did not enroll in CDASS. When calculating average per client long-term home health costs, the Department included the cost for all clients on the waiver which included many clients that had no expenditure. Detailed documentation of the state plan, long-term home health savings calculation can be found in table 5.1.

Next, the Department assumes that there would be an increase in waiver costs from implementing CDASS in HCBS-SLS. The Department anticipates that the cost increase would come from two sources. First, clients who select CDASS would change utilization from state plan home health services to health maintenance services covered under the HCBS waiver. Second, based on the Department's experience with CDASS in HCBS-EBD, is that clients that have a higher potential for utilization of services and features offered through CDASS would be more likely to enroll. Based on trends associated with the CDASS benefit in HCBS-EBD, the Department anticipates that the average utilization of authorized personal care and homemaker services for HCBS-SLS clients that enroll in CDASS would be higher than the average utilization of those authorized services for clients that do not enroll (detailed in table 6.4). The Department anticipates that the average prior authorized amount for CDASS services would be increased after an HCBS-SLS client enrolls in CDASS compared with the prior authorized amount for similar services (personal care, homemaker, and long-term home health) prior to enrolling (detailed in table 6.3). The Department estimated this increase in utilization by analyzing changes in utilization for HCBS-EBD clients who selected CDASS as their service delivery option during calendar year 2013. While the reasons for this increase needs to be studied further, it is likely due to individuals having greater flexibility in who provides services which allows their identified need for services to be more fully met.

The Department assumes that HCBS-SLS clients that enroll in CDASS would not change their utilization of all other waiver services or acute care services because there would be no change in need or access to these services from implementing CDASS in HCBS-SLS.

The Department assumes that the cost of all waiver services normally reimbursed within the HCBS-SLS service plan authorization limit (SPAL) associated with each client's individual support level would continue to be reimbursed within the SPAL for clients that enroll in CDASS in HCBS-SLS with the exception of the additional health maintenance service, which would be reimbursed outside the SPAL and the individual cost maximum of $45,500. The Department assumes that reimbursement of health maintenance services outside of the SPAL for HCBS-SLS clients that enroll in CDASS would be consistent with existing reimbursement of long-term home health services, as health maintenance is a general substitute for long-term home health.

Administration Fee Cost Assumptions

The current CDASS program is administrated through a financial management services (FMS) contractor. This contractor reviews time sheets from attendants, pays attendants for services, provides training to new and existing clients and attendants, etc. This contractor is currently paid a per member per month (PMPM) administration fee for these services. When implementing CDASS in HCBS-SLS, the Department assumes monthly administration fees and attendant training cost for HCBS-SLS clients would also not be included in the SPAL or the individual cost maximum. The cost of monthly administration fees and attendant training would be additional costs to the Department and would not replace or offset the cost of a similar service. When calculating the total cost of monthly administration fees and attendant training for clients that enroll in CDASS in HCBS-SLS, the Department assumes that the rate would be the equal to the rate in effect for CDASS in HCBS-EBD. This rate is, however, currently in flux as the Department procures new FMS vendors and a Training and Operations vendor. The Department's estimate is based on a range of potential PMPM costs from the scope of work released in the Request for Proposals (RFP). Detailed calculation documentation can be found in table 7.1.

System Change Costs

The Department assumes changes for modifying the existing Prior Authorization Request (PAR) in the Medicaid Management Information System related to implementing CDASS in HCBS-SLS waiver would cost $100,000 total funds. This estimate is preliminary and the Department is working with the contractor for a more detailed cost and time estimate. This systems change would modify the way the claims decrement on the HCBS-SLS PARs from the header level to the claims level and would require changes to the way claims decrement for one specific line using roll-up codes. This change would occur after the July 1, 2015 CDASS implementation date; therefore, the Department would implement a temporary manual process at time of implementation to ensure that clients would be able to access the new service option as soon as possible. In order to ensure compliance with correct coding and reporting requirements, however, the Department would need the systems changes completed as soon as possible.

Contractor Costs:

The Department assumes that it would use a competitive bidding process to hire the CFC contractor for technical assistance, cost modeling and stakeholder engagement for regulatory review of participant directed service delivery options, and continued CFC development and implementation planning. The total estimate of $500,000 (detailed in table 4.1) in this request is based upon an estimate provided by the contractor who completed the CFC Feasibility study and assumes that the work would be complete in 24 months, beginning in FY 2015-16. This estimate is based upon having a prime contractor and sub-contractors, including actuaries, at varying hourly rates and also includes travel costs for in person meetings with stakeholders and Department staff.

Additionally, the Department assumes extensive stakeholder outreach would be necessary to implement CDASS in HCBS-SLS by July 1, 2015. Because of the complexity of managing services within and outside of the SPAL limit, the Department plans to work with HCBS-SLS clients and families to develop an allocation process. Because this outreach would need to be completed before implementation, the Department assumes it would use existing FY 2014-15 funding for this stakeholder outreach and education.

FTE Costs:

The Department's request includes base salaries, fringe benefits and operating costs for 1.0 FTE. Detailed calculation documentation can be found in table 3.1.

R-7 Participant Directed Programs Expansion
Appendix A: Calculations and Assumptions

Table 1.1 - FY 2015-16 Estimated Cost Summary by Line Item								
FY 2015-16	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Total Request	**$1,708,633**	**0.9**	**$816,371**	**$0**	**$0**	**$0**	**$892,262**	
(1) Executive Director's Office; (A) General Administration, Personal Services	$58,479	0.9	$29,240	$0	$0	$0	$29,239	50.00%
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$7,927	0.0	$3,964	$0	$0	$0	$3,963	50.00%
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$115	0.0	$58	$0	$0	$0	$57	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$2,306	0.0	$1,153	$0	$0	$0	$1,153	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$2,227	0.0	$1,114	$0	$0	$0	$1,113	50.00%
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$5,573	0.0	$2,787	$0	$0	$0	$2,786	50.00%
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	$250,000	0.0	$125,000	$0	$0	$0	$125,000	50.00%
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Medicaid Management Information System Maintenance and Projects	$100,000	0.0	$25,000	$0	$0	$0	$75,000	75.00%
(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($1,389,674)	0.0	($680,802)	$0	$0	$0	($708,872)	51.01%
(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs, Adult Supported Living Services	$2,671,680	0.0	$1,308,857	$0	$0	$0	$1,362,823	51.01%

Table 1.2 - FY 2016-17 Estimated Cost Summary by Line Item								
FY 2016-17	**Total Funds**	**FTE**	**General Fund**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**
Total Request	**$2,769,835**	**1.0**	**$1,360,259**	**$0**	**$0**	**$0**	**$1,409,576**	
(1) Executive Director's Office; (A) General Administration, Personal Services	$63,800	1.0	$31,900	$0	$0	$0	$31,900	50.00%
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$7,927	0.0	$3,964	$0	$0	$0	$3,963	50.00%
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$126	0.0	$63	$0	$0	$0	$63	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$2,744	0.0	$1,372	$0	$0	$0	$1,372	50.00%
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$2,715	0.0	$1,358	$0	$0	$0	$1,357	50.00%
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$950	0.0	$475	$0	$0	$0	$475	50.00%
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	$250,000	0.0	$125,000	$0	$0	$0	$125,000	50.00%
(2) Medical Services Premiums; Medical and Long-Term Care Services for Medicaid Eligible Individuals	($2,646,627)	0.0	($1,296,583)	$0	$0	$0	($1,350,044)	51.01%
(4) Office of Community Living; (A) Division of Intellectual and Developmental Disabilities; (2) Program Costs, Adult Supported Living Services	$5,088,200	0.0	$2,492,710	$0	$0	$0	$2,595,490	51.01%

Table 2.1 - Summary by Initiative				
Row	**Item**	**FY 2015-16**	**FY 2016-17**	**Source/Calculation**
A	Estimated FTE Costs	$76,627	$78,262	Table 3.1
B	Estimated Contractor Costs	$250,000	$250,000	Table 4.1, Row E
C	Estimated Cost of Systems Changes	$100,000	$0	Placeholder
D	Estimated Long Term Home Health Cost Shift	($1,389,674)	($2,646,627)	Table 5.1, Row E
E	Estimated SLS Waiver Services Costs	$2,037,053	$3,879,557	Table 6.6, Row C
F	Estimated Administration Fees	$634,627	$1,208,643	Table 7.1, Row G
G	**Estimated Total Cost**	**$1,708,633**	**$2,769,835**	Sum of Rows A through F

Table 3.1 FTE Calculations

Calculation Assumptions:

Operating Expenses -- Base operating expenses are included per FTE for $500 per year. In addition, for regular FTE, annual telephone costs assume base charges of $450 per year.

Standard Capital Purchases -- Each additional employee necessitates the purchase of a Personal Computer ($900), Office Suite Software ($330), and office furniture ($3,473).

General Fund FTE -- New full-time General Fund positions are reflected in FY 2015-16 as 0.9166 FTE to account for the pay-date shift.

Expenditure Detail		FY 2015-16		FY 2016-17	
Personal Services:		FTE		FTE	
Participant Direction Policy Coordinator (General Professional IV)	$ 4,764	0.9	52,400	1.0	57,168
PERA			5,319		5,803
AED			2,306		2,744
SAED			2,227		2,715
Medicare			760		829
STD			115		126
Health-Life-Dental			7,927		7,927
Subtotal Position 1, 1.0 FTE		0.9	**$ 71,054**	1.0	**$ 77,312**
Subtotal Personal Services		0.9	**$ 71,054**	1.0	**$ 77,312**
Operating Expenses					
Regular FTE Operating	500	0.9	458	1.0	500
Telephone Expenses	450	0.9	412	1.0	450
PC, One-Time	1,230	1.0	1,230		
Office Furniture, One-Time	3,473	1.0	3,473		
Subtotal Operating Expenses			**$ 5,573**		**$ 950**

TOTAL REQUEST	0.9	**$ 76,627**	1.0	**$ 78,262**
General Fund:		*$ 38,314*		*$ 39,131*
Cash funds:		*$ -*		*$ -*
Reappropriated Funds:		*$ -*		*$ -*
Federal Funds:		*$ 38,314*		*$ 39,131*

Table 4.1 - Estimated Cost of Consultant Contract				
Row	**Item**	**FY 2015-16**	**FY 2016-17**	**Source/Calculation**
A	Project Management	$31,687	$31,687	Estimate from contractor
B	Ad Hoc Reports, Memos, and Presentations	$82,321	$82,321	Estimate from contractor
C	Cost Model	$51,668	$51,668	Estimate from contractor
D	Benefits Collaborative and Rule Review	$84,325	$84,325	Estimate from contractor
E	**Total**	**$250,000**	**$250,000**	Sum of Rows A through D

Table 5.1 - Estimated Long Term Home Health (LTHH) Services Savings from Implementing Consumer Directed Attendant Support Services (CDASS) in the Supported Living Services Waiver (SLS)				
Row	**Item**	**FY 2015-16**	**FY 2016-17**	**Source/Calculation**
A	Estimated Current Average Annual Cost of LTHH Services per SLS-non-CDASS Client	$3,903.58	$3,903.58	MMIS claims data from FY 2012-13; trended with 2.0% rate increases each year in FY 2013-14 and FY 2014-15
B	Estimated Average Annual Cost of LTHH Services per SLS-CDASS Client	$0	$0	See narrative
C	Estimated LTHH Savings per Client	($3,903.58)	($3,903.58)	Row B - Row A
D	Estimated Number of SLS-CDASS Utilizers	356	678	Table 6.2, Row C
E	**Estimated Total Savings to Medical Services Premiums**	**($1,389,674)**	**($2,646,627)**	Row C * Row D

Table 6.1 - Consumer Directed Attendant Support Services (CDASS) Utilization Penetration Rate for Clients on the Elderly, Blind, and Disabled Waiver (EBD)					
Row	**Item**	**FY 2010-11**	**FY 2011-12**	**FY 2012-13**	**Source/Calculation**
A	Number of EBD-CDASS Utilizers	1,721	2,190	2,659	MMIS claims data
B	Number of EBD Clients (CDASS and non-CDASS)	19,373	20,344	21,012	MMIS claims data
C	**EBD-CDASS Utilization Penetration Rate**	**8.88%**	**10.76%**	**12.65%**	Row A / Row B

Table 6.2 - Estimated Supported Living Services Waiver (SLS) CDASS Utilization				
Row	**Item**	**FY 2015-16**	**FY 2016-17**	**Source/Calculation**
A	Estimated Number of SLS Clients	5,210	5,357	Estimated number of full program equivalents from the Department's FY 2015-16 R-5 "Office of Community Living Cost and Caseload Adjustments" budget request
B	Estimated SLS-CDASS Utilization Penetration Rate	6.83%	12.65%	FY 2015-16: Uniform penetration rate ramp-up; FY 2016-17: Table 6.1, Row C
C	**Estimated Number of SLS-CDASS Utilizers**	**356**	**678**	Row A * Row B

Table 6.3 - Average Increase in Authorized Amount for Services from Implementing EBD in CDASS			
Row	**Item**	**CY 2013**	**Source/Calculation**
A	Average Prior Authorized Amount for EBD Clients Prior to Enrolling in CDASS	$17,587.01	MMIS - Prior Authorization Request (PAR) data; procedure codes for CDASS-like services (Personal Care, Homemaker, LTHH)
B	Average Increase in Prior Authorized Amount for EBD Clients After Enrolling in CDASS	$21,705.24	MMIS - PAR data; procedure codes for CDASS services
C	**Percentage Increase in Authorized Amount from Implementing CDASS in EBD**	**23.42%**	(Row B - Row A) / Row A

Note: The comparison in this table is restricted to only those clients who selected CDASS as their service delivery option. Prior authorized amounts for clients who have never selected CDASS are excluded.

Table 6.4 - Average Percentage Utilization of Authorized Services for EBD-CDASS Clients as Percent of EBD-non-CDASS Clients			
Row	**Item**	**CY 2013**	**Source/Calculation**
A	Average Percentage Utilization of Authorized Services for EBD-non-CDASS Clients	62.82%	MMIS - PAR data; procedure codes for CDASS-like services (Personal Care and Homemaker)
B	Average Percentage Utilization of Authorized Services for EBD-CDASS Clients	80.83%	MMIS - PAR data; procedure codes for CDASS services
C	**Percentage Increase in Utilization of Authorized Services from Implementing CDASS in EBD**	**28.67%**	(Row B - Row A) / Row A

Table 6.5 - Estimated Average Annual Cost of Waiver Services for SLS-CDASS Clients				
Row	**Item**	**FY 2015-16**	**FY 2016-17**	**Source/Calculation**
A	Estimated Average Annual Cost of Personal Care and Homemaker Waiver Services per SLS Client	$1,537.75	$1,537.75	FY 2012-13 MMIS claims data; trended with 4.0% (FY 2013-14) and 2.5% (FY 2014-15) rate increases
B	Estimated Percentage Increase in Utilization of Authorized Services from Implementing CDASS in SLS	28.67%	28.67%	Table 6.4, Row C
C	Initial Estimated Average Annual Cost of Personal Care and Homemaker Services per SLS-CDASS Client	$1,978.62	$1,978.62	Row A * (1 + Row B)
D	Initial Estimated Average Annual Cost of Health Maintenance Services per SLS-CDASS Client	$3,903.58	$3,903.58	Table 5.1, Row A; see narrative for assumption
E	Initial Estimated Average Annual Cost of Waiver Services per SLS-CDASS Client	$5,882.20	$5,882.20	Row C + Row D
F	Estimated Percentage Increase in Authorized Amount from Implementing CDASS in SLS	23.42%	23.42%	Table 6.3, Row C
G	Final Estimated Average Annual Cost of Waiver Services per SLS-CDASS Client	$7,259.81	$7,259.81	Row E * (1 + Row F)
H	**Estimated Increase in Cost Waiver Services per SLS-CDASS Client**	**$5,722.06**	**$5,722.06**	Row G - Row A

Table 6.6 - Estimated Increase in Total Cost of Waiver Services from Implementing CDASS in SLS				
Row	**Item**	**FY 2015-16**	**FY 2016-17**	**Source/Calculation**
A	Estimated Increase in Cost Waiver Services per SLS-CDASS Client	$5,722.06	$5,722.06	Table 6.5, Row H
B	Estimated Number of SLS-CDASS Utilizers	356	678	Table 6.2, Row C
C	**Estimated Increase in Total Cost of Waiver Services**	**$2,037,053**	**$3,879,557**	Row A * Row B

Table 7.1 - Estimated Total Administration Fees				
Row	**Item**	**FY 2015-16**	**FY 2016-17**	**Source/Calculation**
A	Estimated Average Number of Waiver Months Per Client for SLS-CDASS Clients	11	11	MMIS claims data; average waiver months per SLS client from FY 2010-11 through FY 2012-13
B	Estimated Per Client, Per Month Administration Fee for EBD-CDASS Clients	$107.06	$107.06	Average of potential contract award amount range (Range: $103 to $111.11)
C	Estimated Per Client, Per Month Attendant Training Costs for EBD-CDASS Clients	$55.00	$55.00	Average of potential contract award amount range (Range: $50.00-$60.00)
D	Total Estimated Per Client, Per Month Administration Fee and Attendant Training Costs for EBD-CDASS Clients	$162.06	$162.06	Row B + Row C
E	Estimated Average Annual Cost of Administration Fees Per SLS-CDASS Client	$1,782.66	$1,782.66	Row A * Row D
F	Estimated Number of SLS-CDASS Utilizers	356	678	Table 6.2, Row C
G	**Estimated Total Cost of Administration Fees that Would Result from Implementing CDASS in SLS**	**$634,627**	**$1,208,643**	Row E * Row F

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-08

Request Titles

R-08 Children With Autism Waiver Expansion

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
OSPB Approval By:			Base Reduction FY 2015-16
			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$6,298,497,758	$0	$6,343,746,027	$10,616,568	$19,042,713
	FTE	360.4	-	360.6	-	-
	GF	$1,788,619,424	$0	$1,834,048,014	$367,564	$8,830,589
	CF	$630,109,143	$0	$635,952,455	$4,840,203	$508,566
	RF	$1,885,519	$0	$1,920,262	$0	$0
	FF	$3,877,883,672	$0	$3,871,825,296	$5,408,801	$9,703,558

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - Personal Services	Total	$26,043,374	$0	$26,913,985	$115,736	$62,000
	CF	$2,676,189	$0	$2,746,161	$0	$0
	FF	$12,679,416	$0	$13,118,575	$57,868	$31,000
	FTE	360.4	-	360.6	-	-
	GF	$8,802,250	$0	$9,128,987	$57,868	$31,000
	RF	$1,885,519	$0	$1,920,262	$0	$0
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	Total	$5,724,352,770	$0	$5,768,568,225	$10,205,160	$18,234,642
	CF	$622,898,368	$0	$628,705,349	$4,840,203	$508,566
	FF	$3,492,641,948	$0	$3,485,278,253	$5,200,111	$9,291,987
	GF	$1,608,812,454	$0	$1,654,584,623	$164,846	$8,434,089
03. Behavioral Health Community Programs - Behavioral Health Capitation Payments	Total	$548,101,614	$0	$548,263,817	$295,672	$746,071
	CF	$4,534,586	$0	$4,500,945	$0	$0
	FF	$372,562,308	$0	$373,428,468	$150,822	$380,571
	GF	$171,004,720	$0	$170,334,404	$144,850	$365,500

Letternote Text Revision Required?	Yes		No	X	**If Yes, describe the Letternote Text Revision:**
Cash or Federal Fund Name and CORE Fund Number:	FF: Title XIX CF: Autism Cash Fund (18A0)				
Reappropriated Funds Source, by Department and Line Item Name:	N/A				
Approval by OIT?	Yes		No	**Not Required:**	X
Schedule 13s from Affected Departments:	N/A				
Other Information:	N/A				

Cost and FTE

- The Department requests $10,616,568 total funds, $367,564 General Fund, $4,840,203 Cash Funds and $5,408,801 federal funds to eliminate the Children with Autism (CWA) waiver enrollment cap, allow for a one-time increase to the expenditure cap and allow it to fluctuate, increase the age limit to eight, allow for three years stay, and continue the waiver effectiveness evaluation. Funding is ongoing and includes a temporary FTE.

Current Program

- The CWA waiver provides behavioral therapy to children, from birth to six, with an autism diagnosis. The waiver is capped at 75 clients, average enrollment age is five-and-a-half, and clients have a $25,000 expenditure cap on waiver services which are funded by the Autism Treatment Fund.

Problem or Opportunity

- There are 320 clients waiting to enroll on the CWA waiver. The Department request to eliminate the waiver enrollment cap, allowing the cap to fluctuate.
- Research suggests treatment is most effective if received before eight, for 20 to 40 hours per week, for three years. The Department requests to increase the age limit to eight and to allow for three year stay on the waiver.
- If clients were on the waiver for a full year, they would spend more than the current expenditure cap. The Department requests a one-time increase of the expenditure cap to $30,000, allowing the cap to fluctuate.
- To manage the number of new enrollees on the waiver the Department requests to increase funding to Community Centered Boards (CCBs) for case management and utilization review.
- The Autism Treatment Fund can only be used for services provided under the waiver; all other services are General Fund. The Department request that any remaining funds would be used to finance state plan expenditures for new and existing enrollees until the fund is depleted.

Consequences of Problem

- If this request is not funded children with ASD will continue to wait for services, or will not have the proper choice of services, when services are appropriate and effective if received properly.

Proposed Solution

- The Department requests $10,500,832 in order to eliminate the enrollment cap, allow for a one-time increase to the expenditure cap, and allow it to fluctuate, increase the age limit to eight and allow for three years on the waiver, and to fund CCBs for case management and utilization review.
- The Department requests $53,736 for a temporary FTE for enrollment and waitlist management and $62,000 to continue the waiver effectiveness evaluation on an annual basis.
- The request requires statutory changes.

Department Priority: R-8
Request Detail: Children with Autism Waiver Expansion

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Children with Autism Waiver Expansion	$10,616,568	$367,564

Problem or Opportunity:

The Children with Autism (CWA) waiver provides intensive behavioral intervention and treatment for children with autism spectrum disorder (ASD). Currently, the waiver has an enrollment cap of 75 clients per year with 320 children waiting to enroll. The CWA waiver is the only Medicaid children's waiver that has a waitlist. The average wait time for enrollment is approximately two-and-a-half years and once clients do enroll, the average length of stay on the waiver is less than a year. The CWA waiver has an age limit of six, but due to the size of the waitlist, children are not able to enroll in the waiver until after they turn five, leaving less than a year for intervention and treatment. This is not enough time to provide an impact to clients and is an inefficient use of limited State resources as the treatments and interventions are ineffective if not received for a longer duration.

Section 25.5-6-804(2), C.R.S. limits expenditure to $25,000 per client per year for behavioral intervention and treatment. The statutory expenditure cap on CWA services has never changed and because of this CWA service rates have remained fixed. CWA service rates have remained constant because a rate increase would lead to less services rendered under the cap creating a needs gap, while a decrease would allow for more utilization. Under either a rate increase or decrease total expenditure would remain constant with either clients receiving less services or providers rendering more services, respectively. Waiver services are funded by the Autism Treatment Cash Fund which receives $1,000,000 per year from the Master Tobacco Settlement. Due to the nature of the funding, CWA waiver expansion and expenditure cap increases are limited to excess funds from previous years and the annual deposit. SB 12-159 added section 25.5-6-804(9), C.R.S. requiring the Department to evaluate the Autism Treatment Fund annually to see if the fund can support higher enrollment.[1] The Autism Treatment Fund can be used for waiver services, but no other services for CWA clients; all other services are funded through the General Fund. The Department cannot unilaterally expand enrollment in the CWA waiver due to the General Fund impact.

[1] http://www.leg.state.co.us/clics/clics2012a/csl.nsf/fsbillcont/C1DDCDA66EA9EFF98725799600525A78?Open&file=159_enr.pdf

The Department initially managed the waitlist by tenure on the waitlist, or first come first serve, but now manages the waitlist by clients with imminent need. SB 12-159 also added section 25.5-6-804(10), C.R.S. which requires the Department to manage the waitlist by prioritizing clients with imminent needs ahead of clients with lesser needs.[1] In November 2013, the Department implemented the objective prioritization procedure which prioritizes the enrollment for children with the highest needs before children with lesser needs. Although children with higher needs are now prioritized for services, the waitlist has grown since the inception of the prioritization procedure.[2]

In July 2014, the Centers for Medicare and Medicaid Services (CMS) released an informational bulletin entitled "Clarification of Medicaid Coverage of Services to Children with Autism", describing the various options available to states to provide coverage for children with ASD.[3] In particular, CMS noted that coverage for certain services for children can be provided via multiple different Medicaid authorities including the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program, and that "if a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a state's Medicaid State Plan, the state will nonetheless need to arrange for and cover it for the child as long as the service or supply is included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act." Although the Department covers the required services under its EPSDT program, there remain a significant number of children who are on the waitlist but do not currently have access to Medicaid because they are over income without access to the waiver program.

Proposed Solution:

The Department requests $10,616,568 total funds, $367,564 General Fund, in FY 2015-16 and $19,042,713 total funds, $8,830,589 General Fund, in FY 2016-17 to eliminate the enrollment cap, increase the age limit to eight, allow for a maximum of three years of stay on the waiver if enrolled before eight, increase the expenditure cap and allow for it to fluctuate, increase funding to Community Centered Boards (CCBs) for case management and utilization review, and continue the program evaluation on a yearly basis. Funding would be ongoing and would require a temporary FTE in FY 2015-16 for enrollment and waitlist management and would require statutory changes.

Eliminating the enrollment cap, which currently is set at 75 clients, would also eliminate the waitlist for the CWA waiver. The Department estimates that about 549 unique clients would enroll within the first year of eliminating the enrollment cap, with the monthly average enrollment for the year totaling 370. In addition to eliminating the waitlist, eliminating the enrollment cap would allow for natural caseload growth in future years. The most recent autism prevalence estimates from the Autism and Developmental Disabilities Monitoring Network (ADDM), which were released by the Center for Disease Control (CDC) in March 2014, show that overall, 1 in 68 8-year-old children were identified with autism. This is roughly a 30% increase from the previous estimate done in 2008, where the prevalence of ASD across the 11 areas of the United States was 1 in 88.[4] The ADDM covers 11 areas of the United States, including the Denver metropolitan

[2] http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251907375582&ssbinary=true
[3] http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf
[4] http://www.cdc.gov/features/dsautismdata/index.html

area where 1 in 101 8-year-old children were identified with ASD.[5] Children being diagnosed with ASD is on the rise nationally and in Colorado, leading to a greater need for behavioral intervention and treatment. Eliminating the enrollment cap would provide much needed access to behavioral intervention and treatment for children in Colorado.

Increasing the age limit from six to eight would allow more Medicaid children to have access to behavioral intervention and treatment by the recommended age and coverage would be more in line with the private insurance market. According to the Lovaas Institute, a leading provider of behavioral treatment for children diagnosed with ASD, intervention should take place between ages two and eight, but no later than twelve.[6] Coupled with the increased age limit, allowing for children to stay on the wavier for a maximum of three years, as long as they are enrolled before the age of eight, would further ensure the delivery of services for the recommended time frame. A recent policy brief by the Center for Evidence-based Policy suggests that early intensive behavioral intervention (EIBI) therapies should be received for 25 to 40 hours for up to three years.[7] For intensive behavior therapies to benefit children most, services must be received for three years. Covering Medicaid children with ASD up to a maximum age of 11 would ensure the proper treatment duration, no matter when a child is enrolled in the waiver. Further, Autism Speaks, an autism advocacy organization that sponsors autism research, says that some preschoolers who received intensive behavioral therapy for two or more years "acquire sufficient skills to participate in regular classrooms with little or no additional support".[8] By allowing more kids with ASD to receive behavioral intervention and treatment earlier, kids would have more success interacting with their peers. Allowing access to a wider age range and allowing for a maximum of 3 years on the waiver would provide needed behavioral treatment and intervention to a wider number of Colorado children with ASD.

The Department is also requesting to continue the CWA waiver program evaluation, and to perform the evaluation on a yearly basis. SB 12-159 added section 25.5-6-806(2)(C), C.R.S. which instructs the Department to perform a program evaluation on or before June 1, 2015 and allows for the Department to contract with an independent program evaluator.[1] The Department has solicited a contractor to perform the one-time program evaluation which is currently on track to be complete prior to June 1, 2015. Evaluations of intensive behavioral intervention and treatment on children with ASD ages 2 through 8 have been shown to be most effective if rendered for three years. The recent policy brief by the Center for Evidence-based Policy states that "Evidence suggests that early intensive behavioral intervention (EIBI) may improve core areas of deficit (e.g., IQ scores, language skills, adaptive behavior skills) for individuals with ASDs. However, randomized controlled trials (RCTs) are few and include small numbers of participants" (Leof, Kriz, Pinson, and Mayer, 3).[7] Although research has shown behavioral intervention and treatment to be effective for treatment of children with ASD, the results are based on small sample sizes. Allowing for the expansion of the waiver and changing the rules would not only allow for the proper treatment of a larger number of children with ASD, but would allow for more data gathering and for current research to be

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[5]Baio, Jon. "Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2010", Surveillance Summaries 63(SS02);1-21, March 28, 2014.
[6]http://www.lovaas.com/approach-suitable.php\
[7]Leof, Allison PHD, Kriz, Heidi MPH, RD, Pinson, Nicola JD, Mayer, Meghan. "Applied Behavioral Analysis Treatment for Autism Spectrum Disorders: Coverage Policies and Implementation", Center for Evidence-based Policy; March 2015.
[8]http://www.autismspeaks.org/what-autism/treatment/applied-behavior-analysis-aba

solidified with larger sample sizes. If approved, the Department would continue the program evaluation on a yearly basis.

Currently, the Department has 25 active providers serving CWA enrollees, or a ratio of about three clients per provider. To serve a larger caseload of children with ASD, for 25 to 40 hours per week, for a longer duration, the Department would need to retain current providers and attract more providers. To keep the current ratio of three clients to one provider, the Department would need to enroll at least 93 provider in FY 2015-16 and another 32 providers in FY 2016-17. To do so, the Department would need to allow for provider rate increases for CWA waiver services; however, because clients are only allowed to receive $25,000 in services per year, an increase in rates would yield a decrease in the amount of services a client can receive under the current per client expenditure cap. The expenditure cap is defined in statute at 5.5-5-804(1)(2), C.R.S. To allow for future rate increases, the $25,000 expenditure cap would need to be able to fluctuate with similar services in the market place. Allowing the expenditure cap to fluctuate with the market would allow rates to increase or decrease consistent with the General Assembly's decision each year on rate increases. Along with the need to increase the number of providers for CWA services, the Department would need to increase funding to the contracts for CWA enrollee case management and utilization review. The Department currently contracts with Community Centered Boards (CCBs) to enroll and provide case management and utilization review services for CWA enrollees. CCBs would need more funding to increase current capacity allocated for CWA client enrollment, case management, and utilization review. Removing the per client expenditure cap on CWA services and increasing funding to CCBs for CWA client enrollment, case management and utilization review would allow for appropriated rate increases to attract and retain providers to provide service to the increased number of children with ASD under the new enrollment cap.

Annually, the Department analyzes the balance of the Autism Treatment Fund to determine if the waiver could sustain more children than the current 75 client enrollment cap. At most, without further changes to the program, the cash fund could support a waiver expansion of 50 more clients, with the Autism Treatment Fund running out of sustainable funding by FY 2019-20, requiring General Fund to support the additional population. However, to increase the waiver cap by any amount, the Department would also need an additional General Fund appropriation for new enrollee medical and administrative services outside of the waiver, because the fund is statutorily limited to paying for only waiver services.

Anticipated Outcomes:

If approved, this request would ensure children with ASD have proper access to behavioral interventions and treatments for the correct duration of time improving health outcomes, the client experience, and possibly lowering future per capita costs for clients with ASD. Along with demonstrating sound stewardship of financial resources, funding this request would allow for the CWA waiver program evaluation to continue on a yearly basis providing the necessary number of clients to solidify current research continuing Colorado's leadership in national health care policy.

If the funding request is denied, children with ASD would continue to wait for services. Once clients on the waitlist are enrolled in the waiver, intervention and treatment would continue to be ineffective because the clients would age out of the waiver before receiving the intervention and treatment for the proper duration, leading to the inefficient use of funds. Funding this request would allow the Department to be better stewards

of financial resources by ensuring that the funds spent on ASD treatment go towards a more comprehensive treatment plan, which is likely to generate better outcomes for children in the future.

Assumptions and Calculations:

This request contains four parts: the elimination of the enrollment cap; increasing the waiver service expenditure cap, allowing for it to fluctuate, which includes the effect of increasing the age limit, allowing for a maximum of three years stay on the waiver; increasing funding to CCBs for case management for newly enrolled clients; and, continuing the waiver effectiveness evaluation. Of the FY 2015-16 total, the Department requests General Fund to eliminate the enrollment cap and the waitlist, allow for a one-time expenditure cap increase to $30,000, make programmatic changes and to continue the waiver effectiveness study. The Department assumes that the Autism Treatment Fund would have a balance of $4,840,203 to start FY 2015-16 and that the fund would be reduced to zero prior to expenditure of General Fund. The state share for waiver service in FY 2015-16 is estimated to cost $4,328,990, leaving a balance of $511,213 in the Autism Treatment Fund. The Department request that any remaining funds would be used to finance state plan expenditures for new and existing enrollees until the fund is depleted. As defined in 25.5-6-805(1), C.R.S. the Autism Treatment Fund can only be used for waiver services, the Department would seek the appropriate legislative changes to allow the fund to cover state plan expenditures, after waiver services are accounted for. The Department assumes that the programmatic changes would be completed by the start of FY 2015-16 and new clients would be enrolled at a pace of 50 enrollees per month. This request does not require any changes to the Medicaid Management Information System (MMIS) or the Colorado Benefits Management System (CBMS) but does require legislative changes.

See Tables 1.1 through 6.4 in the appendix for the Department's calculations.

The elimination of the enrollment cap and waitlist includes increasing expenditures for acute care services, waiver services, and case management services for new enrollees. The Department assumes that there are clients that do not sign up for the waitlist for CWA because the enrollment cap is low relative to the size of the waitlist, creating the perception that there is a very low possibility of actually enrolling. Over the last three years, a total of 95 clients have reached age six while on the waitlist for CWA. Clients that have ASD but are not enrolled would create an additional group of clients that would enroll in the waiver given the elimination of the enrollment cap. The Department assumes the waiver would enroll all clients on the waitlist and an additional 161 clients during FY 2015-16, for an average of 370 clients enrolled on the waiver per month, with a total of 549 unique clients enrolled at the end of the fiscal year. Historically, the average length of stay per client on the CWA waiver has been 154 days per fiscal year, meaning that, on average, a client is only enrolled on the waiver for about five months. In FY 2013-14, the expenditure per client on CWA was $12,385.86. Using FY 2013-14 as a baseline, if a client were to be on the waiver for a full year at a monthly average cost of $1,938.22, they would have cost $23,258.64 per client. Trending the full year expenditure forward the Department assumes each client would spend beyond the current cap. The Department assumes that all enrolled clients, would spend, on average, $25,862.86 each in FY 2015-16. The increase in expenditure per enrollee is due to increasing the age limit to eight and allowing for the three years stay on the waiver as long as children are enrolled prior to their eighth birthday, therefore the Department requests a one-time expenditure cap increase to $30,000 as trended per capita expenditure growth approaches $30,000 in FY 2017-18. The Department estimates that new enrollees would continue to cost, on average, about the

same for state plan services as current enrollees. The Department also estimates that the cost to perform the waiver effectiveness evaluation annually would remain fixed in the future.

Table 1.1
Request Components by Line Item
FY 2015-16

Row	Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Source
A	**Total Request**	**$10,616,568**	**0.0**	**$367,564**	**$0**	**$4,840,203**	**$0**	**$5,408,801**	**Row B + Row E + Row J**
B	**(1) Executive Director's Office; (A) General Administration, Personal Services**	**$115,736**	**0.0**	**$57,868**	**$0**	**$0**	**$0**	**$57,868**	**Row C + Row D**
C	Temporary FTE for Enrollment and Waitlist Management	$53,736	**0.0**	$26,868	$0	$0	$0	$26,868	Table 7.1
D	Waiver Effectiveness Study	$62,000	**0.0**	$31,000	$0	$0	$0	$31,000	Narrative
E	**(2) Medical Services Premiums**	**$10,205,160**	**0.0**	**$164,846**	**$0**	**$4,840,203**	**$0**	**$5,200,111**	**Row F + Row G**
F	Case Management and Utilization Review	$548,634	**0.0**	$274,317	$0	$0	$0	$274,317	Table 5.1 Row C
G	Waiver Expansion and Policy Change	$9,656,526	**0.0**	($109,471)	$0	$4,840,203	$0	$4,925,794	Row H + Row I
H	Waiver Services	$8,836,477	**0.0**	$0	$0	$4,328,990	$0	$4,507,487	Table 4.1 Row C - Total Funds Table 2.1 Row N - Cash Funds
I	State Plan Services	$820,049	**0.0**	($109,471)	$0	$511,213	$0	$418,307	Row J + Row K Table 2.1 Row O Total Cash Funds
J	State Plan Services	$820,049	**0.0**	$0	$0	$401,742	$0	$418,307	Table 4.1 Row D
K	Refinance Existing Clients State Plan Services	$0	**0.0**	($109,471)	$0	$109,471	$0	$0	Row I - Row J
K	**(3) Behavioral Health Community Programs**	**$295,672**	**0.0**	**$144,850**	**$0**	**$0**	**$0**	**$150,822**	
L	Enrollees Newly Eligible for Medicaid	$295,672	**0.0**	$144,850	$0	$0	$0	$150,822	Table 3.1 Row C

Table 1.2
Request Components by Line Item
FY 2016-17

Row	Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Source
A	**Total Request**	**$19,042,713**	**0.0**	**$8,830,589**	**$0**	**$508,566**	**$0**	**$9,703,558**	**Row B + Row D + Row I**
B	**(1) Executive Director's Office; (A) General Administration, Personal Services**	**$62,000**	**0.0**	**$31,000**	**$0**	**$0**	**$0**	**$31,000**	
C	Waiver Effectiveness Study	$62,000	**0.0**	$31,000	$0	$0	$0	$31,000	Narrative
D	**(2) Medical Services Premiums**	**$18,234,642**	**0.0**	**$8,434,089**	**$0**	**$508,566**	**$0**	**$9,291,987**	**Row E + Row F**
E	Case Management and Utilization Review	$941,035	**0.0**	$470,517	$0	$0	$0	$470,518	Table 5.1 Row C
F	Waiver Expansion and Policy Change	$17,293,607	**0.0**	$7,963,572	$0	$508,566	$0	$8,821,469	Row G + Row H
G	Waiver Services	$15,240,715	**0.0**	$6,957,860	$0	$508,566	$0	$7,774,289	Table 4.1 Row C - Total Funds Table 2.1 Row O - Cash Funds
H	State Plan Services	$2,052,892	**0.0**	$1,005,712	$0	$0	$0	$1,047,180	Table 4.1 Row D
I	**(3) Behavioral Health Community Programs**	**$746,071**	**0.0**	**$365,500**	**$0**	**$0**	**$0**	**$380,571**	
J	Enrollees Newly Eligible for Medicaid	$746,071	**0.0**	$365,500	$0	$0	$0	$380,571	Table 3.1 Row C

Table 1.3
Request Components by Line Item
FY 2017-18

Row	Item	Total Funds	FTE	General Fund	General Fund Exempt	Cash Funds	Reappropriated Funds	Federal Funds	Source
A	**Total Request**	**$22,726,738**	**0.0**	**$10,145,262**	**$0**	**$1,000,000**	**$0**	**$11,581,476**	**Row B + Row D + Row I**
B	**(1) Executive Director's Office; (A) General Administration, Personal Services**	**$62,000**	**0.0**	**$31,000**	**$0**	**$0**	**$0**	**$31,000**	
C	Waiver Effectiveness Study	$62,000	**0.0**	$31,000	$0	$0	$0	$31,000	Narrative
D	**(2) Medical Services Premiums**	**$21,740,317**	**0.0**	**$9,661,388**	**$0**	**$1,000,000**	**$0**	**$11,078,929**	**Row E + Row F**
E	Case Management and Utilization Review	$1,070,019	**0.0**	$535,009	$0	$0	$0	$535,010	Table 5.1 Row C
F	Waiver Expansion and Policy Change	$20,670,298	**0.0**	$9,126,379	$0	$1,000,000	$0	$10,543,919	Row G + Row H
G	Waiver Services	$18,146,752	**0.0**	$7,890,094	$0	$1,000,000	$0	$9,256,658	Table 4.1 Row C - Total Funds Table 2.1 Row B - Cash Funds
H	State Plan Services	$2,523,546	**0.0**	$1,236,285	$0	$0	$0	$1,287,261	Table 4.1 Row D
I	**(3) Behavioral Health Community Programs**	**$924,421**	**0.0**	**$452,874**	**$0**	**$0**	**$0**	**$471,547**	
J	Enrollees Newly Eligible for Medicaid	$924,421	**0.0**	$452,874	$0	$0	$0	$471,547	Table 3.1 Row C

Table 2.1
Children with Autism (CWA) Waiver - Autism Treatment Fund Detail

Row	Item	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	Notes
A	Cash Fund Balance at the Beginning of Year	$3,688,400	$4,260,382	$511,213	$508,566	FY 2014-15 Actuals; Otherwise Previous Year of Row O
B	Disbursement from Tobacco Master Settlement	$1,000,000	$1,000,000	$1,000,000	$1,000,000	Statutory Yearly Deposit and Estimated Interest
C	Current Year Cash Fund Amount	$4,688,400	$5,260,382	$1,511,213	$1,508,566	Row A + Row B
D	CWA Expected Enrollees Under Current Policy Expenditure	$674,470	$732,781	$795,444	$862,762	Table 2.2 Row C
E	State Funding Need Prior to November 2014 Revised Forecast	$332,109	$358,989	$389,688	$422,667	Row D * (1-Fiscal Year FMAP); 50.76% FY 2014-15, all other year 51.01%
F	Revised FY 2015-16 R-1: "Medical Services Premiums" Request Forecast	$869,249	$857,684	$1,003,131	$0	November 2014 FY 2015-16 R-1: "Medical Services Premiums"
G	Reconciliation Adjustment to Revised FY 2015-16 R-1: "Medical Services Premiums" Request Forecast	$194,779	$124,903	$207,687	$0	Row F - Row D; FY 2017-18: $0
H	Reconciliation Adjustment -State Funding Need	$95,909	$61,190	$101,746	$0	Row H * (1 - Fiscal Year FMAP); 50.76% FY 2014-15, all other year 51.01%
I	Total State Funding Need for Existing Policy	$428,018	$420,179	$491,434	$0	Row E + Row H; FY 2017-18: $0
J	Increase in Expenditure, New Enrollees, Current Policy	$0	$3,254,409	$5,886,288	$7,057,869	Table 4.2 Row C
K	Increase in Expenditure, All Enrollees, New Policy	$0	$5,582,068	$9,354,427	$11,088,883	Table 4.3 Row F
L	CWA Total Expenditure, All Enrollees, New Policy	$869,249	$9,694,161	$16,243,846	$19,009,514	Row D + Row G + Row J + Row K
M	Total State Funding Need	$428,018	$4,749,169	$7,957,860	$9,312,761	Row L * Fiscal Year FMAP; 50.76% FY 2014-15, all other year 51.01%
N	State Funding Need For New Policy	$0	$4,328,990	$7,466,426	$9,312,761	Row I - M
O	**Cash Fund Balance After Expenditure**	**$4,260,382**	**$511,213**	**$508,566**	**$0**	**FY 2014-15 : $0** **All other years Row I * (-1)**

(1) CWA expenditure adjustments include adjustments made for interest and will not tie out the November 2014 R-1 "Medical Services Premiums" as a result

Table 2.2
Children with Autism (CWA) Waiver Expansion

Row	Item	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	Notes
A	Expected Enrollees Under Current Policy Average Monthly Caseload	66	68	70	72	FY 2014-15[1], otherwise Table 6.1 Row A
B	Current Policy Per Utilizer Expenditure - Waiver Services	$10,219.24	$10,776.19	$11,363.49	$11,982.80	Table 4.4 Row C
C	**Expected Enrollees Under Current Policy Total Expenditure - Waiver Services**	**$674,470**	**$732,781**	**$795,444**	**$862,762**	**Row A * Row B**

(1) S-1, BA-1 February 2014 Exhibit G CWA FY 2014-15 Estimated Average Monthly Caseload

Table 3.1
Children with Autism (CWA) Waiver Expansion Estimated Total Incremental Behavioral Health Organization Expenditure

Row	Item	FY 2015-16	FY 2016-17	FY 2017-18	Notes/Calculation
A	Estimated New CWA Medicaid Enrollees[(1)]	151	367	438	Table 6.1 Row E
B	Estimated Expenditure Per BHO Enrollee	$1,958.09	$2,032.89	$2,110.55	Growth Trend 3.82%[2] Base Per Capita Trend form S-2, BA-2 February 2014 Exhibit DD-Per Cap Summary
C	**Estimated Total BHO Expenditure For New CWA Medicaid Enrollees**	**$295,672**	**$746,071**	**$924,421**	**Row A * Row B**

(1) These are clients that are new enrollees to the CWA Waiver and Medicaid
(2) Growth Trend from S-2A, BA-2 February 2014, Exhibit DD-Per Cap Summary Average Percent Growth FY 2013-14 through FY 2015-16

Table 4.1
Summary of Children with Autism (CWA) Waiver Expansion
Incremental Expenditures on Waiver and State Plan Services by Fiscal Year

Row	Item	FY 2015-16	FY 2016-17	FY 2017-18	Notes
A	Increase in Enrollment - New Enrollees, Current Policy - Waiver Services	$3,254,409	$5,886,288	$7,057,869	Table 4.2 Row C
B	Incremental Increase in Expenditure - All Enrollees, New Policy	$5,582,068	$9,354,427	$11,088,883	Table 4.3 Row F
C	**Total Waiver Incremental Expenditure for New Enrollees and New Policy**	**$8,836,477**	**$15,240,715**	**$18,146,752**	**Row A + Row B**
D	Increase in Enrollment - New Enrollees, Current Policy - State Plan Services	$820,049	$2,052,892	$2,523,546	Table 4..2 Row F
E	**Total Incremental Expenditure**	**$9,656,526**	**$17,293,607**	**$20,670,298**	**Row C + Row D**

Table 4.2
Children with Autism (CWA) Waiver Expansion
Expenditures - New Enrollees, Waiver Expansion, Current Policy

Row	Item	FY 2015-16	FY 2016-17	FY 2017-18	Notes
A	New Enrollee Average Monthly Caseload	302	518	589	Table 6.1 Row C
B	Current Policy Per Capita Expenditure - Waiver Services	$10,776.19	$11,363.49	$11,982.80	Table 4.4 Row C
C	**New Enrollee Total Expenditure - Waiver Services**	**$3,254,409**	**$5,886,288**	**$7,057,869**	**Row A * Row B**
D	New Enrollee Average Monthly Caseload	151	367	438	Table 6.1 Row E
E	Per Capita Expenditure - State Plan Services	$5,430.79	$5,593.71	$5,761.52	Table 4.4 Row H
F	**New Enrollee Total Expenditure - State Plan Services**	**$820,049**	**$2,052,892**	**$2,523,546**	**Row D * Row E**
G	**New Enrollee Total Services Expenditure**	**$4,074,458**	**$7,939,180**	**$9,581,415**	**Row C + Row F**

Row A is the number of new enrollees on the CWA waiver
Row D is the number of new enrollees on the CWA waiver that are also new to Medicaid

Table 4.3
Children with Autism (CWA) Waiver Expansion
Incremental Expenditures - All Enrollees, New Policy

Row	Item	FY 2015-16	FY 2016-17	FY 2017-18	Notes
A	New Enrollee Average Monthly Caseload	302	518	589	Table 6.1 Row C
B	New Policy Per Capita Expenditure - Waiver Services	$15,086.67	$15,908.89	$16,775.92	Table 4.4 Row E
C	**New Enrollee Total Expenditure - Waiver Services**	**$4,556,174**	**$8,240,805**	**$9,881,017**	**Row A * Row B**
D	Expected Enrollees Under Current Rules Average Monthly Caseload	68	70	72	Table 6.1 Row A
E	**Expected Enrollees Under Current Policy Total Expenditure - Waiver Services**	**$1,025,894**	**$1,113,622**	**$1,207,866**	**Row D * Row B**
F	**All Enrollees, New Policy - Total Services Expenditure**	**$5,582,068**	**$9,354,427**	**$11,088,883**	**Row C + Row E**

Table 4.4
CWA Waiver and State Plan Services Cost Per Utilizer and Per Capita Expenditure

Row	Item	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	Notes
A	Waiver Service Prior Year Base Per Utilizer Expenditure	$9,691.08	$10,219.24	$10,776.19	$11,363.49	FY 2013-14 Historical Data; Otherwise Row C of Previous Year
B	Growth Trend	5.45%	5.45%	5.45%	5.45%	Source: S-1/BA-1 February 2014 -Exhibit G CBLTC Base - CWA Average Cost Per Capita Historical Growth
C	**Waiver Service Per Utilizers Expenditure, Current Policy**	**$10,219.24**	**$10,776.19**	**$11,363.49**	**$11,982.80**	**Row A * (1 + Row B)** **5 Months Length of Stay**
D	**Waiver Service Per Capita, New Policy**	**$24,526.18**	**$25,862.86**	**$27,272.38**	**$28,758.72**	**Row C * (12/5)** **Full Year Length of Stay**
E	**Waiver Service Cost Per Capita Incremental Difference Between New Policy and Current Policy**	**$14,306.94**	**$15,086.67**	**$15,908.89**	**$16,775.92**	**Row D - Row C**
F	State Plan Service Prior Year Base Per Capita	$5,119.04	$5,272.61	$5,430.79	$5,593.71	FY 2013-14 Historical Data; Otherwise Row C of Previous Year
G	Growth Trend	3.00%	3.00%	3.00%	3.00%	Source: S-1/BA-1 February 2014 -Exhibit F - Disabled Individuals to 59 Per Capita FY 2015-16 Trend
H	**State Plan Service Per Capita**	**$5,272.61**	**$5,430.79**	**$5,593.71**	**$5,761.52**	**Row F * (1 + Row G)**

Table 5.1
Summary of Children with Autism Waiver (CWA) Incremental Impact to Community Centered Boards (CCBs)
for Case Management and Utilization Review Expenditures for New Enrollees by Fiscal Year

Row	Item	FY 2015-16	FY 2016-17	FY 2017-18	Notes/Calculation
A	CWA New Enrollee Average Monthly Caseload	302	518	589	Table 6.1 Row C
B	CWA Expenditure Per Enrollee Expenditure for Case Management and Utilization Review	$1,816.67	$1,816.67	$1,816.67	Table 5.2 Row C
C	**Estimated CWA Maximum Contract Amount for Case Management and Utilization Review**	**$548,634**	**$941,035**	**$1,070,019**	**Row A * Row B**

Table 5.2
CWA Waiver Estimated Impact to Community Centered Boards (CCBs)
for Case Management and Utilization Review Expenditures Under Current Policy by Fiscal Year

Row	Item	FY 2015-16	FY 2016-17	FY 2017-18	Notes/Calculation
A	CWA Average Unduplicated Clients Under Current Policy	90	90	90	Average of Calendar Year 2012 and 2013
B	CWA Maximum Contract Amount for Case Management and Utilization Review	$163,500	$163,500	$163,500	FY 2014-15 Contract Amount
C	**CWA Per Enrollee Expenditure for Case Management and Utilization Review**	**$1,816.67**	**$1,816.67**	**$1,816.67**	**Row B / Row A**

Table 6.1
Children with Autism (CWA) Waiver Expansion Estimated Average Monthly Caseload by Fiscal Year

Row	Item	FY 2015-16	FY 2016-17	FY 2017-18	Notes/Calculation
A	Estimated Average Monthly Enrollment Under Current Policy	68	70	72	Source: S-1,BA-1 February 2014 Exhibit G - CWA Enrollment; FY 2015-16 Growth Trend: 3.03%
B	Estimated Average Monthly Enrollment After CWA Expansion	370	588	661	Table 6.2 Row N
C	**Incremental Estimated Average Monthly Enrollment**	**302**	**518**	**589**	**Row B - Row A**
D	Categorically Eligible Clients on the Waitlist[2]	151	151	151	Historical Data
E	**Incremental Estimated Average Monthly Enrollment - New Medicaid Enrollees**	**151**	**367**	**438**	**Row C - Row D**

(1) Number of Clients on the CWA Waitlist that are Eligible For Medicaid

Table 6.2
CWA Expansion Enrollment Ramp Up - Average Number of Enrollees Per Month

Row	Fiscal Year	FY 2015-16	FY 2016-17	FY 2017-18
A	Starting Point	68	549	618
B	July	118	555	624
C	August	168	561	631
D	September	218	567	638
E	October	268	573	645
F	November	318	579	652
G	December	368	585	659
H	January	418	591	666
I	February	458	597	672
J	March	498	603	678
K	April	518	608	683
L	May	538	613	689
M	June	549	618	695
N	**Yearly Average Total**	**370**	**588**	**661**

Table 6.3
Estimated Clients that will Enroll in the CWA Waiver If Enrollment Cap Is Removed

Row	Item	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	Notes
A	Prior Year Base Caseload and Waitlist[1]	433	487	549	618	FY 2013-14 Historical Data; Otherwise Row E of Previous Year
B	Prior Year Estimated Children Ages 2-8 on Medicaid with a Diagnosis of ASD	2,459	2,768	3,116	3,508	FY 2013-14 Historical Data; Otherwise Row D of Previous Year
C	Percent of Children Ready to Enroll out of Estimated Population with a Diagnosis of ASD	17.61%	17.61%	17.61%	17.61%	Row A / Row B Identified in FY 2013-14 and Held Static
D	Current Year Estimate of Total Children ages 2-8 with ASD	2,768	3,116	3,508	3,949	Table 6.4 Row E
E	**Estimated Children on Medicaid that Would Enroll on the CWA waiver**	**487**	**549**	**618**	**695**	**Row C * Row D**

(1) Waitlist is at 320 as of the start of FY 2014-15, all 320 will be enrolled in FY 2015-16

Table 6.4
Estimated Children on Medicaid Ages 2-8 with a Diagnosis of Autism Spectrum Disorder (ASD) by Fiscal Year

Row	Item	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	Notes
A	Previous Year Eligible Children on Medicaid Ages 2-8	248,391	279,614	314,761	354,326	FY 2013-14 Historical Data; Otherwise Row C of Previous Year
B	Growth Trend	12.57%	12.57%	12.57%	12.57%	Eligible Children Growth Trend Average Growth FY 2008-09 to FY 2012-13
C	Current Year Eligible Children on Medicaid Ages 2-8	279,614	314,761	354,326	398,865	Row A * (1 + Row B)
D	Denver-Metro Percent of Children with a Diagnosis of ASD by Age 8	0.99%	0.99%	0.99%	0.99%	Narrative
E	**Estimate of Medicaid Population with a diagnosis of ASD Ages 2-8**	**2,768**	**3,116**	**3,508**	**3,949**	**Row C * Row D**

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-09

Request Titles

R-09 Personal Health Records and Online Health Education

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$8,228,926	$0	$12,196,176	$772,570	$1,485,279
	FTE	-	-	-	-	-
	GF	$1,302,893	$0	$1,699,618	$122,257	$352,528
	CF	$0	$0	$0	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$6,926,033	$0	$10,496,558	$650,313	$1,132,751

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - Health Information Exchange Maintenance and Projects	Total	$8,228,926	$0	$12,196,176	$772,570	$1,485,279
	FF	$6,926,033	$0	$10,496,558	$650,313	$1,132,751
	GF	$1,302,893	$0	$1,699,618	$122,257	$352,528

Letternote Text Revision Required? Yes X No ___ **If Yes, describe the Letternote Text Revision:**

The Department requests that the General Assembly add a footnote to the FY 2015-16 Long Bill to allow for roll-forward authority of unspent funding into FY 2016-17.

Cash or Federal Fund Name and CORE Fund Number: FF: Title XIX

Reappropriated Funds Source, by Department and Line Item Name: N/A

Approval by OIT? Yes ___ No ___ **Not Required:** X

Schedule 13s from Affected Departments: N/A

Other Information: N/A

Cost and FTE

- In order to implement online health education and Personal Health Record (PHR) technology for Medicaid clients, the Department requests:
  - FY 2015-16: $772,570 total funds, $122,257 General Fund, and $650,313 federal funds;
  - FY 2016-17: $1,485,279 total funds, $352,528 General Fund, and $1,132,751 federal funds;
  - FY 2017-18: $1,170,279 total funds, $421,028 General Fund, and $749,251 federal funds;
  - FY 2018-19: $1,045,209 total funds, $484,576 General Fund, and $560,633 federal funds; and
  - FY 2019-20 and ongoing: $950,139 total funds, $475,069 General Fund, and $475,070 federal funds.

Current Program

- Online health education and Personal Health Record (PHR) technology have been shown to improve health and reduce health care spending; the Department currently does not offer these services to its clients

Problem or Opportunity

- The Department has an opportunity to improve client health and reduce spending on medical services by implementing online health education and PHR technology
- Online health education enables clients to become better informed about their health conditions and treatment options; research shows that better-informed consumers tend to favor less-invasive and correspondingly less-costly medical services
- PHR technology gives clients access to their electronic medical information and offers various opportunities to improve client health and reduce costs through, for example, PHR-based smoking cessation counseling, medication list sharing to avoid adverse drug interactions, and complete laboratory results sharing to avoid redundant medical tests
- This technology would capitalize on Colorado's growing Health Information Exchange (HIE) network managed by the Colorado Regional Health Information Organization (CORHIO)

Consequences of Problem

- If this request is not approved, the Department would miss opportunities to educate clients about their health conditions and treatment options and clients would continue to be unable to easily access and share their electronic medical information or utilize other features of PHR technology; consequently, the Department would miss an opportunity to improve client health and reduce state spending on medical services

Proposed Solution

- The Department proposes to implement online health education resources and PHR technology for Medicaid clients, who could access these services through a single online portal
- The work would largely be performed by CORHIO
- The Department anticipates clients would use online health education resources to learn more about their health conditions and treatment options and consequently favor less-invasive, less-costly treatments, creating long-term cost savings on medical services for the Department
- The Department anticipates clients would use PHR technology to view their electronic medical information and appropriately share the information and communicate with providers through the PHR technology, leading to long-term cost savings on medical services for the Department and improved client health

Department Priority: R-9
Request Detail: Personal Health Records and Online Health Education

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Personal Health Records and Online Health Education	$772,570	$122,257

Problem or Opportunity:

Online health education and personal health records (PHRs) are new technologies that present an opportunity to increase engagement of Medicaid clients in their health care through client health education and client access to their personal electronic medical data. Industry research has shown that these technologies result in healthier consumers and decreased spending on health care services.

Online health education refers to online health article repositories and online shared decision making tools. Online health article repositories are essentially online encyclopedias covering general health concepts, pathologies, treatments, and more. These articles are tailored to health care consumers and are updated at least annually to include new research and evidence-based practices. Online shared decision making tools provide consumers with information and recommendations on treatment options so that consumers can better participate in health care decisions with their provider. These shared decision making tools can take several forms including informational videos, digital pamphlets, and interactive questionnaires that recommend treatments based on a consumer's preferences and values. Use of these shared decision making tools can be tracked and can be tailored to the consumer based on their medical conditions, demographics, or other data.

PHR technology gives consumers online access to their electronic health records (EHRs). EHRs are an electronic replacement for paper medical records and are created by providers, laboratories, and other health entities using specialized software. They contain information such as client demographics, medical diagnoses, doctor's notes, and laboratory test results. Health Information Exchange (HIE) is a private, statewide computer network managed by the Colorado Regional Health Information Organization (CORHIO) that enables providers and other entities to electronically share EHRs.[1] PHR technology essentially allows consumers to log on to the HIE network to view their aggregated EHRs. This enables consumers to see, for example, treatments they've received or doctors' notes from any provider participating in HIE. Additionally, the consumer can add information to their record such as their height and weight or

[1] For more information about HIE, see the Department's FY 2014-15 R-5 funding request "Medicaid Health Information Exchange."

the results of an at-home medical test such as a blood sugar test. The consumer can also electronically send medical information and exchange secure electronic messages with their provider using the PHR system. This functionality has been shown to help with activities such as smoking cessation management because providers are able to counsel consumers via electronic messaging more frequently and consistently than face-to-face interaction typically allows.

Recent industry research indicates online health education and PHRs produce long-term cost savings after initial implementation costs. Online health education results in greater utilization of lower-cost treatment options, producing long-term net savings on health care services.[2] The reason this occurs is that well-informed health care consumers tend to choose less-invasive, less-risky treatment options and these options tend to cost less than their more-invasive counterparts. Likewise, PHRs have high initial implementation costs, but begin producing a net savings three to four years after implementation due to decreased spending on health care services.[3] PHRs produce savings on health care services through, for example, reductions in drug-drug interaction adverse drug events due to the ability to share complete medication lists through the PHR, avoiding redundant tests through sharing complete test results, and congestive heart failure remote monitoring through the PHR.

Several other states have implemented or are in the process of implementing PHR systems. New York invested in a statewide PHR system in 2013 that is administered by CORHIO's New York counterpart. The system is statewide and utilizes New York's HIE network so that data across all providers and payers is available to the client. Similarly, Kansas and Indiana have invested in PHR systems. After a successful implementation, Indiana published a report on lessons learned. This report has helped inform the proposed solution in this request and emphasizes the value of capitalizing on work done by existing HIE networks to connect disparate data across the health industry.

Proposed Solution:

In order to implement online health education and PHR technology for Medicaid clients in combination with a centralized web portal where clients can access these services, the Department requests:

- $772,570 in FY 2015-16 ($122,257 General Fund, and $650,313 federal funds);
- $1,485,279 in FY 2016-17 ($352,528 General Fund, and $1,132,751 federal funds);
- $1,170,279 in FY 2017-18 ($421,028 General Fund, and $749,251 federal funds);
- $1,045,209 in FY 2018-19 ($484,576 General Fund, and $560,633 federal funds); and,
- $950,139 in FY 2019-20 and ongoing ($475,069 General Fund, and $475,070 federal funds).

Ongoing funding beginning in FY 2019-20 is for continuing maintenance costs of the hardware, software, and services associated with the proposed technology. There are no FTE included with this request.

For the online health education component, the Department proposes to hire vendors to provide an online health article repository and an online shared decision making tool. Medicaid clients would have access to

[2] See "Policy Options to Encourage Patient-Physician Shared Decision Making" by Ann S. O'Malley and others.
[3] See "The Value of Personal Health Record (PHR) Systems" by David Kaelber, MD, PhD and others.

the online health article repository where trustworthy health articles would be maintained and regularly updated by a third-party vendor. Likewise, the shared decision making tool would provide clients with videos, articles, and interactive questionnaires to guide them through their treatment options for any health care decisions they may face. Clients could be required to use the shared decision making tool before certain services are approved; for instance, a client could be required to view a video outlining less invasive options before a surgery is approved.

For the PHR component, the Department proposes to hire a vendor to provide a PHR system that enables Medicaid clients to view, add to, and share their health information as well as securely communicate with their provider. The PHR system would be hosted by CORHIO in order to integrate with Colorado's HIE network, allowing access to EHRs, and to allow for ready expansion of the PHR system beyond Medicaid if desired in the future. The PHR system would also connect to the Medicaid Management Information System (MMIS) and the Colorado Benefits Management System (CBMS) for other client health-related data. Clients would only have access rights to their own information, but could access another client's information if authorized, such as a dependent child's information.

For the centralized web portal component, the Department proposes to hire a vendor to create a website where clients log on for centralized access to the online health education and PHR components described above. Clients could log on from any internet-connected computer or mobile device. Without a centralized web portal, clients would need to visit separate websites with separate logons for each service (at least three separate websites). This would create a barrier to client adoption of the technology that could be avoided with a centralized portal. A centralized web portal provides a user friendly means for clients to access health information and is critical to the success of the other components of this request because they depend on client adoption.

The Department considers the proposed solution the best way to take advantage of the opportunities that online health education and PHR technology offers. The Department has reviewed industry research, pilot programs, and recent implementations of this technology for best practices that are incorporated in this proposal. The time is right for this technology because, although new, it has now been tested in other states and studied enough to demonstrate its ability to improve client health and reduce spending on health services. It is also the right time to implement this technology in Colorado because it capitalizes on the state's ongoing investments in HIE. Today, more than 2,700 office-based providers, 50 hospitals, and 134 long-term and post-acute care facilities participate or are working toward participation in Colorado HIE.

In addition to the funding requested, the Department requests that the General Assembly add a footnote to the FY 2015-16 Long Bill to allow for roll-forward authority for unspent funding. Because a number of these components would need to be competitively procured, the timing for spending FY 2015-16 funding is relatively uncertain; it is possible that lengthy proposals or appeals could delay the start of the project. As a result, the Department may not know that it needs to shift funding into a future year until after the statutory deadline for supplemental requests and budget amendments. A footnote to allow for roll-forward authority would prevent reversions that could impair the project's implementation. The Department is only requesting such a footnote for FY 2015-16; for FY 2016-17 and future years, the Department would be able to use the regular budget process to request any needed funding changes.

Anticipated Outcomes:

The Department anticipates the outcomes of implementing online health education and PHR technology would be improved client health and reduced Medicaid spending on health care services. This outcome would be a result of widespread client adoption of the online health education and PHR technology.

One way the Department would measure this proposal's outcomes would be tracking and analyzing client use of the online health education and PHR technology. Data would be collected in several ways as follows:

- Data would be obtained from logon data from the proposed centralized web portal. This would reveal the frequency and length of client logons.
- Data would be gathered through statistics from the shared decision making tool, revealing which videos or other shared decision making tools each client has used.
- Data would be derived from statistics from the PHR technology, revealing, for example, which clients are participating in smoking cessation management or congestive heart failure remote monitoring through the PHR.

Program success would be evidence of widespread use of the technology, such as frequent user logons and high utilization of PHR functionality.

Another way the Department would measure outcomes would be to compare data on clients who use the technology with those who do not. This could establish causal relationships between use of the technology and other variables, revealing whether or not use of the technology improves client health and reduces spending on health services. Evidences of success in these measurements would be that for clients who access the technology health improves and spending on health care services decreases as compared to those clients who do not use this technology.

If this request is successful, the Department anticipates that it would see reductions in medical spending by Medicaid clients. However, because the literature indicates that savings occur in the medium-to-long term, and because the Department would implement this request in phases, the Department has not included an offset to its Medicaid expenditure as part of this request. Actual savings achieved would be accounted for during the regular budget process through reduced requests for caseload and per capita cost.

If approved, this proposal would contribute to several goals in the Department's FY 2014-15 Performance Plan. First, it would contribute to the Client Engagement goal, which is to foster collaboration between providers, clients, and their families when it comes to health care decisions. This proposal would help foster collaboration through the online shared decision making tools and through clients adding information to and communicating with their providers through the PHR. Second, it would contribute to the Health Information Technology goal, which is to encourage the adoption of EHRs for Medicaid clients. This proposal would contribute to greater familiarity with EHRs among Medicaid clients and help mainstream these technologies. Last, it would contribute to the Cost Containment goal, which is to reduce per capita spending in Medicaid without sacrificing health outcomes or client experience. As discussed earlier in this proposal, research has shown this technology can reduce spending on health care services while improving client health.

Assumptions and Calculations:

Table 1 in the attached appendix shows the requested funding broken out by fiscal year. Table 2 shows the funding again broken out by fiscal year, but also grouped within each fiscal year by federal match rate. Finally, Table 3 gives the most detailed view of the funding, breaking out the funding into each cost-generating component of the request. The information in Table 3 forms the basis for the request. The remainder of this section discusses Table 3 row by row and in doing so, illuminates the assumptions and calculations behind this request.

The funding in Table 3, row A, is for two contracted project managers to perform project planning, communication, technical guidance, and project support for three years beginning in January 2016. Similarly, the funding in row B is for two contracted technical project managers to perform technical support and guidance beginning the second year of the project. These calculations are based on the assumption that each contractor would have equivalent duties and compensation as a General Professional IV classification level. See Table 4 for details. These positions would be filled through the Department's existing contract with CORHIO because most of the work for these positions would be implementing and maintaining the proposed PHR system, which would be hosted by CORHIO. The distinction between the project managers and technical project managers is that the project managers would work from a high-level perspective of the project and the technical project managers would work at a detailed, technical level. The Department assumes the federal government would support these contracted positions with a 90% federal match rate under the Health Information Technology for Economic and Clinical Health (HITECH) Act.

The funding in rows C through F of Table 3 is for a vendor to implement the proposed PHR system. The funding in row C is for obtaining and configuring the system. The funding in rows D through F is for interfacing the PHR system with Colorado's HIE network, CBMS, and the MMIS, which would be done at a rate of approximately one interface per year to pace the cost and work of the project. Although the PHR system would be hosted by CORHIO and built into their network, the work of implementing the system would be performed by a third-party vendor. The interfaces with CBMS and the MMIS would require help from the Governor's Office of Information Technology (OIT) which the Department would pay for through a Memorandum of Understanding (MOU) with OIT. The funding needed to implement the PHR system was estimated based on a recent vendor survey performed by CORHIO that identified typical market pricing for PHR products. The Department assumes the federal government would support this implementation with a 90% federal match rate under the HITECH Act because it would be managed by CORHIO, which the federal government recognizes as the State-Designated Entity (SDE) for Colorado HIE.

The funding in row G of Table 3 is for a vendor to implement the proposed centralized web portal. This funding was estimated based on similar work the Department recently performed to create single sign on functionality between Connect for Health Colorado and CBMS. The Department assumes the federal government would support this implementation with a 90% federal match rate under the HITECH Act.

The funding in Table 3 rows I through K is for ongoing technical project management, PHR system operations, and centralized web portal operations. Technical project management would be needed on an ongoing basis in order to manage the ongoing operations of the various proposed systems. The PHR system would require ongoing operational funding relative to the number of client users of the system. The

Department assumes client use would gradually ramp up during the first three years of having the PHR system, reflected in Table 3 by the funding gradually ramping up for this component. Lastly, the centralized web portal would require ongoing operational funding and was estimated again based on the recent work related to CBMS. The Department assumes the federal government would support these operational costs with a 50% federal match rate.

Finally, the funding in row L of Table 3 is for the shared decision making tool. This funding is ongoing and based on an informal survey by the Department of vendors that offer such tools. The Department assumes the federal government would support this cost with a 50% federal match rate.

Note that the proposed online health article repository is not found in Table 3. The Department assumes it could be implemented at no cost by leveraging free resources already utilized by some Regional Care Collaborative Organizations (RCCOs).

If funding is approved, then approximately the first six months of FY 2015-16 would be required to prepare, receive, and evaluate vendor bids for the following contracts proposed in this request: PHR system implementation, centralized web portal implementation, and the shared decision making tool. These contracts would begin in approximately January 2016. Project management would also begin in approximately January 2016 to manage these contracts, while technical project management would begin in July 2016 to provide additional support as the technical demands of the contracts increase.

Table 1 - Summary by Fiscal Year and Line Item				
Row	**Line Item**	**Total Funds**	**General Fund**	**Federal Funds**
	FY 2015-16			
A	Contracts and Projects, Health Information Exchange Maintenance and Projects	$772,570	$122,257	$650,313
	FY 2016-17			
B	Contracts and Projects, Health Information Exchange Maintenance and Projects	$1,485,279	$352,528	$1,132,751
	FY 2017-18			
C	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Health Information Exchange Maintenance	$1,170,279	$421,028	$749,251
	FY 2018-19			
D	Contracts and Projects, Health Information Exchange Maintenance and Projects	$1,045,209	$484,576	$560,633
	FY 2019-20 and Ongoing			
E	(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Health Information Exchange Maintenance	$950,139	$475,069	$475,070
F	**Total**	**$5,423,476**	**$1,855,458**	**$3,568,018**

Table 2 - Summary by Fiscal Year and Federal Match Rate				
Row	**Year**	**Total Funds**	**General Fund**	**Federal Funds**
	FY 2015-16			
A	90% Federal Match	$660,070	$66,007	$594,063
B	50% Federal Match	$112,500	$56,250	$56,250
C	**Subtotal for FY 2015-16**	**$772,570**	**$122,257**	**$650,313**
	FY 2016-17			
D	90% Federal Match	$975,279	$97,528	$877,751
E	50% Federal Match	$510,000	$255,000	$255,000
F	**Subtotal for FY 2016-17**	**$1,485,279**	**$352,528**	**$1,132,751**
	FY 2017-18			
G	90% Federal Match	$410,279	$41,028	$369,251
H	50% Federal Match	$760,000	$380,000	$380,000
I	**Subtotal for FY 2017-18**	**$1,170,279**	**$421,028**	**$749,251**
	FY 2018-19			
J	90% Federal Match	$95,070	$9,507	$85,563
K	50% Federal Match	$950,139	$475,069	$475,070
L	**Subtotal for FY 2018-19**	**$1,045,209**	**$484,576**	**$560,633**
	FY 2019-20 and Ongoing			
M	50% Federal Match	$950,139	$475,069	$475,070
N	**Subtotal for FY 2019-20**	**$950,139**	**$475,069**	**$475,070**
O	**Total**	**$5,423,476**	**$1,855,458**	**$3,568,018**

Table 3 - Summary by Component							
Row	**Cost component**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**	**Row Total**
	90% Federal Match						
A	Two Contracted Project Managers	$95,070	$190,139	$190,139	$95,070	$0	**$570,418**
B	Two Contracted Technical Project Managers, Implementation	$0	$190,139	$190,139	$0	$0	**$380,279**
C	PHR System Implementation	$150,000	$150,000	$0	$0	$0	**$300,000**
D	Clinical Data Interface	$15,000	$15,000	$0	$0	$0	**$30,000**
E	Eligibility Data Interface	$0	$30,000	$0	$0	$0	**$30,000**
F	Claims Data Interface	$0	$0	$30,000	$0	$0	**$30,000**
G	Centralized Web Portal Implementation	$400,000	$400,000	$0	$0	$0	**$800,000**
H	**Subtotal for 90% Match**	**$660,070**	**$975,279**	**$410,279**	**$95,070**	**$0**	**$2,140,697**
	50% Federal Match						
I	Two Contracted Technical Project Managers, Operations	$0	$0	$0	$190,139	$190,139	**$380,279**
J	PHR System Operations	$62,500	$250,000	$500,000	$500,000	$500,000	**$1,812,500**
K	Centralized Web Portal Operations	$0	$160,000	$160,000	$160,000	$160,000	**$640,000**
L	Shared Decision Making Tool	$50,000	$100,000	$100,000	$100,000	$100,000	**$450,000**
M	**Subtotal for 50% Match**	**$112,500**	**$510,000**	**$760,000**	**$950,139**	**$950,139**	**$3,282,779**
N	**Total**	**$772,570**	**$1,485,279**	**$1,170,279**	**$1,045,209**	**$950,139**	**$5,423,476**

Table 4 - Calculation of Project Manager Contractor Costs			
Row		**Amount**	**Explanation**
A	General Professional IV Salary	$70,422	Middle of salary range ($57,168 to $83,676)
B	Administrative Load[1]	$24,648	Row A * 35%
C	**Total**	**$95,070**	

[1] The 35% Annual Administrative Load includes all health, life, and dental benefits, operating expenses, and commercial leased space.

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-10

Request Titles

R-10 Customer Service Center

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
OSPB Approval By:			Base Reduction FY 2015-16
			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$41,946,320	$0	$41,396,858	$2,077,065	$2,231,328
	FTE	360.4	-	360.6	20.8	25.0
	GF	$14,900,775	$0	$14,507,000	$674,424	$730,175
	CF	$3,966,900	$0	$4,131,201	$364,111	$385,492
	RF	$2,111,659	$0	$2,239,086	$0	$0
	FF	$20,966,986	$0	$20,519,571	$1,038,530	$1,115,661

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - Personal Services	Total	$26,043,374	$0	$26,913,985	$841,275	$1,039,797
	CF	$2,676,189	$0	$2,746,161	$116,601	$144,115
	FF	$12,679,416	$0	$13,118,575	$420,636	$519,898
	FTE	360.4	-	360.6	20.8	25.0
	GF	$8,802,250	$0	$9,128,987	$304,038	$375,784
	RF	$1,885,519	$0	$1,920,262	$0	$0
01. Executive Director's Office - Health, Life, and Dental	Total	$2,476,612	$0	$2,764,474	$190,248	$198,175
	CF	$166,066	$0	$237,248	$26,368	$27,467
	FF	$1,284,665	$0	$1,396,951	$95,124	$99,087
	GF	$896,868	$0	$950,673	$68,756	$71,621
	RF	$129,013	$0	$179,602	$0	$0
01. Executive Director's Office - Short-term Disability	Total	$64,185	$0	$59,620	$1,658	$2,050
	CF	$4,955	$0	$4,521	$230	$284
	FF	$36,233	$0	$30,891	$829	$1,025
	GF	$21,082	$0	$21,545	$599	$741
	RF	$1,915	$0	$2,663	$0	$0

01. Executive Director's Office - Amortization Equalization Disbursement	**Total**	**$1,235,106**	**$0**	**$1,281,593**	**$33,169**	**$44,723**
	CF	$96,428	$0	$97,306	$4,597	$6,199
	FF	$696,733	$0	$664,020	$16,584	$22,361
	GF	$405,144	$0	$462,966	$11,988	$16,163
	RF	$36,801	$0	$57,301	$0	$0
01. Executive Director's Office - Supplemental Amortization Equalization Disbursement	**Total**	**$1,157,972**	**$0**	**$1,237,903**	**$32,038**	**$44,257**
	CF	$90,431	$0	$93,989	$4,440	$6,134
	FF	$653,218	$0	$641,383	$16,019	$22,128
	GF	$379,822	$0	$447,183	$11,579	$15,995
	RF	$34,501	$0	$55,348	$0	$0
01. Executive Director's Office - Operating Expenses	**Total**	**$3,345,159**	**$0**	**$1,946,037**	**$109,672**	**$23,750**
	CF	$62,577	$0	$62,577	$15,201	$3,292
	FF	$1,681,676	$0	$976,139	$54,836	$11,875
	GF	$1,576,996	$0	$883,411	$39,635	$8,583
	RF	$23,910	$0	$23,910	$0	$0
01. Executive Director's Office - Leased Space	**Total**	**$1,472,104**	**$0**	**$1,711,738**	**$76,230**	**$85,801**
	CF	$142,754	$0	$161,899	$10,565	$11,892
	FF	$736,052	$0	$855,869	$38,115	$42,900
	GF	$593,298	$0	$693,970	$27,550	$31,009
01. Executive Director's Office - General Professional Services and Special Projects	**Total**	**$6,151,808**	**$0**	**$5,481,508**	**$792,775**	**$792,775**
	CF	$727,500	$0	$727,500	$186,109	$186,109
	FF	$3,198,993	$0	$2,835,743	$396,387	$396,387
	GF	$2,225,315	$0	$1,918,265	$210,279	$210,279

Letternote Text Revision Required?	Yes	No	X	**If Yes, describe the Letternote Text Revision:**
Cash or Federal Fund Name and CORE Fund Number:	FF: Title XIX CF: Hospital Provider Fee (24A0)			
Reappropriated Funds Source, by Department and Line Item Name:	N/A			
Approval by OIT?	Yes	No	**Not Required:**	X
Schedule 13s from Affected Departments:	N/A			
Other Information:	N/A			

Cost and FTE

- The Department requests an increase of $2,077,065 total funds, including $674,424 General Fund and $364,111 Hospital Provider Fee cash funds in FY 2015-16. This amount is ongoing in order to hire 25.0 Full Time Equivalents (FTE) for the Medicaid Customer Service Center (CSC), the associated leased space for the FTE, and increased funding to for the Interactive Voice Response (IVR) and Customer Relationship Management (CRM) systems needed to support the CSC.

Current Program

- The CSC is the primary point of contact for over one million Medicaid clients regarding all benefit and billing related questions. CSC staff serve these clients through multiple platforms including a call center, an e-mail address, and through an online chat and forms service.

Problem or Opportunity

- Medicaid caseload has increased by 157,801 clients between January and June 2014, a 17% increase, but call volumes have increased 328%, when comparing May 2013 to May 2014. Current staffing levels are not adequate to support the volume increases.
- CSC staff were only able to answer about 50% of calls received in FY 2013-14. The Department expects call volumes to continue to increase as a result of new Medicaid enrollees, the annual redetermination process and the open enrollment period for Connect for Health Colorado. The CSC is also anticipating a reduction in staff during FY 2015-16 due to the expiration of temporary funding for contracted and term-limited staff. This will cause the wait times and abandonment rates to further increase.

Consequences of Problem

- Callers will continue not to be able to get the answers they need related to their health care coverage which present barriers and delays to accessing health care services, leading to poorer health outcomes and subsequent increased costs for the state.

Proposed Solution

- To staff the Customer Service Center with 25.0 additional full-time equivalents (FTE) in order to meet the demand of the growing Medicaid population and provide a comprehensive and efficient customer service experience.
- To increase the funding amount for CRM and IVR system costs.

Department Priority: R-10
Request Detail: Customer Service Center

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Customer Service Center	$2,077,065	$674,424

Problem or Opportunity:

The Department's Customer Service Center (CSC) has experienced an unprecedented increase in call volume as a result of implementation of the Affordable Care Act and program expansions. The CSC is the most widely used communication channel the Department has with over 1 million Medicaid clients. The record call volume has meant that the CSC has only been able to answer about 50.1% of calls to the 1-800 number. This is far from the industry service level standard of 80% of calls answered within 5 minutes.

The Department is committed to operational excellence and delivering an extraordinary customer service experience. Accessible and efficient customer service opportunities that align with industry standards are essential to Medicaid clients who frequently have complex questions. In order to keep up with call volume, the Department has invested in state of the art cloud-based technology for the CSC, and applied LEAN techniques to operations and processes. However, despite these enhancements, the CSC is unable to effectively manage the influx of inquiries due to insufficient staffing levels which has led to long wait times in queues and excessive costs.

Since the implementation of the Affordable Care Act (ACA) and SB 13-200 "Expand Medicaid Eligibility" in October 2013, the Department's Customer Service Center (CSC) has experienced historic call volumes. Call volumes increased from 10,471 calls in May 2013 to 68,169 calls in May 2014 as clients sought information about their health coverage; at the peak in January 2014, the Department received 97,775 calls[1]. Many of the newly eligible clients are not familiar with the Medicaid program and have more complex questions than clients who had previously been eligible for Medicaid, thus leading to longer call lengths, which increases wait times for other callers in the queue. The Department's call center staff are unable to support the increased call volume, which has led to long hold times, high abandonment rates, increased costs, unanswered questions, and frustrated clients. In order to manage the increased costs associated with clients being on hold, the Department has had to regulate the number of calls that can be received, preventing callers

[1] Measurement of the problem has been difficult because accurate wait times are not available prior to October 2013, when the Department was using a different phone system. After implementation of the new Interactive Voice Response (IVR) cloud-based phone technology in October 2013, which was funded through the R-12, "Customer Service Technology Improvements", FY 2013-14 Budget Request, data to show the true number of callers in the queue was available.

from even accessing the Interactive Voice Response (IVR) self-help features. The Department is struggling to manage the current volume and increased telephone system costs and as a result, clients are not getting the service that they need. The Department expects that call volume will continue to increase, from 340,000 calls in FY 2014-15 to 435,000 calls in FY 2016-17 which is likely to further exacerbate the issue.

As a result of the increase in the number of callers in the queue, the Department has experienced unexpected increases in monthly telephone system costs. For FY 2014-15, the General Assembly funded the Department's BA-14 request, "Customer Service Technology True-Up", to help cover the increasing IVR costs. The estimates in that request were based upon the limited data that was available at the time, which was only two months of call volume. The Department's experience has been that even with this additional funding, call volumes were higher than expected and created a need to manage the phone systems to control costs. Beginning in March 2014, the Department took steps to manage these costs by limiting the number of callers in the queue, which means clients are receiving a message instructing them to call back later when all lines are in use and there are more than 20 callers in the queue. This approach leads to callers not being able to get the answers they need related to their health care coverage which can present barriers and delays to accessing health care services.

In an additional effort to help address the staffing shortage, the Department hired additional FTE through freed up state fund dollars realized through enhanced federal funding. The Department received approval for time-limited enhanced federal funding through an Implementation Advanced Planning Document (IAPD) in December 2013 from the Center for Medicare and Medicaid Services (CMS), related to improving eligibility and enrollment processes for implementation of the changes required by the Affordable Care Act (ACA). With the enhanced federal funding, the Department was able to hire five term-limited positions for the CSC. Two of these term-limited positions are direct customer support staff, which brought the direct customer facing staff to a total of 19, and the other three provide critical system and management support for ongoing operations. The IAPD, which includes a 90% federal match rate on activities related to implementing the ACA is only available through December 2015. After that time, the Department would be required to eliminate some, or all, positions, because state funding to maintain the five positions would not be available.

The Department has taken additional steps in an effort to provide adequate assistance to callers, including allocating seven contracted staff from funding received through the Department's September 2013 County Administration Interim Supplemental Request to the CSC. The contracted representatives were added in March 2014 and began taking calls in April 2014. These representatives have helped improve wait times but they are only available for the CSC until December 2014, as the Department only requested funding through that point. As the Department expects call volumes to continue to increase as a result of new enrollees, annual redeterminations and annual open enrollment for Connect for Health Colorado, the expiration of these positions would likely increase wait times and abandonment rates.

In an effort to improve customer accessibility, the Department continues to enhance customer support through use of technology. The bulk of the CSC interactions are over the telephone so the new IVR system includes an automatic call distributor (ACD) to distribute the workload equally to the agents and ensure that the callers wait the shortest time possible. Additionally, supervisory features allow the supervisor to silently monitor both sides of a call and to monitor the call queues real-time. A "screen pop" application brings up a screen

displaying the caller's information when the agents answer the call. The customer relationship management (CRM) system tracks the client interactions and provides a database of analytical tools to look for trends and sort by demographics. With this system, the clients do not have to tell their whole history to the agent, and the agent can see what has been done or is being worked on by others. The CRM includes a knowledge based feature where articles are stored that can be easily searched by the agents. Additional efficiencies are also being gained by lower-cost interaction methods, such as the IVR self-service features, web-based online form and web chat. Effective June 2014, the web-based transactions were implemented and have been very successful. These additional contact methods allow clients who prefer self-serve options to utilize them while lowering the call volume and wait times for those clients either who prefer or whose problems necessitate phone contact with a live representative. The chat feature maximizes productivity because agents are able to chat with up to 5 users at once, as well as assist with responses to the online forms. However, currently the Department can only respond to chat for four hours a day, between 12:30 and 4 p.m., because those agents must also assist with staffing the phones. While these communication methods provide beneficial alternatives, the limited hours of availability are less than ideal for customers. In order to respond timely to the phone and web-based inquiries during all hours of operation, the staffing size must increase.

A successful contact center operation optimizes people, processes, and technology. The CSC has maximized processes and technology performance. However, the substantial growth in customer contacts requires increasing the number of staff. Since ACA implementation, CMS has required each state to complete and submit the "Medicaid and CHIP Eligibility and Enrollment Performance Indicators" report, which includes call center metrics that are made public. As a result of the first reports, CMS has expressed concerns with Colorado's estimated call wait times and abandonment rates. Concerns about long wait times and frustrated clients have also been echoed by advocates and plaintiffs working with the Attorney General's office on eligibility lawsuits.

Proposed Solution:

The Department requests $2,077,065 total funds comprised of $674,424 General Fund, $364,111 Hospital Provider Fee cash funds and $1,038,530 federal funds in FY 2015-16 and ongoing to staff the Customer Service Center with 25.0 additional full-time equivalents (FTE) in order to meet the demand of the growing Medicaid population and provide a comprehensive and efficient customer service experience. Additionally, this request includes additional funding for the IVR system to support the expected volume of calls, which is currently being regulated to manage costs. This request supports the Department's long term, multi-year goal to provide clients with a seamless, coordinated, and efficient customer service experience to ensure they can navigate the system and obtain the services they need.

Additional staff are essential for ongoing operations of the call center. If additional funding is not received, customer facing staff of the CSC will drop from 17 currently to 10 when the funding for the 7 contracted staff ends in FY 2014-15. Additionally, the loss of the 5 IAPD positions who provide crucial systems, help desk and training support to the CSC would have to be absorbed within current resources and would negatively impact wait times and abandonment rates that the Department is already having difficulty managing. Further, the loss of call center FTE could require the Department to implement more call restrictions in order to control costs and maintain a manageable call queue.

By adding 25.0 call center FTE, 20.0 of whom would be new positions to the CSC. Five of the requested FTE are currently funded through the IAPD which will only be available through December 2015. With the requested level of staffing, the Department anticipates that 80% of calls would be answered within five minutes or less. In order to estimate the number of FTE to reach this outcome, the Department utilized the output of the Erlang calculator[2], an industry standard used to estimate how many agents are needed for each hour in an 8 hour day in order to hit a certain level of customer service (80% of calls answered within five minutes). The calculator evaluates call centers based upon three main factors: average call duration, average wrap up time, and call answering target, based upon the hourly call volume input by the Department. Based on the calculator's output the Department would need 28.0 representatives in order to meet the industry standard of 80% of calls, which would require 18.0 additional representatives. The other two requested new FTE would be a team leader and a manager which are critical positions responsible for hiring, call center monitoring, training, reporting and strategic planning.

Two of the continued staff have direct customer contact through online methods and the other three are critical to ongoing systems support of the CSC technology, contract management, training and management of staff. This would allow for a total call center staff of 35.0 FTE, (including the 10 current employees), with 28.0 FTE representatives on the phones and 7.0 FTE for serving clients through web-based help desk, management, training, and call center systems and help desk support, as described in the detailed position descriptions. Detailed descriptions of the 25.0 FTE positions can be found in Appendix A and a summary of these costs can be found in tables 2.1 and 2.2 As Medicaid caseload is expected to continue to increase, the continuation of these positions are critical to the CSC as they support the ongoing operations and new cloud based technology being implemented by the Department. This staffing level would allow for adequate staffing for expected caseload growth and increases in contact with customers through calls, e-mail, and online chat and forms.

The Department believes reaching this target would be most achievable by hiring FTE rather than temporary staff or outsourcing the functions. On a consistent basis, the Department is not able to retain temporary CSC staff long enough to have them fully trained and ready to provide efficient and effective customer service. Operational experience and research carried out by several companies confirms that agents have the greatest impact on customer satisfaction. Medicaid is a complex program requiring many hours of training to fully be able to assist clients. Having all of the staff housed in the same location and reporting to the same management team allows for consistent training for all staff and creates a stronger team environment where staff are better able to learn from one another and have opportunities for career growth, which helps to address turnover issues. Additionally, these staff would be cross-trained so that the CSC has the flexibility to shift job duties to meet changing demands associated with a call center environment as volumes and types of requests fluctuate throughout the year. For example, the CSC now answers inquiries in online chat and forms, and e-mails. In order for staff to answer all inquiries through all methods, a broad level of knowledge and professional communication skills are essential, and can be improved upon through cross training and personnel retention. It would be difficult to achieve the daily and hourly flexibility needed to shift staff based on the type and number of calls if the Department outsourced these staff. In addition to 18 new staff directly helping customers on the phone and through online methods, this request includes 7 staff to manage contracts

[2] http://www.erlang.com/calculator/

and provide system and help desk support for CSC operations. For a detailed look at CSC FTE with and without funding please see the table below.

Call Center Structure With and Without Additional FTE			
Type of Employee	**Current Call Center Structure**	**FY 2015-16 Call Center Structure <u>Without</u> Additional Funding [(1)]**	**FY 2015-16 Call Center Structure With Additional Funding**
IAPD Term-Limited Operations and Management	3	0	0
IAPD Term-Limited Help Desk Representative	2	0	0
Term-Limited Contracted Call Center Representative	10	0	0
FTE Call Center Representative	10	10	28
New/Continued Operations and Management FTE	0	0	7
Total	**25**	**10**	**35**

[(1)] Term-Limited Contractor funding expires at the end of FY 2014-15. IAPD positions expire in December 2015.

Additionally, although supplemental funding was received for increased IVR costs, the current funding is not sufficient to support ongoing call volumes, which has required the Department to continue to limit callers in the queue to manage the budget. This request includes a request for an additional $792,775 to cover IVR costs. Having adequate staff to answer calls would increase the number of callers who are able to get through to a representative and get their questions answered, which leads to increased IVR costs. Detailed calculations of the additional IVR cost can be found in table 4.1 and 4.2.

Anticipated Outcomes:

The Department anticipates that if this request is funded, the call center would have the ability to answer 80% of calls within five minutes, have adequate staffing to respond to online forms and real-time chat, and reduce frustration for customers. Additionally, staffing the CSC is a step towards the long- term goal of a coordinated and efficient customer service experience for Medicaid clients, which would bring together state agencies, counties, providers and stakeholders through an integrated system allowing representatives at any agency to view caller information and offer complete and accurate information to meet their needs.

If this request is not funded, the lack of staff would continue to greatly inhibit the Department's ability to meet Department objectives and stakeholder and CMS expectations of timely and effective customer service. Most importantly, without the resources that the CSC needs, clients would not be able to receive the customer service they need to navigate the complex Medicaid system and receive the services they need. Wait times and abandonment rates would increase as staffing is reduced through the expiration of current funding potentially requiring the Department to implement further call restrictions such as limiting the wait time

before the system hangs up. Additionally, the stress of an understaffed CSC has led to high turnover which would likely continue or increase without additional FTE to support the system. The Department would also continue to pay for long hold times and unanswered call volumes.

Assumptions and Calculations:

In order to calculate the number of FTE to fully staff the call center the Department utilized a basic Erlang calculator. This calculator estimates that, based upon hourly call volume input by the Department, in order for the Department to meet the industry standard of a 20% abandonment rate and calls answered in 5 minutes or less, the CSC would need 28.0 customer facing representatives. Further detail including position descriptions can be found in Appendix A.

The Department's request includes base salaries, fringe benefits, operating costs and leased space costs for 25.0 FTE. The Department assumes that 20.0 new positions would begin employment in July 2015 and the 5.0 would continued FTE would begin in January 2016. Detailed calculation documentation can be found in the attached appendices.

The increase in IVR costs was calculated in Table 4.1, which details the current appropriation and Table 4.2, which shows the incremental difference based upon an estimated need provided by the current vendor. The additional minutes were provided by the vendor as an estimate of actual cost based upon current volume. The additional cost for Salesforce/CRM licenses is based upon the fact that these need to be expensed over the three year period rather than all in year one as previously assumed.

The Department assumes 27.72% of the state share of the request would be funded through the Hospital Provider Fee Cash Fund. This percentage was derived from the anticipated increase in caseload for FY 2015-16 from the Department's FY 2015-16 R-1 "Request for Medical Services Premiums" budget request by calculating the percentage of total Medicaid caseload (excluding non-citizen and partial dual eligible clients) that is financed with hospital provider fee funds. This includes Disabled Buy-In, MAGI Adults and MAGI Parents/Caretakers 69-133% FPL.

Appendix A: Descriptions of Requested Positions

New Proposed FTE Positions

POSITION TITLE	FTE	JOB CLASS	DESCRIPTION OF POSITION
Customer Service Inbound Call Representative	8.0	Technician I	The growth in Medicaid client roster have exceeded the Customer Service Center's (CSC's) capacity resulting in significant customer wait times and lead to a customer response rate under 50 percent. This means that less than half of all calls placed to the CSC's number are answered. This position serves the traditional function of answering inbound calls and answering client questions. In addition, the Department would expand this role, by offering call back features for our clients who don't want to wait and rather leave a message for an agent to call them back in order to minimize client wait time.
Customer Service Representative /PEAK Chat Representative	10.0	Technician II	This position would include all the duties assigned to a Customer Service Inbound Call Representative and would include additional responsibilities concerning PEAK. PEAK traffic continues to grow and with the addition of chat functionality and the increased promotion of the CSC's email address, additional staff will be needed to address these inquiries. These staff would manage the online form ticket queue to the Center, responding to and resolving inquiries so that critical issues are responded to quickly. PEAK chat will ultimately expand beyond the 12:30 pm to 4:00 pm operational hours to match the Service Center's full operational hours of 7:30 am to 5:15 pm Monday through Friday. In addition, chat will grow in popularity as increased use of the PEAK website increases the chat's exposure to clients. Agents in this role would work both functions. In the future they may also support responses to the text/SMS messaging if that function is implemented in the PEAK application.
Customer Service Center Team Lead	1.0	General Professional IV	The position would provide support to the Manager by acting on his/her behalf during absence. Ensure efficient uninterrupted operations within the center. Provides input on staff yearly performance evaluations. Assists with hiring decisions and disciplinary actions when necessary. Provides 1:1 coaching and quality monitoring to support call center standards. Work closely and communicate clearly with Call Center Management team.

POSITION TITLE	FTE	JOB CLASS	DESCRIPTION OF POSITION
Customer Service Center Manager	1.0	General Professional V	The position would serve to provide day-to-day supervision of staff, including ensuring adequate staffing, timely hiring, quality monitoring, training, coaching, performance management and disciplinary actions when necessary. Would work closely with Call Center Management team to develop and support strategic vision for center, ensure alignment of business processes and practices. Provide regular reporting matrix of call center performance, design and implement efficiencies and best practices based on sound data. A second manager would mean an adequate manager to staff ratio of 1:15.
PEAK Help Desk Specialists	2.0	Technician I	These positions exist to support the on-line Help Desk functions of the PEAK client web-based application portal and are responsible for password resets and customer service related questions for consumers using the PEAK Website. More than 176,000 unique visitors have used the PEAK website and 112,934 new PEAK accounts have been created since the site's launch in October. As the Department moves towards a more self-service oriented model of service delivery for consumers, website traffic will become more prevalent and the need for support will continue indefinitely. Additionally, the Department is launching an on-line chat feature and online ticket for medical assistance questions in June 2014 using the PEAK Platform. The implementation of these features will drastically increase traffic flow from phone support to on-line support; so the on-going need for these positions will be critical to the success of PEAK consumer assistance.
Knowledge Management Specialist	1.0	General Professional II	The position supports the CRM and IVR systems for the CSC. This position is a subject matter expert for the CSC regarding call handling and chat scripts, which is required for effective call handling. The position is essential as the Department expands into other platforms besides calls (online customer chat, social media, etc.) which would require new policies and procedures. This position works with program staff to understand changes in regulations, policies, best practices and operations to ensure CSC staff have current and accurate resources to better serve clients. This position plays an integral role in the on-going training and development of staff and ensures consistency when

POSITION TITLE	FTE	JOB CLASS	DESCRIPTION OF POSITION
			interacting with clients, regardless of the method in which the contact the CSC.
Operations Supervisor	1.0	General Professional V	This position exists to provide support to the Client Services Division (CSD) with the implementation and project management of the CSC's technology systems. This position has had an integral role in the implementation of the initial technology improvements required for the implementation of the Affordable Care Act and is critical as the Department implements technology for online chat and social media functions. This position is responsible for managing the new contract management, knowledge management and the quality analytics positions to ensure they operate seamlessly as a team.
CRM Project Manager	1.0	General Professional II	The position serves as the on-site project manager for all aspects of technology in the CSD including the CRM and IVR software. This position handles the behind the scenes technical projects that need to take place on an on-going basis in order to respond to the changing business needs of the CSC. The position manages projects and complex system issues and provides technical assistance to the Department's end users. The position is necessary for continued successful operations of the Department's CRM and IVR.

Table 1.1 Summary by Line Item					
FY 2015-16	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
Total Request	**$2,077,065**	**20.83**	**$674,424**	**$364,111**	**$1,038,530**
(1) Executive Director's Office; (A) General Administration, Personal Services	$841,275	20.83	$304,038	$116,601	$420,636
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$190,248	0.0	$68,756	$26,368	$95,124
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$1,658	0.0	$599	$230	$829
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$33,169	0.0	$11,988	$4,597	$16,584
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$32,038	0.0	$11,579	$4,440	$16,019
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$109,672	0.0	$39,635	$15,201	$54,836
(1) Executive Director's Office; (A) General Administration, Leased Space	$76,230	0.0	$27,550	$10,565	$38,115
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$792,775	0.0	$210,279	$186,109	$396,387

Table 1.2 Summary by Line Item					
FY 2016-17	**Total Funds**	**FTE**	**General Fund**	**Cash Funds[1]**	**Federal Funds**
Total Request	**$2,231,328**	**25.0**	**$730,174**	**$385,493**	**$1,115,661**
(1) Executive Director's Office; (A) General Administration, Personal Services	$1,039,797	25.0	$375,783	$144,116	$519,898
(1) Executive Director's Office; (A) General Administration, Health, Life, and Dental	$198,175	0.0	$71,621	$27,467	$99,087
(1) Executive Director's Office; (A) General Administration, Short-term Disability	$2,050	0.0	$741	$284	$1,025
(1) Executive Director's Office; (A) General Administration, S.B. 04-257 Amortization Equalization Disbursement	$44,723	0.0	$16,163	$6,199	$22,361
(1) Executive Director's Office; (A) General Administration, S.B. 06-235 Supplemental Amortization Equalization Disbursement	$44,257	0.0	$15,995	$6,134	$22,128
(1) Executive Director's Office; (A) General Administration, Operating Expenses	$23,750	0.0	$8,583	$3,292	$11,875
(1) Executive Director's Office; (A) General Administration, Leased Space	$85,801	0.0	$31,009	$11,892	$42,900
(1) Executive Director's Office; (A) General Administration, General Professional Services and Special Projects	$792,775	0.0	$210,279	$186,109	$396,387

[1] Cash Fund Portion is Hospital Provider Fee and is equal to 27.72% of the State's share of expenses

Table 2.1
Summary by Initiative FY 2015-16

Item	Total Funds	FFP	General Fund	Cash Funds[1]	Federal Funds	Source/Calculation
FTE	$1,208,060	50%	$436,595	$167,437	$604,028	FTE Table
Total Leased Space	$76,230	50%	$27,550	$10,565	$38,115	Table 3.2 Row G
Additional IVR and CRM Costs	$792,775	50%	$210,279	$186,109	$396,387	Table 4.2 Row H
Total	**$2,077,065**		**$674,424**	**$364,111**	**$1,038,530**	

Table 2.2
Summary by Initiative FY 2016-17

Item	Total Funds	FFP	General Fund	Cash Funds[1]	Federal Funds	Source/Calculation
Continued FTE	$1,352,752	50%	$488,886	$187,492	$676,374	FTE Table
Total Leased Space	$85,801	50%	$31,009	$11,892	$42,900	Table 3.2 Row G
Additional IVR and CRM Costs	$792,775	50%	$210,279	$186,109	$396,387	Table 4.2 Row H
Total	**$2,231,328**		**$730,174**	**$385,493**	**$1,115,661**	

[1] Cash Fund Portion is Hospital Provider Fee and is equal to 27.72% of the State's Share of expenses.

Table 3.1 FY 2014-15 Commercial Leased Space Summary			
Row	**Item**	**FY 2014-15**	**Source/Calculation**
A	Monthly Rent for 225 East 16th Avenue (242 Workspaces)	$65,962.45	Building Lease
B	Monthly Rent for 303 East 17th Avenue Suite 700 (161 Workspaces)	$46,358.81	Building Lease
C	Total	$112,321.26	Row A+ Row B
D	Total Number of Existing Work Spaces	403	Total Existing Workspaces
E	Monthly Rent per Workspace	$278.71	Row C / Row D
F	**Yearly Rent Per Workspace**	**$3,344.52**	**Row E * 12 Months**

Table 3.2 Projected Leased Space Costs					
Row	**Item**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**Source/Calculation**
A	Average Annual Rate Increase on Current Building Leases	1.3%	1.3%	1.3%	Based on 303 East 17th Building Lease
B	Estimated Yearly Rent Per Workspace	$3,344.52	$3,388.00	$3,432.04	FY 2014-15: Table 3.1 Row F FY 2015-16, FY 2016-17: Previous Fiscal Year Rent * (1+ Row A)
C	Number of Workspaces for Implementation Advance Planning Document (IAPD) Postions[1, 2]	0	2.5	5	Number of IAPD Positions (see narrative)
D	Estimated IAPD Position Leased Space Cost	$0	$8,470	$17,160	Row B * Row C
E	Number of Workspaces for new Positions[1]	0	20	20	Number of new employees (see narrative)
F	Estimated New Position Leased Space Cost	$0	$67,760	$68,641	Row B * Row E
G	**Estimated Total Lease Space Cost**	**$0**	**$76,230**	**$85,801**	Row D + Row F

[1] Number of positions has been used rather than FTE. Leased space is not affected by the General Fund pay date shift.

[2] Leased space for IAPD FTE will be paid using existing enhanced federal funding until December 2015. The position numbers have been halved in FY 2015-16 to account for the partial year funding.

Table 4.1 -Interactive Voice Response (IVR) and Customer Relationship Management (CRM) Systems Funding for FY 2014-15

Row	Item	Total Funds	FFP	General Fund	Cash Funds	Federal Funds
A	Additional Minutes with IVR Vendor	$550,000	50%	$275,000	$0	$275,000
B	OIT Verbal Attestation Storage	$3,468	50%	$1,734	$0	$1,734
C	Salesforce/CRM Licenses	$0	50%	$0	$0	$0
D	Development Hours	$200,000	50%	$100,000	$0	$100,000
E	OIT Business Analyst	$62,000	50%	$31,000	$0	$31,000
F	OIT Senior IT Project Manager	$80,000	50%	$40,000	$0	$40,000
G	Total [1]	$895,468		$447,734	$0	$447,734

[1] Funding for the Customer Service Center was approved through the Department's FY 2014-15 BA-14 "Customer Service Technology True-up" Budget Request.

Table 4.2 -Interactive Voice Response (IVR) and Customer Relationship Management (CRM) Systems Funding Request for FY 2015-16 and Onward

Row	Item	Total Funds	FFP	General Fund	Cash Funds	Federal Funds	Source/Calculation
A	Additional Minutes with IVR Vendor	$1,028,400	50%	$371,664	$142,536	$514,200	Estimate provided by current vendor based upon volume
B	OIT Verbal Attestation Storage	$3,468	50%	$1,734	$0	$1,734	No Changes
C	Salesforce/CRM Licenses	$314,375	50%	$113,615	$43,573	$157,187	Actual cost
D	Development Hours	$200,000	50%	$100,000	$0	$100,000	No Changes
E	OIT Business Analyst	$62,000	50%	$31,000	$0	$31,000	No Changes
F	OIT Senior IT Project Manager	$80,000	50%	$40,000	$0	$40,000	No Changes
G	Total Estimated Need	$1,688,243		$658,013	$186,109	$844,121	
H	**Incremental Difference (Request Amount)**	**$792,775**		**$210,279**	**$186,109**	**$396,387**	**Row G - Table 4.1 Row G**

Table 5.1 Monthly Caseload, Calls Received, and Agent Calls From December 2013 through June 2014

Month	Medicaid Caseload	Total Calls to Customer Service Center [1]	Calls to speak with an Agent[2]	Calls to Agents Answered	Calls to Agents Unanswered	Percent of Calls to Agents Unanswered
April 2013	707,290	19,304	19,304	13,583	5,721	29.64%
May 2013	719,585	16,858	16,858	12,552	4,306	25.54%
June 2013	729,074	16,552	16,552	12,228	4,324	26.12%
July 2013	724,724	19,263	19,263	14,444	4,819	25.02%
August 2013	731,093	20,975	20,975	14,542	6,433	30.67%
September 2013	744,085	19,068	19,068	10,786	8,282	43.43%
October 2013	735,952	45,224	26,355	11,051	15,304	58.07%
November 2013	753,807	54,860	23,040	10,331	12,709	55.16%
December 2013	772,954	68,227	31,654	10,067	21,587	68.20%
January 2014	889,665	97,775	38,655	10,592	28,063	72.60%
February 2014	923,526	90,957	26,155	10,198	15,957	61.01%
March 2014[3]	976,972	95,503	21,681	12,940	8,741	40.32%
April 2014	1,009,483	84,985	17,936	15,325	2,611	14.56%
May 2014	1,021,745	68,169	18,492	13,553	4,939	26.71%
June 2014	1,047,466	64,286	17,295	12,825	4,470	25.85%
Average	**817,140**	**52,133.73**	**24,552.57**	**12,334.47**	**9,884.40**	**40.19%**
Total	**N/A**	**782,006**	**333,283**	**185,017**	**148,266**	**N/A**

[1] Prior to October 2013 the Customer Service Center (CSC) supported both a local 303 area code number and a 1-800 number for clients to call. The local number was discontinued starting in October 2013.The call numbers from April 2013 thru September 2013 include both local and 1-800 call data.

[2] Prior to October 2013 all calls to the 1-800 number were directed to the agent queue . In October, a touch tone self service option was created, meaning that all calls did not immediately flow to the agent queue. These numbers represent non-application calls to the CSC, since application calls are handled by an outside vendor.

[3] In order to control toll-free and IVR charges, the CSC implemented a cap on the number of callers that could be placed on hold at one time in order to limit the number of total agent call minutes to 40,000 a day. The cap causes a caller to hear a busy signal when they call the 1-800 number. This artificially lowers both the number of calls to agents and to the 1-800 number.

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-11

Request Titles

R-11 Public Health and Medicaid Alignment

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$5,724,352,770	$0	$5,768,568,225	$1,400,000	$1,400,000
	FTE	-	-	-	-	-
	GF	$1,608,812,454	$0	$1,654,584,623	$495,740	$495,740
	CF	$622,898,368	$0	$628,705,349	$190,120	$190,120
	RF	$0	$0	$0	$0	$0
	FF	$3,492,641,948	$0	$3,485,278,253	$714,140	$714,140

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	Total	$5,724,352,770	$0	$5,768,568,225	$1,400,000	$1,400,000
	CF	$622,898,368	$0	$628,705,349	$190,120	$190,120
	FF	$3,492,641,948	$0	$3,485,278,253	$714,140	$714,140
	GF	$1,608,812,454	$0	$1,654,584,623	$495,740	$495,740

Letternote Text Revision Required?	Yes	No	X	If Yes, describe the Letternote Text Revision:
Cash or Federal Fund Name and CORE Fund Number:	Hospital Provider Fee Cash Fund (24A0)			
Reappropriated Funds Source, by Department and Line Item Name:	N/A			
Approval by OIT?	Yes	No	Not Required:	X
Schedule 13s from Affected Departments:	N/A			
Other Information:	N/A			

Cost and FTE

- The Department requests funding of $1,400,000 total funds, including $495,740 General Fund and $190,120 Cash Funds to align the work of Colorado's Local Public Health Agencies (LPHAs) with the Accountable Care Collaborative (ACC). The request does not require any additional FTE.

Current Program

- The mission of the ACC is to improve clients' health and reduce costs through a coordinated, client-centered system. It is made up of seven Regional Care Collaborative Organizations (RCCO) that connect clients to Medicaid providers and help clients find community and social services in their area.
- Colorado currently has 54 LPHAs serving 64 Colorado counties that focus on population health, public health initiatives, community health outreach, health education, and many provide direct services such as immunizations and cancer screenings.

Problem or Opportunity

- Clients enrolled in Medicaid often have limited health literacy which can lead them to seek fewer preventive services, have a higher chance for developing a chronic condition, higher hospitalization rates, poorer health status, and often incur higher health care costs when compared to enrollees in private health insurance.
- The Department has the opportunity to utilize the expertise and experience of LPHAs to address gaps in service and education for Medicaid clients.
- By formalizing the relationship between LPHAs and the ACC, the Department can bridge the gap between direct health care and population based health intervention that have the potential to lower health care costs in the long term.
- Funding for integration of population health and individual health care services is currently not available in the ACC Program.

Consequences of Problem

- Without funding, public health services would fail to become an integrated part of the ACC. Population health and individual health services would continue to be provided in siloes, creating duplication and lack of coordination despite both types of services striving to achieve the same goal - a healthy Colorado.
- Poor health literacy is a common problem within the Medicaid population, and can lead to poor health outcomes and expensive treatment. Many LPHAs provide community outreach and health education to alter behaviors that can lead to expensive and unnecessary care. Without funding, the Department would lose the opportunity to utilize LPHA experience that could have a positive impact on health outcomes within the Medicaid population.

Proposed Solution

- The Department proposes that funding will be made available to each of the seven RCCOs to work jointly with LPHAs to support programs and services to Medicaid clients not currently available within the Medicaid framework.
- By establishing a Memorandum of Understanding with each RCCO, the Department would ensure that funding formalizes a relationship that builds on the expertise of LPHAs and RCCOs in providing quality health care that improves health outcomes.

Department Priority: R-11
Request Detail: Public Health and Medicaid Alignment

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Public Health and Medicaid Alignment	$1,400,000	$495,740

Problem or Opportunity:

Individuals with limited health education often seek fewer preventive services, are more likely to have a chronic condition, have higher hospitalization rates, worse health status, and incur higher health care costs than individuals that are more health literate[1]. The Department has an opportunity to utilize the expertise and experience of Local Public Health Agencies (LPHAs) to address gaps in services and education for Medicaid clients to improve health outcomes and contain long term costs. Limited health education is more common among older adults, racial and ethnic minorities, people without a high school diploma, and people with low income levels. These are common traits among the Medicaid population, who currently have few resources to acquire meaningful health education, potentially resulting in poor health outcomes. It is estimated that as many as ninety percent of adults may lack the skills necessary to manage their health to prevent or treat disease[2]. Health education reaches out to the population in an effort to change behaviors in ways that maximize treatments that individuals receive for chronic disease or post-acute care. Health education is a core public health function that can have a lasting impact on health outcomes and health care costs for those given the tools and training to make better health decisions.

Bridging the gap between direct health care and population based health interventions represents a significant opportunity for containing long term costs and improving client outcomes in the Medicaid population. While the Department is well positioned to leverage the Accountable Care Collaborative (ACC) to achieve this type of integration, funding is not currently allocated for this specific type of integration and coordination. The ACC Program aims to improve clients' health and reduce costs through a coordinated, client-centered system. The ACC is made up seven Regional Care Collaborative Organizations (RCCOs) that connect clients to Medicaid providers and also help clients find community and social services in their area. By formalizing a partnership between LPHAs that primarily work on population health and community outreach with RCCOs, the Department could have a long term impact on client health care outcomes while ensuring sound stewardship of financial resources.

[1] Quick Guide to Health Literacy. www.health.gov <http://www.health.gov/communication/literacy/quickguide/factsliteracy.htm>
[2] < http://www.health.gov/communication/literacy/quickguide/factsbasic.htm>

Colorado currently has 54 LPHAs serving 64 Colorado counties. LPHAs focus on population health, public health initiatives, community health outreach, health education, and many provide direct services such as immunizations and cancer screenings. LPHAs are independently operated and largely grant funded, resulting in programs and services that differ significantly depending on the needs of the communities they serve. A recent survey of LPHAs conducted by the Colorado Department of Public Health and the Environment (CDPHE) indicated strong preferences towards a more integrated local health system through increased communication and planning with RCCOs. Funding collaboration would formalize this partnership and take full advantage of the ACC's mission to make innovations in Colorado's health care delivery system.

Significant opportunity exists to leverage the ACC program to better coordinate with LPHAs to ensure Medicaid clients have access to not just direct health care services to treat a defined problem, but population-based health services that cover a wide range of services and programs. For example, some LPHAs provide community-based diabetes management training for the public. Because diabetes is a condition of high prevalence in the Medicaid population, there is high value added when clients are connected to the classes through the ACC as part of the care coordination activities of the RCCOs. Similarly, obesity is common in the Medicaid population and may lead to poor health outcomes that may have been prevented with intervention. 37 LPHAs across Colorado have chosen obesity as a priority for intervention and education[3]. Further opportunity exists if the RCCOs were to work directly with LPHAs to develop Medicaid specific population health interventions. Unfortunately, there is no dedicated funding for this type of coordination, despite the opportunity to leverage additional federal dollars through the Medicaid program.

Proposed Solution:

The Department requests $1,400,000 total funds, including $495,740 General Fund and $190,120 Cash Funds, for FY 2015-16 and future years to provide funding for RCCOs to support programs proposed by LPHAs.

Each of Colorado's seven RCCOs would establish a Memorandum of Understanding (MOU) with the Department to receive grants to work collaboratively with LPHAs in their region. Each RCCO would be eligible for funds to collaboratively administer programs and services targeting Medicaid clients. This would allow RCCOs to muster local resources in non-traditional ways to enhance Medicaid clients' access to quality health care, health education, and non-medical resources within their community. Grants would be awarded based on criteria developed by the Department directed at population health needs in the respective RCCO region. This proposal would formalize community health partnerships in order to create a more integrated health care system. LPHAs and RCCOs would be encouraged to work together in developing and submitting proposals. Likewise, multiple LPHAs could develop a proposal for a joint program to be administered in multiple counties within a RCCO region.

Without funding to support this integration, public health services would continue to be isolated to their respective departments and services would continue to be provided in siloes, potentially duplicating work

[3] Local Public Health Priority Areas
<http://www.chd.dphe.state.co.us/CHAPS/Documents/Local%20Priorities%20Grid_June%202014.pdf>

with un-coordinated programs and goals. The State would continue to have health programs working separately while clients do not receive needed preventive care or education.

Anticipated Outcomes:

Funding collaboration between LPHAs and RCCOs would allow the public health system to become an integrated part of the ACC. LPHAs are ideally positioned to assist Medicaid in meeting the goals of prevention and population health in a high-quality, cost-effective fashion. LPHAs are able to quickly and efficiently address county level population health concerns that may not be addressed at the state level.

Across the nation, integrated health models such as the ACC continue to show encouraging signs of improved client outcomes and cost savings[4]. By expanding the RCCO scope of service beyond direct services to community health programs and population health, the ACC has a greater potential for improving health outcomes and cost savings through enhanced client access and local program coordination. Partnership with the LPHAs would allow RCCOs to use local program coordination, resources, and expertise to improve the health of a community while maintaining the health of individual Medicaid clients.

Funding to align LPHAs and Medicaid could support an improved billing system to ensure more consistent reimbursement when LPHAs provide direct services to Medicaid clients. RCCOs and LPHAs would be able to formally develop population-based health programs such as chronic disease education and self-management. Specific programs would vary depending on the capacity, expertise, and local needs of the LPHAs as well as the needs of the RCCOs.

Assumptions and Calculations:

Of the $1,400,000 requested, each RCCO would receive an average of $200,000 to develop and administer a grant program accessible by LPHAs. Criteria for grant funding would be set by the Department with a focus on program coordination and client health outcomes.

The Department assumes that only some LPHAs would apply for funding, as capacity and interest in such a program would vary. Particularly in counties with a small Medicaid population there may be little interest in a joint program with the RCCOs. The seven RCCOs cover regions of Colorado with varying numbers of Medicaid clients, so the Department assumes an average of $200,000 would be administered to each RCCO to serve the Medicaid population within their region. The Department is unable to estimate the number and scope of requests from LPHAs, so the Department assumes $200,000 for each RCCO, though the Department would shift funding where necessary. Appendix A.1 is included below to provide a reference of the number of clients enrolled with each RCCO. The Department assumes that this amount of funding is sufficient to reach a critical mass of Medicaid clients within the RCCO regions, while small enough in scope to manage and oversee programs effectively as this scope of work would be new under the ACC. Based on a survey of LPHAs conducted by CDPHE showing strong interest for further RCCO collaboration, the Department anticipates roughly 80% of the 54 LPHAs will apply for funding. This would allow for roughly $30,000 for each LPHA to design and administer a program aimed at Medicaid clients in their area.

[4] <http://healthyamericans.org/assets/files/Incorporate%20Prevention03.pdf>

Programs aimed at improving population health have a potential for long term cost savings through reductions in chronic illness, tobacco use, obesity, and emergency room visits. These savings are not included in the calculations as the Department cannot predict the types of programs LPHAs and RCCOs would choose to pursue. Furthermore, the efficacy of these programs would be difficult to calculate and any savings may not be realized until years after implementation. The Department would use the regular budget process to account for any savings achieved.

Appendix A.1: Reference Table of RCCO Client Count			
Row	**Item**	**Client Enrollment June 2014**	**Comment**
A	RCCO 1 Rocky Mountain Health Plans	84,060	MMIS Data June 2014
B	RCCO 2 Colorado Access	48,735	MMIS Data June 2014
C	RCCO 3 Colorado Access	171,329	MMIS Data June 2014
D	RCCO 4 Integrated Community Health Partners	74,336	MMIS Data June 2014
E	RCCO 5 Colorado Access	51,890	MMIS Data June 2014
F	RCCO 6 Colorado Community Health Alliance	82,599	MMIS Data June 2014
G	RCCO 7 Community Care of Central Colorado	96,795	MMIS Data June 2014
	Total	**609,744**	**Row (A + B + C + D + E + F + G)**

Table 1.1 FY 2015-16 Summary and Fund Splits									
Item	**Total Funds**	**FTE**	**General Funds**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Source**
(2) Medical Services Premium									
Public Health and Medicaid Alignment	$1,400,000	0.0	$495,740	$0	$190,120	$0	$714,140	51.01%	Cash fund Percent Table 2.2
Total	**$1,400,000**	**0.0**	**$495,740**	**$0**	**$190,120**	**$0**	**$714,140**		

Table 1.2 FY 2016-17 Summary and Fund Splits									
Item	**Total Funds**	**FTE**	**General Funds**	**General Fund Exempt**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FMAP**	**Source**
(2) Medical Services Premium									
Public Health and Medicaid Alignment	$1,400,000	0.0	$495,740	$0	$190,120	$0	$714,140	51.01%	Cash fund Percent Table 2.2
Total	**$1,400,000**	**0.0**	**$495,740**	**$0**	**$190,120**	**$0**	**$714,140**		

Table 2.1: Total Caseload Excluding Non-Citizens & Partial Dual Eligibles						
Item	**FY 2015-16 Caseload Projection**	**Percent of Caseload**	**FMAP**	**FY 2016-17 Caseload Projection**	**Percent of Caseload**	**FMAP**
Adults 65 and Older (OAP-A)	43,060	3.62%	51.01%	44,025	3.44%	51.01%
Disabled Adults 60 to 64 (OAP-B)	11,442	0.96%	51.01%	11,975	0.93%	51.01%
Disabled Individuals to 59 (AND/AB)	69,042	5.81%	51.01%	71,205	5.56%	51.01%
Disabled Buy-In	4,359	0.37%	48.59%	4,951	0.39%	48.66%
MAGI Parents/ Caretakers to 68% FPL	164,433	13.83%	51.01%	180,501	14.09%	51.01%
MAGI Parents/Caretakers 60% to 68% FPL	6,502	0.55%	51.01%	6,502	0.51%	51.01%
MAGI Parents/ Caretakers 69% to 133% FPL	70,573	5.93%	100.00%	76,305	5.96%	97.50%
MAGI Adults (Excluding Non-Newly Eligibles)	254,703	21.42%	100.00%	285,624	22.30%	97.50%
Non-Newly Eligibles	1,221	0.10%	51.01%	1,221	0.10%	51.01%
Breast & Cervical Cancer Program	169	0.01%	65.71%	59	0.00%	65.71%
Eligible Children (AFDC-C/BC)	468,884	39.42%	51.01%	498,180	38.90%	51.01%
SB 11-008 Eligible Children	56,726	4.77%	82.96%	61,422	4.80%	88.71%
Foster Care	20,920	1.76%	51.01%	21,204	1.66%	51.01%
MAGI Pregnant Adults	15,333	1.29%	51.01%	15,503	1.21%	51.01%
SB 11-250 Eligible Pregnant Adults	1,971	0.17%	52.24%	2,120	0.17%	51.01%
TOTAL	1,189,338	100.00%		1,280,797	100.00%	

Table 2.2: Percent of State Share Funded Through Hospital Provider Fee		
Item	Caseload	Percent of Total Caseload
Disabled Buy-In	4,359	0.37%
MAGI Parents/ Caretakers 69% to 133% FPL	70,573	5.93%
MAGI Adults (Excluding Non-Newly Eligibles)	254,703	21.42%
Total	329,635	27.72%

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-12

Request Titles

R-12 Community and Targeted Provider Rate Increase

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16 FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$6,213,082,980	$0	$6,260,489,404	$32,910,761	$40,356,450
	FTE	-	-	-	-	-
	GF	$1,841,262,753	$0	$1,890,418,928	$11,389,124	$13,748,352
	CF	$656,530,311	$0	$659,507,706	$716,803	$833,125
	RF	$0	$0	$0	$0	$0
	FF	$3,715,289,916	$0	$3,710,562,770	$20,804,834	$25,774,973

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16 FY 2015-16	FY 2016-17 Continuation
02. Medical Services Premiums - Medical and LT Care Services for Medicaid Eligible Indvdls	Total	$5,724,352,770	$0	$5,768,568,225	$27,930,208	$35,208,693
	CF	$622,898,368	$0	$628,705,349	$379,818	$485,498
	FF	$3,492,641,948	$0	$3,485,278,253	$18,507,285	$23,396,659
	GF	$1,608,812,454	$0	$1,654,584,623	$9,043,105	$11,326,536
03. Behavioral Health Community Programs - Behavioral Health Fee-for-Service Payments	Total	$7,107,049	$0	$7,119,717	$75,092	$89,841
	CF	$0	$0	$0	$666	$797
	FF	$3,607,360	$0	$3,628,550	$51,823	$62,002
	GF	$3,499,689	$0	$3,491,167	$22,603	$27,042
04. Office of Community Living - Adult Comprehensive Services	Total	$347,106,514	$0	$346,283,894	$3,520,301	$3,630,334
	CF	$33,628,301	$0	$30,798,715	$336,283	$346,794
	FF	$160,845,358	$0	$161,214,181	$1,641,308	$1,692,610
	GF	$152,632,855	$0	$154,270,998	$1,542,710	$1,590,930

04. Office of Community Living - Adult Supported Living Services	**Total**	**$70,648,433**	**$0**	**$74,777,870**	**$747,779**	**$791,487**
	FF	$31,938,485	$0	$34,150,260	$341,503	$361,464
	GF	$38,709,948	$0	$40,627,610	$406,276	$430,023
04. Office of Community Living - Children's Extensive Support Services	**Total**	**$24,610,892**	**$0**	**$24,665,461**	**$246,655**	**$247,202**
	FF	$12,530,479	$0	$12,605,609	$126,056	$126,336
	GF	$12,080,413	$0	$12,059,852	$120,599	$120,866
04. Office of Community Living - Case Management	**Total**	**$29,300,733**	**$0**	**$29,095,579**	**$290,956**	**$288,918**
	FF	$13,706,137	$0	$13,665,625	$136,656	$135,699
	GF	$15,594,596	$0	$15,429,954	$154,300	$153,219
04. Office of Community Living - Family Support Services	**Total**	**$6,828,718**	**$0**	**$6,843,859**	**$68,439**	**$68,590**
	GF	$6,828,718	$0	$6,843,859	$68,439	$68,590
04. Office of Community Living - Preventive Dental Hygiene	**Total**	**$65,754**	**$0**	**$65,892**	**$642**	**$628**
	CF	$3,642	$0	$3,642	$36	$36
	GF	$62,112	$0	$62,250	$606	$592
04. Office of Community Living - Eligibility Determination and Waiting List Management	**Total**	**$3,062,117**	**$0**	**$3,068,907**	**$30,689**	**$30,757**
	FF	$20,149	$0	$20,292	$203	$203
	GF	$3,041,968	$0	$3,048,615	$30,486	$30,554

Letternote Text Revision Required? Yes X No	**If Yes, describe the Letternote Text Revision:** See Appendix
Cash or Federal Fund Name and CORE Fund Number:	Medical Services Premiums: $197,939 Hospital Provider Fee Cash Fund (24A0) and $308,558 Adult Dental Cash Fund (28C0); Office of Community Living: Client Cash Sources.
Reappropriated Funds Source, by Department and Line Item Name:	N/A
Approval by OIT? Yes No	**Not Required:** X
Schedule 13s from Affected Departments:	N/A
Other Information:	N/A

Cost and FTE

- The Department requests $32,910,761 total funds, including $11,389,124 General Fund in FY 2015-16.

Current Program

- Provider reimbursement for most Medicaid services does not change over time absent increases or decreases to appropriation by the General Assembly. Subsequently, rates for many services do not change based on the costs of providing the service. Provider costs can increase with inflation and other economic factors, or decrease with new technology and efficiencies.
- In FY 2012-13 and FY 2013-14, the General Assembly appropriated funds to partially restore reimbursement to prerecession levels as providers experienced multiple rate reductions since FY 2009-10.

Problem or Opportunity

- For some services, reimbursement is insufficient to maintain provider participation in the long run.
- An inconsistent, fixed fee schedule that has not been updated to account for changes in costs and potential efficiencies can create incentives for providers to utilize higher cost, less effective, and less efficient services.

Consequences of Problem

- Reduced provider participation reduces clients' access to health care. Reduced access to health care can, in turn, result in poor client outcomes and subsequent higher costs for the State.
- Incentives for providers created by insufficient and/or inconsistent reimbursement can result in utilization of services that are inefficient, less effective, and more costly. As with access issues, there are negative impacts for client outcomes and fiscal impacts for the State.

Proposed Solution

- The Department requests $32,910,761 in total funds for FY 2015-16 to increase provider rates by 1%.
- Investing in adequate provider rates and aligning payment with high value services would result in better outcomes for clients and lower costs for the State.

Department Priority: R-12
Request Detail: Community and Targeted Provider Rate Increase

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Community and Targeted Provider Rate Increases	$32,910,761	$11,389,124

Problem or Opportunity:

Investing in adequate provider rates and aligning payment with high-value services is a critical component of ensuring clients have sufficient access to care, quality outcomes are achieved, and services provided are cost-effective.

Many services provided to Medicaid clients are paid at a fixed level that does not change unless the General Assembly explicitly approves an increase or decrease to reimbursement. Throughout the recession, provider rates were reduced repeatedly. However, in FY 2012-13 and FY 2013-14 the General Assembly appropriated funding to partially restore provider rates, bringing provider rates closer to prerecession levels. However, many services continue to be reimbursed below historical levels. Inadequate reimbursement is unsustainable in the long run as it would likely limit access to care for Medicaid clients. Subsequently, limited access to care can result in poor quality outcomes and higher costs for the State as conditions that could have been prevented exacerbate in the absence of early intervention.

In addition to addressing inadequate reimbursement, there is an opportunity for the Department to establish policy that incentivizes the use of high value services and disincentivizes low-value procedures. Reimbursement for most services does not change, even though the cost of providing those services increases over time with inflation and other economic factors. Further, reimbursement for a service does not change relative to alternative services that may have shown to produce better client outcomes at a lower long term cost. Consequently, the Medicaid fee schedule does not truly incentivize providers to provide the most clinically effective, cost efficient services. In fact, because the fee schedule has not changed to accommodate the aforementioned factors, incentives to bill high volume, low efficacy procedures likely exists. This is not a problem that can be resolved with an across-the-board rate increase.

Proposed Solution:

The Department requests $32,910,761 total funds, $10,482,785 General Fund, for FY 2015-16 to increase provider rates for eligible providers. The Department would use half of the funding to provide a 0.5% rate increase for most services and use funding equal to a 0.5% rate increase in order to provide targeted increases to specific services.

In aggregate, the increases would help address adequacy of payment. Additionally, the Department would use targeted rate increases to specifically address the underlying incentive structure inherent in the Medicaid fee schedule, in order to promote utilization of high quality, cost effective procedures that ultimately improve client outcomes and reduce expenditures for the State. In cases where rates are insufficient to promote sufficient access to services, targeted rate increases would also be used.

HCPF Legislative Request for Information #1 requested that the Department submit a plan to the JBC for an ongoing annual process to address disparities in Medicaid rates. The Department contracted with the Public Consulting Group to develop a proposal based on research of insurance industry (public and private) best practices. The Department submitted its proposal on November 1, 2014; however, because that proposal requires specific approval from the General Assembly, it is possible the process could not be used for the FY 2015-16 budget cycle.

Even though the annual process has not yet been approved, it is important that the Department receive community input before proposing targeted rate increases in order to properly identify where targeted rate increase should be applied. For FY 2015-16 rate increases, the Department will work with stakeholders and interested legislators from November 2014 through January 2015 to develop a proposal that will be presented to the Joint Budget Committee by February 15, 2015. The Department requests a separate hearing with the Joint Budget Committee in February 2015 to present its rate increase proposals. This process would allow for adequate time for the Joint Budget Committee to receive input from stakeholders prior to the Department's Figure Setting, which typically occurs during the second week of March.

Anticipated Outcomes:

Implementing a provider rate increase would reduce the financial strain and risk to client access that accompanied several years' worth of rate reductions that have only partially been restored. Additionally, targeted increases would more appropriately align incentives, encouraging positive outcomes for clients and allowing the Department to pay for value rather than volume of services. Access issues related to inappropriate reimbursement rates, particularly important with the Medicaid expansion and exacerbated in rural areas, would be partially alleviated.

Providing adequate reimbursement to providers encourages participation in Medicaid and therefore increases client access, which aligns with the Department's Strategic Plan.

Assumptions and Calculations:

Implementing a provider rate increase would reduce the financial strain and risk to client access that accompanied several years' worth of rate reductions that have only partially been restored. Additionally, targeted increases would more appropriately align incentives, encouraging positive outcomes for clients and allowing the Department to pay for value rather than volume of services. Access issues related to inappropriate reimbursement rates, particularly important with the Medicaid expansion and exacerbated in rural areas, would be partially alleviated.

Providing adequate reimbursement to providers encourages participation in Medicaid and therefore increases client access, which aligns with the Department's Strategic Plan.

Assumptions and Calculations:

Estimates are based on the Department's FY 2015-16 base budget. As the Department will be revising Medicaid caseload and per capita cost forecasts through the supplemental process, adjustments to estimates may be necessary in the future.

Although these rate increases would affect most Medicaid providers, a number of providers would be exempted from rate increases or receive different rate increases. These distinctions include:

- A portion of physician and EPSDT services are not eligible for an increase in rates due to rates already being increased under Section 1202 of the Affordable Care Act and subsequently continued under state authority.
- A portion of expenditure related to non-medical emergency transportation services is not eligible for an increase due to services rendered under a fixed price contract.
- Dental administrative payments are ineligible for rate increases because the contract was competitively procured, with payment rates agreed upon during the procurement.
- Reimbursement to pharmacies are not eligible for the rate increase. Pharmaceutical reimbursement has transitioned to a methodology that reflects the actual costs of purchasing and dispensing medications. Further, pharmaceutical reimbursement is unique in that the reimbursement methodology is directly tied to a moving price statistic that increases reimbursement as provider costs increase.
- Rates for rural health clinics (RHCs) are based on actual cost or the Medicare upper payment limit. RHCs have previously not been subject to rate decreases or increases due to the unique manner in which these rates are calculated.
- Rates for Federally Qualified Health Centers would be ineligible due to recent increases bringing reimbursement for this provider type to the upper limit of allowed amount under the current reimbursement methodology.
- Rates for services provided under the home and community based services (HCBS) waiver for children with autism would be ineligible because of the cap on client expenses. An increase in rates would reduce the amount of services that clients are able to receive. For this reason, the Department has not applied rate reductions to this program in prior years and would not apply a rate increase to the reimbursement of these services.[1]
- Class I and Class II nursing facility rates are determined in accordance with statutory guidelines which has the effect of increasing reimbursement to most providers each year, based on providers' cost. Therefore, the Department is not requesting funding to increase nursing facility rates. In addition, the Department would exempt hospice rates that set in part as a function of nursing facility rates and in part

[1] The Department has submitted a separate budget action regarding the Children with Autism waiver program, requesting to allow the cap on client expenses to be adjusted for appropriated rate increases. If approved, the rationale for exempting this program from rate increases would no longer be valid, and it may be appropriate to include these services in any approved rate increase for FY 2015-16. If requested, the Department can provide the incremental cost associated with increasing rates for services in the Children with Autism waiver program.

as a result of federal requirements. Hospice rates that are not related to nursing facility rates are included in the Department's proposal.

- Physical health managed care programs, including risk-based health maintenance organizations such as the providers for the Program of All-Inclusive Care for the Elderly (PACE), are negotiated within the parameters of their respective rate setting methodology and may or may not be impacted by rate increases.
- Risk-based physical health managed care programs for Medicaid and the Child Health Plan *Plus* (CHP+) and behavioral health organizations (BHO) would not receive direct rate increases as part of this change request. Rates are set in accordance with federal regulation and actuarial standards, which do not generally permit general provider rate increases. The Department notes, however, that BHO and CHP+ rates generally increase in response to provider cost, and rates Medicaid managed care organizations would increase indirectly based on increases applied to fee-for-service rates.

See Appendix A for detailed calculations.

Table 1a: FY 2015-16 - Amounts Eligible for Rate Increase by Funding Source (Includes Budget Actions Not Yet Approved)				
Long Bill Group	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Federal Funds**
(2) Medical Services Premiums				
Acute Care	$2,317,266,793	$677,253,014	$37,841,117	$1,602,172,662
Community Based Long Term Care	$444,092,656	$216,234,601	$0	$227,858,055
Program for All-Inclusive Care for the Elderly	$0	$0	$0	$0
Service Management	$31,661,269	$10,822,841	$140,654	$20,697,774
Total Medical Services Premiums	**$2,793,020,718**	**$904,310,456**	**$37,981,771**	**$1,850,728,491**
Impact of 1% Rate Increase	**$27,930,208**	**$9,043,105**	**$379,818**	**$18,507,285**
(1) Amount of cash fund by cash fund: Hospital Provider Fee: $219,361; Breast and Cervical Cancer Prevention and Treatment Fund: $15,063; Adult Dental Fund: $145,394				
(3) Behavioral Health Community Programs				
Mental Health Fee-for-Service	$7,509,126	$2,260,265	$66,578	$5,182,283
Impact of 1% Rate Increase	**$75,092**	**$22,603**	**$666**	**$51,823**
(1) Amount of cash fund by cash fund Hospital Provider Fee: $666				

Table 1a: FY 2015-16 - Amounts Eligible for Rate Increase by Funding Source (Continued)				
Long Bill Group	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Federal Funds**
(7) Office of Community Living				
Adult Comprehensive Services	$352,030,121	$154,270,998	$33,628,301	$164,130,822
Impact of 1% Rate Increase	**$3,520,301**	**$1,542,710**	**$336,283**	**$1,641,308**
Adult Supported Living Services	$74,777,870	$40,627,610	$0	$34,150,260
Impact of 1% Rate Increase	**$747,779**	**$406,276**	**$0**	**$341,503**
Family Support Services	$6,843,859	$6,843,859	$0	$0
Impact of 1% Rate Increase	**$68,439**	**$68,439**	**$0**	**$0**
Children's Extensive Support Services	$24,665,461	$12,059,852	$0	$12,605,609
Impact of 1% Rate Increase	**$246,655**	**$120,599**	**$0**	**$126,056**

Table 1a: FY 2015-16 - Amounts Eligible for Rate Increase by Funding Source (Continued)				
Long Bill Group	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Federal Funds**
Case Management	$29,095,579	$15,429,954	$0	$13,665,625
Impact of 1% Rate Increase	**$290,956**	**$154,300**	**$0**	**$136,656**
Eligibility Determination and Waiting List Management	$3,068,907	$3,048,615	$0	$20,292
Impact of 1% Rate Increase	**$30,689**	**$30,486**	**$0**	**$203**
Preventive Dental Hygiene	$64,239	$60,597	$3,642	$0
Impact of 1% Rate Increase	**$642**	**$606**	**$36**	**$0**
Total Impact	**$32,910,761**	**$11,389,124**	**$716,803**	**$20,804,834**

(1) Amount of cash fund by cash fund
Child Welfare Transition Fund: $28,296; Cash from Clients: $307,987; Local Funds: $36

Table 1b: FY 2016-17 - Amounts Eligible for Rate Increase by Funding Source				
Long Bill Group	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Federal Funds**
(2) Medical Services Premiums				
Acute Care	$2,964,153,301	$866,314,471	$48,404,816	$2,049,434,014
Community Based Long Term Care	$524,091,004	$255,186,857	$0	$268,904,147
Program for All-Inclusive Care for the Elderly	$0	$0	$0	$0
Service Management	$32,624,967	$11,152,264	$144,935	$21,327,768
Total Medical Services Premiums	**$3,520,869,272**	**$1,132,653,592**	**$48,549,751**	**$2,339,665,929**
Impact of 1% Rate Increase	**$35,208,693**	**$11,326,536**	**$485,498**	**$23,396,659**
(1) Amount of cash fund by cash fund Hospital Provider Fee: $280,247; Breast and Cervical Cancer Prevention and Treatment Fund: $19,269; Adult Dental Fund: $185,982				
(3) Behavioral Health Community Programs				
Mental Health Fee-for-Service	$8,984,084	$2,704,231	$79,656	$6,200,197
Impact of 1% Rate Increase	**$89,841**	**$27,042**	**$797**	**$62,002**
(1) Amount of cash fund by cash fund Hospital Provider Fee: $797				

Table 1b: FY 2016-17 - Amounts Eligible for Rate Increase by Funding Source (Continued)				
Long Bill Group	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Federal Funds**
(7) Office of Community Living				
Adult Comprehensive Services	$363,033,459	$159,093,017	$34,679,414	$169,261,028
Impact of 1% Rate Increase	**$3,630,334**	**$1,590,930**	**$346,794**	**$1,692,610**
Adult Supported Living Services	$79,148,675	$43,002,315	$0	$36,146,360
Impact of 1% Rate Increase	**$791,487**	**$430,023**	**$0**	**$361,464**
Family Support Services	$6,859,034	$6,859,034	$0	$0
Impact of 1% Rate Increase	**$68,590**	**$68,590**	**$0**	**$0**
Children's Extensive Support Services	$24,720,151	$12,086,592	$0	$12,633,559
Impact of 1% Rate Increase	**$247,202**	**$120,866**	**$0**	**$126,336**

Table 1b: FY 2016-17 - Amounts Eligible for Rate Increase by Funding Source (Continued)				
Long Bill Group	**Total Funds**	**General Fund**	**Cash Funds[(1)]**	**Federal Funds**
Case Management	$28,891,862	$15,321,919	$0	$13,569,943
Impact of 1% Rate Increase	**$288,918**	**$153,219**	**$0**	**$135,699**
Eligibility Determination and Waiting List Management	$3,075,712	$3,055,375	$0	$20,337
Impact of 1% Rate Increase	**$30,757**	**$30,554**	**$0**	**$203**
Preventive Dental Hygiene	$62,759	$59,201	$3,558	$0
Impact of 1% Rate Increase	**$628**	**$592**	**$36**	**$0**
Total Impact	**$40,356,450**	**$13,748,352**	**$833,125**	**$25,774,973**

(1) Amount of cash fund by cash fund
Child Welfare Transition Fund: $29,180; Cash from Clients: $317,614; Local Funds: $36

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-13

Request Titles

R-13 ACC Reprocurement Preparation

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$6,151,808	$0	$5,481,508	$250,000	$100,000
	FTE	-	-	-	-	-
	GF	$2,225,315	$0	$1,918,265	$125,000	$50,000
	CF	$727,500	$0	$727,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,198,993	$0	$2,835,743	$125,000	$50,000

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - General Professional Services and Special Projects	Total	$6,151,808	$0	$5,481,508	$250,000	$100,000
	CF	$727,500	$0	$727,500	$0	$0
	FF	$3,198,993	$0	$2,835,743	$125,000	$50,000
	GF	$2,225,315	$0	$1,918,265	$125,000	$50,000

Letternote Text Revision Required?	Yes	No	X	**If Yes, describe the Letternote Text Revision:**
Cash or Federal Fund Name and CORE Fund Number:	FF: Title XIX			
Reappropriated Funds Source, by Department and Line Item Name:	N/A			
Approval by OIT?	Yes	No	**Not Required:**	X
Schedule 13s from Affected Departments:	N/A			
Other Information:	N/A			

Cost and FTE

- The Department requests $250,000 total funds, $125,000 General Fund, in FY 2015-16 and $100,000 total funds, $50,000 General Fund, in FY 2016-17.
- No FTE are requested with this Change Request.

Current Program

- The Accountable Care Collaborative (ACC) Program serves as Colorado's platform for reforming Medicaid care delivery, and has demonstrated a net return on investment while simultaneously improving client outcomes.
- Seven Regional Care Collaborative Organizations (RCCOs) are the primary entities responsible for driving change in the ACC Program.

Problem or Opportunity

- The RCCO contracts, central to the ongoing operation of the ACC Program, will be reprocured during FY 2016-17, with new contracts effective July 1, 2017.
- The Department lacks sufficient resources to carry out key functions that will ensure a successful reprocurement process that moves the ACC Program forward.
- The ACC reprocurement presents an important opportunity to make significant improvements in the ACC Program, such as behavioral health integration.

Consequences of Problem

- Without a neutral convener to facilitate stakeholder engagement, the Department could fail to adequately engage with stakeholders and thereby undermine long-term program efficacy.
- The Department risks a failed reprocurement, which could result in additional Medicaid enrollees in fee for service, or a loss of faith and engagement amongst the stakeholder community.
- The Department requires additional expertise in technical assistance regarding financial analysis. Without such assistance, the Department could lose an opportunity to make significant improvements in the ACC Program, or even risk losing hard-earned progress in containing costs and improving client outcomes.
- With a constraint on internal resources, the Department would not have the capacity to perform the research and outreach necessary to develop all processes necessary for the next phase of the program.

Proposed Solution

- The Department requests $250,000 total funds, $125,000 General Fund, in FY 2015-16 and $100,000 total funds, $50,000 General Fund, in FY 2016-17 to hire consultants to provide assistance in facilitating stakeholder engagement, researching policy options, and providing recommendations for program design.
- The Department would seek consultants with expertise in conducting complex stakeholder engagement processes and in Medicaid system redesign, drawing on expertise from other states to enable Colorado to make programmatic decisions in a way that leverages the lessons and best practices from other states and other programs.
- This proposal would allow the Department to maximize investment in the program to ensure continued improvements in the way that it serves Medicaid clients in the ACC Program, which is essential to the Department's mission to improve health care access and outcomes for Coloradoans and the Governor's goal to make Colorado the healthiest state in the nation.

Department Priority: R-13
Request Detail: ACC Reprocurement Preparation

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
ACC Reprocurment Preparation	$250,000	$125,000

Problem or Opportunity:

In 2009, the General Assembly approved a budget action authorizing the Medicaid Value-Based Care Coordination Initiative, now known as the Accountable Care Collaborative (ACC) Program. Contracts central to the ongoing operation of this program, for the Regional Care Collaborative Organizations (RCCO), will be reprocured during FY 2016-17, with new contracts effective July 1, 2017. Because these contracts will shape the future of the ACC Program and the Medicaid delivery system in Colorado, a successful reprocurement incorporating program elements that drive future quality outcomes and cost efficiencies in the Medicaid program is critically important. However, the Department lacks sufficient resources to carry out key functions that will ensure a successful reprocurement process that moves the ACC Program forward. Specifically, the Department has identified that additional resources are needed to support an independent stakeholder engagement process, technical support, and program/policy assessment. Without additional support through the reprocurement process, the State would risk loss of gains the ACC Program has created both in terms of cost efficiencies and client outcomes.

The ACC Program serves as Colorado's platform for reforming Medicaid care delivery, and has demonstrated a net return on investment while simultaneously improving client outcomes. Regional entities, the RCCOs are the primary entities responsible for driving change in the program. The state is geographically divided into seven regions, each one with one RCCO responsible for all of the ACC members in that region. The RCCOs' four main responsibilities and mechanisms for driving change include the following:

- Network Development: RCCOs are charged with the development of a formal contracted network of primary care providers and an informal network of specialists and ancillary providers. This addresses the core program goal of ensuring access to primary care.
- Provider Support: RCCOs are charged with support of primary care physicians participating in the ACC in providing efficient, high-quality care through activities such as providing clinical tools, client materials, administrative support, practice redesign, etc. This responsibility ties to the core program goal of ensuring a positive provider experience.

- Medical Management and Care Coordination: the RCCOs must ensure that every client receives an appropriate level of medical management and care coordination. This links to the program goal of ensuring a positive provider experience as well as a positive member experience. RCCOs can assist providers with addressing the non-medical needs of their clients that they may not have the in-house capacity to address.
- Accountability and Reporting: the RCCOs are responsible for reporting to the state on the regions' progress.

Needed support for re-procurement of RCCO contracts falls into three domains: stakeholder engagement, technical assistance related to financial processes, and program / policy assessment.

For reprocurement to be successful, the Department must conduct an intensive stakeholder-engagement process. With a weak engagement of clients, providers, and other stakeholders, the Department risks a failed reprocurement which could result in additional Medicaid enrollees in fee for service, or a loss of faith and engagement amongst the stakeholder community. Continuing to improve the ACC Program is essential to the Department's mission to improve health care access and outcomes for Coloradoans and the Governor's goal to make Colorado the healthiest state in the nation.

The ACC reprocurement presents an important opportunity to make significant improvements in the ACC Program. One important area for improvement is behavioral health integration. A robust strategic planning and stakeholder process could result in a more significant step towards integration at both the system level and at the point of care. This could result in administrative efficiencies as well as improvements in care delivery that could result in lower costs and better outcomes.

The Department also requires additional expertise in technical assistance regarding financial analysis. Goals of the ACC include moving towards purchasing value and away from an expensive and inefficient "volume-driven" system of payments. Technical assistance is necessary to expediently evaluate current payment methodologies, best practices in payment from other states, and opportunities for cross-agency savings.

Finally, technical assistance is required for program design and assessment. Policy analysis of the strengths and weaknesses of the current ACC program would help to guide contract requirements for the RCCOs during the reprocurement process. Additional national perspective and research capacity would help to identify best practices in the area of primary care practice support and subsequently the manner through which such best practices can be operationalized through the forthcoming contracts. Furthermore, this technical assistance and research capacity will also help to identify care coordination best practices in the current system and elsewhere and then establish care coordination requirements derived therefrom.

Proposed Solution:

The Department requests $250,000 total funds, $125,000 General Fund, in FY 2015-16 and $100,000 total funds, $50,000 General Fund, in FY 2016-17 to hire consultants to provide assistance in facilitating stakeholder engagement, researching policy options, and providing recommendations for program design. The Department does not currently have the range of expertise to research and evaluate these options adequately. Furthermore, a neutral convener would be helpful in conducting necessary stakeholder

engagement. External consultants would provide the temporarily-necessary capacity to complete this work. The Department would seek consultants with expertise in conducting complex stakeholder engagement processes and in Medicaid system redesign. Consultants with expertise from other states could enable Colorado to make programmatic decisions in a way that leverages the lessons and best practices from other states and other programs.

The Department believes that hiring a consultant to perform this work is the best solution to the problem for several reasons. First, external consultants would have more national exposure to best practices and other states' policies than is currently available internally. The broader range of expertise would be required to complete a thorough analysis of the program subsequently informing the reprocurement of the RCCO contracts. Second, this solution would allow an independent party to interface with relevant stakeholders and solicit information and feedback on the program and its future. Third, this proposal would allow the Department to maximize the investment in the program to ensure continued improvements in the way that it serves Medicaid clients in the ACC Program. This additional expertise would help to accelerate payment reform and delivery system redesign in Colorado.

If this request is not be approved, the Department could lose an opportunity to make significant improvements in the ACC Program, or even risk losing hard-earned progress in containing costs and improving client outcomes. Without these resources, the Department would not be able to learn about methods that are working in other states that may also work for Colorado. Furthermore, the Department could fail to adequately engage with stakeholders and thereby undermine long-term program efficacy. With a constraint on internal resources, the Department would not have the capacity to perform the research and outreach necessary to develop all processes necessary for the next phase of the program.

Anticipated Outcomes:

As a result of the research completed by the consultant, the Department expects to have a clear understanding of the best ways to deliver services for ACC clients that could be leveraged in the reprocurement of the RCCO contracts. This could have significant impacts in the cost and quality of services.

The outcomes mentioned above align with the Department's performance plan by striving to improve health outcomes, client experience, and lower per capita costs through the strategy of benefit and program design.

Assumptions and Calculations:

FY 2015-16 costs associated with the request would be $250,000 total funds, of which $125,000 is General Fund, paid to the consultant for the deliverable(s). This request would not require any additional FTE. This cost estimate is based on data on comparable activities performed for other states as well as experience in costs for the initial phase of the development of the ACC Strategic Plan. During the spring of 2014, the Department contracted with the Colorado Health Institute (CHI) to conduct initial stakeholder meetings across the state. This contract resulted in 10 meetings across the state, as well as revisions to the ACC Strategic Plan, and insight that shaped the request for information associated with this reprocurement. The contract with CHI, for $50,000, was more limited in scope than is the stakeholder engagement effort that would be financed through this request.

The specific costs components of the request include:

- $100,000 for client, provider, and other stakeholder engagement across Colorado. This funding would allow for targeted workgroups, facilitating in-depth technical discussions with stakeholders and other experts as necessary during the re-procurement. The Department intends to engage with two to three times the number of stakeholders as during the spring 2014 CHI stakeholder effort. Based on the larger scope of work, a stakeholder outreach effort of this size would require an outlay approximately twice the size of the initial CHI contract.
- $150,000 for technical assistance on financial analysis and development of best practices. This funding supports research into provider reimbursement and payment methodologies, cross-agency savings opportunities, and other payment reforms. Assistance also facilities independent guidance on maximizing strengths of the ACC program, as well as best practices for care coordination and practice support.

The Department assumes ongoing stakeholder engagement throughout FY 2016-17 leading up to the July 1, 2017 reprocured contract effective dates would cost $100,000.

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-14

Request Titles

R-14 Primary Care Fund Audit

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$55,334,780	$0	$56,205,391	$0	$0
	FTE	360.4	-	360.6	-	-
	GF	$9,771,533	$0	$10,098,270	$0	$0
	CF	$29,766,609	$0	$29,836,581	$0	$0
	RF	$1,885,519	$0	$1,920,262	$0	$0
	FF	$13,911,119	$0	$14,350,278	$0	$0

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - Personal Services	Total	$26,043,374	$0	$26,913,985	$76,056	$76,056
	CF	$2,676,189	$0	$2,746,161	$76,056	$76,056
	FF	$12,679,416	$0	$13,118,575	$0	$0
	FTE	360.4	-	360.6	-	-
	GF	$8,802,250	$0	$9,128,987	$0	$0
	RF	$1,885,519	$0	$1,920,262	$0	$0
01. Executive Director's Office - Professional Audit Contracts	Total	$2,463,406	$0	$2,463,406	$50,000	$50,000
	CF	$262,420	$0	$262,420	$50,000	$50,000
	FF	$1,231,703	$0	$1,231,703	$0	$0
	GF	$969,283	$0	$969,283	$0	$0
05. Indigent Care Program - Primary Care Fund Program	Total	$26,828,000	$0	$26,828,000	($126,056)	($126,056)
	CF	$26,828,000	$0	$26,828,000	($126,056)	($126,056)

Letternote Text Revision Required?	Yes	X	No		**If Yes, describe the Letternote Text Revision:**
Cash or Federal Fund Name and CORE Fund Number:	Primary Cash Fund (18L0)				
Reappropriated Funds Source, by Department and Line Item Name:	N/A				
Approval by OIT?	Yes		No		**Not Required:** X
Schedule 13s from Affected Departments:	N/A				
Other Information:	N/A				

Cost and FTE

- $0 total funds in FY 2015-16 and beyond, and 0.0 FTE, for a budget neutral transfer of $126,056 cash funds from the Primary Care Fund Program line item, of which $50,000 would transfer to the Professional Audit Contracts line item and $76,056 would transfer to Personal Services.

Current Program

- The Primary Care Fund provides an allocation of moneys from Colorado's tax on cigarettes and tobacco products to health care providers that make comprehensive, primary care services available in an outpatient setting to residents of Colorado regardless of their ability to pay.

Problem or Opportunity

- The Department does not audit the information provided on applications for funding through the Primary Care Fund and thus unable to verify the accuracy and validity of the data submitted.
- Provider's eligibility status and the amount of payments they receive may be inaccurately determined.
- Inaccurate allocations to providers could reduce or compromise services to the target populations of uninsured or medically indigent patients in a manner that would adversely affect the health outcomes of these patients.
- Additionally, the portion of the Primary Care Fund retained by the Department for administering the Primary Care Fund does not accurately reflect the amount of funds needed for the Department's allocated workload and operating costs associated with the program.

Consequences of Problem

- The availability and quality of health care services could be reduced or compromised in a manner that would adversely affect the health outcomes of uninsured or medically indigent patients.
- The General Fund would continue to fund a portion of administrative and operating expenses of the Primary Care Fund Program.

Proposed Solution

- Procure a contractor for a compliance audit of the data submitted by Primary Care Fund applicant providers to verify the accuracy and validity of the data.
- Transfer funding from the Primary Care Fund to fund the Department's administrative costs to more accurately reflect the Department's allocated workload and operating costs associated with the program.

Department Priority: R-14
Request Detail: Primary Care Fund Audits

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Primary Care Fund Audit	$0	$0

Problem or Opportunity:

The Department does not audit information provided on the applications for funding through the Primary Care Fund by the applicant providers and is unable to verify the accuracy and validity of the data submitted. This information is used to determine the provider's eligibility status to receive the funding as a qualified provider and the amount of payments they receive. It is imperative that these payments be accurately allocated to providers serving the target populations of uninsured or medically indigent patients. Otherwise, the availability and quality of these services could be reduced or compromised in a manner that would adversely affect the health outcomes of these patients.

The Primary Care Fund provides an allocation of moneys from Colorado's tax on cigarettes and tobacco products, as authorized in section 24-22-117 (2) (b), C.R.S. (2014), to health care providers that make comprehensive, primary care services available in an outpatient setting to residents of Colorado regardless of their ability to pay. Qualified providers must serve a medically underserved population and/or area of Colorado. Funds are allocated to each qualified provider based on the number of medically indigent patients served in an amount proportionate to the total number of medically indigent patients served by all health care providers who qualify for moneys from this fund. Essentially, the grant awards are reimbursing providers for their otherwise uncompensated costs and charity care. Funding is used by providers to extend hours of operation, serve more patients, create diabetes management programs, comply with electronic health record regulations, and hire additional staff, etc.

Qualified providers are required to use an independent entity to certify patient counts. Providers who receive $250,000 or more from the Primary Care Fund are required to use a Certified Public Accountant (CPA) as their independent entity. However, the Department is unable to ensure consistency in sampling methodologies and certification practices across all applicants. Assuring a correct allocation of the Primary Care Fund awards would support the continued availability of these basic health care services and reduce the risks of cost-shifting by the providers to other patients.

Additionally, the portion of the Primary Care Fund retained by the Department for administering the Primary Care Fund does not accurately represent the amount of funds needed for the Department's allocated workload

and operating costs associated with the program. Currently, the Department is appropriated $60,039 from the Primary Care Fund to fund 0.5 FTE and $3,183 for indirect costs recovery. However, the Primary Care Fund should be covering more of the costs of program staff who have a direct responsibilities for the program and staff throughout the Department who have a supporting role in program operations. This includes funding for a portion of time for the program supervisor and management, and for staff who perform centralized functions (i.e. budget, data analysis, accounting, etc.).

Proposed Solution:

The Department requests a budget neutral transfer of $126,056 cash funds in FY 2015-16 and beyond from its Primary Care Fund Program line item, of which:

- $50,000 would transfer to the Department's Professional Audit Contracts line item to procure a contractor for a compliance audit of the data submitted by Primary Care Fund applicant providers; and,
- $76,056 would transfer to the Department's Personal Services line item to more accurately reflect the Department's administrative costs associated with operating the Primary Care Fund.

As authorized in sections 25.5-3-302 (3) C.R.S. (2014), the Department may retain three percent of the total amount of money annually appropriated by the General Assembly for administrative costs of the program. The total FY 2014-15 Primary Care Fund appropriation is $26,828,000. Of this amount up to $804,840 could be utilized for administrative costs of the program, but only $63,222 (0.25% of the total appropriation) can be withheld for administration costs in FY 2014-15. This request would increase funding for administrative costs in FY 2015-16 forward to a total $189,278 (0.71% of the FY 2014-15 appropriation), well below the statutory limit.

These transfers would reduce the total amount available in the Primary Care Fund that could otherwise be distributed among qualified providers. The proposed compliance audit was strongly supported by stakeholders and current qualified providers at the May 1, 2014, annual stakeholders meeting of the Primary Care Fund. Their support of the audit stemmed from the desired goal for enhanced transparency, and the ability to demonstrate sound stewardship of tax dollars to preserve funding for the Primary Care Fund.

The Department is responsible for fiscal oversight of the Primary Care Fund. A statewide compliance audit by an independent auditor would increase the integrity of the program as well as ensure the accuracy and validity of the data submitted by the applicant. The Department would use the requested funding to procure a contractor to ensure accuracy and consistency in reporting of information across providers in accordance with the Primary Care Fund program requirements.

The Department estimates that $50,000 would allow for approximately one-third of the providers, or thirteen providers, to be audited each fiscal year from FY 2015-16 forward. Applicants are required to have an outside entity verify their patient-count submissions provided in their application for funding. Along with this independent review, auditing a provider approximately once every three years should provide sufficient frequency of scrutiny that the Department is seeking to assure consistency, accuracy and transparency, while also minimizing the impact on funding available for services.

The Department would use the funding to procure a licensed Certified Public Accountant as a contractor with auditing experience related to Medicaid or similar services or grants for medically indigent patients. At minimum, the auditor would perform the following tasks:

- Develop the audit instrument and document an audit method.
- Conduct exit and entrance conferences.
- Audit providers' annual Primary Care Fund applications and lists of patient records comprised of all patients receiving comprehensive primary care services to assure unduplicated patient counts are reported.
- Of the total unduplicated patient counts, the auditor would review the number of patients reported by category of payment source, including Medicaid, CHP+, or who are medically indigent patients.
- Approximately six Level II reviews would be completed. Level II reviews are more complex secondary reviews performed by a senior auditor of randomly selected provider applications to assure compliance of applicable financial reporting standards and regulatory requirements of Primary Care Fund Program.
- Determine if the data supports that the provider met all requirements to be designated as a qualified provider to receive funding through the Primary Care Fund Program.
- Determine if corrections to the data are necessary that would result in funding adjustments. Provide a written audit report to the Department detailing findings for each provider audit completed.
- Assist the Department in addressing appeals by providers related to changes resulting from the audits.

The Department would make corrections to the allocations of funding to qualified providers as necessary during the annual reconciliation process, if errors in the information reported by providers are discovered through these audits.

As part of this request, the Department is also requesting funding to increase its administrative funding from the Primary Care Fund. The Department is working towards a revised cost allocation plan, which would account for the increased workload corresponding to the compliance audit, allocate costs of centralized department functions, such as budget, data analysis, and accounting, management and supervision as well as allow the Department additional flexibility in its Personal Services budget. The Department's current cost allocation methodology does not include a distribution of costs to the Primary Care Fund associated with centralized functions. In addition, the Department anticipates that there would be additional workload resulting from responsibilities associated with the audit request herein. The Department is not seeking a General Fund reduction as those funds appropriated to the Department were not intended to support the Primary Care Fund and would be utilized for programs and functions requiring General Fund support as intended when appropriated.

Anticipated Outcomes:

Grant awards based on inaccurate data can adversely impact services to patients by qualified providers by reducing their respective share of the Primary Care Fund. A compliance audit would further the Department's sound stewardship of the financial resources appropriated to the Primary Care Fund by ensuring that the grant awards are accurately targeted and thus supporting the continued availability of health care services to the medically indigent and uninsured. If an audit reveals that inaccurate data has been submitted, the affected

providers would be required to resubmit corrected data. This would require reallocation of the available funds to appropriately distribute funds based on accurate information.

Under current protocol, the Department provides a preliminary allocation of funds based on the appropriation of Primary Care Funds in the Long Bill for a fiscal year. The Department revises the allocation in the fourth quarter of the fiscal year to adjust for the actual tobacco tax collections received by the State. The Department anticipates that any adjustments to funding allocations related to audit findings would also occur during the fourth quarter allocation reconciliation process.

Costs for the administrative workload throughout the Department associated with the Primary Care Fund program will be more appropriately charged to the Primary Care Fund and free up General Fund for more appropriate administrative usage.

Assumptions and Calculations:

The detailed calculations for this request can be found in the attached appendix.

Table 2, "Primary Care Fund - Annual Administrative Cost Appropriation History" is provided to show the amount and percentage of appropriated funds for administrative costs compared to the Primary Care Fund appropriation for service provision by fiscal year. The administrative appropriations have been less than one-quarter of a percent of the Primary Care Fund appropriation. This request maintains the appropriation at less than three-quarters of a percent, well below the three percent allowed.

Table 3, "Annual Primary Care Fund Audit Cost Estimate by Audit Component", contains a summary of the Department's calculations for this audit request. The estimate of hourly rates and number of hours needed per audit is comparable to recently procured audits by the Department, including Disproportionate Share Hospital (DSH) and Nursing Facility audits.

Table 4, "Primary Care Fund - Administrative Workload Estimate", shows the Department's estimate of the administrative workload throughout the Department which includes estimates of the FTE equivalent of workload for program staff, management and supervision, and centralized Department staff functions. Estimates shown in Table 4.2, "Primary Care Fund Additional Administration Costs" calculate the needed funding associated with workload throughout all Department responsibilities associated with the Primary Care Fund Program, including supervision, management and centralized functions. This estimate is based on the mid-range of the salary at the General Professional IV classification level and 35% of the salary to account for related administrative load which includes all health, life, and dental benefits, operating expenses, and commercial leased space. The Department is not requesting an increase in FTE, only a transfer of funding from the Primary Care Fund. Because the funding is primarily for portions of staff time associated with the Primary Care Fund program throughout the Department performing centralized functions or for management and supervision, the funding is primarily needed to more accurately attribute operational costs to the Primary Care Fund.

R-14 Primary Care Fund Audits
Appendix A: Calculations and Assumptions

Table 1.1
FY 2015-16 Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$76,056	0.0	$0	$76,056	$0	$0	Table 4.2, Row E
B	(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$50,000	0.0	$0	$50,000	$0	$0	Table 3, Row L
C	(5) Indigent Care Program, Primary Care Fund Program	($126,056)	0.0	$0	($126,056)	$0	$0	(-1) * (Row A + Row B)
D	**Total Request**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**SUM (Row A + B + C)**

Table 1.2
FY 2016-17 Summary by Line Item

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	Source
A	(1) Executive Director's Office; (A) General Administration, Personal Services	$76,056	0.0	$0	$76,056	$0	$0	Table 4.2, Row E
B	(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$50,000	0.0	$0	$50,000	$0	$0	Table 3, Row L
C	(5) Indigent Care Program, Primary Care Fund Program	($126,056)	0.0	$0	($126,056)	$0	$0	(-1) * (Row A + Row B)
D	**Total Request**	**$0**	**0.0**	**$0**	**$0**	**$0**	**$0**	**SUM (Row A + B + C)**

Table 2 - Primary Care Fund - Annual Administrative Cost Appropriation History						
Fiscal Year	Primary Care Fund - Long Bill Appropriation	Administrative Costs Appropriation	Audit Funding Request	Administration Cost for Workload Costs Request	Total Administration Cost Appropriation	% of PCF
FY 2011-12	$28,253,000	$57,639	-	-	$57,639	0.20%
FY 2012-13	$27,968,000	$58,152	-	-	$58,152	0.21%
FY 2013-14	$27,759,000	$58,305	-	-	$58,305	0.21%
FY 2014-15	$26,828,000	$63,222	-	-	$63,222	0.24%
FY 2015-16[1]	$26,828,000	$63,222	$50,000	$76,056	$189,278	0.71%

[1]The FY 2015-16 PCF appropriation will be set based on the December 2014 revenue forecast by Legislative Council staff of the tobacco tax revenue.

Table 3 - Annual Primary Care Fund Audit Cost Estimate by Audit Component						
Row	**Audit Method & Reporting Requirements**	**Number of Provider Audits**	**Number of Hours Per Provider**	**Number of Hours Per Auditor Type**		**Description**
A	Auditor Type			Senior Auditor	Junior Auditor	
B	Entrance Conference			8	12	Based on information from recently procured audits.
C	Desk Review Audits of Provider Application	13	12 hours	0	156	Number of Provider Audits multiplied by Number of Hours Per Provider
D	Level II Review of Selected Provider Applications	6	10 hours	60	0	Number of Provider Audits multiplied by Number of Hours Per Provider
E	Draft Report of Audit Findings			24	76	Based on information from recently procured audits.
F	Exit Conference			8	12	Based on information from recently procured audits.
G	Final Draft Report (Department's Responses Incorporated)			10	10	Based on information from recently procured audits.
H	Auditor Remains Available for Questions/Appeals			10	36	Based on information from recently procured audits.
I	**Total Auditor Hours by Auditor Type**			**120**	**302**	**Sum of rows B through H**
J	Hourly Rate by Auditor Type			$165.00	$100.00	
K	Subtotal of Audit Cost by Auditor Type			$19,800	$30,200	Row I * Row J
L	**Total Estimated Audit Cost**				**$50,000**	**Sum of Row K**
The number of audit hours required per audit component and Senior and Junior auditor rates are based on various Department audits including the DSH audit and Nursing Facility audit, and the Department's FY 2014-15 Price Agreement List.						

Table 4.1 - Primary Care Fund - Administrative Workload Estimate						
Row	Item	Program Staff	Supervisor/ Management	Centralized Functions Staff	Total	Notes
A	Estimated Administrative Workload FTE Equivalent	1.0	0.1	0.2	1.3	Estimated amount of staff time for all administrative functions.
B	PCF FTE Appropriation	0.5	0.0	0.0	0.5	Long Bill Appropriation
C	**Difference**	**0.5**	**0.1**	**0.2**	**0.8**	**Row A - Row B**

Table 4.2 - Primary Care Fund - Additional Administration Costs			
Row	Item	Amount	Notes
A	FTE Equivalent Currently Not Funded by PCF	0.80	Table 4.1, Row C (Total)
B	Annual Salary Cost Basis	$70,422	General Professional IV salary range midpoint
C	Requested Increase in Personal Services	$56,338	Row A * Row B
D	Annual Administrative Load[1]	$19,718	Row A * 35%
E	**Total Additional Administrative Costs**	**$76,056**	**Row C + Row D**

[1] The 35% Annual Administrative Load includes all health, life, and dental benefits, operating expenses, and commercial leased space.

Table 5. History of Primary Care Fund Payments by Provider											
Clinic	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10[1]	FY 2010-11[1]	FY 2011-12[1]	FY 2012-13	FY 2013-14	FY 2014-15 (Estimated)	Total
Basin Clinic	$0	$0	$0	$60,134	$0	$0	$0	$0	$0	$0	**$60,134**
Castle Valley Children's Clinic	$0	$28,756	$33,107	$0	$0	$5,246	$0	$0	$0	$0	**$67,109**
St Anthony Family Med Residency	$378,324	$202,573	$186,882	$140,213	$99,044	$94,523	$62,828	$103,370	$78,361	$103,892	**$1,450,010**
St Mary Corwin Health Foundation	$457,508	$289,164	$232,984	$215,154	$163,440	$176,961	$80,287	$168,656	$170,228	$149,167	**$2,103,549**
Chaffee People's Clinic	$0	$0	$0	$0	$0	$0	$43,617	$95,207	$48,620	$0	**$187,444**
Mission Medical Clinic	$65,987	$54,638	$57,859	$62,854	$60,196	$65,857	$37,576	$51,685	$57,072	$82,744	**$596,468**
Clinica Campesina Family Health	$2,912,217	$2,236,300	$2,776,002	$2,534,100	$920,244	$0	$0	$2,119,046	$2,012,160	$2,101,823	**$17,611,892**
Clinica Colorado	$0	$0	$0	$0	$0	$0	$0	$378,110	$416,926	$528,968	**$1,324,004**
Colorado Coalition for the Homeless/ Stout Street Clinic	$1,640,872	$1,057,601	$1,012,999	$1,026,815	$392,797	$0	$0	$859,586	$753,085	$819,922	**$7,563,677**
Commerce City Community Health Services/Kids First	$92,382	$162,954	$112,005	$85,215	$96,711	$103,048	$61,137	$106,089	$109,117	$85,867	**$1,014,525**
Denver Health Hospital Authority	$10,518,296	$6,785,906	$6,333,567	$6,378,160	$2,391,260	$0	$0	$5,524,750	$5,376,485	$5,040,741	**$48,349,165**
Doctors Care	$70,386	$134,517	$143,565	$124,197	$114,326	$115,320	$71,709	$155,054	$159,069	$145,761	**$1,233,904**
Community Health Clinic	$127,574	$0	$36,201	$69,502	$36,902	$0	$0	$57,124	$69,196	$76,783	**$473,282**
Grace Health Clinic	$0	$0	$0	$0	$0	$0	$0	$204,016	$152,881	$133,413	**$490,310**
High Plains Community Health Center	$624,675	$432,306	$393,566	$374,706	$155,608	$0	$0	$301,943	$291,329	$294,928	**$2,869,061**
Spanish Peaks Family Clinic	$0	$0	$63,119	$0	$0	$0	$0	$0	$0	$0	**$63,119**
Inner City Health Center	$1,007,399	$732,652	$730,201	$645,763	$492,537	$410,973	$209,690	$573,964	$539,764	$581,624	**$5,924,567**
La Clinica Tepeyec, Inc.	$0	$0	$159,345	$357,179	$434,673	$479,078	$351,718	$690,934	$692,286	$756,196	**$3,921,409**
Plains Medical Center	$87,982	$34,187	$70,235	$82,194	$44,395	$0	$0	$277,463	$301,464	$0	**$897,920**
Marillac Clinic Inc.	$1,143,771	$863,016	$872,219	$919,843	$681,612	$460,000	$315,000	$677,333	$628,612	$589,572	**$7,150,978**
Metro Community Provider Network	$3,770,046	$3,279,524	$3,639,558	$3,262,057	$1,219,179	$0	$0	$2,333,943	$2,416,649	$2,597,154	**$22,518,110**
Olathe Medical Clinic	$0	$66,140	$0	$55,299	$38,264	$41,781	$54,491	$165,932	$133,836	$140,651	**$696,394**
Columbine Family Health Centers	$686,263	$483,429	$496,599	$480,772	$160,567	$0	$0	$440,676	$470,410	$486,248	**$3,704,964**
North Colorado Family Medicine	$131,974	$138,990	$151,300	$92,166	$56,347	$0	$0	$0	$0	$0	**$570,777**
Northwest Colorado Visiting Nurses Assoc.	$0	$0	$0	$86,122	$107,508	$100,000	$15,000	$187,695	$165,832	$358,796	**$1,020,953**
Open Bible Medical Clinic	$0	$0	$0	$0	$0	$0	$36,428	$97,927	$118,025	$126,884	**$379,264**
Peak Vista Community Health Center	$3,708,458	$2,968,954	$2,667,400	$2,936,305	$1,124,755	$0	$0	$2,646,767	$2,664,114	$3,318,294	**$22,035,047**
Pediatric Associates of Southern Colorado	$0	$0	$0	$0	$0	$0	$0	$8,162	$30,300	$87,144	**$125,606**
People's Clinic Inc.	$1,165,767	$787,290	$0	$0	$0	$0	$0	$0	$0	$0	**$1,953,057**
Salud Family Health Center	$7,144,171	$5,519,339	$4,976,197	$4,452,051	$1,687,696	$0	$0	$3,449,230	$3,270,923	$2,763,352	**$33,262,959**
Ft. Collins Family Residency Program	$0	$105,761	$224,320	$245,674	$221,653	$182,675	$117,561	$209,458	$212,101	$199,694	**$1,718,897**
Prowers Medical Center Foundation	$0	$0	$0	$0	$0	$0	$0	$0	$249,617	$0	**$249,617**
Pueblo Community Health Center	$1,684,863	$1,326,955	$1,430,390	$1,126,535	$419,445	$0	$0	$761,659	$953,415	$905,931	**$8,609,193**
Rocky Mountain Primary Care Clinic	$0	$0	$0	$0	$0	$0	$0	$13,601	$14,174	$8,516	**$36,291**
Rocky Mountain Youth Medical	$862,228	$417,929	$416,153	$405,831	$355,695	$321,603	$209,750	$416,194	$290,404	$324,307	**$4,020,094**
SET of Colorado Springs	$0	$0	$0	$155,624	$252,334	$312,890	$244,850	$383,549	$353,152	$287,548	**$1,989,947**
Bruner Family Medicine	$0	$0	$119,741	$191,584	$163,206	$165,438	$105,358	$217,618	$253,399	$281,019	**$1,497,363**
Southeast Colorado Hospital	$0	$78,601	$0	$0	$0	$0	$0	$0	$0	$0	**$78,601**
Summit Community Care Clinic	$642,272	$391,089	$327,972	$425,775	$388,126	$379,590	$0	$489,638	$358,888	$516,053	**$3,919,403**
Sunrise Community Health Center	$2,960,608	$1,881,316	$1,584,475	$1,680,737	$679,282	$0	$0	$1,580,443	$1,560,322	$1,645,238	**$13,572,421**
Uncompahgre Medical Center	$101,180	$73,169	$63,428	$52,279	$23,042	$0	$0	$62,566	$44,632	$56,062	**$476,358**
Sheridan Health Services	$0	$0	$0	$0	$0	$0	$19,815	$68,005	$53,741	$134,548	**$276,109**
The Pediatric Associates	$0	$0	$0	$0	$15,050	$67,075	$30,327	$13,601	$7,887	$12,774	**$146,714**
Eage Care Medical Clinic	$0	$0	$0	$99,116	$142,791	$77,942	$68,688	$108,808	$47,370	$0	**$544,715**
Alamosa Family Medical Clinic	$2,014,797	$1,418,975	$1,629,957	$1,394,269	$527,841	$0	$0	$1,202,335	$1,158,753	$1,023,164	**$10,370,091**
Total Amount	**$44,000,000**	**$31,952,031**	**$30,941,346**	**$30,218,225**	**$13,666,526**	**$3,560,000**	**$2,135,830**	**$27,202,137**	**$26,684,598**	**$26,764,778**	**$237,125,471**

[1]**Note**: During declared fiscal emergencies, Primary Care Fund appropriations were reduced via special bills during FYs 2009-10 through 2011-12. See SB 09-271, HB 10-1321, HB 10-1378, and SB 11-219.

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-15

Request Titles

R-15 Managed Care Organization Audits

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$2,463,406	$0	$2,463,406	$300,000	$300,000
	FTE	-	-	-	-	-
	GF	$969,283	$0	$969,283	$150,000	$150,000
	CF	$262,420	$0	$262,420	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$1,231,703	$0	$1,231,703	$150,000	$150,000

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - Professional Audit Contracts	Total	$2,463,406	$0	$2,463,406	$300,000	$300,000
	CF	$262,420	$0	$262,420	$0	$0
	FF	$1,231,703	$0	$1,231,703	$150,000	$150,000
	GF	$969,283	$0	$969,283	$150,000	$150,000

Letternote Text Revision Required?	Yes	No X	If Yes, describe the Letternote Text Revision:	
Cash or Federal Fund Name and CORE Fund Number:	FF: Title XIX			
Reappropriated Funds Source, by Department and Line Item Name:	N/A			
Approval by OIT?	Yes	No	Not Required:	X
Schedule 13s from Affected Departments:	N/A			
Other Information:	N/A			

Cost and FTE

- The Department requests ongoing funding of $300,000 total funds, including $150,000 General fund to hire an auditing firm to perform audits on financial reports and encounter data from physical and behavioral health managed care organizations that contract with the Department. This request would not require any additional FTE.

Current Program

- The Department contracts with behavioral and physical health managed care organizations to provider or arrange for services for Medicaid clients enrolled with one of these organizations.
- In FY 2013-14 the Department spent over $700,000,000 on behavioral health and physical health managed care contracts.

Problem or Opportunity

- Currently, the Department does not audit the financial or encounter data beyond assessing the reasonableness of payment at a high level of aggregation based on summary statistics.
- Similarly, the Department is currently evaluating applying medical loss ratios (MLRs) across all managed care plans as an effective way to ensure that health plans are adequately funding the provision of medical services. The Department would benefit from assistance in the form of experience and guidance in incorporation MLRs across all managed care plans.
- Furthermore, the Department requires assistance to ensure that contract language provides for adequate and enforceable oversight of managed care plans.

Consequences of Problem

- Without an in depth audit to ensure that reported charges are both reasonable and allowable, the Department risks over payment for services provided to Medicaid clients under managed care contracts.
- Without assistance in instituting MLRs across all managed care plans, the Department would lose valuable out-of-state experience and background to ensure proper implementation and enforceability in contract language.

Proposed Solution

- The Department requests to hire an auditor to conduct a thorough review of current managed care contract language and provide experience and guidance in implementing MLRs across all managed care plans.
- The auditor would use selected algorithms to analyze claims data from one managed care plan to identify outlier populations that could be at risk of overpayment. Further analysis of these outlier populations would ensure compliance with regulations for allowable medical expenses.

Department Priority: R-15
Request Detail: Managed Care Organization Audits

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Managed Care Organization Audits	$300,000	$150,000

Problem or Opportunity:

The Department utilizes a combination of financial reports, encounter data, and claims data to establish capitation rates for physical health and behavioral health service managed care contracts. Currently, the Department does not audit the financial or encounter data beyond assessing the reasonableness of payment at a high level of aggregation based on summary statistics; managed care contractors attest that the information is accurate. The Department does not have the internal resources to perform in depth analyses to ensure proper payment, which is essential to demonstrating sound stewardship of financial resources as part of the Department's mission. In FY 2013-14 the Department spent over $700,000,000 on behavioral health and physical health managed care contracts. Furthermore, a recent report by the U.S. Government Accountability Office strongly recommended that states conduct audits of payments to and by managed care organizations within Medicaid[1]. Without an in depth audit to ensure that reported charges are both reasonable and allowable, the Department risks over payment for services provided to Medicaid clients under managed care contracts.

Furthermore, the Department is currently evaluating applying medical loss ratios (MLRs) across all managed care plans, as MLRs are an effective way to ensure health plans are adequately funding the provision of medical services. In recent communication with the Department, CMS has indicated that they are adding additional MLR requirements to the expansion rate approval process. It is also likely that CMS will require Medicaid health plans to implement MLRs in the near future, and the federal Office of Inspector General (OIG) has stated that MLRs will be a focus of their 2014 work plan[2]. To this end, the Department would benefit from assistance in incorporating MLRs across all managed care plans. Implementation assistance would entail contract language recommendations, guidance in defining administrative expenses, designing a financial reporting template, and guidance in developing a rate setting timeline. The Department would draw on the auditors experience implementing MLRs in other states to guide a successful implementation that meets federal requirements.

[1] <http://www.gao.gov/products/GAO-14-341>
[2] <http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf>

Proposed Solution:

The Department requests $300,000 total funds, including $150,000 General Fund, in FY 2015-16 and future years to contract with an auditing firm to analyze financial reporting and claims submitted by health plans to ensure that submissions are both allowable and reasonable, in order to ensure proper payment for services provided by physical and behavioral health plans. Specifically, the auditor would perform the following tasks:

- Conducting a thorough review of current managed care contract language to identify weaknesses and recommend appropriate changes and specific language.
- Providing experience and guidance to the Department with implementing MLRs across all managed care plans.
- Using selected algorithms on claims data of one or more managed care plans to identify outlier populations that could be at risk of overpayment.
- Further testing identified outlier populations to ensure compliance with regulations for allowable medical expenses.
- Tying financial reports to supporting information to ensure reporting accuracy in accordance with standards established by the American Institute of Certified Public Accountants.
- Auditing of administrative expenses to ensure reported expenses are allowable and accurate.

Stronger contract language would ensure the Department has proper and enforceable oversight of managed care plans. The Department would ensure proper submission of financial and encounter data, assist with recoupment, and protect Department rights in future years. By running algorithms on claims data, the auditor may identify outlier payments and verify if the Department overpaid in these instances. Implementing MLRs across all managed care plans would meet federal requirements for administrative spending, ensure appropriate funding of medical services, and drive quality outcomes for clients.

Anticipated Outcomes:

As a result of the auditor's analysis, the Department would be able to: assess if overpayment has already occurred and potentially recoup those funds; mitigate future overpayments by correcting errors in the reporting process; strengthen the enforceability of contract provisions and requirements; and implement MLRs across all Medicaid managed care plans.

Though the Department cannot guarantee savings will result from audit findings, savings can result from both a recoupment of inappropriate payments and avoidance of future overpayments. In FY 2013-14 the Department spent roughly $190,000 on audits of nearly $400,000,000 in outpatient hospital expenditures. This led to approximately $25,000,000 in recoupments and $28,000,000 in avoided future overpayments.

Ensuring proper payment for services aligns with the Departments performance plan by ensuring sound stewardship of financial resources. Implementation of MLRs align with the Department performance plan by striving to improve health outcomes, client experience, and lower per capita costs.

Assumptions and Calculations:

Based on estimates submitted by an auditing firm, the Department is requesting $300,000 total funds, including $150,000 General Fund, to hire an auditor to complete the work described. This request would not require any additional FTE. A full breakdown of estimated charges and services provided is provided in table

2. Costs for contract reviews are based on estimates of 25 hours per contract for the 14 contracted managed care plans as detailed in table 2 at a cost of $200 per hour. Other costs are estimated using the upper limit of a proposal from an auditing firm. As the Department spent over $700,000,000 on managed care plans in FY 2013-14, it is reasonable to assume that the upper limit will be required to audit abnormalities that may arise in the data. As seen in table 2, the Department would utilize additional funds to audit managed care plans on a rotating basis. Audits would vary based on scope and size of the managed care plans in a given year. For example in FY 2016-17 the Department would need further contract review, so funds would be used for additional audits of managed care plans or analysis of outlier populations.

Potential for savings due to recoupment or avoided overpayments are not included in the calculations as the Department does not have evidence that overpayments have occurred. The Department would use the regular budget process to account for any savings achieved as a result of the audit findings.

Table 1.1 - Managed Care Organization Audits FY 2015-16								
Item	**FTE**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Source**
(1) Executive Director's Office, (F) Professional Audit Contract								
Managed Care Audits	0.0	$300,000	$150,000	$0	$0	$150,000	50.00%	Table 2 Row G
Total	**0.0**	**$300,000**	**$150,000**	**$0**	**$0**	**$150,000**		

Table 1.2 - Managed Care Organization Audits FY 2016-17								
Item	**FTE**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Source**
(1) Executive Director's Office, (F) Professional Audit Contract								
Managed Care Audits	0.0	$300,000	$150,000	$0	$0	$150,000	50.00%	Table 2 Row G
Total	**0.0**	**$300,000**	**$150,000**	**$0**	**$0**	**$150,000**		

Table 1.2 - Managed Care Organization Audits FY 2017-18								
Item	**FTE**	**Total Funds**	**General Fund**	**Cash Funds**	**Reappropriated Funds**	**Federal Funds**	**FFP Rate**	**Source**
(1) Executive Director's Office, (F) Professional Audit Contract								
Managed Care Audits	0.0	$300,000	$150,000	$0	$0	$150,000	50.00%	Table 2 Row G
Total	**0.0**	**$300,000**	**$150,000**	**$0**	**$0**	**$150,000**		

Table 2 - Breakdown of Audit Costs					
Row	**Item**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**Comments/Calculation**
A	MCO and BHO Contract Review	$70,000	$45,000	$45,000	25 Hours Per Contract *14 Contracts * $200 Hourly Rate
B	Algorithmic Review of MCO Claims Data	$75,000	$75,000	$75,000	Price to identify outlier populations in **one** MCO claims data
C	Testing of Outlier Populations	$30,000	$30,000	$30,000	Cost to audit outlier populations identified with algorithms
D	Tying of Financial Reports to Supporting Information	$50,000	$50,000	$50,000	In accordance with the American Institute of CPAs
E	Administrative Expense Audits	$50,000	$50,000	$50,000	Cost per MCO
F	Additional Review of Claims Data or Administrative Expense Audits	$25,000	$50,000	$50,000	This may change in each FY based on rotation cycle as the Department will audit one or more managed care plans per year
G	**Total**	**$300,000**	**$300,000**	**$300,000**	Row (A + B + C + D + E + F)

Table 3 - HCPF Payments to BHOs and MCOs FY 2013-14			
Row	**Item**	**Paid Amount**	**Calculation/Comment**
	CHP MCOs		
A	Kaiser	$15,598,137	Historical Data
B	Denver Health	$9,475,106	Historical Data
C	CO Access HMO	$72,679,232	Historical Data
D	Colorado Choice	$2,862,640	Historical Data
E	Delta Dental	$11,268,968	Historical Data
F	CO Access SMCN	$32,053,728	Historical Data
G	Rocky Mountain Health	$16,930,036	Historical Data
H	Subtotal CHP+ MCOs	$160,867,847	Row (A + B + C + D + E + F + G)
	Medicaid MCOs		
I	Denver Health	$118,574,749	Historical Data
J	Rocky Mountain HMO	$7,329,446	Historical Data
K	Subtotal Medicaid MCOs	$125,904,195	Row (I + J)
	Mental Health BHOs		
L	Colorado Access Behavioral Care	$74,077,413	Historical Data
M	Behavioral Health Care Inc.	$96,803,924	Historical Data
N	Colorado Health Partnerships	$137,226,809	Historical Data
O	Foothills Behavioral Health Partners	$62,539,714	Historical Data
P	Northeast Behavioral Health Partners	$46,264,217	Historical Data
Q	Subtotal Mental Health BHOs	$416,912,077	Row (L + M + N + O + P)
R	**Total**	**$703,684,119**	Row (H + K + Q)

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-16

Request Titles

R-16 Comprehensive Primary Care Initiative Funding

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$6,151,808	$0	$5,481,508	$84,952	$194,760
	FTE	-	-	-	-	-
	GF	$2,225,315	$0	$1,918,265	$42,476	$97,380
	CF	$727,500	$0	$727,500	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,198,993	$0	$2,835,743	$42,476	$97,380

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - General Professional Services and Special Projects	Total	$6,151,808	$0	$5,481,508	$84,952	$194,760
	CF	$727,500	$0	$727,500	$0	$0
	FF	$3,198,993	$0	$2,835,743	$42,476	$97,380
	GF	$2,225,315	$0	$1,918,265	$42,476	$97,380

Letternote Text Revision Required?	Yes	No X	If Yes, describe the Letternote Text Revision:	
Cash or Federal Fund Name and CORE Fund Number:	FF: Title XIX			
Reappropriated Funds Source, by Department and Line Item Name:	N/A			
Approval by OIT?	Yes	No	Not Required:	X
Schedule 13s from Affected Departments:	N/A			
Other Information:	N/A			

Cost and FTE

- The Department requests $84,952 total funds, $42,476 General Fund, in FY 2015-16 and $194,760 total funds, $97,380 General Fund, in FY 2016-17.
- No FTE are requested with this Change Request.

Current Program

- The Comprehensive Primary Care (CPC) initiative is a multi-payer initiative that began in 2012. It fosters collaboration between public and private health care payers for the purpose of improving client outcomes and containing costs through collaboration and coordination between payers and providers.

Problem or Opportunity

- The CPC initiative strives for success through improving care coordination, but the lack of integrated data reporting across payers for participating practices is a persistent obstacle to that goal.
- A unique opportunity exists for the multiple payers in the CPC initiative to establish the necessary infrastructure to support an aggregated data reporting solution for primary care so that their patients can benefit from improved health outcomes and quality of care.

Consequences of Problem

- Without continued funding, the Department would be unable to meet its share of the payer group's cost obligation, which may cause other payers to back out of the initiative. This would make the CPC initiative less likely to succeed, which would result in patients not realizing the health and care benefits that would otherwise be possible through care coordination and better health care delivery from primary care practices with aggregated data reporting across multiple payers.
- If the CPC initiative does not pursue an aggregated data solution, payers would continue to have incongruent solutions, with no incentive for collaboration among payers or payer resources without a mechanism through which payers can share the cost of implementing innovative technology solutions.

Proposed Solution

- The Department requests funding for a single resource for practice reporting and consolidating multi-payer data within a practice, which would reduce the administrative burden of care coordination for primary care practices and enhance the continuity of care for clients who transition between payers.
- The aggregation of paid claims data from multiple payers within a practice would allow for the dissemination of claims-based performance measures to practices, resulting in clear and observable goals for practices to target. This would improve care coordination.
- Clients would experience improved health outcomes and quality of care due to continuity in care across payers and care coordination. The payers would achieve lower costs as care coordination positively impacts client health outcomes.
- The requested funding is Medicaid's share of costs to fund an aggregated data reporting solution with the other payers of the CPC initiative. Total costs consist of funding for the aggregated data solution platform, project management, payer group facilitation, and data analytics.

Department Priority: R-16
Request Detail: Comprehensive Primary Care Initiative Funding

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Comprehensive Primary Care Initiative Funding	$84,952	$42,476

Problem or Opportunity:

The Comprehensive Primary Care (CPC) initiative is a multi-payer initiative that fosters collaboration between public and private health care payers for the purpose of improving client outcomes and containing costs through collaboration and coordination between payers and providers and improved data infrastructure. While there would be a significant benefit from continued Department participation in the goals of the initiative, funding is not currently available for this purpose. Funding the State's fair contribution of administrative expenditures related to implementation of the next goals of the initiative would be necessary to continue participation.

In the spring of 2012, the Centers for Medicare and Medicaid Services (CMS) began working with private health plans, Medicare, and Medicaid to bolster primary care by offering bonus payments to primary care doctors who better coordinate care for their patients. CMS also provides resources that allow doctors to better coordinate primary care, such as technical assistance through practice coaching, webinars, and collaborative learning. Aetna, Anthem Blue Cross Blue Shield, Cigna, Colorado Access, Colorado Choice, Rocky Mountain Health Plans, United Healthcare, and the Department signed Memoranda of Understanding (MOUs) with CMS and take part in the CPC initiative. These payers formed a payer group that has met monthly since May 2012 to coordinate resources and support for 74 participating practices statewide. The initiative focuses not only on cost reduction, quality of care, and improved health outcomes, but also on enhanced data reporting and analytics, quality measure development, and new payment methodologies.

While the CPC initiative strives for success through improving care coordination, the lack of integrated data reporting across payers for participating practices is a persistent obstacle to that goal. The payer group has identified the implementation of an aggregated data reporting solution as the next step in facilitating care coordination. Such a solution would centralize payer data within a practice; create and maintain a person-centered view across multiple payers; implement common metrics across payers for ranking, benchmarking, and longitudinal analysis; and allow for reporting and analyzing total cost of care across payers. Streamlining the secure production of agreed data elements in a standardized format for use by existing practice registries

or related clinical analytics tools would help produce credible comparative analytics and support productive alignment of individual payer programs and initiatives.

This aggregated data reporting solution is similar to the health information exchange (HIE) network that was funded during the FY 2014-15 budget cycle. However, this solution and the HIE network are different in fundamental ways. The primary difference is that the CPC initiative's aggregated data reporting solution is designed to support intra-provider data aggregation, while the HIE network is designed for inter-provider data exchange. The HIE network allows for the secure electronic exchange of Medicaid patient records, referrals, lab results, etc. among different health entities, such as primary care, hospitals, clinics, labs, and government databases. The aggregated data reporting solution undertaken by the CPC initiative seeks to provide a platform where all participating payers' client information can be consolidated in the same format, to allow for outcome benchmark and quality measure building across payers within a practice. Once this information is aggregated on a single platform with a universal format, physicians can strive toward health goals for all of their clients, not just those of a single payer. This solution benefits Colorado Medicaid, but also benefits private insurers and Medicare as well.

A unique opportunity exists for the payers to establish the necessary infrastructure to support an aggregated data reporting solution for primary care so that their patients can benefit from improved health outcomes and quality of care. At the same time, payers would enjoy future cost reduction through client care coordination and the ability to encourage best practices through targeted quality metrics that span multiple payers' clients, facilitating the delivery of preventive services. A single resource for practice reporting and consolidating multi-payer data within a practice would reduce the administrative burden of care coordination for primary care practices and enhance the continuity of care for clients who transition between payers. The aggregation of paid claims data from multiple payers within a practice would allow for the dissemination of claims-based performance measures to practices, resulting in clear and observable goals for practices to target.

Funding is necessary to continue the Department's participation in the CPC initiative, which is important to achieving progress in health outcome goals through the implementation of innovative technology and the exploration of health care in new ways by multiple payers.

Proposed Solution:

The Department requests $84,952 total funds, $42,476 General Fund, in FY 2015-16, and $194,760 total funds, $97,380 General Fund, in FY 2016-17 to support its share of the overall cost an aggregated data reporting solution for the remainder of the initiative. The group has agreed to a cost sharing mechanism among the payers based on the number of each payer's covered clients participating in the initiative. The Medicaid fair share, based on the proportion of Medicaid clients to all clients in the initiative, is approximately 21% of the total cost. A large portion of this funding would be one-time in order to implement foundational infrastructure. The remainder would be ongoing funding to maintain the infrastructure initially put in place.

The Department requests to support the CPC initiative with data and technical assistance from existing state contractors as necessary to ensure the successful implementation of data aggregation. Department support would include contracted services for continued payer group facilitation and project management through

the CEbP and administrative payer data provision, possibly through the All-Payer Claims Database (APCD) if selected by the payer group to supply data aggregation in a standardized format in year two.

If the requested funding is not approved, the Department would be unable to meet its share of the payer group's cost obligation, which may cause other payers to back out of the initiative. This would make the CPC initiative less likely to succeed, which would result in patients not realizing the health and care benefits that would otherwise be possible through care coordination and better health care delivery from primary care practices with aggregated data reporting across multiple payers. Payers would continue to have incongruent solutions, with no incentive for collaboration among payers or payer resources without a mechanism through which payers can share the cost of implementing innovative technology solutions.

Anticipated Outcomes:

The requested funding would allow the CPC initiative to continue and incorporate the aggregated data reporting solution described above. A key goal of data aggregation is to provide practices with utilization, cost, and outcome reports for attributed patients in order to support individual practices in the development of effective strategies to improve health and lower costs. Clients would experience improved health outcomes and quality of care due to continuity in care across payers and care coordination. Primary care practices would benefit from reduced administrative burden for care coordination for their patients across all payers and be able to conduct effective quality improvement projects across their practice's population. The payers would achieve lower costs as care coordination positively impacts client health outcomes.

This initiative ties to the state plan by furthering the Department's goals of improving health outcomes and client experience and achieving lower per capita costs; sustaining effective external relationships with CMS and private health insurance payers; and providing exceptional service through technological innovation.

Assumptions and Calculations:

The total cost of funding an aggregated data solution, project management, and payer group facilitation for the CPC initiative is estimated at $1,425,880 over the course of two years. This cost consists of one-time funding to Rise Health, the aggregated data solution platform, in order to build necessary infrastructure for the data component of this request. It also includes ongoing funding for Rise Health, as well as the CEbP for project management and payer group facilitation services. All cost estimates are based on actual estimates from the proposed vendors.

The Department's share of the total cost is based on a tiered cost allocation methodology that was agreed upon by the payer group, based on the proportion of each payer's clients attributed to the 74 participating providers. The Medicaid proportion of clients is approximately 25%, which places Medicaid in the highest payment tier along with three other payers. The highest payment tier is responsible for 84% of total cost, and since there are a total of four payers at the highest tier, each payer in that tier is responsible for one-quarter of the total costs in the tier. Therefore, the Department's share of costs would be 21% of the total, which is $299,435. The Department's first year costs are reduced by $19,723, the amount that the State has previously paid the CEbP for costs related to CPC facilitation. The Medicaid share of total costs, after accounting for this credit, is $279,712 for the two year total. The Department would receive a 50% federal financial participation (FFP) rate on its share of administrative costs.

The Department would also need to pay its share of costs by contributing to project management and payer group facilitation (CEbP). In the second year, the Department would pay the remainder of its portion of costs through additional funding mechanisms, such as a direct contract with vendors such as the Center for Improving Value in Health Care (CIVHC).

Table 1 outlines the breakdown of the Department's share of costs among these cost sources.

Table 1: Medicaid Share of CPC Initiative Data Aggregation Costs			
Item	FY 2015-16	FY 2016-17	Total Funding
Data Extraction/Analysis	$0	$121,535	$121,535
Project Management and Payer Group Facilitation (CEbP)	$84,952	$73,225	$177,900
Total Medicaid Costs	**$84,952**	**$194,760**	**$279,712**

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-17

Request Titles

R-17 School Based Early Intervention and Prevention

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$548,101,614	$0	$548,263,817	$4,216,324	$4,216,324
	FTE	-	-	-	-	-
	GF	$171,004,720	$0	$170,334,404	$1,999,674	$1,999,674
	CF	$4,534,586	$0	$4,500,945	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$372,562,308	$0	$373,428,468	$2,216,650	$2,216,650

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
	Total	$548,101,614	$0	$548,263,817	$4,216,324	$4,216,324
03. Behavioral Health Community Programs - Behavioral Health Capitation Payments	CF	$4,534,586	$0	$4,500,945	$0	$0
	FF	$372,562,308	$0	$373,428,468	$2,216,650	$2,216,650
	GF	$171,004,720	$0	$170,334,404	$1,999,674	$1,999,674

Letternote Text Revision Required?	Yes	No X	If Yes, describe the Letternote Text Revision:	
Cash or Federal Fund Name and CORE Fund Number:	FF: Title XIX			
Reappropriated Funds Source, by Department and Line Item Name:	N/A			
Approval by OIT?	Yes	No	Not Required:	X
Schedule 13s from Affected Departments:	N/A			
Other Information:	N/A			

Cost and FTE

- The Department requests $4,216,324 total funds, including $1,999,674 General Fund and $2,126,650 federal funds, to continue school-based prevention and early intervention services related to marijuana through the Department's Behavioral Health Organizations (BHO).

Current Program

- The Department's BHOs reported that they provide school-based prevention and early intervention substance use disorder services in approximately 230 schools during the 2013 school year. The $4,363,807 General Fund appropriation in 2014-15 has allowed the BHOs under contract to increase the number of school health professionals who provide youth substance abuse services to during 2014.

Problem or Opportunity

- The Department was appropriated $4,363,807 in FY 2014-15 to provide school-based prevention and early intervention services related to marijuana through contracts with its BHOs, but without continuation funding in FY 2015-16, the scope will again be limited to lower historical levels.

Consequences of Problem

- Given the recent legalization of recreational marijuana, there is a risk of an increase in drug use. Failure to respond to these risks could result in an increase in the current physical and mental health consequences of drug abuse that are already being experienced.
- In a large survey of adolescent health, Colorado ranked in the top ten for rates of past-month marijuana and other illegal substance use among 12 year olds and those between 18-25 years. Up to 56.5% of Colorado teens have used some form of illegal substance by the 12th grade, with up to 6.8% having used an illegal substance before age 13 (Matheson & McGrath, 2012).

Proposed Solution

- Recognizing the need to increase the prevalence and availability of targeted outreach programs in schools, particularly related to the usage of marijuana, the Department is requesting continuation funding to maintain and expand upon the essential resources needed for early intervention and prevention of youth marijuana use.
- The Department proposes to use $1,999,674 General Fund and $2,126,650 federal funds to maintain higher levels of school-based prevention and early intervention substance use disorder services through its BHO contracts and to combat the negative side effects of the increase in marijuana use.

Department Priority: R-17
Request Detail: School Based Early Intervention and Prevention for Substance Use

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
School Based Early Intervention and Prevention for Substance Use	$4,216,324	$1,999,674

Problem or Opportunity:

In SB 14-215, the General Assembly appropriated $4,363,807 total funds, including $2,000,000 General Fund to the Department for Behavioral Health Organization (BHO) contracts which provide school-based prevention and early intervention services to schools to accomplish the following State-wide objectives related to marijuana:

(1) Provide substance use treatment for youth who use marijuana through an increase in the number of school health professionals;
(2) Allow for community-based programs to provide marijuana prevention and intervention services to youth; and
(3) Prevent underage marijuana use by creating community evidence-based prevention and intervention programs and funding public education awareness campaigns.

The 2014-15 appropriations are currently allowing the Department to address these objectives by increasing the number of school health professionals through its BHO. However, the BHO contracts will need dedicated continuation funding for marijuana prevention and intervention services in 2015-16 in order to address the objectives outlined in SB 14-215 going forward.

Today's youth face many risks, and responding to these risks before they become problems can be difficult. Substance use disorders have serious consequences in our homes, schools, and communities. In a large survey of adolescent health, Colorado ranked in the top ten for rates of past-month marijuana and other illegal drug use among 12 year olds and those between 18-25 years. Across the U.S., many families struggle with teen alcohol and other drug use or misuse. Results from a 2010 survey show that by the 8th grade about 36% of teens in the U.S. have used alcohol at some point in their life; this number increases to 71% by the 12th grade (NIDA, 2011). These results are true at the state level as well; results from a 2009 survey by the Department of Public Health and Environment show that by the 12th grade 81% of Colorado teens have used alcohol at some point in their life, with almost 19% having had their first drink before age 13 (CDPHE, 2009). Up to

56.5% of Colorado teens have used some form of illegal substance by the 12th grade, with up to 6.8% having used an illegal substance before age 13 (Matheson & McGrath, 2012).

In 2009-2010, there were 1,792 public schools in Colorado with 832,368 students. Currently, the Department's Behavioral Health Organizations report that they provide services in approximately 230 schools. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that, nationally in 2012, among persons aged 12 or older, an estimated 1.4 million first-time past year marijuana users initiated prior to the age of 18. The estimated 1.4 million persons in 2012 who initiated prior to the age of 18 represented the majority (57.3 percent) of the 2.4 million recent marijuana initiates. With the recent legalization of recreational marijuana, there is a clear need to increase the prevalence and availability of targeted outreach programs in schools.

Proposed Solution:

The Department requests $4,216,324 total funds, including $1,999,674 General Fund in FY 2015-16 and beyond to ensure that the above mentioned objectives in SB 14-215 would continue to be addressed through the Department's BHO contracts.

The BHOs contracts are currently accomplishing these goals by increasing the number of school health professionals in schools they already provide services to while increasing the number of schools which receive substance abuse prevention and intervention services. The FY 2015-16 request is intended to expand the current school-based early intervention and prevention programs to provide targeted prevention and early intervention services to youth who are at risk to develop substance use disorders including disorders related to marijuana (cannabis) use. Consistent with literature on early intervention, structured skills-oriented curricula would be used to increase self-efficacy, drug knowledge, decision-making skill, and peer pressure resistance among high risk youth. Interventions would include three elements: (1) individual consultation for school staff and education or students and school personnel (2) group-based interventions driven by self-referral and referrals by school staff, faculty, parents and other community organizations; and (3) referral and coordination with treatment resources. Services would be provided through a range of facility providers including mental health centers and substance use disorder facilities. In all cases, staff providing these services would be credentialed as prevention specialists or certified addictions counselors. In some cases, existing behavioral health prevention services would be expanded to specifically address cannabis-related disorders. In addition, schools without existing behavioral health counselors would be added.

The Department intends to use longitudinal data from the Colorado Department of Public Health and Environment's Colorado Youth Risk Behavior Survey to perform an analysis on marijuana use impact for schools receiving substance use prevention services from the above mentioned programs.

Anticipated Outcomes:

Research shows that early intervention is an effective and cost-efficient method:

- Studies have indicated that school-based programs are successful reducing marijuana use, especially those that target students at earlier stages (Porath-Waller, Beasley, Beirness, 2010).

- Researchers have estimated that for every dollar invested in school-based early intervention programs there are around $10 in savings (Stephen, 2012).
- A review of 32 separate studies showed that 'skills focused interventions' in schools did decrease drug use among students (Faggiano, Vigna-Taglianti, Versino, Zombon, Borraccino, Lemma, 2005)

According to a 2009 study from the Substance Abuse and Mental Health Services Administration (SAMHSA), if effective prevention programs were implemented nationwide, substance abuse initiation would decline for 1.5 million youth and be delayed for 2 years on average. It has been well established in peer reviewed literature that a delay in onset of substance abuse reduces subsequent problems later in life. SAMHSA estimates that effective school-based programs could save an estimated $18 per $1 invested, and that effective nationwide school-based substance abuse prevention programming would offer State savings within 2 years in health services, education, and juvenile justice.

Assumptions and Calculations:

The Department used its most recent caseload forecast for FY 2015-16 to estimate the per member per month (PMPY) rate and the General Fund breakdown between the two eligible groups receiving youth drug-prevention and intervention services from BHO contracts: Medicaid eligible children and former Child Health Plan Plus (CHP+) children who are eligible under SB 11-008 who receive an enhanced federal medical assistance percentage (FMAP). The information in the table conveys how the continuation funding for the BHO contracts will be used during FY 2015-16.

Table 1.1
Funding Calculation for FY 2015-16

Eligibility	Caseload(1)	Estimated PMPY	Total Funds(2)	General Fund	Federal Funds	FFP Rate
Eligible Children	477,567	*$7.89*	$3,768,004	$1,845,945	$1,922,059	51.01%
SB 11-008 Former CHP+ Children	56,821	*$7.89*	$448,320	$153,729	$294,591	65.71%
Total	**534,388**	***$7.89***	**$4,216,324**	**$1,999,674**	**$2,216,650**	

(1) FY 2015-16 R-1: "Medical Services Premiums" Request, Exhibit B1
(2) Products may not sum due to rounding

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-18

Request Titles

R-18 DDDWeb Stabilization

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	**Total**	**$7,723,551**	**$0**	**$8,800,570**	**$205,260**	**$96,242**
	FTE	-	-	-	-	-
	GF	$3,002,505	$0	$3,567,649	$102,629	$48,121
	CF	$732,305	$0	$737,647	$0	$0
	RF	$0	$0	$0	$0	$0
	FF	$3,988,741	$0	$4,495,274	$102,631	$48,121

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
01. Executive Director's Office - Payments to OIT	**Total**	**$1,571,743**	**$0**	**$3,319,062**	**$0**	**$96,242**
	CF	$4,805	$0	$10,147	$0	$0
	FF	$789,748	$0	$1,659,531	$0	$48,121
	GF	$777,190	$0	$1,649,384	$0	$48,121
01. Executive Director's Office - General Professional Services and Special Projects	**Total**	**$6,151,808**	**$0**	**$5,481,508**	**$205,260**	**$0**
	CF	$727,500	$0	$727,500	$0	$0
	FF	$3,198,993	$0	$2,835,743	$102,631	$0
	GF	$2,225,315	$0	$1,918,265	$102,629	$0

Letternote Text Revision Required?	Yes	No	X	**If Yes, describe the Letternote Text Revision:**
Cash or Federal Fund Name and CORE Fund Number:	FF: Title XIX			
Reappropriated Funds Source, by Department and Line Item Name:	N/A			
Approval by OIT?	Yes	X	No	**Not Required:**
Schedule 13s from Affected Departments:	N/A			
Other Information:	N/A			

Cost and FTE

- FY 2015-16: $205,260 total funds, $102,629 General Fund, and $102,631 federal funds.

Current Program

- DDDWeb, which is the Department's case management system for clients with intellectual and developmental disabilities, must be a secure and stable system in order to ensure the privacy of client health information stored in DDDWeb and the uninterrupted delivery of medical services that rely on an authorization process via DDDWeb

Problem or Opportunity

- DDDWeb is unacceptably insecure and unstable, putting the Department at risk of breaching health information and disrupting delivery of critical client medical services
- DDDWeb is insecure because it requires an ad hoc network connection between the Department and the Department of Human Services (DHS) that is vulnerable to cyber-attacks and relies on software slated to lose manufacturer support due to age within the next year, which will leave the software vulnerable to cyber-attacks
- DDDWeb is unstable because it relies on an outdated physical server architecture that uses old hardware vulnerable to malfunction or failure due to age

Consequences of Problem

- If the insecurity and instability of DDDWeb is not corrected, then DDDWeb will be at an unacceptably high risk of cyber-attack or system malfunction until it is replaced in November 2016 by the Department's new Medicaid Management Information System (MMIS)

Proposed Solution

- The Department proposes to transfer DDDWeb from the DHS network to the Department's network, thereby eliminating the ad hoc network connection between the two Departments; updating DDDWeb's software to more recent software versions that will not imminently lose manufacturer support due to age; and finally, transferring DDDWeb from physical servers to virtual servers, which are a more modern and stable system architecture
- The Department expects these changes to DDDWeb would greatly improve the system's security and stability, helping to ensure that no protected health information is breached from DDDWeb and that client services requiring DDDWeb are not disrupted
- There are ongoing DDDWeb maintenance costs associated with this proposal, but funding is not requested in this proposal for these costs because they will be accounted for in common policy adjustments by the Governor's Office of Information Technology (OIT)

Department Priority: R-18
Request Detail: DDDWeb Stabilization

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
DDDWeb Stabilization	$205,260	$102,629

Problem or Opportunity:

The Department's case management system for clients with intellectual and developmental disabilities, known as DDDWeb, uses outdated hardware and software that increases DDDWeb's risk of security breaches and system malfunction. This is a problem because sensitive health information is stored on DDDWeb that needs to remain secure and delivery of services to clients would be disrupted if the system malfunctions. Additionally, DDDWeb is installed on the Department of Human Services' (DHS) servers instead of the Department's own servers and thus requires an ad hoc network connection between DHS and the Department that is vulnerable to security breaches and requires DHS involvement for administrative tasks such as adding a new user account, slowing down the process. Because DHS staff currently maintain responsibility for the server, the departments must share resources, and therefore the Department cannot prioritize DDDWeb issues or control when and how issues are resolved. As long as these problems are not addressed, there will continue to be a risk of a breach of health information and risk of federal penalties associated with breaches, a risk of disruption in service delivery, and inefficient system administration.

DDDWeb is used to coordinate service delivery for clients with intellectual and developmental disabilities. Community Centered Boards (CCBs) are responsible for entry of client demographic information and service authorization requests into DDDWeb. The service authorizations are mostly system approved when within allowable criteria. Remaining service authorization requests that fall outside the automated criteria are reviewed by Department staff and manually approved or rejected as applicable. Providers may perform authorized services and can update client information in DDDWeb for new authorized services as needed.

DDDWeb is also used by CCBs to document applicant developmental delay and/or developmental disability determination information; to add eligible clients to the waiting list(s) for services requested but not yet available; and to submit critical incident reports when expedited Department review is required for medical reasons.

Although the Department's Division for Intellectual and Development Disabilities (DIDD), previously known as the Division for Developmental Disabilities, was transferred from DHS to the Department in early 2014 by HB 13-1314, DDDWeb remained on DHS servers. At the time of the transition, it was thought that

moving and updating DDDWeb could be avoided since DDDWeb will be replaced by the Department's new Medicaid Management Information System (MMIS) in November 2016. However, since the transfer, it has become clear that the security risks presented by the outdated system components and ad hoc network connection between the Department and DHS are too great to continue operations of DDDWeb as-is until the November 2016 replacement.

Proposed Solution:

The Department requests an increase of $205,260 total funds in FY 2015-16, including $102,629 General Fund and $102,631 federal funds in order to transfer DDDWeb from DHS's servers to the virtual server environment maintained by the Governor's Office of Information Technology (OIT), and to update the application's software to current versions. The Department requests $96,242 in FY 2016-17, including $48,121 in General Fund and $48,121 federal funds for ongoing system maintenance costs. This work would be performed by OIT staff and require approximately six months to complete. Work would begin in July 2015 and be completed by January 2016. There are also annual maintenance costs shown in Table 3 of the attached appendix that would be accounted for in common policy adjustments in future years.

If the proposed solution is not implemented, DDDWeb would be at risk of system failure because hardware becomes prone to failure as it ages. Furthermore, the software that DDDWeb uses: the server operating system, SQL database software, and Business Objects analytics software, are all outdated versions of the software, and as such, are slated to lose support from the manufacturer within the next year. Without manufacturer support, the software would not be regularly patched to prevent security breaches, exposing DDDWeb's sensitive information and the DHS and Department's networks to security threats. System failure would significantly impact service delivery to clients with intellectual and developmental disabilities because medical information could not be submitted by providers and authorized services could not be verified in the system. Intensive manual workarounds would be required to continue service delivery during the downtime and the Department would incur unplanned costs in compensation to OIT and their vendors for repairing DDDWeb. Unscheduled downtime due to hardware failure could cause the system to be offline for weeks because new or used physical parts are often difficult to acquire; vendor inventory is low for antiquated parts and some parts may no longer be produced by the manufacturer.

Additionally, without funding to migrate DDDWeb, DHS would continue to be involved in administering the system, requiring continued use of DHS staff resources to perform administrative tasks in the system. This could result in delays in completion of these tasks due to the need to coordinate across departments and because the Department is not able to prioritize work on DDDWeb.

Anticipated Outcomes:

The proposed solution would increase the stability and security of DDDWeb by moving it onto virtual servers and updating its software. Physical servers such as the ones currently running DDDWeb are being phased out by OIT in favor of more secure and flexible virtual servers. A major benefit of virtual servers is that the length of downtime due to system failure is greatly reduced. The system can be functioning again within hours, instead of days or weeks as with physical servers. Updated software ensures ongoing manufacturer support. The manufacturer would provide updates to protect against security threats or fix defects discovered

in the software after its release. This is critical to protecting private health information contained in the system, and protecting against unplanned system failures and the resulting system downtime.

Additionally, the proposed solution would eliminate the need for DHS involvement in basic administrative tasks like managing user accounts. Currently, when DIDD requires a new user account for DDDWeb, a new DHS network account may also be required, which generates additional work for DHS to set up and maintain. The Department's proposed solution would eliminate the need for these additional accounts because DHS network access would no longer be required to access DDDWeb.

As an alternative to the proposed solution, the Department considered keeping DDDWeb in its current state on DHS's servers until it is replaced by the Department's new MMIS in November 2016. This alternative would require no additional funding unless the system fails, in which case the Department would incur unplanned costs to compensate OIT for making emergency repairs to the system. This alternative would also not address the administrative inefficiency of housing DDDWeb at DHS and the security risks of outdated hardware and software and the ad hoc network connection between the Department and DHS. A major system failure could result in multiple weeks of downtime, during which The Department and providers would be unable to verify what services have been authorized for clients or authorize new services using DDDWeb. This would leave providers unsure if the services they provide will be reimbursed by Medicaid and lead to billing and payment problems. This would also likely disrupt service to clients, many of whom have a critical need for services to be provided without interruption.

The proposed solution would help the Department achieve two goals of the Department's five-year strategy plan. First, the proposed solution would help achieve the goal to "improve health outcomes, client experience, and lower per capita costs" by ensuring that authorized services for clients with intellectual and development disabilities are kept up-to-date and are available when the client needs them. Second, the proposed solution would help achieve the goal to "enhance efficiency and effectiveness through process improvement" by eliminating unnecessary administrative processes with DHS to manage DDDWeb.

Assumptions and Calculations:

Funding for this request is based on estimates from OIT. In the attached appendix, see Table 1 for a summary of this request by line item and Table 2 for a break out of the cost components of this request. Table 3 shows the ongoing costs of the request for informational purposes only; these costs would be accounted for through OIT's annual common policy adjustments. For all components, the Department assumes a federal match rate of 50%.

The 'OIT Staff Resources' components, shown in table 1, rows A through F, are to pay for OIT staff time to move DDDWeb to the virtual environment and update its software components. The 'Space on Virtual Block' component, shown in table 1, row G, is for the hard drive space required to store DDDWeb in the virtual environment. The 'Operating System Update' component, shown in Table 1, row H, is the licensing cost of updated Windows Server operation system software for DDDWeb. The 'SQL Update' component, shown in table 1, row I, is the licensing cost of up-to-date SQL server software required for DDDWeb. Finally, the 'Business Objects Update' component, shown in Table 1, row J, is for both the licensing cost of

up-to-date Business Objects software as well as one-time configuration costs performed by the vendor required to properly integrate the updated software with DDDWeb.

Table 1 - Summary by Line Item				
Line Item	**Total Funds**	**General Fund**	**Federal Funds**	**Source**
(1) Executive Director's Office; (A) General Administration, General Professional Services	$205,260	$102,629	$102,631	See Table 2, Row L
Total	**$205,260**	**$102,629**	**$102,631**	

Table 2 - Components of Proposal (One-time costs)					
Row	**Cost component**	**Total Funds**	**General Fund**	**Federal Funds**	**Federal Match Rate**
	OIT Staff Resources				
A	Network	$2,215	$1,107	$1,108	50%
B	Developer	$22,200	$11,100	$11,100	50%
C	Security Analyst	$2,230	$1,115	$1,115	50%
D	Server Administrator	$5,574	$2,787	$2,787	50%
E	Tester	$8,361	$4,180	$4,181	50%
F	Access Control	$5,800	$2,900	$2,900	50%
G	Database Administrator	$10,880	$5,440	$5,440	50%
	Hardware and Software				
H	Space on Virtual Block	$36,000	$18,000	$18,000	50%
I	Operating System Update	$31,000	$15,500	$15,500	50%
J	SQL Update	$36,000	$18,000	$18,000	50%
K	Business Objects Upgrade	$45,000	$22,500	$22,500	50%
L	**Total**	**$205,260**	**$102,629**	**$102,631**	**50%**

Table 3 - Ongoing Annual Costs (To be accounted for in Common Policy)					
Row	**Cost component**	**Total Funds**	**General Fund**	**Federal Funds**	**Federal Match Rate**
	OIT Staff Resources				
A	Database Administrator	$10,880	$5,440	$5,440	50%
	Hardware and Software				
B	Space on Virtual Block	$36,000	$18,000	$18,000	50%
C	Business Objects	$49,362	$24,681	$24,681	50%
D	**Total**	**$96,242**	**$48,121**	**$48,121**	**50%**

Schedule 13

Funding Request for the FY 2015-16 Budget Cycle

Department of Health Care Policy and Financing

PB Request Number R-19

Request Titles

R-19 Public School Health Services

Dept. Approval By:	Josh Block		Supplemental FY 2014-15
		X	Change Request FY 2015-16
			Base Reduction FY 2015-16
OSPB Approval By:			Budget Amendment FY 2015-16

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
Total of All Line Items	Total	$54,353,956	$0	$54,353,956	$5,476,888	$9,443,673
	FTE	-	-	-	-	-
	GF	$0	$0	$0	$0	$0
	CF	$26,919,482	$0	$26,833,650	$2,683,127	$4,626,455
	RF	$0	$0	$0	$0	$0
	FF	$27,434,474	$0	$27,520,306	$2,793,761	$4,817,218

Line Item Information	Fund	FY 2014-15 Appropriation	FY 2014-15 Request	FY 2015-16 Base Request	FY 2015-16	FY 2016-17 Continuation
06. Other Medical Services - Public School Health Services	Total	$54,353,956	$0	$54,353,956	$5,476,888	$9,443,673
	CF	$26,919,482	$0	$26,833,650	$2,683,127	$4,626,455
	FF	$27,434,474	$0	$27,520,306	$2,793,761	$4,817,218

Letternote Text Revision Required?	Yes	No X	If Yes, describe the Letternote Text Revision:	
Cash or Federal Fund Name and CORE Fund Number:	CF: Certified Public Expenditures; FF: Title XIX			
Reappropriated Funds Source, by Department and Line Item Name:	N/A			
Approval by OIT?	Yes	No	Not Required:	X
Schedule 13s from Affected Departments:	N/A			
Other Information:	N/A			

Cost and FTE

- FY 2015-16: $5,476,888 total funds, including $2,683,127 cash funds and $2,793,761 federal funds, and 0.0 FTE; and
- FY 2016-17: $9,443,673 total funds, including $4,626,455 cash funds and $4,817,218 federal funds, and 0.0 FTE.
- The increase in funds will allow the Department draw down federal matching funds for allowable expenditures that will be used to fund the unmet health needs for all students served by participating providers of the Public School Health Services Program.

Current Program

- The Public School Health Services (SHS) Program allows public schools, Boards of Cooperative Education Services (BOCES), or state educational institutions that serve students in kindergarten through twelfth grade (hereafter referred to as "providers") to access federal Medicaid funds for health services delivered to eligible clients.
- SHS providers are required to use the federal funding received through this program to offset costs incurred for the provision of student health services or to fund other student health services. The funding generated through this program can be used to fund the unmet health needs for all students served by participating providers, as identified in the providers' Local Service Plans. Additionally, providers have been able to address some of the health care needs unique to their local communities.

Problem or Opportunity

- As the overall population Medicaid eligible children increases, the Department anticipates a corresponding increases in caseload and certified public expenditures (CPE) in the Public School Health Services program. These CPE are eligible for federal Medicaid matching funds.
- Growth in expenditures is anticipated due to the overall growth in the number of Medicaid eligible children statewide resulting from expansion under the Affordable Care Act, the Department's "continuous eligibility" policy, along with outreach and enrollment assistance by both the Department and participating providers.

Consequences of Problem

- Without sufficient spending authority, reimbursement to program participants will be delayed until supplemental funding is approved or over-expenditure authority is granted.
- Delays in reimbursement may discourage provider participation in the program, resulting in fewer health services to students.

Proposed Solution

- This increase in funds would allow SHS providers to certify their Medicaid allowable costs as certified public expenditures and receive federal matching funds allowed under the Department's federally-approved reimbursement methodology.
- SHS providers would use the funds to support local school health services, increase access to primary and preventive care programs to low-income, under or uninsured children, and improve the coordination of care between schools and health care providers.

Department Priority: R-19
Request Detail: Public School Health Services Funding Adjustment

Summary of Incremental Funding Change for FY 2015-16	Total Funds	General Fund
Public School Health Services	$5,476,888	$0

Problem or Opportunity:

As the overall population Medicaid eligible children increases, the Department anticipates a corresponding increases in caseload and allowable expenditures in the Public School Health Services (SHS) program. The State share of this reimbursement comes from certification of public expenditure (CPE) by qualified providers; no other State funds are required. Without sufficient spending authority, reimbursement to program participants will be delayed until supplemental funding is approved or over-expenditure authority is granted. Delays in reimbursement may discourage provider participation in the program, resulting in fewer health services to children.

The School Health Services Program, section 25.5-5-318, C.R.S. (2014), allows public schools, Boards of Cooperative Education Services (BOCES), or state educational institution that serves students in kindergarten through twelfth grade (hereafter referred to as "providers") to access federal Medicaid funds for health services delivered to eligible clients.

To be eligible for SHS Program benefits, the client must meet all of the following criteria:

- Be enrolled in Medicaid;
- Be enrolled in a public school or a participating district or BOCES;
- Be under 21 years of age;
- Have a disability or be considered medically at risk; and
- Be referred for school health services according to an Individual Education Program **(**IEP**)** or Individualized Family Services Plan (IFSP).

Requirements of program participation by a provider are:

- Have a Local Services Plan (LSP) approved by the Colorado Department of Education (CDE);
- Have a contract with the Department;
- Enroll as a Medicaid provider in the Medical Assistance Program;

- Participate in the Random Moment Time Study (RMTS); and
- File appropriate financial and statistical reports on a quarterly and annual basis.

The SHS program provides health services as required in a child's IEP or the IFSP. The IEP and IFSP, required documents under the Individuals with Disabilities Education Act (IDEA), spell out the specific special education and related services, including health services, to be provided to meet the student's needs. Providers can receive reimbursement from Medicaid for health services that are medically necessary to Medicaid eligible clients as prescribed in the child's IEP or IFSP. Covered services may include direct medical services, including rehabilitative therapies, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, Targeted Case Management and Specialized Non-Emergency Transportation services.

Growth in expenditures is anticipated due to the overall growth in the number of Medicaid eligible children statewide.

Growth in the number of Medicaid eligible students can be attributed to:

- More adults are eligible for and enrolled in Medicaid expansion programs under provisions of the Affordable Care Act. Eligibility for available public benefits is being determined, not only for these adults, but also for their children, and therefore more eligible children are being enrolled in Medicaid programs.
- The Department implemented continuous eligibility for children, effective March 2, 2014, providing continuity of care by granting 12 months of continuous eligibility regardless of changes in income and household size. These children would otherwise have been disenrolled from the Medicaid program.
- Outreach and enrollment assistance by the Department and by providers to assist uninsured families' access public benefits, including Medicaid.

The SHS program expenditures are anticipated to increase because the number of students who are Medicaid eligible and on an IEP or IFSP is increasing. The increase to this line item is needed to provide the Department necessary spending authority to reimburse the federal share of certified public expenditures to program participants without delay. These funds can then be used for other unmet health care needs for all students served by the provider.

Proposed Solution:

The Department requests $5,476,888 total funds in FY 2015-16, including $2,683,127 cash funds and $2,793,761 federal funds, and $9,443,673 in FY 2016-17, including $4,626,455 cash funds and $4,817,218federal funds, to draw down federal matching funds to be used to provide reimbursement to participating SHS providers for students' health needs. Cash funds are certified as expenditures incurred by school districts that are eligible for federal financial participation under Medicaid and do not impact any State cash fund. This request has no General Fund impact.

The increase would allow SHS providers to certify their Medicaid allowable costs as certified public expenditures and receive additional federal matching funds allowed under the Department's federally-approved reimbursement methodology.

Anticipated Outcomes:

The SHS Program uses Medicaid funds received to support local school health services, increase access to primary and preventive care programs to low-income, under or uninsured children, and improve the coordination of care between schools and health care providers. SHS providers are required to use the federal funding received through this program to offset costs incurred for the provision of student health services by the provider or to fund other student health services. The funding generated through this program can be used to fund the participating providers cost of serving their students' health needs, as identified in the providers' Local Service Plans. Providers have been able to address some of the health care needs unique to their local communities.

Types of services that can be funded include, but are not limited to:

- Enhanced clinic aid or nurse services;
- Dental, vision and pharmacy vouchers to uninsured or under-insured students;
- Outreach and enrollment assistance to medical assistance benefits to uninsured families;
- Health supplies and equipment; and
- Enhanced physical or mental health services.

This request would assist the Department in meeting its performance measures related to increasing access to health care. By allowing the Department to reimburse participants for incurred Medicaid costs on a timely basis, the approval of this request would ensure that the SHS program can retain current participants and potentially attract new providers, thus increasing provider participation and access to health care for children.

Assumptions and Calculations:

Detailed calculations for this request are provided in the attached appendix.

The SHS program is a cost based program based on certified public expenditures rather than a fee-for-service based program. As a result, the Department does not reimburse SHS providers based on the specific services they provide; rather, the Department provides reimbursement based on provider costs, adjusted by random moment time sampling and the fraction of qualifying clients. The Department's predicted cost increases are conservative to obtain sufficient spending authority as to avoid overexpenditure in the program.

Table 1 shows a summary of the total requested funds and fund splits. The federal medical assistance percentage (FMAP) used for the calculations of federal funds is 51.01%. Table 2 shows the calculations to determine the incremental request.

SHS qualifying children are the Medicaid eligible children in special education programs with participating providers with an IEP or IFSP. The Department anticipates that the number of SHS qualifying children will grow proportionately to the percentage of growth projected for all Medicaid eligible children. Table 3 uses

the predicated growth rate of qualifying children to calculate predicted expenditures in the request years. Table 4 projects the number of qualifying children based on predicted Medicaid eligible children caseload.

The Department assumes that growth in Medicaid caseload will be the driving factor in expenditure program over the next several years. In table 4, the Department compares prior year Medicaid caseload to the number SHS qualifying children; the actual growth rates between the total Medicaid eligible children and the SHS qualifying children are comparable. In FY 2012-13, the percentage increase in payments was similar to the percentage increase in caseload; the Department experienced a 16.6% increase in payments compared to a 13.1% increase in caseload. However, in FY 2013-14, payments declined slightly despite caseload growing by 14.7%. The Department believes that this payment decline was a one-time event, and that the relationship between payments and qualifying children will resume in the current year and the request years.

Table 1
Summary by Fiscal Year and Line Item

Row	Line Item	Total Funds	Cash Funds	Federal Funds	FMAP	Source
	FY 2015-16					
A	(6) Other Medical Services; Public School Health Services	$5,476,888	$2,683,127	$2,793,761	51.01%	Table 2, Row C
	FY 2016-17					
B	(6) Other Medical Services; Public School Health Services	$9,443,673	$4,626,455	$4,817,218	51.01%	Table 2, Row C

Table 2 - Public School Health Services Provider Payments Request				
Row	**Item**	**FY 2015-16**	**FY 2016-17**	**Source**
A	Provider Payments Forecast	$59,830,844	$63,797,629	Table 3, Row D
B	FY 2015-16 Base Request	$54,353,956	$54,353,956	Long Bill Appropriation (HB 14-1336)
C	**Request**	**$5,476,888**	**$9,443,673**	**Row A - Row B**

Table 3
Expenditure Forecast

Row	Item	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	Source
A	Qualifying Children	34,214	40,181	43,082	45,938	Table 4, 'School Health Services Qualifying Children'
B	Growth Rate		17.44%	7.22%	6.63%	Table 4, 'School Health Services Qualifying Children'
C	Base Expenditure		$47,515,279	$55,801,944	$59,830,844	FY 2013-14: Actual Expenditure FY 2014-15 - FY 2016-17: Row D
D	**Predicted Expenditure**	**$47,515,279**	**$55,801,944**	**$59,830,844**	**$63,797,629**	**Row C * (1 + Row B)**

Table 4
Forecasted Caseload Growth

Row	Year	Average Monthly Eligible Children Caseload[1]	Growth Rate	School Health Services Qualifying Children	Growth Rate	Source
A	FY 2011-12 Actual	334,633		26,372		Qualfiying Children from reported actuals
B	FY 2012-13 Actual	368,079	9.99%	29,821	13.08%	Qualfiying Children from reported actuals
C	FY 2013-14 Actual	424,377	15.30%	34,214	14.73%	Qualfiying Children from reported actuals
D	FY 2014-15 Predicted	498,404	17.44%	40,181	17.44%	Qualifying Children calculated as: Row C * (1 + Row D Growth Rate)
E	FY 2015-16 Predicted	534,388	7.22%	43,082	7.22%	Qualifying Children calculated as: Row D * (1 + Row E Growth Rate)
F	FY 2016-17 Predicted	569,812	6.63%	45,938	6.63%	Qualifying Children calculated as: Row E * (1 + Row F Growth Rate)

(1) Caseload data for FY 2014-15 through FY 2016-17 from the Department's November 1, 2014 R-1 request, and includes both the 'Eligible Children' and 'SB 11-008' categories